

There is a high prevalence of conditions such as autism-spectrum disorders and people with intellectual disability are strongly represented (Bhaumik *et al*, 2008). Training should incorporate a culturally appropriate interpretation of the mental state examination. For instance, lack of direct eye contact or social reciprocity in an Aboriginal setting is not necessarily evidence of impaired social functioning.

The establishment and retention of a specialised workforce in intellectual disability also needs to be urgently undertaken. For example, the Kimberley region of Western Australia, which spans 500 000 km² and has almost 25% of the state's Aboriginal population, has just two adult psychiatrists. Neither has subspecialty training in intellectual disability. Although the Royal Australian and New Zealand College of Psychiatrists provides a 12-month training fellowship in intellectual disability and mental health, the programme does not specifically address Aboriginal intellectual disability. Forming links with groups of psychiatrists such as the Psychiatry of Learning Disability Faculty of the Royal College of Psychiatrists could help with gaining skills to meet the needs of indigenous people with intellectual disability.

References

Australian Bureau of Statistics (2004) *National Aboriginal and Torres Strait Islander Health Survey, 2002*. ABS.

- Australian Bureau of Statistics (2006) *National Aboriginal and Torres Strait Islander Health Survey, 2004–05*. ABS.
- Australian Health Ministers' Advisory Council (2006) *Aboriginal and Torres Strait Islander Health Performance Framework Report*. AHMAC.
- Bhaumik, S., Tyrer, F. C., McGrother, C., *et al* (2008) Psychiatric service use and psychiatric disorders in adults with intellectual disability. *Journal of Intellectual Disability Research*, **52**, 986–995.
- Cohen, A. (1999) *The Mental Health of Aboriginal Peoples – An International Review*. World Health Organization.
- Dingwall, K. M. & Cairney, S. (2010) Psychological and cognitive assessment of Indigenous Australians. *Australian and New Zealand Journal of Psychiatry*, **44**, 20–30.
- Glasson, E. J., Sullivan, S. G., Hussain, R., *et al* (2005) An assessment of intellectual disability among Aboriginal Australians. *Journal of Intellectual Disability Research*, **49**, 626–634.
- Morgan, D. L., Slade, M. D. & Morgan, C. M. A. (1997) Aboriginal philosophy and its impact on health outcomes. *Australian and New Zealand Journal of Public Health*, **1**, 597–601.
- Parker, R. (2010) Australia's Aboriginal population and mental health. *Journal of Nervous and Mental Disease*, **198**, 3–7.
- Stopher, K. & D'Antoine, H. (2008) *Aboriginal People with Disability: Unique Approaches to Unique Issues*. Available at <http://www.disability.wa.gov.au> (last accessed March 2011).
- Swan, P. & Raphael, B. (1995) *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*. Office of Aboriginal and Torres Strait Islander Health.
- Wen, X. (1997) *The Definition and Prevalence of Intellectual Disability in Australia*. AIHW Cat. No. DIS2. Australian Institute of Health and Welfare.
- Zubrick, S., Silburn, S. R., Lawrence, D. M., *et al* (2005) *Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*. Curtin University of Technology and Telethon Institute for Child Health Research.

THEMATIC PAPER – EMPOWERING PEOPLE WITH INTELLECTUAL DISABILITY

Services for adults with intellectual disability in Mexico: opinions and experiences of service users

Betania Allen-Leigh,¹ Gregorio Katz² and Eduardo Lazcano-Ponce³

¹Population Health Research Center, National Institute of Public Health, Cuernavaca, Morelos, Mexico; ²Integral Training and Development (CADI), Mexico State, Mexico; ³Population Health Research Center, National Institute of Public Health, Cuernavaca, Morelos, Mexico, email elazcano@insp.mx

We have conducted a qualitative study to collect information about services for adults and older adolescents with intellectual disability in Mexico, as part of ongoing research on intellectual disability from a public health and rights-oriented perspective. Our focus is on existing services and outstanding needs. One of our main goals is to provide an opportunity for people with intellectual disability to convey their experiences and express their opinions about the additional services they require. Three types of service are included: those supporting autonomy or independence (personal and economic);

those enhancing community inclusion; and those providing vocational opportunities.

