Abandoned & Disappeared:

Mexico's Segregation and Abuse of Children and Adults with Disabilities

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Disability Rights International (DRI - formerly Mental Disability Rights International), is an international human rights organization dedicated to the rights and full participation in society of people with disabilities. DRI documents abuses and promotes international awareness and oversight of the rights of people with disabilities. DRI trains and supports disability rights and human rights activists worldwide to promote rights enforcement and service-system reform.

DRI is based in Washington, DC with regional offices in Mexico and Serbia. DRI has investigated human rights conditions and collaborated with activists in more than two dozen countries of the Americas, Asia, Europe, and the Middle East. DRI has authored or published reports on the United States (2010), Vietnam (1999, published by UNICEF), Serbia (2007), Argentina (2007), Romania (2006), Turkey (2005), Peru (2004), US Foreign Policy (2003, published by the US National Council on Disability), Kosovo (2002), Mexico (2000), Russia (1999, published by UNICEF), Hungary (1997), and Uruguay (2005). These reports have brought unprecedented international attention to the human rights of people with disabilities.

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The Comisión Mexicana de Defensa y Promoción de los Derechos Humanos, A.C. (CMDPDH) is a nongovernmental organization with a 20 year history defending victims of human rights violations and promoting a culture in the field that serves to strengthen the rule of law. CMDPDH has set very important legal precedents in a variety of topics, including: military justice and due process through the case of General José Francisco Gallardo, transitional justice in the case of community leader Rosendo Radilla, who disappeared during the "dirty war" and was brought to the Interamerican Court of Human Rights; femicide through a program of strategic litigation in Chihuahua and Ciudad Juárez; the protection of Economic, Social and Cultural Rights through health cases in Chiapas and the presentation of diverse cases before the Inter-American Commission on Human Rights. It is noteworthy that the CMDPDH has a program of psychosocial support to victims and a communication and advocacy program, which allows us to address our cases in a comprehensive and multidisciplinary way.

In 2009, the CMDPDH in a joint project with Disability Rights International, began a series of visits to several psychiatric hospitals in the Mexican Republic in order to observe, document, inform and raise awareness on the situation of extreme vulnerability and systematic violation of persons with psychosocial disabilities' (PCDPS) human rights, detained in these places. Based on the needs identified and given the importance of defending and promoting the rights of PCDPS, a new disability area within the CMDPDH was created to achieve through strategic litigation, national and international advocacy and building capacities, structural changes and significant progress in this populations attention paradigm shift, beyond the model of welfare and implementing a model of protection, respect and enforcement of human rights.

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Dedication

This report is dedicated to:

Ilse Michelle Curiel Martinez. After allegedly suffering from abuse in her home at six years old, the authorities placed her in an institution. Ilse's grandmother reported to us that she and other family members offered to take her in, but the authorities would not let the girl stay with them. When her parents went to look for Ilse at the Casita del Sur, where authorities placed her in June 2007, she had disappeared. After a long investigation, the authorities have not given the family any information about her whereabouts. Officials at the Human Rights Commission of the Federal District believe she was trafficked.

Ardelia Martinez Estrada, Ilse's grandmother. She reported to us that she tried to stop Ilse's placement by offering to take her in. She refuses to give up the search for her missing granddaughter.

The thousands of children and adults in Mexico's institutions who have no opportunity to return to the community. The government of Mexico has no record as to how many people are detained in its psychiatric facilities, orphanages, shelters, and other institutions for people with disabilities.

Table of Contents

Executive Summary viii
Conclusions xvii
Preface: Human Rights Reporting under the Disability Convention xix
Acknowledgements xxi
I. Segregation from Society of People with Disabilities 1
A. Abandonados remain in the institution for life 3
B. People are detained in institutions because of a lack of community services 4
II. Conditions in Institutions 6
A. Inhumane and degrading conditions 7
1. Filthy and unhygienic conditions 7
2. Lack of adequate clothing 8
3. Lack of privacy and personal space 8
4. Lack of protection against violence and sexual abuse 9
B. Long-term physical restraints 10
C. Lack of rehabilitation and habilitation 13
D. Dangers caused by lack of care or inappropriate treatment 15
E. Psychosurgery 17
III. Segregation of Children with Disabilities 18
A. Gateway to life-time of institutionalization 19
B. Lack of community support 20
C. Discrimination against children with disabilities in out-placement 20
D. Lack of care and habilitation leads to increased disability in children 21
IV. Disappearances, Exploitation and Trafficking 23
A. Danger of abuse and trafficking 24
B. Lack of monitoring and oversight 25
C. Forced labor 26
D. Failure to protect against violence and trauma 27
V. Hidalgo Model of Reform 27
A. Closure of Ocaranza and creation of villas in Hidalgo 28

B. Current operation of the Hidalgo model 30
VI. Violations of International Law 34
A. Discrimination on the Basis of Disability 35
B. Segregation from Society and the Right to Community Integration 35
C. Lack of Habilitation and Rehabilitation 40
D. Threats to Life and Health 41
E. Cruel, inhuman or degrading treatment and torture 42
F. Arbitrary Detention 48
G. Guardianship, Legal Capacity and Choice 51
H. Access to Justice 54
VII. Mexico's Obligations under International Law 55
Recommendations 58
Appendix 1: List of Mexican Institutions visited by DRI and CMDPDH 64
Endnotes 68

Executive Summary

> ***My mother told me I was born in hell. She put me in this shelter, and I am afraid I will be here forever. I am eight years old, and I think I am too old to be adopted.*** – Child living in Shelter #2 for children with disabilities, Oaxaca, Mexico

Disappeared and Abandoned: Mexico's Segregation and Abuse of Children and Adults with Disabilities is the product of a year-long investigation and collaboration between Disability Rights International (DRI) and the Comisión Mexicana de Defensa y Promoción de los Derechos Humanos (CMDPDH). From August 2009 through September 2010, DRI and the CMDPDH investigated psychiatric institutions, orphanages, shelters, and other public facilities that house children and adults with disabilities.[*] This report documents violations of the rights of people with disabilities under the new United Nations Convention on the Rights of Persons with Disabilities (CRPD)[1] and other human rights treaties ratified by Mexico.

The investigative team documented a broad array of human rights violations against people with disabilities and found that many people are forced to live their entire lives in institutions in atrocious and abusive conditions. This report concludes that Mexico segregates thousands of children and adults with disabilities from society in violation of CRPD article 19 which guarantees the "right of all persons with disabilities to live in the community with choices equal to others." The primary reason for institutionalization is Mexico's lack of community-based services to provide the support necessary for individuals with mental disabilities to live in the community. People without families who are willing or able to support them are officially referred to as abandonados, and they are relegated to languish in institutions without hope for return to the community. Children with disabilities may have loving families. But without support, many parents of children with disabilities have no choice but to place their children in institutions.

Within institutions, children and adults with disabilities are subject to inhuman and degrading conditions of detention that violate the CRPD and other human rights conventions, such as the American Convention on Human Rights,[2] the International Covenant on Civil and Political Rights,[3] and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[4] Filthy, run-down living areas, lack of medical care and rehabilitation, and a failure to provide oversight renders placement in some institutions dangerous and even life-threatening. The use of long-term restraints in institutions

[*] This report documents the detention of people with all types of disabilities in institutions, including children and adults with mental, physical, or sensory disabilities. People with mental disabilities include those who have a psychiatric diagnosis or an intellectual disability. We have documented abuses against any person detained in these institutions based on a perception that they have a disability – whether or not they are actually disabled. Since all children detained in institutions are at higher risk of becoming disabled, we have broadly included institutionalized children in this report.

may rise to the level of torture under the UN Convention against Torture.[5] The failure to provide essential medical care to people detained in Mexican facilities violates their right to life under the CRPD and the American Convention on Human Rights.[6] Due to a failure to provide oversight, children have literally disappeared from institutions. Some of these children may have been subject to sex trafficking and forced labor. Mexico's laws fail to protect children or adults with disabilities against arbitrary detention in violation of the CRPD and American Convention. Once in institutions, the right to legal recognition as a person – as protected by article 12 of the CRPD – is denied by the arbitrary denial of the right to make the most basic decisions about life.

Ten years ago, DRI (then called Mental Disability Rights International), published ***Human Rights & Mental Health: Mexico*** **(2000)**, a report documenting human rights violations in Mexico's mental health system. After extensive attention within Mexico and in the international press,[7] the Mexican Secretary of Health stated that he would order national reforms and reintegrate people with mental disabilities into society.[8] **The major finding of this ten-year follow-up investigation is that almost no change has taken place in Mexico's mental health system, and the government's promises of reform have not been fulfilled.**

> **They arrive here. They grow up here. And then they die here. –** *Director of Fraternidad sin Fronteras*

Key Findings

- Children with disabilities are disappeared and trafficked

Mexico's system of institutions for children is de-centralized and children are placed mainly in private facilities. There is a near total lack of oversight in these facilities, and there is no centralized or consistent system to monitor what happens to a child placed in one of these facilities. Without such oversight, all children in institutions are at risk of serious human rights violations. Without community-based alternatives, children with disabilities are particularly at risk.

