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Mental Health Services in Mexico*

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The history of mental health services in Mexico is traced from the time of the Spanish conquest to modern times. The present structure of mental health services is outlined as it relates to the overall social services and health care system in Mexico. Inpatient, aftercare, partial hospitalization, and outpatient service are outlined and described. Levels of service and distribution of facilities and staff by region are given. Methods of intervention are described from traditional healers, to highly specialized modern psychiatry, to innovative community self-management programs. Key issues in the future are financial resources, distribution of services and staff, and ways to optimally use human resources.

Mexico had a population of over 79 million people in 1986. While the birth rate has declined from 44/1000 in 1970 to 27.3 in 1986 the population is still very young. Thirty-nine percent of the population is under the age of 15. The social class distribution is 55% in the subproletariat, which includes peasants and poor people in urban centers, 25% in the proletarian class, 18% in the middle class, and 2% in the privileged class (Lenero, 1982).

Epidemiological studies reveal that the incidence and prevalence of psychiatric illnesses do not differ substantially from those in other countries. Ten out of every 1000 people suffer some kind of psychosis and 12 out of 1000 are afflicted with some type of mental retardation (Calderón & Cabildo, 1970). The population in hospitals is composed of those suffering from developmental disorders, cerebral damage early or

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late in life, and psychotic disorders, primarily schizophrenia. The outpatient population consists of several types of neuroses and somatoform disorders (De La Fuente, 1989). The incidence of epilepsy is 18/1000. The more prevalent childhood pathological conditions are: attention deficit disorders with hyperactivity, developmental and conduct disorders (Escotto, 1983; Zimmerman, Baez, & Vargas, 1981b).

Substance abuse has been on the increase in Mexico. The rate of alcohol consumption in the population over 15 years old, expressed in terms of pure ethanol, increased from 4.7 liters per person per year in 1974 to 5.4 liters in 1984 (Soberón, Kumate & Laguna, 1989a). A recent survey showed that 4.3% of the population, between 12 and 65 years of age consumed one or more drugs and that active consumers make up 0.8% of the population. The highest percentage of active drug users was found in young males between the ages of 12 and 34. In this age group 7.9% have used drugs at least once and 1.7% are active users. Specific drugs dependency percentages in the population at large are: Marihuana 2.5%, tranquilizers 1.71% solvents 0.65%, cocaine 0.28%, and heroin 0.09% (Medina-More, Tapia & Sepúlveda, 1989).

Mexico has had epidemiological patterns similar to those identified with developing countries, but in recent years those patterns prevalent in developed nations are also occurring. Mexico had a death rate in 1983 of 554/100,000 inhabitants. It has significant environmental health problems ranging from the lack of proper sewage disposal to pollution by toxic waste. The national and international economic crisis of recent years has worsened adding to the stress on individuals, families, and the health care system. For example between the years of 1981 and 1986 the purchasing power of minimum wages dropped 37% (Anuario Estadístico, 1986).

Mexico, as most of the world, is faced with difficult challenges and situation creating a high level of stress contributing to the appearance of dysfunctional behaviors such as anxiety disorders, depression, and psychological factors affecting the physical condition. These stressors may be as concrete as malnutrition, famine, drought, or high rates of mortality, and social factors such as crowding, lack of education, unemployment,

underemployment, and migration from rural areas to urban areas. These conditions foster aggressiveness, alcoholism, delinquency, drug addition, and prostitution. All of these factors affect the social and functional unity of the family.

History of Mental Health Services in Mexico

The prehispanic cultures of Mexico considered that certain phenomena, which today we classify as psychopathology, were caused by divine influences. Treatment services were therefore focused on calming down the ire of the Gods. Special priests intervened with religious procedures to re-establish lost equilibrium (Somolinos 1976). Descriptions of pre-Columbian medical practices can be found in the following documents from the sixteenth century: *Codice Badiano* (De La Cruz, 1964), *Historia General de las Cosas de la Nueva Espana* (Sahagún, 1569–1582) and the *Codice Mendoza* (1938). Additional sources are to be found in the works of protomedic Francisco Hernández (1946) and Morley (1961), where we find a description of psychopathology in the Mayan culture. In the works of Lopez-Austin (1971) and Martinez Cortes (1965) descriptions of psychopathology in the Nahuatl culture can be found.

