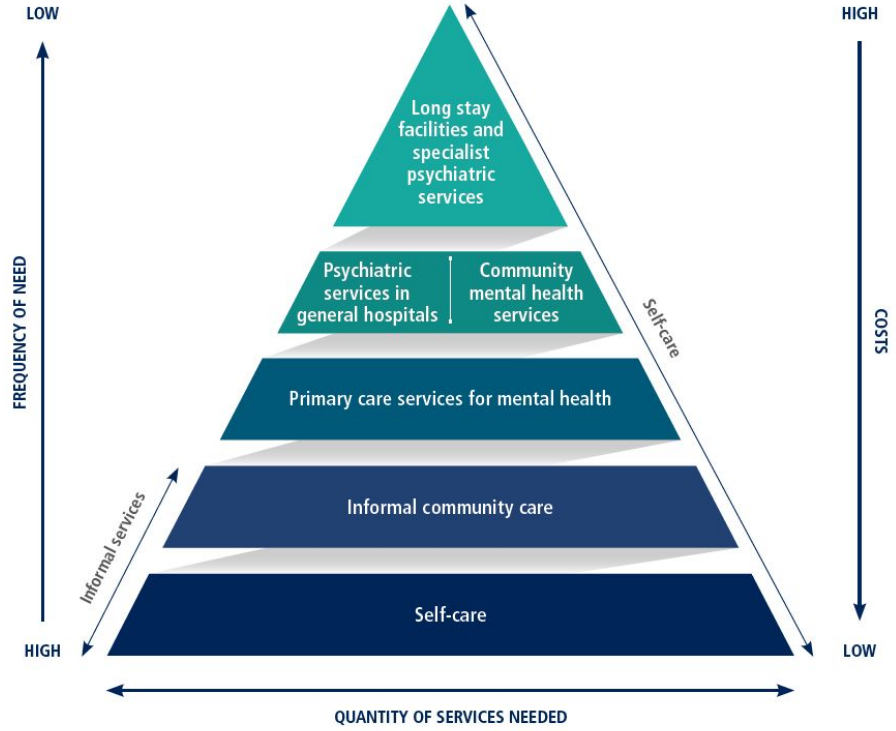
Figure 2. **WHO service organization pyramid for an optimal mix of services for mental health**