According to the Federal District Human Rights Commission, children from these facilities have literally "disappeared" – without any record of their name, age, or location of placement and no way for parents to find them. Our investigation similarly found that authorities provide inadequate oversight and may not provide any follow-up on children placed in private facilities or in public facilities. At a residential home for girls we visited in Xalapa, Casa Hogar de Coapexpan, the staff at the facility did not know the name, age, or even the diagnosis of the children with disabilities placed in the facility. We found two young women who had grown up in the facility who now work without pay. The facility reports that there is no public record of the placement of these women in the institution, and there is no legal review needed to detain them indefinitely as laborers. In effect, they are being forced into the modern-day equivalent of slavery because of the lack of available options that would allow them to leave and lead a normal life in the community.

> **We are legally obligated to regulate all institutions for children – where they are, how many are in the institution, and what treatment they get. This is the goal. But the actual system is a black hole.** – *Official of the Department for Infants and Family (DIF Federal)*

> **There is no registry of children sent to institutions […] DIF has no idea how many children are in institutions – no idea. –** *Official from the Federal District Human Rights Commission*

In Mexico there are a "huge number of street children," with approximately 25,000 in the Federal District alone.[9] An estimated 20,000 children are trafficked every year.[10] The lack of assistance to families to keep children with disabilities at home creates an especially high risk of abuse and a special vulnerability to being caught up in trafficking. In Mexico, children with disabilities have literally disappeared into the social service system -- at best. At worst, they have been abandoned into a world of exploitation and abuse.

- People left in permanent restraints are subject to torture or ill-treatment

We observed individuals left permanently tied down in Hospital Psiquiátrico José Sáyago ("Sáyago"), Hospital Psiquiátrico Samuel Ramírez Moreno ("Samuel Ramírez Moreno"), Hospital Psiquiátrico Dr. Adolfo M. Nieto ("Nieto"), and Centro de Atención Integral de Salud Mental de Estancia Prolongada ("CAISAME E.P. Guadalajara"). At Shelter #2 for children in Oaxaca, we observed a girl tied into her shirt sleeves so she is never able to use her hands. In CAISAME E.P. Guadalajara, we found a man wrapped in gauze strips tied head-to-toe in full bodily restraints. Staff says he has been held this way for years. We saw him tied to a wheelchair when we visited ten years earlier in the same room of the same facility. In Sáyago, we found one woman we had met in Ocaranza in 1999. Her photograph appeared in the New York Times story about our findings, showing her entire upper body tied into restraints. More than ten years later, we found her tied to a wheelchair.

The practice of leaving people tied down and restrained over a lifetime causes tremendous suffering and is extremely dangerous. Staff at these facilities report that they tie people down as a way of controlling self-abusive or aggressive behavior. Many people referred to as "chronic patients" are tied down because staff members say they do not have the personnel to provide alternative care for these individuals. People who are subject to long-term restraints suffer the same pain and indignity and are at risk for the same dangers whether the practice is committed out of administrative convenience, because well-meaning staff members are simply overwhelmed, or because professional care is not available to provide necessary treatment. The widespread abuse of physical restraints constitutes cruel, inhuman or degrading treatment or punishment under international law. In some cases, the long-term use of physical restraints may rise to the level of torture.[11]

- The use of lobotomies and psychosurgeries

At Fraternidad sin Fronteras, Hospital Psiquiátrico La Salud Tlazolteotl ("La Salud"), and Hospital Psiqiátrico Campestre Dr. Rafael Serrano ("El Batam"), authorities reported that in the absence of other forms of treatment for behavior problems or aggression, they usually use psychotropic medications. But

when this does not work, people may be subject to psychosurgery. At La Salud, the director reported that four patients had lobotomies over the last four years, though the director at El Batam said that he had not sent a patient away for psychosurgery within the last six years.

> **There are patients where medication does not work. For them, we have brain surgery. They remove the part of the brain that causes aggression. One woman, Pancha, was tied up in the hospital for months but was still aggressive. So we sent her for brain surgery.** – *Director of Fraternidad sin Fronteras*

The directors of Fraternidad sin Fronteras and La Salud both said that they had sent patients for lobotomies. At La Salud, DRI and the CMDPDH investigators observed a man who had received brain surgery. He was slumped over in a wheelchair, and his speech was slow and slurred. The director said that the man had been aggressive in the past, but that since the surgery, he was entirely passive. At La Salud, authorities reported that an independent team must approve before a patient can be subject to psychosurgery. At Fraternidad sin Fronteras, however, authorities reported that psychosurgery needs only be approved by the director of the facility who also acts as a guardian.

The World Health Organization has stated that because of the "irreversible nature" of psychosurgery, psychosurgery should not be performed on people who are unable to give "informed consent."[12] This consent must be "genuine" as determined by an independent review body.[13] Moreover, according to the MI Principles, "Psychosurgery […] shall never be carried out on a patient who is an involuntary patient in a mental health facility."[14] At present, Mexican law does not have the safeguards in place for people detained in institutions to provide the necessary protections against an abuse of psychosurgery.

❖ "A*bandonados*" languish in institutions for a lifetime

DRI and the CMDPDH visited twenty institutions that detain thousands of children and adults in Mexico City and the States of: Jalisco, Mexico, Oaxaca, Puebla, and Veracruz. In most of these facilities, *abandonados* languish for a lifetime. The only exception, among the places we visited, is Hospital Psiquiátrico Fray Bernardino Alvarez ("Fray Bernardino") in Mexico City, which has much greater staff resources than other facilities and treats people for much shorter periods of time. Even at Fray Bernardino, however, people are discharged to Mexico City's locked, residential shelter system if they cannot live independently or do not have family to take care of them in the community. Once placed in these shelters (*casas hogares)*, known as the *Centros de Asistencia e Integración Social* (CAIS), individuals become *abandonados.* We visited CAIS Azcapotzalco, CAIS Coruña, and CAIS Villa Mujeres.

The other long-term institutions we visited throughout Mexico – all locked facilities – detain some or all of their residents indefinitely. The facilities we visited ranged from seventeen to more than 450 beds. Most are located in remote areas that make it difficult or impossible for families or friends to visit. We visited one private facility and one social security hospital, which were cleaner and better staffed than the public facilities. We also visited the *Ciudad Asistencial Conecalli* ("Conecalli"), an orphanage that has a beautifully maintained campus and buildings. Whether institutions are kept clean

or subject patients to squalid conditions, all of these facilities isolate and segregate people needlessly from society in violation of their rights under international law.

> **I love my son, but I cannot afford medications. So I must send him to [the institution.]** – *Letter from a parent, sent to Voz Pro Salud, a non-governmental organization made up of family members and users.*

> **There are no services in the community for people with mental retardation. There are no community services for people with mental illness.** – *Director of Samuel Ramírez Moreno*

- Children with disabilities are subject to discrimination in outplacement and adoption

> **There is no adoption of children with disabilities within Mexico. I have seen only one case in seven years. So children with disabilities remain here for life.** – *Director of Conecalli, an institution for children in Veracruz, including children with disabilities*

Authorities at institutions for children we visited – Conecalli in Veracruz, Fraternidad sin Fronteras in Mexico City, Casa Hogar de Coapexpan, and Shelters #1 and #2 in Oaxaca – report that the primary reason for placing children with disabilities in institutions is that parents do not receive the support they need to keep their children at home. There is no system of foster care for children with or without disabilities. As a result, children from abusive homes, street-children, and children with disabilities are often swept into the same facilities. The only way out of institutions for most children is through adoption or reunification programs for families. Children with disabilities are at a disadvantage because the system of adoption largely excludes them. It is assumed that children with disabilities can never be adopted. Without support for families to accept children with disabilities, it is nearly impossible for families in Mexico to adopt a child with a disability. At the facilities we visited, outplacement services designed to reunite children with families – or provide alternative community placements – are rarely available for children with disabilities.

- Lack of treatment, habilitation, and rehabilitation

Children and adults are detained in institutions because of a lack of treatment, habilitation, and rehabilitation programs – as well as other supports – that would allow them to develop the skills they need to live in the community. Within institutions, the lack of treatment, habilitation, and rehabilitation result in increased disabilities and a danger to their health.

> **We observed a young girl with arms left tied in her sleeves. Staff had no program to treat her self-destructive behavior except to tie her down or hold her. As soon as the staff let go, we observed her hitting her head against the tile floor. The sound was so loud we could hear it out in the hallway. –** *DRI investigator at Shelter #2 for children in Oaxaca*

We observed a near total lack of behavioral treatment for children or adults with problems of self-abuse in all the institutions we visited. In cases where children or adults are self-abusive or have behavioral problems, we observed the lack of programs in Mexico that have proven effective in other countries to respond to underlying symptoms. At the facilities we visited, staff members were unaware of these options and made clear that chemical or physical restraints were the only option available.

