People with Disabilities and Mental Health Disorders in Mexico: Rights and Practices

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Overview

Mexico is located in a region of the world (i.e., Latin America) with the highest level of socioeconomic inequality (UNU-WIDER, 2014). The progression of disability is linked to socioeconomic conditions, particularly poverty, in a reciprocal cycle (Diaz-Venegas, Reistetter, & Wong, 2016). Mexican migrants leave economically depressed rural areas and go to urban areas in Mexico, leaving severe poverty in rural areas (Guarnaccia, Martinez, & Acosta, 2005). In 2006, Mexico was one of the 96 countries to ratify the United Nations Convention on the Rights of Persons with Disabilities; however, the Mexican regulations for people with mental disorders have not changed with the reforms. Legislative changes have been made to procedural codes with regard to specific supports that must be implemented for persons with sensory disabilities (Puente & Benavides, 2013). Although strategies for mental health programs have been developed, large-scale implementation is hampered by the lack of specialized human resources and the general budget restrictions on healthcare initiatives (Gonzalez & Alvarez, 2016). See Table 20.1 for timeline of disability legislation in Mexico. According to Jacoby (2016), Mexico's "mental health system is so dysfunctional that the unlucky patients under its care are colloquially referred to as 'abandanodos' – abandoned ones." Disabled World (2015) described the legal status of disability rights in Mexico as contradictory.

In a comparison between General Law for the Inclusion of People with Disabilities, which mandates the state to promote, protect, and guarantee the use of all human rights and liberties of people with disabilities, ensuring the full inclusion into society with respect, equality, and equal opportunities (Consejo Nacional Para las Personas con Discapacidad [CONADIS], 2011) in Mexico, and the Americans with Disabilities Act (ADA), Armendariz and Saladin (2012) assert with the Mexican law being passed in May of 2011 there is not enough information that provides criticism to the effectiveness of the law and how it has impacted its citizen. Conversely, others (i.e., Disabled World, Disability Rights International [DRI], O'Neill Institute for National and Global Health Law) presented evidence to the contrary. Although Mexico has legislation and international agreements in place to ensure the inclusion and nondiscrimination of people with disabilities, the language in those documents is vague and goes mostly unenforced (Russell, 2016). In January of 2017, DRI and the O'Neill Institute for National and Global Health Law filed a case with the Inter-American Commission on Human Rights

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Table 20.1 Timeline of disability legislation

1984 – The General Law of Health is revised to include provisions concerning disability
1986 – National Social Security laws are promulgated, granting the rights of social assistance to people with disabilities.
1991 – The General Assembly adopts principles for the protection of persons with mental illness
1993 – The General Law of Education is revised to include provisions concerning inclusion of disability
1994 – Other laws are revised for inclusion of disability: the Stimulus Bill and Promotion of Sports, the General of Human Settlements, and the Law of Public Federal Administration
1999 – The House of Deputies approves legislation reform in favor of persons with disabilities having full access to healthcare rights
2005 – National disability law is signed by congress, General Act on the Inclusion of Persons with Disabilities
2007 – The United Nations Convention on the Rights of Persons with Disabilities (CRPD) signed and ratified
2011 – National disability law is signed and ratified, General Act on the Inclusion of Persons with Disabilities
2014 – Concluding recommendations for the CRPD Committee published

Adapted from Global Disability Rights Now (n.d.)

(IACHR) for the egregious human rights violations against 37 persons with disabilities who were detained at the "Casa Esperanza" institution in Mexico City, Mexico. The case was modeled on the US Supreme Court Case of *Olmstead v. LC* (527 U.S. 581). The decision in *Olmstead* requires all states to provide appropriate services and supports in the community so that children and adults with disabilities are not unnecessarily institutionalized in order to receive services and can live as equal members in the community (Consortium for Citizens with Disabilities, 2013). The case against Casa Esperanza "seeks recognition under the international law that all people with disabilities have the right to live in the community" (O'Neill Institute for National & Global Health Law, 2017, p.1).

Contextually, it is important to know historical events in Mexico that lead to the passing of the law and to understand the Mexican disability background (Armendariz & Saladin, 2012). Nevertheless, awareness of disability rights in Mexico is low for both people with and without disabilities (Disabled World, 2015) and for children and adults (Consortium for Citizens with Disabilities, 2013). The most recent assessment is that Mexico authorities fail to protect children and adults with disabilities. In Mexico, "mental health is recognized as one of the main unresolved issues within the government's health policy agenda" (Gonzalez & Alvarez, 2016, p. 2).

Learning Objectives

Upon completion of this chapter, the reader will be able to:

1. Understand Mexican beliefs about wellness and healthcare practices.
2. Understand social exclusion and the rights of people with disabilities.
3. Identify challenges of persons with mental disabilities in the Mexican criminal justice system.
4. Identify barriers to service delivery and treatment.
5. Consider strategies to improve service deliver for people with disabilities.