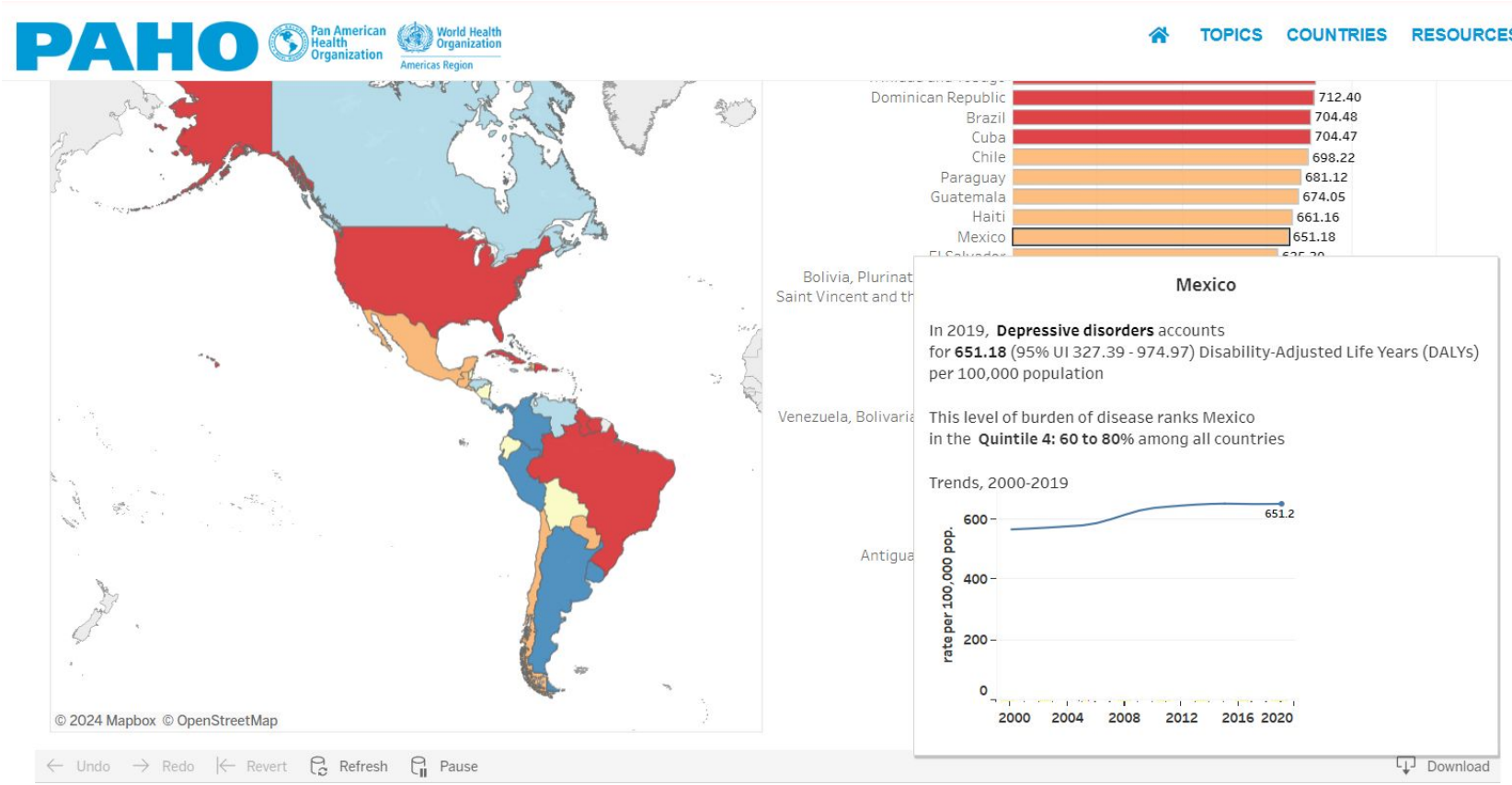


Source: *Integrating mental health into primary care: a global perspective.*

Brief Interventions to selective and indicative prevention in mental health and addictions

Silvia Morales Chaine

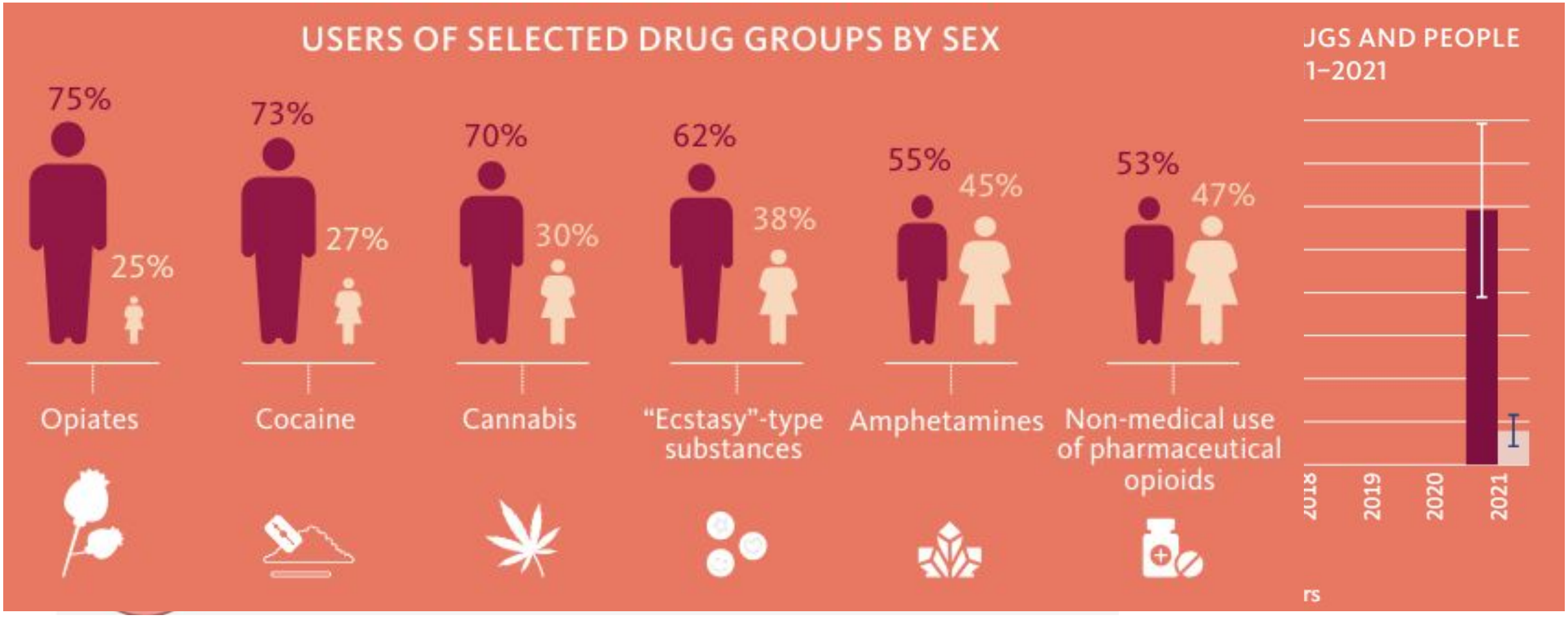
Antecedents



An increase in **drug use and mental health** problems has been reported in low- and middle-income countries