Physical therapy for individuals with cerebral palsy is also extremely limited. At Conecalli and at Children's Shelters #1 and #2 in Oaxaca, we observed individuals left in beds whose arms and legs had become increasingly contorted due to lack of use. These individuals appear to leave their beds very rarely, if at all. At Conecalli, authorities report that such individuals receive therapy or organized activities for one or two hours a day – but they remain in bed the rest of the day. This is not enough activity to stop increased deformities and other disabilities. At the Oaxaca children's shelters, they report such activities for one or two hours a week. While staff may do their best with limited resources, individuals with cerebral palsy will become increasingly disabled without continual support.

- Living conditions are inhumane and degrading

> **We have running water for about an hour every morning. We set aside as much water as we can during the day, but by late afternoon we are out of water to clean and we have no more clean cloths. By evening, we have no choice but to leave people sitting in filthy clothes. The smell gets worse and worse as the day goes on. It is very hard to work here, particularly in the night shift.** – *Ward staff of Samuel Ramírez Moreno*

Many of Mexico's institutions are filthy, leaving people to walk around in ragged clothing on barren floors covered with urine and feces. At Hospital Psiquiátrico Cruz del Sur ("Cruz del Sur") in Oaxaca and Samuel Ramírez Moreno in the Federal District, buildings are so old that roofs leak. At most long-term facilities we visited, bathrooms are open and exposed, and people are given showers in groups. There is no privacy. Adults change their clothes, shower, and use the bathroom in full view of other patients and both male and female staff. The investigation team observed adults wandering half-naked in open courtyards, defecating in fields, and remaining outdoors without assistance or redirection from the staff. At El Batam and Nieto, people complained about a lack of hot water and poor food. During our September 2010 visits to Samuel Ramírez Moreno and Cruz del Sur, there was no running water for much of the day. During our visit to Samuel Ramírez Moreno ten years ago, authorities promised that this would soon be fixed, yet no action was taken in the interim.

In most long-term facilities, clothing is shared. Many people lack belts, so their pants are kept up by string. Hospital de Salud Mental Dr. Victor M. Concha Vásquez ("Concha Vásquez") is a converted jail, where patients are kept in small cells behind bars. Even in facilities that are kept clean, however, there is a total lack of privacy or any ability to make the most fundamental choices about life. People eat, go to sleep, or receive medication at the convenience of the institution.

During our visits to long-term facilities in the Federal District of Mexico and the States of Jalisco, Mexico, Oaxaca, Puebla, and Veracruz, we observed thousands of individuals languishing in near-total inactivity – crowded onto benches of barren rooms, lying on the grass or the concrete floor of institutions, or sitting on beds. These environments are totally unsuitable to rehabilitation and regaining the skills needed to reintegrate people into the community. Routines are regimented as people wake up at the same time, go to sleep at the same time, and line up for food at the same time. Most institutions do not allow people to keep their own clothing, and they walk around half-dressed in rags.

❖ Loss of legal capacity

> **For the abandonados, the states make all decisions. It is up to the director of the hospital. I am responsible. –** *Director of El Batam*
>
> **We are legal guardians of everyone here….We do not have to go through any legal process. –** *Director of Fraternidad sin Fronteras*
>
> **If any person living in Mexico City's shelter system wants to have sex, I have to decide if it is safe and consensual. It's up to me to decide for everyone. They have disabilities, so it is very hard**. – *Operations Coordinator of the Federal District's shelter system (CAIS) for 2,700 people*

The law in Mexico recognizes the rights of adults in the general population to work and earn their own money, to own or inherit property, to make choices about place of residence, to marry, to decide on the type of medical care he or she may receive, or about when to have a child of her own, to adopt, or how to raise a child. For individuals with disabilities, however, these rights may be stripped away by the Mexican legal system when individuals are declared disabled or mentally incompetent. Additionally, our investigation has found that people detained in institutions are subject to even broader restrictions. People placed in an institution lose the right to make even the most fundamental daily decisions of life – with no legal process whatsoever. In the regimented confines of an institution, people must wake up, go to sleep, eat, or wear clothing of the institution's choosing and at the time most convenient for ward staff or institutional authorities. Major decisions, such as whether a pregnant woman can keep her child -- or even see her children -- are subject to the decisions of institution directors.

> **I encountered a pregnant woman in one of the long-term wards at Nieto. I asked the director what would happen to the child. He informed me that the baby would be taken from the mother as soon as it was born. I asked whether the mother might be discharged or found to be in a condition that she could keep her child. He flatly answered that, since she was in the facility, this was evidence of the fact that she could not take care of her child and there was no other option. The woman looked on in shock.** – *DRI investigator*

- Access to Justice

The *de facto* denial of legal capacity for individuals with disabilities detained in institutions leaves these individuals unable to seek enforcement of all other rights. These individuals are systematically denied access to justice to challenge their guardianship or to make claims for any other rights that may be violated. Under CRPD article 13, governments must ensure effective access to justice for individuals with disabilities.

- New investments in segregated care

Article 19 of the CRPD creates an obligation on all governments to move away from institutions to guarantee every person with a disability an opportunity to live in the community. Our investigation finds that Mexico is moving in the opposite direction. Instead of investing in the creation of community-based alternatives to meet the enormous gap in services, we observed extensive new building on the grounds of segregated facilities in every area we visited: the Federal District of Mexico City and the States of Jalisco, Mexico, Oaxaca, Puebla, and Veracruz. A representative of the federal Secretariat of Health reported in September 2010 that a major new building program was planned for Samuel Ramírez Moreno in Mexico City. In Guadalajara, mental health authorities reported that they are constructing a new 20 bed residential facility for children. In Orizaba, they are closing down an old facility in the center of the city to create a large, new facility outside of town. A small handful of patients who live in the hospital have jobs in the community, but they will most likely be forced to give them up upon moving to the more remote institution. One new facility for children in Veracruz, Conecalli, was built in 1989 and has the capacity for 100 beds. The facility is rapidly growing to reach capacity, as currently 91 children reside there. In the absence of community services, the director of Conecalli reported to DRI and the CMDPDH investigators that new buildings will be needed within a few years to expand the facility. The Operations Coordinator for CAIS in Mexico City informed us that the population of shelters for people with and without disabilities has increased from 2,300 people four years ago to 2,700 people currently.

Many of the new building programs we observed since our visit in 2000 are small houses on the grounds of existing facilities – in such facilities as CAISAME E.P. Guadalajara, Sáyago, and Samuel Ramírez Moreno. While physical conditions are greatly improved in these new buildings, they continue to segregate people from society. Based on our experience, it is a mistake to use scarce resources to build transitional housing within the walls of a psychiatric facility or other institution.

- 2011 update: New law fails to provide a right to community inclusion

In preparation for Mexico's first report to the UN CRPD Committee, Mexico adopted a new Law for the Inclusion of Persons with Disabilities. The stated goal of this law is to bring about compliance with the CRPD and to promote full inclusion of people with disabilities into Mexican society. The actual provisions of the law fall far short of this goal. The law does not create any right to live in the

community, and it does not create any mandate for the creation of community services. The law does not remedy any of the human rights violations documented in this report.

Conclusions

Mexico has failed to enforce a broad array of rights under the CRPD for thousands of children and adults with disabilities – particularly individuals with mental disabilities – detained in the country's abusive orphanages and psychiatric facilities. The failure to implement the right to live independently in the community, as protected by CRPD article 19, has meant that people with disabilities are unnecessarily detained in institutions and end up having to forfeit almost every other right they have under the new convention. People with disabilities are arbitrarily detained (in violation of CRPD article 14); denied their right to recognition as a person and legal capacity (article 12); denied the right to health (article 25); rehabilitation and habilitation (article 26); and education (article 24). Conditions within institutions violate the right to freedom from torture, cruel, or inhuman treatment or punishment (article 15), and the failure to provide medical care subjects them to a violation of the right to life (article 10). By placing institutionalized people with disabilities under *de facto* guardianship without due process or legal control, individuals are vulnerable to abuse and lose their right of access to justice (article 13). Mexico has failed to create a system of monitoring and oversight for institutions or communication programs as required (article 16). As a result, women and girls are particularly vulnerable to abuse – and they may be subject to trafficking for sex or forced labor.

These findings are particularly disappointing since the conclusions of this report are nearly identical to what we published in ***Human Rights & Mental Health: Mexico*** in 2000 and what the Pan American Health Organization assessment found in 2004. The government of Mexico has been on notice about the urgent concerns of people detained in Mexico's institutions – yet it has not taken action to remedy these serious human rights violations.