Shortly after the Spanish conquest in 1566, the first psychiatric hospital of America was established. The friars of the Hipolito Order were entrusted with the care of older and mentally afflicted people. In 1602 the Juaninos Order took on the responsibility of caring for the destitute, many of whom were mentally ill. The Hospital of San Hipolito and another founded by Jose Sayago in 1690 dedicated to the care of demented women, remained active until 1910 when they were replaced by the "Manicomio General De La Castaneda (Insane Asylum of the "Castenneda"). This new hospital was built with all the latest technology available at that time, with a capacity of 1000. The facility soon became filled beyond capacity, however, and in the later part of its existence services deteriorated as it served over 3000 patients. Several other provincial psychiatric hospitals had been started in the 1800s as well as a few general hospitals with psychiatric units (Calderón, 1970).

In 1946 a psychiatric division of the Mexican Institute of Social Security (IMSS) was established. This period saw the

introduction of many new ideas. For the first time psychoanalytic teachings became important for many psychiatrists. Other developments included a rural hospital in 1944 with agricultural activities for the rehabilitation of the mentally ill and occupational and recreational therapy. In 1948 the first private general hospital (Hospita Espanol) began to offer psychiatric services and in 1954 the Universidad Iberoamericana established the first center for psychological service for a university community. This center became part of a training program for licensed psychologists teaching the methods of Carl Rogers (Lartigue, 1976). In 1955 the Faculty of Medicine of the National University of Mexico organized a Department of Medical Psychology, Psychiatry and Mental Health which provided services to students (De La Fuente, Díaz & Fouilloux, 1987).

Other developments of this period include the creation of the National System for the Family's Integral Development (DIF) in 1977, which grew out of the early Institute for the Protection of Infants, which had been founded in 1961. This period also saw the opening of 12 regional psychiatric hospitals and the closing of the deteriorated "Castenada" facility in 1965 (Calderón, 1970).

Present Structure of Mental Health Services

The right to receive mental health services was raised to the institutional level in 1983 as an amendment to Article IV of the Constitution. The resulting General Health Protection Law (1984) created a national health care system designed to harmonize programs developed at the federal level with those developed by the states. Out of this initiative the Department of Public Health (Secretaria de Salud, SSA) developed a national health program which included thirteen top national priorities. The seven related to mental health are: medical attention, environmental health, social assistance, general health education, infant-maternal care, and programs against addiction. The importance and complexity of the alcoholism and addiction problems were considered so great that a National Council Against Alcoholism and a National Council Against Addiction were created (Soberón Kumate & Laguna, 1989a).

Overview of Mental Health Services

Mental health services are classified under three important headings in Mexico: (a) medical attention, (b) social assistance, and (c) social solidarity. Social solidarity refers to programs of joint responsibility, involving the people in marginal communities without health care services who work together with the government in order to generate needed services. The most important institutions providing medical services are: a special program of the Secretariat of Health and Public Assistance (SSA), a division of the Mexican Institute of Social Security (IMSS), the Institute of Social Security for State Employees (ISSSTE), The Federal District Department's medical services (DDF), the Army, the Navy, the Mexican Petroleum Corporation (PEMEX), and the Collective Transportation System. Social Assistance is carried out by a department of the Integral System for Family Development (DIF), the National Institute for Senior Citizens (INSEN), and the Juvenile Integration Centers (CIJ). Social solidarity services are provided through the IMSS-COPLAMAR program (Coordination for the Marginal Groups Plan).

The IMSS has a general plan for the provision of psychiatric and mental health services.