(Pan American Health Organization [PAHO], 2020; 2021)

Antecedents



(United Nations Office on Drugs and Crime [UNODC], 2022)

Antecedents

In México,

18.93% of Mexican youths suffered from harm **Alcohol or Drug** (AOD) use,

44.46% from **depression**,

47.90% from **anxiety**,

and 29.47% from **post-traumatic stress** symptoms

(Morales-Chaine et al., 2023),

33.30% from for at least one Suicide Thoughts Behaviors (**STB**),

38.30% from **chronic pain – emotional** symptoms,

and 4.20% from **thoughts-plans-acts of self-harm** during the COVID-19 pandemic

(Morales-Chaine et al., 2024)

SCAN ME

SCAN ME

Antecedents

The **intervention gap** is still wide in Mexico.

Number of treatments provided, by drug class

Region	Country/Territory	Drug class	Drug	Source	2017	2018	2019	2020	2021
Americas	Mexico	Amphetamine-type stimulants	Amphetamines (amphetamine/methamphetamine)	ARQ					0
			Amphetamine-type stimulants	ARQ	23542	34821	71202	30522	62678
			Methamphetamine	ARQ		33714	69369	29680	60054
			Non-medical use of pharmaceutical products containing amphetamine-type stimulants	ARQ				93	182
			Other amphetamine-type stimulants	ARQ		24			16
		Any drug	Any drug	ARQ	77681	92458	121228	71949	96772
		Cannabis-type drugs	Cannabis herb (marijuana)	ARQ				16267	15952
			Cannabis or hashish oil	ARQ					0
			Cannabis resin (hashish)	ARQ				18	5
			Cannabis-type drugs	ARQ	33098	29231	29990	16285	15961
			Other types of cannabis products excluding synthetic cannabinoids	ARQ					4

(United Nations Office on Drugs and Crime [UNODC], 2022)

(Morales et al., 2019)

SCAN ME

Entidad Federativa en México	Número de habitantes	Profesionales de la salud por cada 100 mil habitantes	
		(n=2,441)	(n=1,304)
Aguascalientes	1,312,544	3.43	2.13
Baja California	3,315,766	5.61	2.68
Baja California Sur	712,029	5.9	4.21
Campeche	899,931	4.44	2.56
Chiapas	5,217,908	1.69	1.17
Chihuahua	3,556,574	2.64	1.57
Coahuila	2,954,915	1.79	1.46
Colima	711,235	5.76	2.53
CDMX	8,918,653	1.38	0.76
Durango	1,754,754	2.34	1.08
Estado de México	16,187,608	1.2	0.85
Guanajuato	5,853,677	1.78	1.32
Guerrero	3,533,251	2.66	1.81
Hidalgo	2,858,359	2.66	0.87
Jalisco	7,844,830	1.96	1.26
Michoacán de Ocampo	4,584,471	0.65	0.33
Morelos	1,903,811	2.57	1.58
Nayarit	1,181,050	3.89	1.95
Nuevo León	5,119,504	2.38	1.82
Oaxaca	3,967,889	1.84	1.41
Puebla	6,168,883	1.18	0.57
Querétaro	2,038,372	2.35	0.74
Quintana Roo	1,501,562	3.33	0.67
San Luis Potosí	2,717,820	1.88	0.63
Sinaloa	2,966,321	1.21	0.4
Sonora	2,850,330	1.93	0.53
Tabasco	2,395,272	2.67	1.09
Tamaulipas	3,441,698	3.2	0.87
Tlaxcala	1,272,847	3.38	1.02
Veracruz	8,112,505	1.49	0.47
Yucatán	2,097,175	2.34	0.95
Zacatecas	1,579,209	2.85	1.14
Total	119,530,753	2.04	1.09

Goal

This study describes the evidence-based brief intervention implemented to face AOD use, and mental health risks during COVID-19 in Mexico.

We evaluated mental health risks and drivers of change, set behavioral **goals**, collaborated on developing **action plans**, and followed up on **achieving these life goals**.

We quickly intervened and economically explored behavior changes, helping to address mental and physical health risks.

We adhered to **observable phenomena** and **pragmatic conditions**, focusing on the **repetitive behavioral sequences** that promote mental health (mhGAP, 2016; 2023).

Method

PAHO recommended **informal actions** in the community (mhGAP, 2019) and **primary care** (mhGAP, 2016; 2023) **to close the gap** in mental health and substance use disorders.