Mexico's international leadership in advancing the rights of people with disabilities by sponsoring the CRPD at the United Nations provides new hope that the government of Mexico will now take the action necessary to protect the rights of children and adults with disabilities detained in its facilities. Even more importantly, a movement of people with disabilities is growing and taking the initiative to hold its government accountable to implement the rights established under the new CRPD. This new movement run by people with disabilities – and the national accountability they demand – provides the greatest hope for change in Mexico.

Obligations Under International Law

As a member of the United Nations and the Organization of American States, and a country that has ratified the CRPD, as well as other international human rights instruments, Mexico has an obligation to ensure that people with disabilities receive full protection under international law. By ratifying the CRPD, Mexico has agreed to adopt the appropriate legislative, administrative or other measures necessary "to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities."[15] Mexico must adopt and enforce laws that protect the right to non-

discrimination, legal capacity, and protection from arbitrary detention. Mexico is required to provide adequate care and protection from harm as part of its obligation under international law. Mexico is also required to protect against the abuse of restraints that constitute torture or cruel, inhuman or degrading treatment or punishment. Mexico has an immediate obligation to establish an open, transparent, and accountable process of planning for mental health and social service system reform to end discrimination, enforce the right to self-determination, community inclusion, and ensure that adequate services are available to implement the right to health, rehabilitation, and habilitation. As described in Section VII of this report, international law provides guidance to governments about the concrete and deliberate steps they must take ensure accountability in national planning to fulfill their legal obligations. As required by the CRPD, this includes an obligation on Mexico to involve organizations of people with disabilities throughout this process.

Our recommendations for steps Mexico can take to implement these rights follow at the end of this report.

June 2011 update: Since we first released the report in November 2010, we have received no official response to the report. On April 27, 2010, the government of Mexico submitted its official report to the UN CRPD Committee on compliance with the convention. The government's official report fails to address the enforcement of human rights for the thousands of children and adults with disabilities detained in Mexico's orphanages, psychiatric institutions, or other facilities. It fails to respond to any of the documentation of abuses we have included in this report. While the official report discusses the protection of article 12 in depth, it does not respond to documentation in this report that Mexico's own law is systematically ignored and that people detained in institutions are systematically denied any protection of their right to legal personhood or legal capacity. By failing to recognize the basic rights violations documented in this report, Mexico cannot set itself on the road to enforcement of this convention.

The government of Mexico has yet to withdraw its reservation as to article 12 of the CRPD. On May 27, 2011, the President of Mexico "promised to support the proposal of Senator Guillermo Taborrel to analyze the issue and proceed with the withdrawal of the declaration."[16] Mexico continues to pervasively deny the right's protected under article 12 for individuals with disabilities detained in institutions.

Preface: Human Rights Reporting under the Disability Convention

The government of Mexico is the world's leader in bringing about international recognition of the rights of people with disabilities under international law. In December 2001, Mexico introduced a resolution at the United Nations General Assembly to create a committee that would "consider proposals" for drafting a new convention on the rights of persons with disabilities.[17] With support from Mexico, the United Nations convened drafting sessions that included disability leaders, human rights experts, and governments around the world to draft the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD was adopted by the United Nations on December 13, 2006,[18] and it entered into force as binding international law on May 3, 2008 after the first twenty countries ratified it. The convention has since gained worldwide support with unprecedented speed.[19] As of May 2011, 148 countries have signed the CRPD and 100 have ratified it.[20] According to the United Nations, the CRPD has gained worldwide support faster than any human rights convention in history.[21]

Mexico was among the first countries of the world to ratify the CRPD and its Optional Protocol on December 17, 2007.[22] By ratifying the Convention, Mexico has agreed to "adopt all appropriate legislative, administrative and other measures" necessary for implementation of the rights established in the convention.[23] In addition, every government that ratifies agrees to report to the UN Committee on the Rights of Persons with Disabilities (UN CRPD Committee) on steps it is taking "to give effect to its obligations" with the terms of the convention.[24] The UN CRPD Committee then issues an assessment of the country's steps toward implementation of the CRPD. Governments that have ratified the CRPD are obligated to report within two years after it enters into force in those countries, followed by reports every four years or at the request of the UN CRPD Committee.[25] Not only do these reports provide a means of ensuring compliance, but they provide States Parties with "the opportunity to take stock of the state of human rights protections within their jurisdiction for the purpose of more efficient policy planning and implementation of the Convention."[26]

It is common for non-governmental organizations to submit "shadow" or "parallel" reports to UN oversight bodies to provide independent documentation that will help evaluate a country's compliance with international law, while also providing policy and implementation recommendations. Parallel reports can be useful to provide a commentary or critique of official government submissions to UN oversight agencies. As one of the first countries to ratify the CRPD, Mexico is one of the countries to be reviewed by the UN CRPD Committee this year. Mexico's official report is now due.

As they prepare their official reports to the United Nations, the CRPD specifies that governments are "invited to consider doing so in an open and transparent process" and to give "due consideration" to the perspectives of persons with disabilities consistent with article 4(3) of the CRPD.[27] That provision of the CRPD requires governments to "consult with and actively involve persons with disabilities […] through their representative organizations."[28]

DRI and the CMDPDH will join other disability rights and human rights organizations in Mexico to submit coordinated parallel reports to the United Nations once the official Mexican report has been published. The DRI-CMDPDH report, ***Abandoned and Disappeared,*** is intended to provide background information to disability rights activists, the public, and the government of Mexico to assist in the preparation of official and parallel reports with regard to Mexico's population of children and adults with disabilities who are detained in institutions. ***Abandoned and Disappeared*** identifies policies, programs, and legislation that should be reformed to bring Mexico into compliance with the CRPD.

People with disabilities have been involved in all aspects of investigating, writing, and publishing this report. The authors have solicited testimonies, in particular, from individuals with psychosocial disabilities who have received services through Mexico's mental health and social service system. These testimonies are attached to this report and posted on the web at www.disabilityrightsintl.org. We have consulted extensively with Mexican organizations made up of people with disabilities in preparing this report, as well as family organizations of people with intellectual disabilities, such as the Confederación Mexicana de Organizaciones en Favor de la Persona con Discapacidad Intelectual (CONFE).

People detained in institutions are inherently vulnerable to abuse in any country because of their isolation from society. In addition to the CRPD-mandated process of consulting with disability organizations, extra effort is needed to ensure transparency and public understanding of conditions in institutions. Once they are segregated from public life, people in institutions may lose their connections with friends, family, and independent advocacy groups that might otherwise help them should they face violations of their rights. An understanding of the human rights and daily living concerns of people with disabilities requires direct first-hand observation within institutions, as well as interviews with the people who live and work in institutions.

In preparing this report, DRI draws on our experience of conducting similar investigations and assessments in more than two-dozen countries. We have written or published human rights reports on eleven countries of Europe, South America, Asia and the United States (*see* www.disabilityrightsintl.org). In 2000, DRI published ***Human Rights and Mental Health: Mexico*****,** which provided us with background information that allowed us to assess the changes in mental health practices that have taken place over the last decade. The CMDPDH draws on their experience of investigating and publishing human rights reports, as well as litigation on a broad range of human rights issues in Mexico over the last twenty years (*see* www.cmdpdh.org).

It is not our intent to place personal blame on any of the staff who work in Mexico's institutions. These individuals work under extremely difficult circumstances. Many of the staff have opened doors and have given generously of their time to explain the operation of institutions and to describe human rights concerns. Some of the staff and institutional authorities who we interviewed told us that they were taking personal risks to speak out about problems in the institutions. A number of staff told us it was their hope that our report would bring public exposure to conditions in institutions and would bring about more resources and better treatment for individuals with disabilities. DRI and the CMDPDH hope that this report will assist the public and the government of Mexico in identifying major priorities for reform to end the most egregious abuses being faced by people with disabilities within institutions –

and to lead Mexico toward the full enforcement of its obligations under the CRPD to provide full community inclusion and participation in society by people with disabilities.

In our experience, the government of Mexico has done an outstanding job of meeting its obligation to promote openness and transparency in preparing its official report, as required by article 35 of the CRPD. We obtained nearly complete access to visit institutions and programs serving people with disabilities throughout Mexico from federal, state, and Mexico City authorities. The Instituto de Asistencia e Integración Social (IASIS) was also enormously helpful. The Secretariat of Health and the Department of Psychiatric Services opened their doors to allow us to conduct a workshop about the CRPD and its significance for mental health reform.

Mexico is a large and varied country, and DRI and the CMDPDH recognizes that this report describes only part of a complex system of services. This report provides a general picture of the public services available to people with mental disabilities within the Federal District, a city of 21.3 million people.[29] It also includes findings from institutions in the States of Mexico, Puebla, Jalisco, Oaxaca and Veracruz. While conditions may vary throughout Mexico, the Chief of Mental Health Services for the federal government told DRI and the CMDPDH in November 2009 that mental health services in the Federal District are significantly better than in the rest of the country. The investigators are interested in any information that may help us improve our report to the UN CRPD Committee. Please send any comments or corrections to this report to info@disabilityrightsintl.org and info@cmdpdh.org

This report examines Mexico's public system of services for people with disabilities. It does not examine the country's extensive private system of care. The greatest source of hope that we see for reform in Mexico comes from the independent, non-governmental sector. We have observed the development of a growing disability-controlled advocacy movement that is now actively engaged in human rights and public policy advocacy. This advocacy is supplemented by many impressive initiatives that have been established by private, non-governmental organizations. These new initiatives provide crucial support for participation in society by people with disabilities. We have attached commentaries by some of these independent activists and service providers.