- (a) Preventive psychiatry. This consists of public health promotion services whose primary goals are to foster the self-help abilities of individuals, families and communities. Education materials are designed to provide information on the prevention of mental illness and knowledge about when professional services are needed and where they might receive mental health services.
- (b) Primary psychiatric treatment. This service is largely provided by family doctors properly qualified for this purpose. They diagnose and treat mild and moderate cases. In general family medicine clinics or in outpatient clinics of general hospitals, referrals are made to special psychiatric services when required.
- (c) Medical psychiatric referral network. This service connects psychiatric patients who have other illnesses to the specific medical services required and vice versa.

- (d) Short term psychiatric hospitalizations. This service is focused on remedial and rehabilitation interventions and is intended for patients who need only temporary hospitalization.
- (e) Services to the chronically mentally ill. This service cares for patients who require long-term hospitalization or custodial care. Special attention is given to after-care and prevention services and includes day, night and weekend partial hospitalization facilities, as well as preventive services to support the family and optimal use of community resources (Soberón, Kumate, & Laguna, 1989c)

Psychiatric Hospitals

The World Health Organization has recommended a minimum of one psychiatric bed for each 10,000 inhabitants. In 1980, the Federal District and neighboring states' ratio was, one bed for every 5,453 inhabitants and in 1986 one bed for every 8,881 inhabitants. During the same period, the country's southeast had one bed for every 20,876 inhabitants, and the Zacatecas, San Luis Potosi, and Aguascalientes had one bed for every 55,315 residents (Soberón, Kumate, & Laguna, 1989b). Under the SSA there are now 17 registered psychiatric hospitals in Mexico; three in the Federal District of Mexico City, five in the State of Mexico, and one each in the following states: Durango, Guanajuato, Hidalgo, Michoacan, Nuevo Leon, Oaxaca, Puebla, Sonora and Tabasco (Anuario Estadístico, 1986).

The Valley of Mexico (the Federal District and State of Mexico) contains almost half of the psychiatric hospitals under the Department of Health (SSA) and 63.1% of the psychiatric beds of the entire country (see Table 1). It also has 70.6% of the doctors and 76.4% of the paramedics. Of the 385 medical doctors, 147 are psychiatrists, 49.3% them work in the Federal District and 10.9% work in the State of Mexico. (Soberón et al., 1989b). Of the 25 psychologists working for the Department of Health, 15 work in the Federal District (Census of Human Resources, 1988).

Table 1

Inventory of Beds, Medical Consultants Offices (MCO) and Human Resources of the Psychiatric Hospitals of the Department of Health in 1986

Localities	Units	Beds	MCO	Human Resources				
				Total	Med	Paramed	Sick	Other
DF	3	1278	80	1076	157	54	400	465
Durango	1	110	4	84	7	2	27	48
Guanajuato	1	177	7	93	6	52	9	26
Midalgo	1	600	3	245	11	18	64	152
Mexico State	5	2054	59	1374	125	54	480	664
Michoacan	1	72	3	72	10	7	27	28
Nuevo Leon	1	120	5	130	12	10	74	34
Oaxaca	1	160	5	89	7	6	28	48
Puebla	1	474	13	236	20	9	95	112
Sonora	1	112	6	110	9	16	43	42
Tabasco	1	120	5	192	21	10	40	121
TOTAL	17	5277	190	3701	385	1368	1740	

Note. From *Anuario Estadístico*, 1986, pp. 329–345.

A number of other psychiatric hospitals and units work in coordination with the Department of Health, some of these are operated by the Mexican Institute of Social Security. The Mexican Institute of Psychiatry and the National Institute of Neurology and Neurosurgery as well as the hospitals connected with ISSTE, the Army, the Navy, PEMEX, and the Collective Transportation System, all have psychiatric units and can supplement the service to other government facilities and private hospitals.

Methods of Treatment

The main treatment approach in the psychiatric hospitals under the Department of Health is pharmacological with parallel assistance in behavioral, occupational, and recreational therapy based on a behavioral contingency management system

using a token economy. It is also common, however, for electroconvulsive therapy and insulin shock to be used as treatment.