We programmed **algorithms** into the action program's clinical handbook to reduce the primary healthcare gap.

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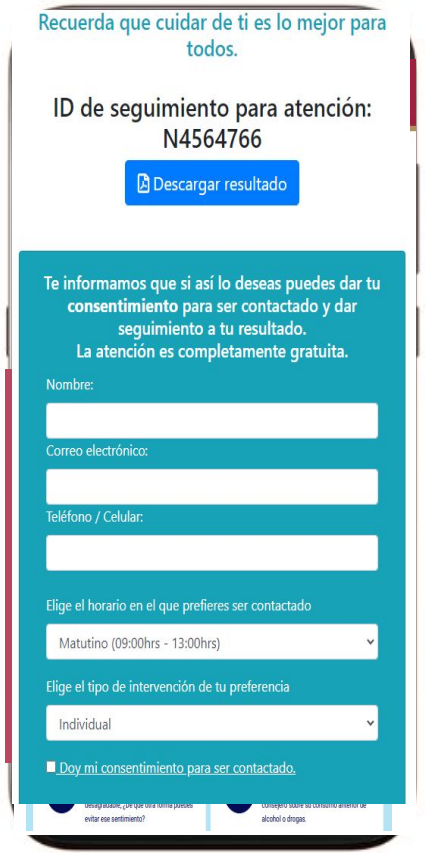
SCAN ME

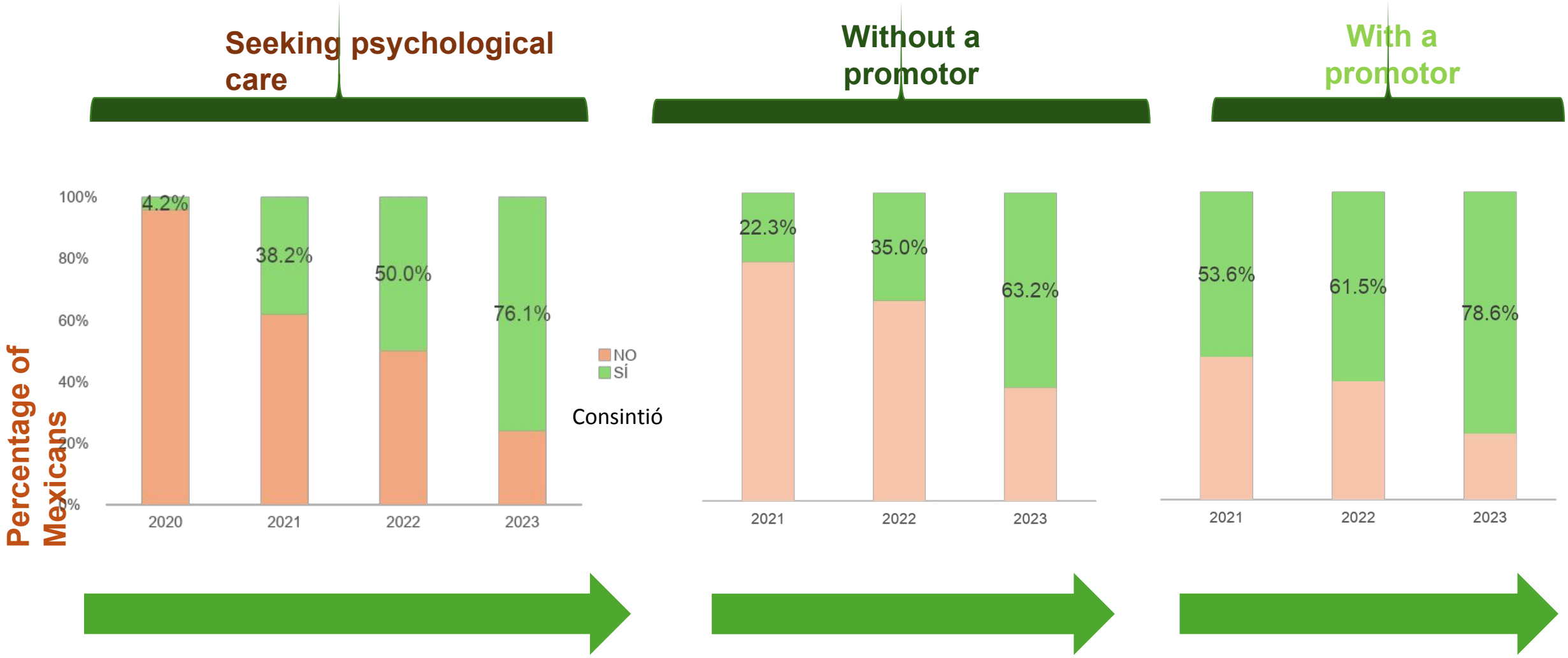


Algorithms (p.ej., ASSIST), Feedback - Triage (e.g., Self-harm/suicide: encryption).