June 2011 update: This report was released in Mexico City on November 30, 2010, and the findings represent our knowledge as of that time. The revised edition of this report, published in June 2011, reflects legal developments in Mexico through May 2011.

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about the significance of the CRPD and the right to community inclusion in Mexico. The Human Rights Commission of Mexico City and the Children's Rights Network provided us with valuable information about special concerns of children in institutions. Confederación Mexicana de Organizaciones en Favor de la Persona con Discapacidad Intelectual (CONFE), Asociación de Familiares y Amigos de Personas Esquizofrénicas (AFAPE), and Voz Pro Salud Mental introduced us to members of their organizations and gave us essential background about the operation of the mental health and social service system. The Instituto Mexicano de Derechos Humanos shared invaluable information and insights about human rights in Mexico's disability service system. Above all, we thank current and former users of mental health system and their family members who courageously shared details about their lives and experiences receiving care in Mexico's institutions. We are grateful for their contributions to this report.

A number of key experts helped us with this report. Gabriella Camera and Amalia Gamio provided us with invaluable insights as to the operation of Mexico's mental health and social service system. Ximena Antillon organized our initial investigation and conducted numerous site visits with our team.

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I. Segregation from Society of People with Disabilities

> **Decisions to isolate or segregate persons with mental disabilities, including through unnecessary institutionalization, are inherently discriminatory and contrary to the right of community integration enshrined in international standards. Segregation and isolation in itself can also entrench stigma surrounding mental disabilities. –** *UN Special Rapporteur on the Right to Health, Paul Hunt*[30]

> ***States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right….*** **–** *Article 19 of the CRPD*

The segregation of a person from society in a closed institution for a long period of time is enormously disruptive to a person's life in the community. For a young person, it may disrupt his or her education, professional development, and establishment of normal social ties. For a working person, it may mean the loss of a job and the economic opportunity to care for oneself or one's family. For a mother, father, husband or wife, placement in an institution may take a person away from family members they love and who depend on them. Research has shown that people can develop behavior disorders and mental deterioration as a result of institutionalization.[31]

Based on these findings, the Pan American Health Organization gathered experts from around the Americas twenty years ago to establish consensus for the *Declaration of Caracas* calling for the transformation of mental health care systems to permit community integration.[32] While the *Declaration of Caracas,* a non-binding declaration that was the product of a technical agency dedicated to the advancement of good mental health care, it established a human rights principle that has now come to be recognized as binding international human rights law. Article 19 of the CRPD now recognizes "the equal right of all persons with disabilities to live in the community, with choices equal to others…."

Mexico's mental health system segregates thousands of people for life in long-term institutions, some of which are known as "*granjas"* (farms). Our investigative team visited twenty long-term institutions, in which more than 1,890 children and adults are segregated from society. This constitutes only a small portion of the total number of individuals detained in Mexican institutions. According to the Secretariat of Health, there are 33 psychiatric and mental health hospitals in Mexico.[33] There are 31,532 clinics and 36,351 beds for the uninsured in the health sector, but only 1.8% of the resources allocated to mental health are for clinics and 12.7% are for in-patient beds.[34] 0.65% of resources for health are allocated to psychiatric and mental health services.[35] The Secretariat of Health estimates that "Of 100 people with severe mental disorders, only 2.5% receive the necessary care."[36] The actual number of people detained in psychiatric and mental health hospitals may be much higher, as the system is decentralized and the federal government does not monitor or regulate many institutions run at the state level. The Secretariat of Health numbers also do not include the thousands of children in

institutions. Children's institutions are theoretically under the authority of the Sistema Nacional para el Desarrollo Integral de Familia (DIF Federal), but authorities from DIF Federal informed DRI and the CMDPDH investigators that they have no idea how many children are in institutions. As the Jefe de la Unidad de Asistencia e Integración Social (Chief of Assistance and Social Integration) Unit pointed out to us, federal monitoring of children's facilities requires voluntary reporting by states – and many states simply never report to the DIF Federal.

> **There is no registry of children sent to institutions….DIF has no idea how many children are in institutions – no idea.** – *Official from the Federal District Human Rights Commission*

This report confirms the finding of an assessment by the Pan American Health Organization (PAHO) in 2004, which says: "In sum, it cannot be asserted that the Mexican health system embraces a community approach; the 'pillar' of the system is still the psychiatric hospital, with the observed shortcomings and its elevated cost. Almost all of the hospitalization and most of the outpatient activities are offered still within the psychiatric hospital, rather than in the general hospital or the community."[37] As PAHO found, there is almost no alternative to long-term psychiatric institutions for people with mental disabilities. The supports people with disabilities need to live in the community are almost entirely absent – including a lack of housing, occupational opportunities, income support, or assistance with leisure activities and social inclusion.[38] The PAHO study found that only a small number of people who are receiving social security have access to mental health services at a general hospital. In the region studied by PAHO, people who need in-home support have no choice but to receive inpatient services in psychiatric facilities.[39] Community mental health centers do exist, according to PAHO, but they do not address the needs of individuals with psychiatric or intellectual disabilities.[40] These are the children and adults most at-risk of detention in an institution and segregation for life in Mexico's institutions.

This report focuses on the system of public health care that serves the majority of the population of Mexico. There is a private system available in Mexico for individuals who can afford it. In addition, there is a social security system serving about 40% of the population, which provides some mental health care.[†]

Our investigative team met with the Chief of Psychiatric Services for the Secretariat of Health within the Federal Government who explained that the problem of public institutions is a result of limited funds – and a misdirected use of the funding that is available. He explained that only 2% of the federal health budget goes to mental health and less than 10% of people with mental health needs or other mental disabilities receive *any* form of treatment. Most health resources go to general hospitals, which do not provide mental health services. Mexico's strategic plan for mental health states that everyone in need of mental health treatment should receive such treatment in the community. In practice, says the Chief of Psychiatric Services, there is no funding for community services. At Fray Bernardino and La Salud, two facilities with a commitment to outpatient care, authorities explained that

[†] There is one system for government workers (ISSSTE) and another (IMSS) for individuals who have paid into a social insurance system through their employment. Concerns about gaps in mental health treatment through the social security system are described in section C below.

they need to take funds out of their budget for inpatient care to pay for community-based care. Without any independent source of funding for services, the provision of community services is virtually impossible.

> **It is a paradox – we know what the problem is and we know how to fix it. But the problem is still there and we don't move forward. –** *Chief of Psychiatry for the Secretariat of Health, referring to the lack of funding for community-based services.*

> **The government says it wants to build a safety net in the community so we can reduce the size of the institution. It exists only in their head. We have no plan. We have nothing. –** *Director of a major institution in Mexico who requested his comment to remain anonymous*

A. Abandonados remain in the institution for life

> **Most [patients] are here at this facility because of extreme poverty and mental disability. We have adults without identification. We don't know where they came from.** – *Director of Fraternidad sin Fronteras*

At the long-term facilities and *granjas* we visited – Samuel Ramírez Moreno, Nieto, Sáyago, El Batam, CAISAME E.P. Guadalajara, Cruz del Sur, Concha Vásquez, and Fraternidad sin Fronteras, a large portion of patients are referred to as *abandonados* because they have no contact with families and no place to go. These individuals have no opportunity to return to the community and are inevitably left to live out their entire lives in institutions. The majority of individuals at each of the facilities we visited were referred to as *abandonados.* These individuals are also sometimes referred to as *crónicos* because their mental condition is never expected to improve.[‡] At El Batam, for example, authorities reported that 80% of the patients are "crónicos" who will "stay here forever." The other patients can return to the community only if "they have families who will take them."

At El Batam, the director stated that the problem of the *abandonados* is closely linked to the lack of community-based services. Family members unable to afford care for their relatives simply drop off their relatives at the institution and do not leave any contact information or address so the facility cannot contact them. As a result, authorities at El Batam and other facilities reported that in many cases they do not know the identities of the *abandonados.*

> **Sometimes the families give us a fake address so we can't find them again. They just put them [family member with a disability] in a taxi and send them to us.** – *Director of El Batam*

The director of El Batam also described pressure from political authorities to accept patients who are not disabled but simply have no place else to go. **"**Unfortunately," he told us, "we have a big

[‡‡] As described in section II, part B, long-term institutionalization itself contributes to increased disability. It has been established in the psychiatric literature that perceptions of an individual prognosis as "hopeless" can lead to being considered chronic.

problem with the homeless. People are living in the streets because of poverty. The police bring them here, even if they do not have a mental illness. We generally do not accept them. We are not supposed to take new long-term patients, but we have to. There is no other option for them." During our visit to El Batam, we interviewed a number of patients who reported to us that they were admitted to the facility simply because they were homeless and had no place to go. One woman said she did not know if she would ever get out.