Introduction

Mexico (the United Mexican States) is a federal constitutional republic in North America that is bordered on the north by the USA; on the south and west by the Pacific Ocean; on the southeast by Guatemala, Belize, and the Caribbean Sea; and on the east by the Gulf of Mexico. It is the fifth largest country in the Americas and the most populous Hispanophone (Spanish-speaking) country on earth (Disabled World, 2015). Mexicans have a unique culture of their own, speak a variety of languages and dialects and have different communication styles, vary in the acculturation process, and have gender role and generational expectations and cultural practices. The Mexican government estimates there are over 12 million indigenous people in Mexico coming from diverse cultures and speaking 62 officially recognized languages (Instituto Nacional de Estadistica Geographica e Informatica, 2007).

Overwhelmingly, Mexicans are Roman Catholic, followed by Protestantism. A small percentage of Mexicans adhere to *spiritism* (belief in God and spirits, Allan Kardec, the codifier of spiritism) in which they are supported and enriched through prayer and belief (Kardec, 2007). Religion and faith are considered important to the maintenance of health and well-being (Ortiz, Shields, Clauson, & Clay, 2007).

Family is another vital part of Mexican culture and is actively involved in health practices and healthcare-seeking behaviors of family members. Mexican families are traditionally large, and it is not uncommon for multiple generations to live in the same household. There is extensive family involvement and much emphasis is placed on helping one another in day-to-day life. Both status and opportunities of individuals are strongly influenced by family ties across the lifespan (Willey et al., 2017). Mexicans value inclusion of all family members. Although Mexican families tend to be patriarchal and follow a rigid hierarchical structure and women are expected to manifest respect and even submission to their husband, privately it is some women (the mother) who holds a greater degree of power and plays a pivotal role in healthcare decisions (Medina, n.d.). Many Mexican women assert their influence indirectly, thus preserving the appearance of male control (Durand, 2011). It is important to understand that while Mexicans share common attributes, beliefs, and norms, they are not homogeneous but have a distinct culturally hybrid characteristic because of the influence of Spanish colonization and native culture.

The daily lives of people of Mexico vary dramatically according to socioeconomic status, educational level, gender, ethnicity and racial perceptions, regional characteristics, rural versus urban differences (Willey et al., 2017), and disability. Rural poverty is widespread due largely to an increasing proportion of rural residents that do not own land and depend on day labor, which pays less than minimum wages. Similarly, the majority of urban dwellers have incomes below the poverty level (Willey et al., 2017). People with disabilities are overrepresented among the poor, especially for older adults (Comision Economica Para America Larina Y El Caribe (ECLAC, 2012; Laurin-Bowie, 2004). According to the ECLAC (2012), both emotional and financial responsibility of care for people with disabilities fall on the immediate family because significant shortfall exists in care services provided by the state, the market, and civil society organizations. Laurin-Bowie asserts "poverty, in itself, is an effect. It exists due to the concentration of a number of factors" (p. 21). These causes are structural (social, political, economic, and dominant cultural structures that have developed over time), current (social factors and phenomena that worsen the conditions of poverty), and external ("streams of thought and action outside of the country that influence the particular conditions in a determinate way, and are combined in order to increase the social gap, and consequently the incidence of poverty," p. 22).

Cultural Beliefs About Wellness/Illness and Mental Health

In keeping with Mexican practice, discussion of psychiatric disorders or mental illness and somatic diseases is not dichotomized. Mexicans have distinctive beliefs about wellness/illness. In traditional Mexican culture, it is believed that illness results from three causes: sin, imbalance, and witchcraft (Cartwright & Shingles, 2011). Life is about balance, and imbalance may make a person sick. The mind-body-soul must be in balance in order to maintain wellness. A mental or emotional imbalance (illness) may cause physical imbalance (illness) because of too much stress. Thus, each person is responsible for maintaining his or her balance (Cartwright & Shingles). *Curanderismo* greatly influences the beliefs of Mexicans regarding illness and mental health. *Curanderismo* is a mind-body-spirit healing approach steeped in tradition and ceremony. Religious beliefs greatly influence wellness practices. Mexicans have a strong belief that life is in God's hands (Spector, 2017). In Mexican culture the belief of health and illness is based on the thought that physical and mental illness is God's way of conveying unhappiness with a person

(Cartwright & Shingles). Good health means one is being rewarded from God for good behavior. Mexicans may take a seemingly passive approach to addressing illness and resign themselves to the influence of fate (*fatalismo*). This approach is grounded in an external locus of control.

A third belief is that illness can result from an imbalance of hot and cold and wet and dry properties (Giger, 2017). Hot and cold do not strictly refer to temperature but refer to the cultural classification of a particular substance or illness. "Hot" illnesses should be treated with "cold" remedies. "For example, penicillin, which is classified as a 'hot' medication, should not be used in treating 'hot' symptoms such as rashes. Another view of the role of 'hot' and 'cold' balance in illness is that the cold should be avoided after having an extremely hot experience. For example, after doing extensive ironing in the house, a person should avoid stepping directly into the outside air in order to avoid becoming sick" (Spector, 2017, p. 220). This belief is tied to the four body humors (blood, yellow bile, phlegm, and black bile). An imbalance in the humors is believed to cause either physical or emotional illness (Cartwright & Shingles). Clearly, illness is viewed as a discord between elements of balance or as a punishment.