Method

We interviewed a convenience sample of 17 young adults and older adolescents (9 women and 8 men, age range 16–41 years, median age 25 years) with moderate to mild intellectual disability, in central Mexico. Most of the people interviewed worked ($n = 14$) and most had used both public

and private vocational, medical and social services ($n = 13$). Interviewees lived with their families, in an institution or with other people with intellectual disability (independently but with some supervision). Interviews were conducted at the workplace of the participants, or at the institution where they lived; they lasted 20–45 minutes and were recorded.

Results

Personal autonomy

As independence is both a human right and a central element of the quality of life, we asked interviewees about the training they had received to help them live independently. The following responses describe some of their experiences within public services or with a private not-for-profit training centre, *Capacitación y Desarrollo Integral (CADI; Integral Training and Development)*, which provides training and support for community inclusion:

Yes, I feel like I am self-sufficient. Before, in the public home, I didn't know what to do out on the street. But now that I am at CADI, I go out more and, well, I am learning a little more to be independent, more, um, learning many things, to be outside, and I don't know, cross the street, to be out on the street. Yes, I feel like I am self-sufficient. (Amelia, age 29)

At CADI, they show us how to make breakfast, by ourselves. Once a week, each one of us. Then other flat-mates do [clean] the bedroom. Another, the dining room. Another, the bathroom. Another, the kitchen. (Javier, age 41)

They even teach you how to cross the street, what to take, what bus to take, so we are independent. Up to now we go with a teacher to see if we do it right or if there is still some mistake we make. (Ana, age 19)

Economic autonomy

Economic autonomy is an important element of quality of life, is linked to other areas of autonomy and contributes to social and community inclusion. Interviewees with intellectual disability emphasised the importance of economic autonomy, stating, for example:

I work to value money and to be independent. (Fernando, age 29)

Well yes, I work to live my life independently. (Ana, age 19)

Others spoke of the educational services they had received that had helped them acquire the skills they needed for economic autonomy:

Here they have a programme that they carry out. This programme, if you, you need toiletries, cleaning [supplies] you buy it with your own money. If you need clothes, if you need, if you want something for yourself, for yourself, you also buy it with [your money]. Now that you are earning money, well, now you are going to do what you want. Now you are going to buy it with your effort. But there is a programme, because you are not going to spend your whole salary in a week. Really, they make a budget for you. There is a budget for spending. Because each month you buy cleaning supplies, each week you buy toiletries. Then, but if you want something, something else, you need to buy

a Discman, mobile phone, that is another thing. (Alejandro, age 34)

Also, also they put, they teach us how to spend it. Right now we are only spending it on our toiletries, things we use like lip gloss, or if we want to get a present for someone. Like they help us to manage it so we don't spend it all in an instant. On the needs we have, we spend it. Or on clothes. (Ana, age 19)

Community inclusion

While there is a trend towards the greater social inclusion of people with intellectual disability in Mexico, the focus is mainly on educational inclusion. Policies and services supporting community inclusion are extremely limited, although some training initiatives do exist. Interviewees who lived at CADI described some services that they were currently using in this area:

One Wednesday we go to the movies and one Wednesday we go out for dinner. So that is when we are with other people more. (Liliana, age 25)

Mondays we go shopping, Wednesdays movies or dinner. Saturdays we have field trips, to the park. Sundays we train [for the Special Olympics]... During the week I am no longer going to be able to [train] because we are working. My work hours are from 7.30 in the morning to 5.00 in the evening ... you're tired when you get here [home]. (Alejandro, age 34)

Saturdays and Sundays we have field trips. Saturdays we go to museums and that sort of thing, Sundays we have sports. Actually, I work here [at a special education centre] Monday to Thursday and then when we get home we don't have time or we're tired. Fridays are for remembering the rules, the structure and everything [of independent living training] and then Saturdays and Sundays are like free time and everything. (Ana, age 19)

Vocational experiences and services

Inclusion in employment is also a human right and forms part of community inclusion, as well as making important contributions to social inclusion. Working and earning a salary are important if people with intellectual disability are to feel productive, be more independent and achieve economic autonomy. Some interviewees said that their motivation to work was economic:

I work to earn money. (Saul, age 33)

I work because I have to, sometimes for money, sometimes to help. (Liliana, age 25)

Other reasons for wanting to work were also mentioned. The following two examples are from men who worked in a factory:

I like to work to meet people, spend time with other people. Be in a different place and I have fun packing toys. (Fernando, age 29)

To learn, to know, to be part of society, to get to know more people, to feel how it is to work in a factory. (Alejandro, age 34)

Two women and a man who worked with children as special education aids said of their motivation to work:

I work because I very much like to be here. (Julia, age 17)

I like to be with the children, um, play with them, um, talk to them so they are happy that, that I am working with them ... I work because I like to, I like this type of work, working with special children. (Amelia, age 29)

I like to be close to the children. Also, um, what I like the most is to help the children do well. To be useful and to click with them, so I can say, 'I did it'. (Javier, age 41)

In Mexico, both public and private vocational training programmes exist for people with intellectual disabilities, providing skills and sometimes work placements. Vocational training and experience acquired from public services in Mexico were described as follows by interviewees who had used them:

I come from the National Family Development [public] system. They put me in the company ... they teach you the basics first, the basics but they teach you, they practise some things with you. Then later they place you in a company or a place. But I also took courses in carpentry, upholstery, wood

carving, leather embossing ... I got into the public system and worked in industry. (Alejandro, age 34).

I was in a school ... there were a lot [of things] to study, whatever you wanted. There was cooking, carpentry and bakery. I chose bakery and I graduated. (Andrea, age 41)

At the public home, well, that is, there when you went to school, you learned, and like they taught me carpentry and that, and also they taught us to take care of the little ones. So I was catching on to what they told us. What I do here at the clinic [special education centre] and everything. (Ana, age 19)

Conclusions

This study supports the idea that it is important to combine training in basic, practical skills for independent living with services to support social inclusion as well as vocational training and job placement services for people with intellectual disability. Our findings also suggest the need for public policy to support community and employment inclusion and the importance of public campaigns to facilitate it.

The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributions. Please email ip@rcpsych.ac.uk

COUNTRY PROFILE

Psychiatry in the UK: an overview

Vicky Banks¹ MB BS MRCGP FRCPsych, Geoff Searle² MB BS BSc FRCPsych and Rachel Jenkins³ MB BChir MD (Cantab) FRCPsych FFOHM FRSPH

¹Consultant in Older Persons' Mental Health and Deputy Medical Director, Hampshire Partnership Foundation Trust, and Associate Dean, Royal College of Psychiatrists, email Vicky.Banks@hantspt-sw.nhs.uk; ²Crisis Team Consultant, Dorset Healthcare Foundation Trust, Core and Quality Training Programme Director, Wessex Deanery; ³Director and Professor of Psychiatry, WHO Collaborating Center and Section for Mental Health Policy, Institute of Psychiatry, London, UK

The National Health Service (NHS) serves the UK through four devolved organisations for England, Scotland, Wales and Northern Ireland. It is one of the largest public healthcare systems in the world, universal and free at the point of delivery. Its key challenge is to maintain this approach within tight financial constraints, while embracing new technologies, treatments and styles of service delivery, as well as meeting the health needs of an ageing population.

The population of the UK was 61 792 000 in mid-2009. Children aged under 16 represented approximately one in five of the total population, around the same proportion as those of retirement age (over 65). In mid-2009 the average age of the population was 39.5 years, up from 37.3 in 1999. Population growth is greatest in the over-85s, who currently number around 1.4 million, a figure which is estimated to reach 3.5 million by 2034, which will represent 5% of the population.

Mental health in the UK

Mental illness contributes 22.8% of the total burden of disability-adjusted life years (DALYs) in the UK (World Health

Organization, 2008). One in six adults has a mental health problem at any one time (World Health Organization, 2004).

Half of those with a long-term mental illness have it by the age of 14 (Kim-Cohen *et al*, 2003) and three-quarters by their mid-20s (Kessler & Wang, 2007). The most deprived communities in the UK have the poorest mental health and physical health (McManus *et al*, 2009). People with severe mental illness die on average 20 years earlier than the general population. Mental health problems cost England approximately £105 billion each year, including costs of lost productivity and the wider impacts on well-being (Centre for Mental Health, 2010), and represent the largest single cost to the NHS, accounting for 11% of the secondary care budget (Department of Health, 2009).

Further key statistics are presented in Box 1.

Mental health service policy development and delivery

When it was created in 1948, the NHS took over a large number of old mental asylums. The movement towards