Due to the overwhelming shortage of community-based services and supports, some institutions have made the decision only to take *abandonados* who have no place else to go. These individuals may actually have a family, but their disability is considered so "severe" that their relatives cannot or do not care for them at home. At Fraternidad sin Fronteras, for example, authorities report that some of these relatives maintain contact and come to visit their relatives in the facility.

According to the president of Voz Pro Salud Mental, an association of family members and users, the remote location of institutions contributes to abandonment. Many families of people with disabilities have to travel from distant parts of the country to place a person in an institution in an urban area, she explained, and the cost of travel on the part of family members can be prohibitive. Even for family members who live in Mexico City, "we have cases where families have to take three buses to get their loved one to a hospital to get care."

B. People are detained in institutions because of a lack of community services

> **If you have a suicidal relative, there is no treatment available outside the hospital (unless you have enough money to pay for a private hospital). One of our members committed suicide recently while waiting for treatment. It was tragic.** – *President of Voz Pro Salud Mental, an organization of family members of people with psychosocial disabilities*

Even where people have families to take care of them, many people are forced into institutions because of a lack of medications or support in the community. The Pan American Health Organization similarly found that there is a lack of support for outpatient treatment, including medications.[41]

> **I love my son, but I cannot afford medications. So I must send him to [the institution.]** – *Letter from a parent, sent to Voz Pro Salud Mental*

> **They can buy tortillas, or they can take their medication. They can't do *both*.** – *Director of Samuel Ramírez Moreno Hospital*

> **There are no services in the community for people with mental retardation. There are no community services for people with mental illness. There is no net of services for people outside the hospital….If we reduced the hospital**

> **size right now, we would have a big problem of homeless people.** – *Director of Samuel Ramírez Moreno Hospital*

Very often, families place their relatives in the institution simply because they cannot afford the cost of medications in the community. The director of Samuel Ramírez Moreno stated that medications are free at his facility, but he was unaware of any program to provide free medications in the community. "Perhaps the Federal District provides some free care," he conceded, "but most of the patients at his facility cannot benefit from it."

According to the director of Fraternidad sin Fronteras, the lack of access to medications in the community and lack of training for parents to help them work with their children are the "main obstacles" to children staying with their families. The lack of treatment and support in the community creates a vicious cycle, even when institutions try to return a family member to the community.

In CAISAME E.P. Guadalajara, authorities explained that "people leave here, they cannot get access to medications, they break down again, and so they have to come back." This was particularly true of a young woman, E., who the investigatory team met at Sáyago. Although she was able to hold a job in the community doing housekeeping, her mother would bring her to the institution for month-long stays. As such, E. cycled in and out of the institution because there were no community services.

The problem of lack of medications leads some women into the criminal justice system and to jails or prisons At the Mexico City jail, *Centro Femenil* de *Readaptación* Social en el T*epepan*, a psychiatrist observed that, in his experience, some women commit minor crimes so they can return to jail and get the medical care and medications they need.

In theory, the social security system covers mental health care in the community, but family members report large gaps within this system as well. "They don't recognize some mental disabilities," according to the president of Voz Pro Salud Mental. "There is no coverage for bipolar disorder. They do provide some treatment for depression, but if you lose work because of depression, they do not recognize you as disabled."

The investigative team visited La Salud, a psychiatric facility in the State of Mexico. Authorities at this facility report that they have an out-patient program that provides mental health care, public education, and outreach in the community to individuals who are part of the social security system. The director of La Salud reports that "it's cheaper to provide outpatient care, so it is our policy to [provide the community care necessary to] reduce the inpatient population." While the authorities at La Salud are proud of their program, they report numerous bureaucratic hurdles that limit the extent of community care they can provide. People in the social security system have access to a broad array of health care services in the community, and there are an enormous number of people who need access to psychotropic medications to live independently in the community. "But the problem," according to the director of La Salud, is that "only psychiatrists can prescribe this type of medication, and they are all here at this hospital." This creates an enormous burden on the facility. Authorities at La Salud report that there is no funding dedicated to community services, and they get no extra funds for any of the

community outreach that they choose to provide. While they could serve many more people by providing community care, they can only do so at the expense of the already limited hospital budget.

II. Conditions in Institutions

I walked into a room that I had visited ten years before at CAISAME E.P. Guadalajara. Ten years ago, children were left lying on mats in this room, rocking back and forth, some gouging their fingers in their eyes. When I came back, I found many of the same people in the same room but now they are in their teens or early twenties. They were in the exact places, still on the floor on mats. Many of them had bandaged hands from biting themselves. I saw the same boy in a wheelchair that I had met ten years before in the same chair. Staff confirmed that he was kept permanently restrained. – *DRI investigator at CAISAME E.P. Guadalajara*

Conditions in Mexico's institutions are nearly identical to conditions we observed ten years ago and documented in ***Human Rights & Mental Health Mexico*** **(2000).** Short term facilities like Fray Bernardino – where they also have much higher levels of staffing and psychiatrists than at any other institution – are far better than at other institutions. Some long-term facilities we visited are kept physically clean, while others are filthy and filled with overpowering smells. Some of the facilities we visited were clean in the morning but slowly degenerated over the course of our stay (in some places this is because of the lack of running water that prevents cleaning in the afternoon and evening). The facilities that cater to patients on social security and the one private facility we visited were physically much cleaner and better staffed than public facilities. Apart from these cosmetic differences, however, the conditions and human rights concerns in long-term facilities are strikingly similar. Many of the large facilities for adults have large open areas with fields and trees. Yet people are grouped together in crowded rooms. The vast majority of people languish in inactivity, sitting on beds, chairs, or floors doing nothing. Clothing is shared, old, and ill-fitting. At most facilities, we observed almost no interaction between patients and staff. We observed patients eating from floors covered in urine at Nieto and Samuel Ramírez Moreno, and the staff did not intervene.

I observed a woman tied to a wheelchair and sitting in a puddle of her own urine at El Batam. I pointed this out to the nursing staff, who did nothing to help her. After a while, I asked the director why no one helped this woman. The director of the facility explained that the institution lacks funds for diapers. He then did nothing. I pressed the director as to why the nurses did not at least clean the woman. Finally, he explained that the union had negotiated a contract that only the cleaning staff would do such jobs and the nurses were not required to do so. There were apparently no cleaning staff available, so the woman remained sitting in filth. *– DRI investigator*

In many of the institutions we visited, authorities reported that, due to applicable working contracts to union workers, the staff at the hospitals only do what it is explicitly said in such contracts. Investigators

are in no position to evaluate this claim. Ultimately, it is up to mental health authorities to ensure that people with disabilities are treated in a manner that is professional, caring, and respectful of the choices and needs of individuals being served.

A. Inhumane and degrading conditions

> **They treat us like garbage. At first it looks nice here, but it is really not. They hit us. They don't listen to us. They do not even give us Kotex. –** *Woman detained at Sanatorio Psiquiátrico de Nuestra Señora de Guadalupe*

1. Filthy and unhygienic conditions

Conditions at many of the long-term facilities we visited are filthy and unhygienic. At CAIS Villa Mujeres, a shelter under the authority of the Ministry of Social Development of the Distrito Federal, the smells are so overpowering that some patients reported they sat outside to get away from the odor of the buildings. The Operations Coordinator of CAIS reported that their budget is so low that they cannot afford toilet paper or soap for the residents; they rely on donations or require residents to buy their own. At the Samuel Ramírez Moreno and Nieto, our investigative team observed men and women wandering around or lying on concrete floors completely naked or partially clothed. We observed residents on these wards urinate on the floors, step in it, and mill around in their own filth. At Nieto, we observed a man pick up a food container from an open sewer and lick it – in front of staff that did nothing to intervene. The smell of human waste overwhelmed these wards. A nurse at Cruz del Sur reported that water leaks in the facility when it rains and that, until recently, patients were forced to sleep on the floor because of a lack of mattresses. As of September 2010, the director of Samuel Ramírez Moreno told us that running water was only available from 6am to 9am each morning. For the rest of the day, there is no water for toilets, sinks, showers, or laundry.