Psychoeducation, modeling (e. e., self-care, relaxation), and skills teaching by Moodle and Apps (e.g., Parent training).

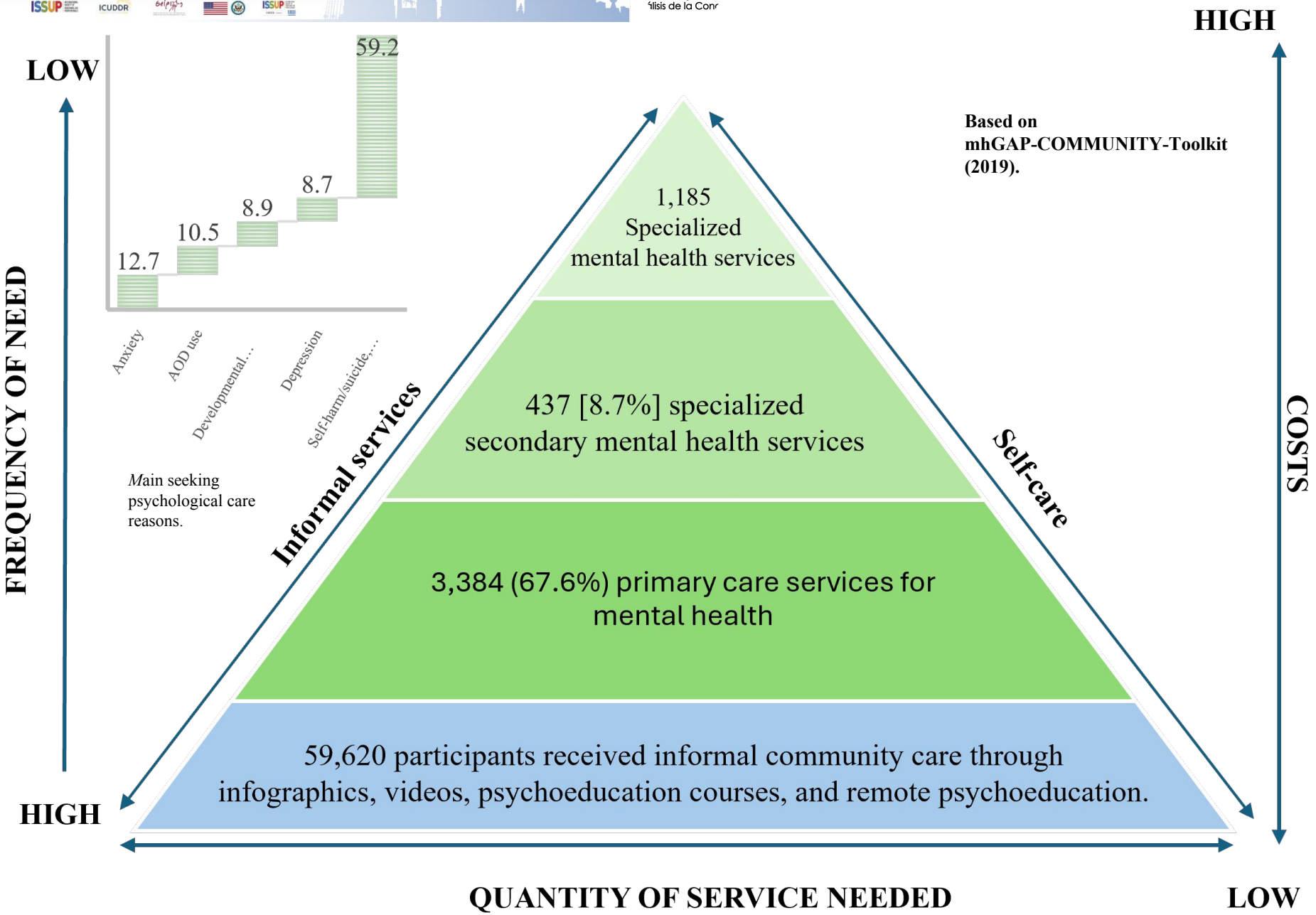
It is based on consent to use the data for epidemiological issues and to accept psychological care: primary level