Witchcraft and superstition are highly integrated into Mexican culture and healthcare beliefs and practices (Sparks, 2009). Some beliefs in Mexican culture of the cause of illness include the "evil eye" (*mal de ojo*, belief that someone with evil powers or thoughts can cause you to get sick just by giving the person the evil eye), fright (*susto*), shock (*espanto*), and bad air caused by exposure to drafts (*mal aire*) (Berger, 2012). Another belief is envy (*envidia*) which may cause illness when a person experiences success. The belief is that one should keep quite about his or her success because others may envy him or her, thus resulting in illness due to good fortune (Spector, 2017).

Curanderismo is defined as a medical system. The *curandero* (shaman) is a holistic healer, and the people seek help from him for social, physical, and psychological purposes (Sparks, 2009). Curanderismo has historical roots combined with Aztec, Spanish, European witchcraft, Greek humoral (equilibrium of hot and cold), spiritualism and psychic, homeopathic, African (*Santeria* blend of Catholic saints and African *Orishas*), Judeo-Christian (gift from God and belief in God), and scientific elements (Torres, 2005). Often, traditional family or folk medicine has priority over Western medicine.

In Mexico, cultural stigma is associated with mental illness, which results in reluctance to seek treatment. The term *loco* is often used when Mexicans think of mental illness. In addition, *machismo* (manliness) also can be a barrier to male seeking treatment. Machismo means that the husband is the protector, provider, and the decision-maker for the family. Often, the concept of *machismo* is used in popular press as a stereotype to describe Mexican males as having an exaggerated sense, and it has also become distorted by many Mexican males who abuse their power within the family (Medina, n.d.). Unfortunately, the concept of *machismo* is seen as an assumptive attitude of strength and entitlement to dominate as attributes of masculinity (Dictionary.com, 2017). In addition, the gender role of *marianismo* serves both to idealize women in some respects and oppress them in others.

Cultural beliefs and practices can be both a motivator for and a barrier against accessing and following through with services. Because of the unique cultures of Mexicans, it is important to understand the contextualization of their beliefs if progress is to be made in reducing and/or eliminating the disparities found in the availability, access, and provision of mental health service delivery. Acosta (2008) offers guidelines on do's and don'ts when working with Hispanic in mental health (see http://www.nrchmh.org/attachments/DoAndDont.pdf).

Prevalence of Disabilities and Mental Health Disorders

Estimating the prevalence of disability in Mexico is difficult for several reasons: (a) each country uses different measuring instruments with variations in questions, (b) the use or nonuse of a

priory definition of disability, (c) lack of a common language, (d) surveys with limited focus and domain coverage looking mostly at few impairments, and (d) limited linkage with health surveys (Soliz, 2005). Often, these reasons lead to underestimation of the number of people with disabilities. However, data do exist that provide some context of disability in Mexico. Furthermore, it is suggested worldwide and in Mexico the number of people with disabilities is increasing due to the rise of chronic diseases, injuries, violence, automobile accidents, and other causes such as aging (Soliz). In Mexico, mental disorders have been shown to increase the risk of other diseases and are strongly associated with the prevalence of chronic diseases. In addition, individuals with chronic diseases are more prone to experience depression or other mental health disorders. Furthermore, depressive disorders in Mexico create a comparable disease impact to that of interpersonal violence, road injuries, or congenital anomalies and a greater impact than that of cerebrovascular disease, HIV/AIDS, or some types of cancer (Gonzalez & Alvarez, 2016).

According to the Diario Oficial De La Federacion (2014), in Mexico, 7.5% (9.17 million) of the population has a disability, of which 45.33% (4.16 million) are mobility related, 26.01% (2.39 million) are visual, 16.13% (1.48 million) are cognitive, 15.70% (1.44 million) are auditory, 4.87% (0.45 million) are speech, and 23.5% (0.10 million) are others. A larger percentage (27.4%, 2.41 million) of people with disabilities live in rural areas versus 26.4 million (21.6%) live in urban areas. More males (53%, 4.86 million) than females (47%, 4.31 million) have a disability. In comparison to the total population receiving a secondary education 78.3% (95.76 million), only 15% (1.38 million) of people with a disability are receiving a secondary education. The employment rate for people with disabilities is 47.2% (4.33 million) in comparison with the total population (60.1%, 73.50 million). A substantially higher percentage of people with disabilities (45%, 4.13 million) live in poverty compared to the total population (11.3%, 13.82 million). The rate of disability increases with age, with the highest rate among adults age 60 and over (51.4%, 4.71 million). Rates of occurrence of disability among other age groups are (a) ages 0–14 at 7.3% (0.62 million), (b) ages 15–29 at 7.6% (0.70 million), and (c) ages 30–59 at 33.7% (3.09 million) (Diario Oficial De La Federacion, 2014).