> **I first visited Samuel Ramírez Moreno Hospital in 1992, and they told me that they were about to fix the water pipes because of the lack of water in the institution. I returned to the facility in 1999 and the problem had still not been fixed. In September 2010, I returned to the facility and observed people sitting in clothes covered in urine and feces. Staff told me that they had run out of water to clean the patients, and there was no clean clothing. Authorities promised that the water problems would soon be solved by a major rebuilding project at the facility.** *– DRI investigator*

At El Batam, DRI and the CMDPDH investigators observed a man tied to a wooden bench in the men's ward. Restrained and unable to walk to the bathroom, the man urinated on the bench where he was. He then took off his pants and tried to wring them out. Nobody came to help him change or to clean up the urine. In another ward, DRI and the CMDPDH investigators observed an elderly woman in a wheelchair covered in urine and feces. When investigators alerted the director to the woman's

condition, he ordered a nurse to clean her up and to put a diaper on her. The nurse took the woman to another room. After five minutes, investigators observed the same woman in the sleeping area. She had not been changed, but had simply been placed in a corner. When we asked the director again about the woman, he admitted that the institution does not have a budget for an adequate supply of diapers. Despite this, no effort was made to clean the woman.

At CAISAME E.P. Guadalajara, we observed an entire ward line up to take their medication. One by one, they received their pills from the nurse and swallowed them with water from a single plastic cup that everyone shared. The risk of disease or infection was ignored.

2. Lack of adequate clothing

During its investigation, DRI and the CMDPDH investigators observed a basic lack of adequate clothing at many of the institutions. Of the people that were wearing clothes at the CAISAME E.P. Guadalajara, Nieto, Sáyago, El Batam, La Salud, Samuel Ramírez Moreno, and Concha Vasquez, many were dressed in identical or interchangeable garments. Residents wore clothes that were too big or too small. Many residents tied their pants up with string or simply let them fall off. At CAISAME E.P. Guadalajara, one resident's pants were kept in place with adhesive tape around his waist.

Another detail that DRI and the CMDPDH investigators noted was the lack of shoes. In all of the above institutions, many of the residents walked the grounds without shoes. Their feet were covered in dirt, thick calluses, and open sores. The director of Samuel Ramírez Moreno said that often residents do not like to wear shoes and choose not to. However, at El Batam, one resident pointed at her feet that were covered in sores and began to moan. She explained to a DRI investigator that although she had shoes, they hurt her and did not fit properly. Either way, DRI and the CMDPDH observed many people with calluses and sores.

3. Lack of privacy and personal space

Just as residents lacked personal clothing, residents also lacked places to keep personal possessions. In all of the adult psychiatric institutions, except for the "Hidalgo model" programs and one private facility we visited (Sanatorio Psiquiátrico de Nuestra Señora de Guadalupe), beds were lined up in rows with little decoration or personalization to distinguish one from the other. At La Salud, old rusted lockers leaned against some of the walls, but when DRI and the CMDPDH inquired about their use, we were told that they were for hospital personnel only.

> **They make us all shower together. There is no privacy. In the morning, it is cold and the wind goes right through the door. I hate it.** – *Young woman at Concha Vásquez*

At almost all of the public facilities, toilet stalls are open and there is a lack of individual showers. A middle-aged man at La Salud complained about communal showers, adding that if residents get up very early, they can take a shower individually. Otherwise residents must shower together. At

Nieto, Samuel Ramírez Moreno, El Batam and Cruz Del Sur we observed adults forced to stand naked in front of staff and other patients when they showered, went to the bathroom, or changed their clothes.

4. Lack of protection against violence and sexual abuse

> **The staff beat us. Patients hit each other. There is no way to protect ourselves here. –** Male patient at CAISAME E.P. Guadalajara
>
> **I was raped here two years ago by a member of the staff. The man who raped me ran away. I asked to be transferred to this ward where the patients are older and I feel safer […] The truth is, I felt safer when I was living on the streets. –** Blind woman with a psychosocial disability detained at the CAIS Villa Mujeres in Mexico City

Numerous patients in Mexico's psychiatric facilities report physical and sexual violence within institutions. With extremely low staffing in most facilities, patients wander the halls and are left alone in rooms without supervision. Given these staffing levels, it is impossible to protect patients from violence.

At CAISAME E.P. Guadalajara, DRI and the CMDPDH investigators observed a resident with black eyes and a nose that was swollen and bandaged in white gauze. The director of the institution said that he had been hit by another resident, but that no measures had been taken to ensure the safety of the other residents. At the same institution, a young resident confirmed what we had been told about violence among the residents, saying that when residents got into fights, the staff did nothing or gave the residents sedatives.

At Nieto, DRI and the CMDPDH investigators observed another incident of neglectful inter-resident violence. In a small, secluded courtyard, one resident pushed another resident and knocked her over backward. The woman fell and smacked her head against the ground and immediately began to sob. Neither staff nor hospital personnel moved to help, and we had to help the woman up off the ground and ask for assistance ourselves. After some time, staff from the institution came and helped her into the ward and put her in bed with a blanket. No one assessed the woman for head injuries even though her head had hit the cement with considerable force nor did anyone examine her arm even though she was cradling it as though it hurt.

At the CAIS Villa Mujeres for women in Mexico City, the Operations Coordinator said that she is very sensitive to the concerns of women who allege that they have been abused in the facility. She was also sensitive to resident's sexual needs, even though there is no private space for sexual relationships. Given the fact that many women spend their lifetimes in the facility, she says it is impossible to stop them from having sexual relationships with other residents of the facility or outsiders. She explained that it is up to her personally to try to make sure that relationships are not coercive or abusive. There is no formalized system for approving relationships, and it is entirely up to her as guardian of everyone in the facility to determine relationships are consensual. As Operations Coordinator of all CAIS facilities,

she is the *de facto* guardian for more than two thousand residents. She says that this is difficult because many of the residents have mental disabilities, and they are hard to understand. She explained that "I try to make sure that their situation is equal."

When women allege sexual abuse at CAIS Villa Mujeres, the Operations Coordinator says that she is very concerned about protecting her residents. There is no specialized care or counseling for such women, however, and there is no mechanism for privately reporting abuse. The Operations Coordinator explained that she always brings the women to the police. We discussed the case of a blind woman with a psychosocial disability who was abused in her family and was homeless before being placed in the institution. She was raped two years ago in the facility, and she frequently reports being abused again in the facility. The Operations Coordinator brings her to the police whenever this woman reports abuse, but the director explained that the woman always refuses to talk to the police. The Operations Coordinator says that the known abuser was removed from the staff two years ago, but she does not know what to do when the woman continues to allege abuse. This woman has no family to help her and no outside friends. She knows of no outside women's organizations or other independent groups that could help her.

B. Long-term physical restraints

> **One can take a perfectly healthy human being, tie them in a wheelchair, and they will die if you leave them immobile for long periods of time. Everything shuts down. All body systems are dependent on movement. –** *Karen Green McGowan, developmental disabilities nurse*
>
> **He has spent his whole life in this bed. –** *Director of Samuel Ramírez Moreno*
>
> **Although most nurses cite the rationale for placing a restraint on a patient is for his own safety, there is little evidence that patient safety or reduction in injuries is actually achieved.[42] –** *Lippincott Manual of Nursing Practice*

The widespread use of long-term physical restraints is perhaps the most serious human rights violation we observed in institutions in Mexico. The long-term detention of a person in restraints can cause great suffering, and it has been identified by international human rights authorities as a practice that may constitute torture (see discussion in section V-D below).[43] From a strictly medical perspective, this practice is extremely dangerous and is likely to cause medical complications that can be life-threatening.[44] The World Health Organization has determined that "long-term bodily restraint" is a "cruel treatment often leading to muscular atrophy and skeletal deformity."[45]

The use of long-term restraints in Mexican institutions is particularly dangerous because it is used as a means of long-term maintenance of patients for whom there are no other forms of rehabilitation or habilitation. Thus, restraints are not a temporary exception to daily routine; they are

the routine for people who are left in institutions for years. We observed this practice at Sáyago, El Batam, Fraternidad sin Fronteras, CAISAME E.P. Guadalajara, Samuel Ramírez Moreno, and Nieto.

On numerous occasions, we were told by hospital directors and nurses throughout Mexico that restraints were necessary to either prevent falls or control self-injurious or disruptive behavior. However, according to the Lippincott Manual of Nursing Practice, "[m]ultiple studies have found that restraints actually increase incidence of falls, can result in patient strangulation, can increase patient confusion, can cause pressure ulcers and nosocomial infections, can decrease functional ability, and can result in social isolation."[46] Moreover, "[i]n regard to the patient's personal and social integrity, restraints have resulted in emotional responses of anger, fear, resistance, humiliation, demoralization, discomfort, resignation, and denial."[47]

In CAISAME E.P. Guadalajara, we found the same man restrained to an ill-fitting wheelchair who we had filmed ten years ago tied down head-to-toe. Staff said that he had to be restrained to prevent self-abuse. In Sáyago, we found a room with thirty-two people all tied to wheelchairs. We identified one woman tied to a wheelchair in Sáyago whom we had photographed ten years earlier in a wheelchair at the Ocaranza psychiatric facility in Hidalgo. Not one of the wheelchairs we observed in any of the facilities was adjusted to properly fit the people who spent most of their waking hours in them. In addition to use of wheelchairs, we also witnessed other forms of permanent physical restraints. At Samuel Ramírez Moreno, we found a man with a helmet that was strapped tightly to his head. His arms are tied behind his back in his shirt sleeves, and his hands are covered. We visited this facility in March and September 2010 and found the man in the exact same form of restraints wandering around in a court yard. Staff showed us his bed which is equipped with leather straps. Staff explained that he is kept permanently in restraints day and night. The Subdirector of Hospitalization said that the institution had no other option but to place the man in restraints. Upon questioning, however, he conceded that the man was not receiving any sort of behavior modification therapy or less restrictive treatment to reduce the need for this type of restraint.