Results

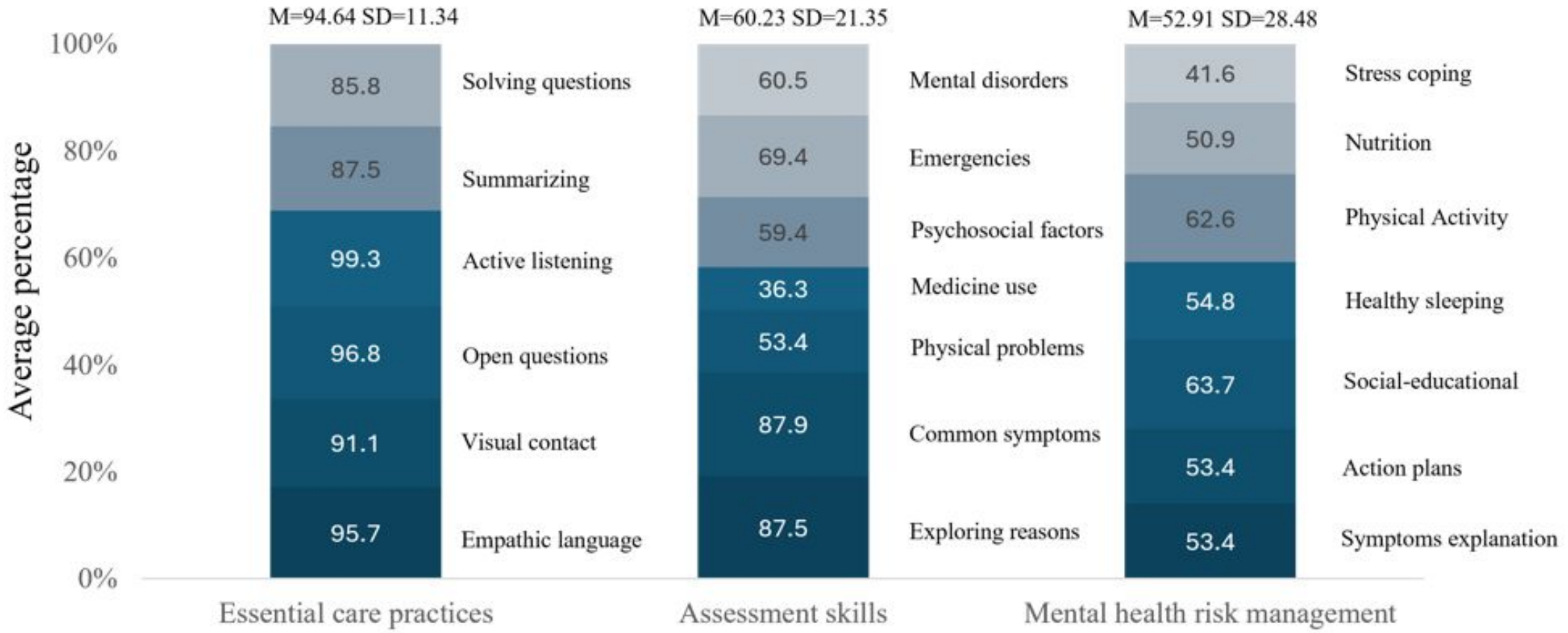


We found a reduced gap in remote psychological services over the years.

Results


HIGH
LOW
59.2
8.7
8.9
10.5
12.7
Anxiety
AOD use
Developmental…
Depression
Self-harm/suicide…
Main seeking psychological care reasons.
Based on mhGAP-COMMUNITY-Toolkit (2019).
1,185 Specialized mental health services
437 [8.7%] specialized secondary mental health services
3,384 (67.6%) primary care services for mental health
59,620 participants received informal community care through infographics, videos, psychoeducation courses, and remote psychoeducation.
Informal services
Self-care
FREQUENCY OF NEED
COSTS
HIGH
QUANTITY OF SERVICE NEEDED
LOW