Medina-Mora et al. (2005) assert while psychiatric disorders are common (12-month prevalence of 12.1%), very severe mental disorders are less common (3.7%) in Mexico. In addition, extreme underutilization of mental health services exists, with only 24% of individuals more severely affected using any services at all. The most commonly identified disorders included specific phobia (4.0%), major depression (3.7%), and alcohol abuse (2.2%; Medina-Mora et al., 2005). Severity of illness was correlated with income, with people with low incomes more likely to report a disorder. Females were more likely to report a mood and anxiety disorder and less likely to report a substance abuse disorder (Medina-Mora et al.). In a subsequent study, Medina-Mora, Borges, Benet, Lara, and Berglund (2007) found of those surveyed, 26.1% had experienced at least one psychiatric disorder in their life and 36.4% of Mexicans will eventually experience one of these disorders. Moreover, half of the population with a psychiatric disorder present so by the age of 21 and younger cohorts are at greater risk for most disorders.

The prevalence of intellectual and developmental disabilities (I/DD) is even more difficult to gage than other types of disabilities because psychiatric hospitals for the adult population neither refer to nor quantify intellectual disability as a primary diagnosis. In addition, population surveys of psychiatric disorders often use the Composite International Diagnostic Interview (CIDI), which does not include a validated questionnaire of I/DD. Furthermore, mental health professionals in Mexico either underreport or misclassify intellectual disability (Katz, Marquez-Caraveo, & Lazcano-Ponce (2010). Despite the difficulty to determine the magnitude of intellectual disability, Lazcano-Ponce, Rangel-Eudave, and Katz (2008) estimate a prevalence rate of about 3% (3 million). According to

Emerson (2007), failure to include or the social exclusion of people with intellectual disability is directly proportional to the degree of poverty and conceptually related to three components: (a) economic deprivation (insufficient family income, inadequate job training, and a lack of job opportunities for this population), (b) social deprivation (families segregate people with I/DD from the community where the likelihood of disruption of social and family ties is greater in this population), and (c) the absence of political representation and, subsequently, of social empowerment (the lack of participation in decisions that affect their daily life).

Diaz-Venegas et al. (2016) explored the progression of disability in Mexico by implementing a model to examine how this process compares to the USA, with a focus on gender differences. The USA and Mexico exhibit different epidemiological, socioeconomic, and health characteristics that not only expose individuals to specific living conditions but put them at risk of acquiring a disability in old age. A proposed model for disablement is one that progresses from no limitations to one limitation (only in mobility), to two limitations (in mobility and limitations in instrumental activities of daily living [IADLs] or activities of daily living [ADLs]), to three limitations (in mobility, ADLs, and IADLs), and finally to death. The goal is to establish the order in which the combination of disabilities will be present in a population of healthy adults (see Research Box 20.1).

Research Box 20.1
See Diaz-Venegas et al. (2016).

Objective: This study seeks to document the progression of disability in a developing country by implementing a model to examine how this process compares to a developed country.

Method: Data were analyzed from the Mexican Health and Aging Study (MHAS), including a baseline survey in 2001 and a follow-up in 2003, and from the US Health and Retirement Study (HRS), using 2000 and 2002 waves. An ordinal logistic regression approach is used to examine a progression of disability that considers (a) no disability, (b) mobility problems, (c) mobility plus limitations with IADLs, (d) mobility plus limitations with ADLs, (e) limitations in all three areas, and (f) death.

Results: In both data sets, approximately 44% of the sample remained in the same level of disability at the 2-year follow-up. However, the progression of limitations with two disabilities differs by gender in the MHAS but is consistent for both men and women in the HRS.

Conclusion: One model reflects the importance of ADLs in the disablement process in Mexico. We speculate that the difference in lifetime risk profiles and cultural context might be responsible for the divergence in the progression of disability by gender.

Questions
1. Were the sampling frames comparable in this study?
2. What other type of methodology might have been used in this study?
3. What implication does this study have for planning collaboration in disability service delivery between Mexico and the USA?

Ethnic and Ethnopharmacology

Ethnic pharmacology refers to the correlation between race/ethnicity and how a person's body metabolizes medications. Although "ethnopharmacology deals with how physiological and genetic differences between racial and ethnic groups impact the effectiveness of pharmacological products, it also looks at how people's cultural beliefs about their health have an impact on the medications they use, how they use them, as well as how racial bias and cultural attitudes affect the development and prescribing of certain drugs" (Minority Nurse, 2013). Understanding the

effects of medication on ethnic minorities in the treatment of for depression is increasingly important because pharmacological treatment is effective only in a certain portion of the population. According to Belle and Singh (2008), individuals vary widely in their response to drug for various reasons, but genetic factors are estimated to account for 20% to 95% of variance. The reason for such wide variance is because genetic influences on drug metabolism interact with physiologic and cultural, behavioral, and environmental characteristics of a person to determine the outcome from treatment with any medication.

Treating Mexicans for medical conditions and mental disorders requires an understanding of cultural beliefs and ethnic pharmacology. For example, Mexicans have a higher sensitive to antidepressants than individuals of most cultures (Purnell & Paulanks, 2013).