The Juan N. Navarro Hospital provides special services for children and adolescents. In addition to pharmacotherapy and psychotherapy, treatments include special education, therapy of mothers, group psychotherapy, speech therapy and recreational therapy (Macias & Verduzco, 1984).

In the hospitals under the Mexican Institute of Social Security, multi-modal therapies are used. Whether or not psychopharmacology is used, various techniques of behavior modification are applied. A variety of occupational therapy methods are used including recreation, cultural activities and other work activities. In these institutes group treatment is preferred over individual treatment and the family is provided with information and family therapy if it is needed.

In private hospitals psychotherapy is provided in addition to psychopharmacological treatment. Psychotherapy is available to individuals, groups and families. There are three therapeutic communities with a psychoanalytic orientation in Mexico, one is private and two are in government institutions.

Around 1971, some members of the Mexican Psychoanalytic Association (APM) established the first therapeutic community in the country, the "Mexico City Psychiatric Institute" which remained operative for five years. At a later date, 1978, the second therapeutic community was established by a psychoanalyst under the name of "Instituto Mendao". This institute provided services mainly for the upper class, and a with a strong emphasis on research activities (A. Mendizabal 1983; M. Mendizabal, 1985, 1989). There is a third existing community which has been active since 1986 called the "Psychiatric Regional Hospital" which is run by the IMSS system in the state of Nuevo Leon.

The "Mendao Therapeutic Community" trained the mental health professionals who later worked in the "Michocan Therapeutic Community" which is a public facility under the State Government; this hospital no longer works solely according to the psychodynamic model with which it started.

Although these facilities can cover a very small number of patients in relation to demand, they are the first therapeutic

communities with a more integral approach, where psychodynamic, family, social and occupational aspects are employed in order to return the patients to their communities with a better chance for success.

Aftercare Services

The Federal District Department of Health provides four general hospitals, two specialized and three psychiatric hospitals. There are 118 general hospitals at the state level: 96 offering outpatient psychiatric consultation services and 5 providing beds for temporary hospitalization (De la Fuente, 1989). The other governmental institutions mentioned also offer services in their general, regional and specialized hospitals.

The Mexican Foundation for the Rehabilitation of Persons with Mental Disorders (which is affiliated with the Richmond Fellowship) provides some of the most outstanding work reintegrating patients back into their community. This is a private organization established in 1978, providing rehabilitation services in the "Jose Sayago National Hospital". This facility also runs a day care center and two half-way centers where mental health technicians are also trained. The Iberoamerican University and the Psychiatric Hospital of Orizaba's Voluntary Association, joined with this foundation in 1981 to establish a special rehabilitation program of the mentally ill with a special emphasis on conduct disorders. This program developed capable expert teams by integrating its own methodology with ecological, legal, familial, organizational, and social approaches. Unfortunately the State political climate failed to nurture this project further (Lartigue 1981; Lartigue and Blanco 1982).

Outpatient Mental Health Services

The Department of Health provides health care services through 1751 health centers and 351 community health centers and 108 of these centers provide outpatient mental health services. A survey of the 28 center providing mental health services in the Valley of Mexico determined that 96% of the centers had departments of clinical psychology, 71% had departments of psychiatry and social work, and 46% provided educational

services. The greatest number of patients, 51%, were in the 6 to 12 age range (Zimmerman, Morales, Buendia, & Saad, 1981a). The mental health of children and adolescents is a high priority for the Department of Health.

The Mexican Institute of Social Security provides mental health services as part of its social security program. It makes available a team made up of one psychiatrist and one psychologist for every 150,000 insured members. Workers and employees are registered as members by law, paying a monthly quota in proportion to income, and the cost is shared with the employer and the government. In addition each general hospital counts on a minimum of one psychiatrist and one psychologist for each 372,500 insured persons. There are 65 psychiatric service units in such hospitals which can provide temporary hospitalization if needed (IMSS Instructivos 1987a, 1987b).