Results

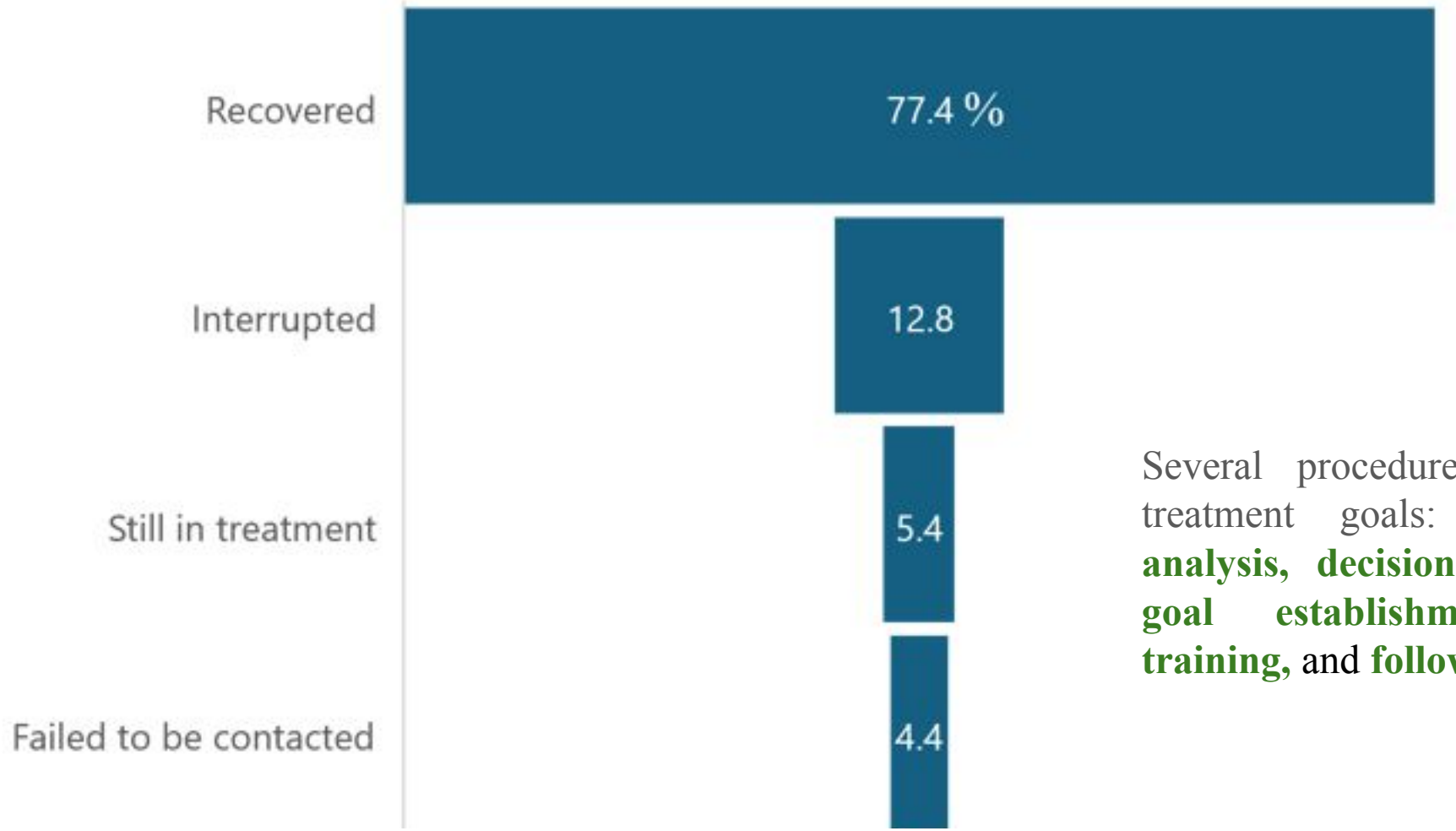


Brief-intervention **implementation** - analysis of **7,420** behaviors among participants: 2,032 behaviors on essential care, 2,938 on assessment, and 2,450 on management.

Results

We established **operational goals** and **intervention plans** with the beneficiaries' **participation**