Barriers to Service Delivery and Treatment

One of the most pervasive barriers to services for people with disabilities in Mexico is the lack of publicly available community care programs and facilities. According to Rodriguez et al. (2015), the lack of public services "in Mexico City or anywhere in the country is inexcusable given the tremendous international attention this issue has received – including condemnation by United nations human rights authorities" (p. iii). According to Gonzalez and Alvarez (2016), the most relevant challenges for the Mexican mental health programs reside in (a) strengthening prevention programs, (b) establishing primary care as the articulating axis for mental health, (c) improving the training of health workers, and (d) improving patient rehabilitation and reinsertion. Other persistent barriers include underreporting of mental health disorders, stigma, and misconceptions associated with beliefs about depression and other mental disorders. Because of these sigma and misconceptions and linking psychotropic medication use to illicit drug use, many Mexicans (and Latinos) may resist treatment with medications and prefer psychotherapeutic treatments ("talking cures," counseling; Kramer Guarnaccia, Resendez, & Lu, 2009). There is a strong belief that people should be able to control their symptoms on their own (*hay que ponerse de su parte* – one has to do one's part or make an effort to get better). Thus, needing to take medication is seen as a sign of weakness or laziness and means that the person is not working hard enough to get well (Kramer et al.). See Discussion Box 20.1 for examples of stigma and popular misconceptions about depression.

Discussion Box 20.1

Stigma and Misconceptions about Mental Health Disorders

Depression is only in the mind and can be cured by positive thoughts.

Mental illness is a sign of personal weakness.

Strong and mature individuals do not suffer from mental illness.

Men cannot have depression.

Nobody can die from depression, so what does not kill you makes you stronger.

Seeking mental health treatment is simply an escape for those who cannot handle their daily problems.

Mental illness is a sign of loss of control.

Questions

1. What are the cultural influences to consider?
2. How does gender impact stigma about MH?
3. How is locus of control interpreted in Mexican culture and how is it applied to the conception of MH?

Adapted from Gonzalez and Alvarez (2016) and Kramer et al. (2009)

In treatment of mental health disorders, research suggests a direct correlation between poor insight and poor treatment adherence and, consequently, with poorer outcomes and

functioning (Buckley et al., 2007; Gomez-de-Regil, 2015). In a study to examine barriers to initiation and continuation of mental health treatment among people worldwide with common mental disorders, Andrade, Alonso, Mneimneh, and Wells (2014) found the two major barriers to seeking and staying in treatment are low perceived need and attitudinal barriers. In addition, a desire to handle the problem on one's own was the most common barrier among respondents with a disorder who perceived a need for treatment. Attitudinal barriers were more important than structural barriers to both initiating and continuing treatment, with attitudinal barriers which dominate for mild-to-moderate cases and structural for severe cases. The most commonly reported reasons for discontinuing services were ineffective treatment, followed by negative experiences with treatment providers. In a survey of treatment of mental disorders for adolescents in Mexico City, Borges, Benjet, Medina-Mora, Orozco, and Wang (2008) found less than one in seven respondents with psychiatric disorders used any mental health services during the previous year. Of those who did use services, respondents with substance use disorders reported the highest prevalence of service use and those with anxiety disorders the lowest. Furthermore, about one in every two respondents receiving any services obtained treatment that could be considered minimally adequate.

When looking at Mexican migrant farmworkers, Dolan and Lee (2010) contend there is sufficient evidence that indigenous cultural belief systems and practices combine with the social, political, and economic marginalization of indigenous Mexican communities in Mexico and the USA to limit access and use of mainstream health care. According to Linares (2008), indigenous groups are subjected to racism in Mexico, and they come to the USA with a fear of mainstream institutions because of prejudice, discrimination, and violence experienced in Mexico. In their study of indigenous and Mestizo Mexican migrant farmworkers, Dolan and Lee found indigenous participants reported significantly higher stress compared to groups, and the prevalence of culture-bound syndromes (recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM diagnostic category, Kramer et al., 2009) was highest for indigenous females. The more Spanish-literate indigenous respondents were less likely to report culture-bound syndromes, and more educated indigenous respondents were less likely to have a depressive syndrome. Indigenous participants living in the USA for 7 years or more were significantly less likely to report poorer emotional/mental health and reported significantly lower stress. The conclusion is that adult education and literacy programs may be especially effective emotional/mental health intervention for newly arrived indigenous Mexican-origin migrants (Dolan & Lee).

The family and community, highly valued in Mexican culture, may present as a barrier to treatment as well. Individuals with mental illness or symptomology often fear rejection by family members and members of the community. Therefore, they deny and conceal their illness, with the purpose of protecting the family reputation (Kramer et al., 2009). The family, in turn, reinforces and supports the denial.

Status of People with Disability and Mental Illness

A report by *Disability Rights International* (DRI) asserts "behind the closed doors of Mexico City's institutions for people with disabilities, atrocious abuses are taking place that amount to nothing less than torture" (Rodriguez et al., 2015, p. i). People across all ages with disabilities in these institutions are described as being denied treatment, sexually abused and exploited, left to languish in filthy dehumanizing conditions, are restrained, and exploited in unimaginable ways. The DRI report explicitly asserts social service authorities have acted in concert with private institutions to exploit and cause increased mental and physical disabilities of residents with disabilities to the point that is life threatening. Overall, Mexico's national and city authorities have been aware of these practices for years and have not

taken the action necessary to end the abuse of people with disabilities and have failed to implement systematic human rights monitoring for any institution for people with disabilities (Rodriguez et al.). In the following section, two populations are discussed, older adults and inmates.