The National System for the Integral Development of the Family (DIF) has the mission of serving the least favored sectors of the population, like abandoned minors, the dispossessed, the elderly and the needy handicapped. It has under its charge 13 programs related to mental health, such as those concerned with social and family integration, services to preschool age children, fostering community development and social readaptation of juvenile delinquents and prevention of child abuse. The DIF has over 10,000 persons working directly in the community or in its 148 special units which include: 24 Rehabilitation and Special Education Centers, 23 Centers for Community Development, 22 Family Centers, 18 Centers of child Development, 13 Centers of Social and Urban Welfare, 7 Vacation Centers, 8 Rehabilitation Centers, 5 Mobile Units, two Temporary Shelters, a Community Health Service and the DIF National Institute for Mental Health, as well as other services such as foundling homes, shelters, and cultural and recreation centers (Soberón, Kumate, & Laguna, 1989d).

The National Institute of Mental Health (integrated in the DIF services) is the institution charged with designing, developing, and evaluating research programs in the mental health field focusing on four areas: psychiatry, neurology, pediatrics, and institutional support services. In psychiatry the project is directed toward mental health disorders of the underprivileged,

addiction, social maladjustment, community disasters, family and mental health epidemiological studies. The National Institute also offers external medical consultation to children and young people with learning difficulties, psychomotor retardation and convulsive disorders. The National Institute of Senior Citizens (Instituto Nacional de la Seneotud, INSEN) provides psychological and psychometric evaluation services, occupational therapy workshops, day-time residences and shelters (Soberón et al., 1989d).

There is a wide range of other institutions providing specialized services and doing advanced research, for example the National Institute of Nutritional Research, the Children's Hospital Federico Gomez, The National Institute of Neurology, the Mexican Institute of Psychiatry. Outpatient mental health services are also provided by the hospitals and health care systems serving special groups such as the Army, Navy, PEMEX, and Collective Transportation System.

Services are also available for mentally retarded people. The Center of Personal and Social Training (CAPIS) evaluates and trains this clientele for work placement in supervised settings. Individual and group treatment is provided for community functioning and the development of survival and work skills (Zacariás, 1983).

In 1973 a special program was started called IMSS-COPLAMAR (Coordination for the Marginal Groups Plan). It was developed with the purpose of providing social services to deeply deprived and isolated communities in rural and urban areas of the country. The program functions in 19 states and its infrastructure is comprised of 51 rural hospitals, 2,264 rural medical units, and 104 auxiliary medical units. It offers services to 10 million people who represent 64% of the deprived rural population.

The COPLAMAR program starts with the organization of the community and concludes with the achievement of self-managing health care. This program is targeted at problems resulting from poverty and underdevelopment. It functions with voluntary social workers that give support to families and the community, in order to develop self-help capacities. The alcoholism program is an example: in 1986, 22,730 cases of

alcoholism were detected, 5,437 were integrated into existing Alcoholics Anonymous Groups, and 807 new self-help groups were formed, making a total of 1974 operating groups (Soberón et al., 1989c).

Outpatient Service Methods

In a study of the 28 health centers providing mental health services, it was found that 10 used the diagnostic classification system of the World Health Organization, four used a plan set up by the "Group for the Advancement of Psychiatry", two used a system of behavioral change classifications, and one applied the DSM-III. Six centers did not use any classification system and two did not specify. The treatment methods used by the health center were as follows: 67% relied on psychopharmacology, 48% on psychodynamic therapy, 44% behavior management methods, and 12% used other kinds of therapy. Only 36% of the centers in question gave treatments in the patient's environment, services such as orientation to the community and community prevention (Zimmerman, Baez, & Vargas, 1981b).

The Juvenile Integration Centers (CIJ) were merged into the Department of Health in 1982, in the social assistance subsector with the purpose of preventing drug addiction and to provide treatment and rehabilitation services. A primary goal of this program is to reintegrate the drug addict into the family and social nucleus. The principal method used is brief psychotherapy offered on an outpatient basis. In some cases the patient is hospitalized in detoxification clinics. Currently there are 39 local Centers, two hospitalization units and a service-by-phone operating 24 hours a day in the Federal District (Soberón et al., 1989d).