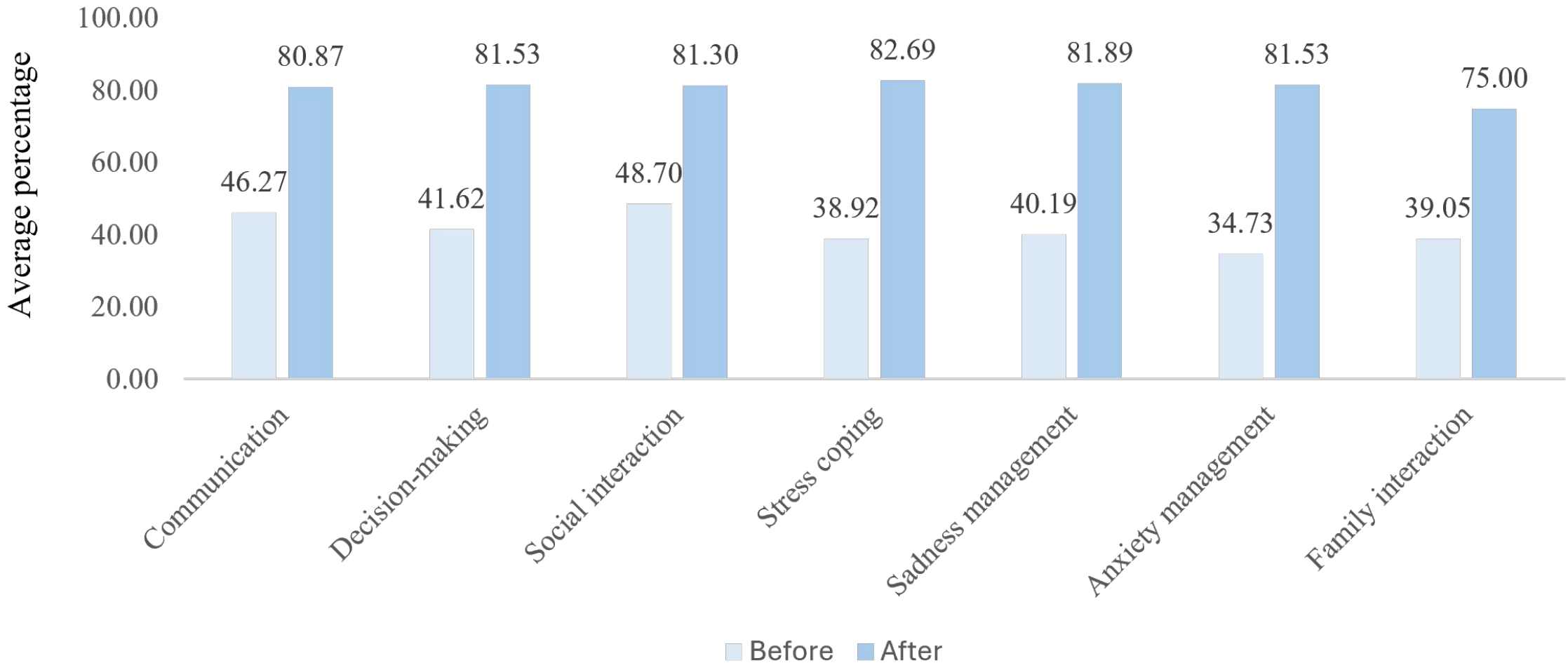
They´ve **designed** the elements for **well-being recovery**.



Several procedures impacted treatment goals: **functional analysis, decisional balance, goal establishment, skill training,** and **follow-up**.

Brief interventions **based on scientific evidence** helped to reduce risk from AOD use and mental health conditions at the community level.

Results


Average percentage
100.00
80.00
60.00
40.00
20.00
0.00
46.27
80.87
41.62
81.53
48.70
81.30
38.92
82.69
40.19
81.89
34.73
81.53
39.05
75.00
Communication
Decision-making
Social interaction
Stress coping
Sadness management
Anxiety management
Family interaction
Before
After

Conclusions

Mexican **skills** to cope with mental health and drug use damages **increased** at the end of the intervention.

77.4% of participants **accomplished their goals** and were successfully discharged from treatment. It means that **almost 8 out of 10 beneficiaries** interrupted their **mental health or AOD use**.

Despite this, we must solve intervention **barriers** with approximately **two out of 10** Mexicans in our program.

Concerning satisfaction, **100**% of those who completed the intervention reported that the service received was **helpful**.

93.7% said it helped them **deal with their problems** better and were **very satisfied** with the **selective and indicative brief intervention**.

Conclusions

We have described the **optimal mix of services** for mental health – **100**% received informal community care tools, **67.6%** formal first-level care, **8.7%** secondary care services, and **23.7%** specialized third-level care (mhGAP, 2019).

12.7% of participants accepted treatment because they suffered from **anxiety**, **10.5%** from **AOD** use, **8.9%** from **developmental** disorders, **8.7%** from **depression**, and **59.2%** from **other** conditions such as **self-harm/suicide, violence, stress, or family problems**.

We **evaluated behavior implementation** of **essential care practices** (94.64%), **assessment** (60.23%), and **management** skills of mental health and drug use conditions (52.91%; mhGAP, 2016; 2023).

Brief intervention has involved **goal** setting to change behavioral patterns, action-support **plans**, and life **skills** to cope with the severity of mental health symptoms and AOD use (Félix et al., 2018; Palafox et al., 2017; mhGAP 2016; 2023).

Conclusions

The **Functional analysis**, **decisional balance**, **goal establishment**, **skill training**, and **follow-up** resulted in 8 out of 10 participants successfully discharged from the brief scientific-based intervention, indicating high satisfaction with the quality of the services.

The Information Technology System (**ITS**) **helped to reduce the care gap** for remote psychological services by addressing participant mental health by risk level.

The program enabled **early detection of risk** in the Mexican community and **interrupted** the progression toward severity.

The **algorithms** made it easier to early detect and **discriminate** cases requiring specialized brief evidence-based intervention from those who just may require psychoeducation and community intervention alone.

Public policies should consider planning cost-effective, **preventive interventions** to address **harmful AOD use and improve mental health** as a **reduction gap strategy** at the community.


#TelevisaTeAcompaña
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