Older Adults with Disabilities Although Mexico has a lower level of socioeconomic development than the USA, the levels of disability prevalence among older adults are lower in Mexico (Wong, Gerst, & Michaels-Obregon (2010). Wong, Gerst, and Michaels-Obregon suggest with Mexico's higher infant and childhood mortality rates, it is likely that only the "strongest" survived into old age and are relatively more robust than older adults in the USA. The Mexican older population (age 60 and older) is expected to grow to 15% of the total population by 2027 (Wong & Palloni, 2009).

Older Mexican adults with long-term disabilities have a high prevalence of abuse. Giraldo-Rodriguez, Rosas-Carrasco, and Mino-Leon (2015) found a 32.1% prevalence of abuse among older adults with long-term disabilities without cognitive decline. The most frequent type of abuse was psychological at 28.1%. Almost 58% of respondents reported one type of abuse, 34% reported two types, and 8% reported more than three types. Psychological with financial exploitation was the most common combination of two types of abuse. Individuals age 80 and older who experienced psychological, physical, and sexual abuse had three or more disabilities, emotional symptoms, a history of hospitalization, limited education, and negative self-rated health and were unemployed. With the addition of being married or living with a partner and living in an urban area, the same variables were associated with those who experienced financial exploitation (Giraldo-Rodriguez et al.).

Data from the National Institute of Statistics and Geography (INEGI) reported a decrease of 29% in the number of deaths related to mental and behavioral disorders between 1998 and 2008 but an increase of 33% between 2008 and 2014. The decrease was among younger individuals (age 29 and below), and the increase was among older adults (ages 50–54) (Estadisticas de Mortalidad, Consulta Interative de Datos, n.d.). In addition, the increase in mortality associated with mental health disorders occurred for both men and women. Gonzalez and Alvarez (2016) speculate that the global financial crisis of 2008 and the Mexican government's war against drugs (which started in 2006) "may have created an atmosphere of social unrest" that contributed to these trends (p. 3).

Mental Disabilities in the Criminal Justice System In a review of the rights of persons with mental disabilities in the Mexican criminal justice system, Puente and Benavides (2013) assert that "for any criminal justice system to work effectively, it is essential to take into account the rights of persons with mental disabilities given that they are more likely than the rest of the population to be involved in criminal proceedings, either as defendants, victims or witnesses" (p. 6). Mexico reports about 2% of its criminally incarcerated population have a mental disability, yet Mexico has no effective system for identifying people in the criminal justice system with mental disabilities, and by definition it also becomes clear that Mexico does not have an adequate system for diversion or treatment (Puente & Benavides, 2013). Furthermore, Puente and Benavides emphasize the urgency of action to ensure effective access to justice for persons with mental disabilities. Movement toward prison reform in Mexico came closer realization in 2016 when the senate unanimously approved a wide-ranging prison reform bill, the National Penal Enforcement Law. However, it is too early to tell if these measures will be enough to revamp a prison system badly in need of improvement. The National Penal Enforcement Law is designed to ensure that Mexico prisons will no longer perpetuate massive violations of the rights that are guaranteed by the constitution. More specifically, the bill (a) prohibits the use of torture and other cruel, inhuman, or degrading disciplinary measures, (b) bans the use of solitary confinement for more than 15 continuous days, (c) establishes gender-specific rights for incarcerated women, and (d) grants immediate eligibility for release to

nonviolent offenders convicted of possessing less than 5 kilograms of cannabis, as well as those convicted of stealing less than the equivalent of about US $340 (LaSusa, 2016). LaSusa stresses that although prison reform is greatly needed, the use of taxpayers' money for prisons, especially those aimed at improving conditions for inmates, is generally unpopular.

Latin-American countries have the highest incarceration rates in the world, and these rates are inversely related to the level of service access and investment. Furthermore, the conditions in these prisons range from poor to extremely harsh, overcrowded, and life threatening (Almanzar, Katz, & Harry, 2015). In Mexico, access to psychiatric services is difficult because of the limited number of psychiatrists. In addition, many of these psychiatrists are inadequately trained and lack forensic expertise. According to Walker et al. (2013), overcrowding in prisons has negative effects on the physical and mental health of individuals living in these conditions and can be detrimental to their general well-being because of increased prevalence in infectious disease and psychiatric disorders.

In a study of connectivity between mental health and contextual of prison environment factors among prisoners in Mexico, Albertie, Bourey, Stephenson, and Bautista-Arredondo (2017) found severe depression, substance abuse, and heavy substance use were prevalent. The protective factors for severe depression were recent visitors, conjugal visits for any substance abuse, and prison employment for heavy substance use. Physical attacks were associated with increased prevalence of depression, time served with both any and heavy substance use and overcrowding with any substance use.