Information on the number of private mental health professionals is not available, though it is estimated that 20% of the total number of psychiatric hospital beds available are private. The methods used by psychotherapists, psychiatrists, and psychoanalysts are diverse. They include pharmacological treatments and psychotherapies ranging from classical psychoanalysis to expressive and supportive therapies with a psychoanalytic orientation. Other methods include: behavior therapy,

rational emotive therapy, biofeedback, body therapies, transactional analysis, gestalt therapy, transpersonal therapies, and bioenergetics. The treatment can be individual, couple, family, or group, and are usually moderate or long-term in duration.

"Folk medicine" has received little attention in the medical literature of Mexico, though it is an important recourse to people when facing suffering and disease. From the time of ancient Mexican history, there have been tribal leaders regarded as having outstanding intuition, intelligence, and overseer capacity. In the times of the Toltecs, these men of knowledge founded their lineages in order to transmit their particular way of creating a reality, from one generation to the next. These lineages survived the conquest and still exist today. They are scattered in the countryside and in the cities where they form very complex subcultures. These leaders are called "Chamanecas", and are still advisors for the people that search for their guidance and relief. They consider themselves as defenders of the weak and the needy, informing of old traditions and representing a deep root in the pre-Hispanic culture. Their rituals, willpower, and optimism are used for healing the sick, forecasting the future, giving advice and relieving anxiety. (Grinberg, 1987)

Current Issues and Future Perspectives

Financial Resources

Health care expenditures amounted to 8% of the federal government's budget in 1986. Of the funds available to the Department of Health (SSA), 14.4% was allocated for preventive care, 39.8% to curative care, and 26.7% to administrative expenses. Thus, administrative costs consumed twice the amount used for preventive health care. The budget available to the Institutos Nacionales de Salud (National Health Institutes) was 12.02% of the total health care expenditures (Anuario Estadístico 1986).

In the last few years both the total national budget and the specific budget for the Health Sector have been severely reduced due to the Mexican foreign debt problem. The financial resources available have provided for a 87% population coverage. Forty-nine percent of this fund has gone to the population covered by the social security system and 33% has been used

by those who are not covered but still depend on governmental health services. An additional 5% goes to private health care. Ten million Mexican citizens remain without permanent health care (Soberón et al., 1989a).

Mental Health Distribution and Staffing

Mental Health services are still being concentrated in the Valley of Mexico even though the government has attempted to geographically decentralize the service system. The centralization of services has had a detrimental affect on the rest of the country.

The process of deinstitutionalization of psychiatric patients is a long term task and is far from completion. Ignorance, irrational fears and prejudices about mental illness are serious obstacles in the way of accomplishing this objective. Furthermore, the lack of a service infrastructure does not facilitate the organization of a mental health system which could help integrate psychiatric patients back into community and family life. Also needed are employment services able to train these former patients for productive and creative tasks.

Staff limitations also are a serious problem for the delivery of mental health services in Mexico. The country has only a total of 1,108 psychiatrists. This results in 1.5 specialists for every 100,000 persons; a number far from the 5 per 100,000 recommended by the World Health Organization. While the number of psychologists exceeds 10,000, very few work in psychiatric hospitals of health centers. Only 250 social workers are adequately trained in the field of mental health, and there are only 30 rehabilitation technicians in the entire country able to care for the mentally ill.

It is true that Mexico is a country still in a developing stage and therefore limited in available economic and technological resources. On the other hand, it has the experience of an enormous human potential even though it is not as yet aware of its capabilities. The society's developmental power was demonstrated through the acts of civil responsibility, principally in Mexico City, in the months following the 1986 earthquake. These acts were not only expressive of a solidarity from a fraternal point of view, they were effective from the perspective of the results

attained and their usefulness in the prevention of psychopathological disorders.

The adequate structuring of this creative potential is needed along with indispensable changes in the socio-political system that would make such structuring possible. This would provide a foundation for the improvement of mental health services in a country marked by many contrasts and cultural diversity.

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