Mental Health Legislation and Policy

In 1990, the Latin-American countries signed the Caracas Declaration, which emphasized the human and civil rights of persons with mental disorders and promoted restructure of the psychiatric care system from hospital-based to community care alternatives (Levav & Gonzalez-Uzcategui, 2001). Over the years, this declaration has been ratified, expanded, and operationalized through documents such as the Brasilia Principles on the Development of Mental Health Care in the Americas in 2005 (Brasilia Ministry of Health of Brizil, Pan American Health Organization, & World Health Organization [WHO], 2005), and the Panama Consensus in 2010 (Pan American Health Organization, World Health Organization, 2010), as well as the Mental Health Intervention Program (mhGAP), a resource published by WHO to assist professionals in the clinical management of priority conditions in nonspecialist health settings (WHO, 2010). Currently, disease-specific policy does not exist in Mexico. According to Gonzalez and Alvarez (2016), however, the government has given more emphasis to mental health with the Specific Action Program for Mental Health (SAPMH) 2013–2018 (see https://www.mindbank.info/item/5884). The SAPMH is aligned with the National Development Plan 2013–2018 and the Health Sector's Plan. The strategy is called Miguel Hidalgo's Model for Mental Health, and emphasis is placed on (a) the promotion and prevention of MH disorders, (b) with the aim of increasing early diagnoses, (c) increasing quality of care, and (d) reducing cost of care. The program is a tool to assist in multidisciplinary coordination on MH, as well as promote the organization of services through a community-based network (WHO, 2017).

In an analysis of the mental health legislation in Mexico using the *WHO Checklist on Mental Health Legislation*, Sotelo-Monroy Cavazos-Olivo, Sauer-Vera, and Rosa-Donlucas (2014) found legislation in Mexico adequately covers 37 (28.9%) of the 128 items examined, 42 (32.8%) items were covered to some extent, and 49 (38.3%) items were not covered at all. Sotelo-Monroy et al. assert their findings are consistent with earlier about the right to the protection of MH and the regulation of MH services in Mexico, in which "Mexican law confers excessive deference to medical decisions on controversial issues in which there might be an involvement of the user rights" (p. 17). In an earlier study, Gorn, Solano, Medina-Mora, Basauri, and Reyes (2013) evalu-

ated the key indicators that characterized the Mexican mental health system using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS). The author found of the total budget for health, only 2% is allocated for mental health, and, of that share, 80% is used in the operation of psychiatric hospitals. Other results are (a) the pivotal point for MH care is in the psychiatric hospital; (b) there are very few psychiatric units in the general hospitals, few residential establishments, and few services targeted specifically to care for children and adolescents; (c) access is limited because of the centralized healthcare system, with the majority located in large cities; (d) only 30% of primary care services have protocols for the evaluation and treatment of mental disorders; and (e) in the MH facilities, the ratios of psychiatrists, other physicians, nurses, and psychologists per 100,000 population are 1.6, 1.3, 3.4, and 1.5, respectively. Clearly, increased funding, more specialists, periodic in-service training for personnel at the first level of care, and greater participation by the general public are needed.

Overwhelmingly, the literature is consistent in observation that implementation of community MH in Mexico is slow and there remains a significant gap in the healthcare system, which prevents people from accessing mental health services, particularly in rural areas. According to Gonzalez and Alvarez (2016), "evidence indicates that, in addition to the medical relevance of the subject, the individual and societal costs associated with mental disability must be considered when prioritizing polices in the health sector's agenda" (p. 3).

Recommendation to Improve Services

Mental health care in Mexico is not only in need of improvement, but many would argue it is in need of a complete overhaul. Consideration to the needs of offenders with mental health disorders increases the urgency for improvement. Recommendations for immediate action to ensure effective access to justice for persons with mental disabilities are associated with Mexico's recent ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRDP). Mexico needs to urgently address the following areas (Puente & Benavides, 2013):

1. Internationally accepted legal standards for determining criminal responsibility
2. Effective assistance of counsel for people with mental disabilities
3. Accessibility in criminal justice proceedings
4. Supported decision-making for people with mental disabilities
5. Jail diversion programs to the community with community-based support
6. Community support to assist with reintegration to society (p. 8)

Puente and Benavides emphasize further that immediate improvements to protect people with disabilities in the criminal justice system (CJ) could be made by (a) creating new accommodations within the CJ system, (b) training CJ officials and criminal defense attorneys, and (c) improving community-based diversion and support programs. Implicit in these recommendations for improvement is promotion of the ethical principles of autonomy, beneficence, fidelity, justice, nonmaleficence, and veracity.

The Sequential Intercept Model (SIM) is another approach Mexico's CJ system can implement to identify where changes need to happen to have a real impact (Griffin, Heilbrun, Mulvey, DeMatteo, & Schubert, 2015). The SIM provides a basis for thinking about the five intercept points (law enforcement, initial detention/initial court hearing, jails/courts, reentry, and community corrections) and how the CJ system can make changes to impact the number of people with mental illnesses coming to and staying in jail/prison. The SIM can be used to identify points in the system where officials could implement new policies, practices, or programs (Griffin et al.).

Other more general recommendations for improving the rights of persons with disabilities are presented by Rodriguez et al. (2015):

1. Draw up comprehensive plans to integrate all people with disabilities into the community.
2. Bring new placements to an end of children in institutions.

3. Avoid dumping people into the community with no services.
4. Develop an individualized plan of support.
5. Create family-based alternatives for children.
6. Allocate resources for crisis intervention and crisis stabilization (pp. 23–24).

The premise of these recommendations is the right of people with disabilities to have the legal capacity to be protected by Mexican law. The intent is to bring Mexico's mental health law and psychiatric commitment procedures into compliance with CRPD to ensure that people are not arbitrarily detained in institutions (Rodriguez et al.).

Often, change starts as a grassroots initiative. Persons with disabilities and family organizations should become advocates to move the mental health agenda forward. Advocates should organize to influence government on mental health policies and laws and to educate the public on social integration of people with disabilities (Funk, Minoletti, Drew, Taylor, & Sacaceno, 2005). The importance of advocacy and activism has taken hold in Mexico in which ex-patients (i.e., Colectivo Chuhcan, http://colectivochuhcan.webnode.mx) are policing the mental health system and demanding an end to the systemic problems. Because of government's piecemeal and unfulfilled promises to improve the system repeatedly fall short, with money and attention focused on short-term or cosmetic improvements instead of the development of long-term care and rehabilitation (Zabludovsky, 2013), the need for advocacy and activism has become increasingly critical. Advocacy can result in positive outcomes such as reduction in stigma and discrimination and improvements in policies and practices of governments and institutions (WHO, 2009).

In an era of technological advances, e-treatment and e-counseling should be explored as viable alternative to providing treatment to persons with disabilities and mental health disorders. Virtual intervention is proven effective in various settings and across different populations. Moreover, the use of virtual intervention may offer a means to reduce stigma associated with mental illness. That is, e-treatment does not call attention to the person receiving services.

Finally, people with disabilities and mental health disorders need services from multiple providers. Any approach to services should include an interdisciplinary approach, for example, leaving mental health care to the domain of primary care providers. However, research suggests implementation of mental health services in primary care clinics in Mexico will be difficult because the system is already fragile and underfunded, service issues, language and cultural issues, care recipient characteristics, and issues with lack of knowledge (Martinez, Galvan, Saavedra, & Berenzon, 2016). Much more effort is needed to ensure that mental health programs are effectively diffused as community-based and inclusive of comprehensive services including screening, assessment, and treatment components.

Summary

Many people in Mexico living with disabilities and/or mental health disorders encounter barriers when they seek treatment and often experience abuse. A substantial gap exists in mental health care. Cultural beliefs about mental health disorders serve to further stigmatize and prevent individuals from seeking help. Untreated mental health disorders adversely affect other health conditions. Harsh conditions in institutions and prison for persons with disabilities are recognized as dismal by international disability rights organizations. Often, legislation is inadequate or not implemented. Overall, mental health and disability services in Mexico are impaired by poor socioeconomic conditions, lack of infrastructure, and limited knowledge and inexperience of psychiatric service providers.

Resources

2013–2018 Plan Nacional de Desarrollo: http://www.dof.gob.mx/nota_detalle.php?codigo=5343100&fecha=30/04/2014

COAMEX: http://coalicionmexico.org.mx
Global Disability Rights Library (Category Mexico): https://www.widernet.org/portals/index.php?PortalID=18&PortalPageID=4546&view=pub
Improving Health Systems and Services for mental Health: http://apps.who.int/iris/bitstream/10665/44219/1/9789241598774_eng.pdf
Movement for Global Mental Health (MGMH): http://www.globalmentalhealth.org/category/country/mexico
Portal del Empleo: https://www.empleo.gob.mx

Learning Exercises Self-Check Questions

1. What did Armendariz and Saladin (2012) emphasize as important to understanding the difference in the route to passage of the Americans with Disabilities Act and the Ley General para la Inclusion de las Personas con Discapacidad?
2. What is the importance of family participation in the health care of members in Mexican culture?
3. What are the stigmatizing terms and meanings used to describe mental illness in Mexico?
4. What are the cultural beliefs about the cause of illness in Mexican culture?
5. What is the status of intervention services for people with mental illness in Mexico?

Experiential Activities

1. Examine the ADA and the Ley General para la Inclusion de las Personas con Discapacidad and compare and contrast them. Discuss the strengths of each law and identify areas you consider to be in need of improvement.
2. Participate in a Study Abroad Program in Mexico in rehabilitation counseling, counselor education, counseling psychology, or social work. Consider one of the following activities: (a) schedule to visit in a mental health institution or prison/jail and interview staff about their needs to more effectively provide services to the population with whom they work, (b) become a trainer of mental health service providers, or (c) assist in the development of an advocacy plan.
3. Work with a local group of Mexicans/Mexican Americans/Latinos to educate about mental health disorders and to address culture-bound syndrome.

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