At many of the facilities, we observed individuals in wheelchairs with legs and feet swollen and purple. The swelling and discoloration is caused by the lack of circulation that results from the immobility and abnormal positioning. Left untreated, the legs and feet may develop gangrene, and they may have to be amputated. At Sáyago, DRI and the CMDPDH investigators observed a number of women missing one or both lower extremities. It is possible that these women had their legs amputated as a result of the lack of circulation caused by being left in the wheelchair, though we were unable to view their medical records to know for sure. We also observed people who were left hunched over in a wheelchair without adequate leg and foot support. These individuals are at risk of spinal abnormalities, including painful and dangerous musculoskeletal complications.

We observed many people in ill-fitting wheelchairs whose heads are tilted back due to lack of support. These individuals are susceptible to aspiration pneumonia and other dangerous infections. Aspiration pneumonia occurs when a person inhales saliva or stomach contents into their lungs.[48] Because their upper airway is open when their heads are tilted back, they are more susceptible to food and fluid falling directly into the lungs. People subject to long-term restraints are also at-risk of gastro-

intestinal or bowel obstruction (GT). Intestinal obstruction is "an interruption in the normal flow of intestinal contents along the intestinal tract."[49] When an individual is left immobile in an ill-fitting wheelchair, the food moves through the tract very slowly and may cause obstruction or death in some cases. Intestinal or bowel obstruction is exacerbated by antipsychotic medications and a lack of fibrous, nutritious food.[50]

Pressure ulcers, otherwise known as bed sores, often develop as a result of long periods spent immobile.[51] However, they can also develop within a short period of time.[52] In Mexico, everyone left lying in bed or tied to a wheelchair is at high risk for bedsores. To prevent and relieve bed sores, it is important to inspect the skin several times a day, to wash and dry the skin, to reposition the person every 2 hours, and to provide activity and movement for bed sores.[53] DRI and the CMDPDH investigators found many people lying in bed covered with filth and without any supervision.

In addition to people being physically restrained, we observed children and adults with disabilities who are unable to move and who can be restrained simply by being placed in cribs or beds with metal sides. Many of these people have cerebral palsy, which, left untreated, may result in dislocated or semi-dislocated hips.[54] Once people are unable to move due to their hips, they are at the highest risk for developing scoliosis, or curvature of the spine.[55] Stretching and positioning are "essential" to preventing these deformities.[56] At Samuel Ramírez Moreno, DRI and CMDPDH investigators found a man curled into a fetal position in a rusted hospital bed. He was apparently unable to move from the bed. The director gestured to the man and said, "He has spent his whole life in this bed."

> **I observed a young woman tied to a bed in five point restraints – arms and legs tied to the bed and one strap across her chest. She was screaming loudly, but she had been left alone in her room. When I was able to find the ward staff member responsible for her treatment, she explained that no one in the hospital knew why she was screaming. The woman spoke an indigenous language of Mexico, and no one could translate. The staff member said she would be held in restraints until her family members came in to explain what was happening. –** DRI investigator at Cruz del Sur, Oaxaca

At many facilities, people are detained in restraints and it is impossible tell how long they are kept in this position. At most facilities, there are stated policies against the long-term use of restraints. But there are no controls in place to protect against abuse or to determine whether policies are enforced. At the private Sanatorio Psiquiátrico de Nuestra Señora de Guadalupe, for example, the director brought out a set of leather straps with metal buckles and demonstrated how they were attached to residents' wrists and ankles to restrain them. According to her, there are no public guidelines enforced at this private facility or even internal written policies. Rather, restraints may be used whenever "necessary." A doctor is necessary to sign off on the use of restraints, but no records are kept of the use of restraints. She said that residents are left in restraints up to 24 hours.

The use of restraints can be very dangerous when people are not closely watched or monitored to protect against choking or other medical conditions that might require immediate attention – particularly for people on high levels of psychotropic medication. At El Batam, many of the beds in the residential wards had leather straps dangling from them, suggesting that restraints could be used almost anywhere. Our team observed one man who had been left alone on a residential ward, without supervision, tied by one arm and the opposite foot to his bed. Another man was tied by one foot to a bench. Because no one was there to untie him and take him to the bathroom, he was forced to urinate on the floor while we were there.

At the CAISAME E.P. Guadalajara, a member of DRI observed a man isolated in a dorm room. The first time DRI and the CMDPDH investigators visited this institution, staff reported that the facility does not isolate residents. Upon returning for a second time to the facility, however, one DRI investigator observed a man tied to a bed and left alone in a room. According to the Head of Hospitalization, this man is left in isolation throughout the day and is tied into his bed at night. The Chief of Hospitalization said that the reason for this isolation and the use of restraints was his aggressive behavior, yet the treating psychiatrists stated that the man is not receiving any other forms of therapy or rehabilitation.

At Nieto, the director took us to a small cement courtyard, where he explained that patients who demonstrate aggressive or difficult behaviors are tied to one of eight concrete washstands in an outdoor courtyard. The director said that doctors are not required to review or approve the use of these restraints, and staff is not required to document the use of restraints in the residents' records. Also, it is clear that there is no staff supervision in this courtyard to ensure that patients are safe. While we were in this courtyard, one patient slammed another down onto the concrete pavement where she smashed her head. This woman lay on the ground and received no attention until DRI and the CMDPDH investigators helped her up and alerted the staff.

C. Lack of rehabilitation and habilitation

> **I just want to do something. I would do anything. I would clean the bathrooms. But there is nothing to do here**. – *Woman detained at El Batam in the State of Puebla*

Doing nothing makes them become like savages. – Medical Director at Samuel Ramírez Moreno

At the long-term adult facilities we visited – in Federal District and State of Mexico, Oaxaca, Puebla, Veracruz, and Jalisco – our team observed a near total lack of activity. To the extent that any occupational programs exist, only a few people are deemed able to participate, and without any real opportunity to return to the community due to the current lack of services, occupational activities take on a futile quality and provide no hope of community integration. The only exception to this is a specialized program known as the "Hidalgo model." This program, which provides cleaner living conditions and rehabilitation programs for a small number of people in institutions, is described further in section V of this report.

To the extent that occupational programs do not exist or people are deemed unable to participate in existing occupational programs, people are likely to experience a decrease in social and psychological functioning.[57] Without activities to occupy them, adults with disabilities may be heavily medicated to keep them sedated. DRI and the CMDPDH investigators observed a few patients involved in rehabilitation programs or living in what are called the "Hidalgo model" sections of CAISAME E.P. Guadalajara, Sáyago, and Concha Vásquez[58] (see section V of this report for further analysis of the "Hidalgo model"). However, we observed many more people who had nothing to do, who had lost social and psychological functioning, and who were highly medicated.

CAISAME E.P. Guadalajara, Sáyago and Concha Vásquez had incorporated "Hidalgo model" sections into the institutions. The small number of residents fortunate enough to live in these sections of the institution participated in arts and crafts and lived in villas intended to simulate a more community-like setting. These villas are limited to a small number of people, however, and do not actually integrate residents into the community.

At CAISAME E.P. Guadalajara, a new supervised residence is being equipped so that a few very "functional" residents are able to start integrating into the community. These persons will be supervised by an authorized staff member of the hospital on daily bases, with the goal of finding employment for them in town. At present, this valuable program is limited to less than ten individuals.

Concha Vásquez, La Salud, and CAISAME E.P. Guadalajara provide some rehabilitation programs. At Concha Vásquez, two men work as grounds men in a park in the community and live with support in the community. The man who lived with them explained, however, that "they don't earn money because they don't have the ability to handle the money" and they "smoke too much, so they would just spend money on cigarettes." While these two men are in a much better situation than most institution residents, the program is not designed to allow them ever to integrate fully into the community. The program, while very important, is limited to two people at the facility. At La Salud, a mini-store has been set up where residents can buy candy and soda with the money they earned doing light chores around the institution.

The majority of residents in all of the adult institutions that we visited – Sáyago, Nieto, Samuel Ramírez Moreno, El Batam, CAISAME E.P. Guadalajara, Concha Vásquez, La Salud and the Sanatorio Psiquiátrico de Nuestra Señora de Guadalupe – however, did not receive any sort of rehabilitative services. These people wandered the grounds of the institutions or lay on the ground. One member of the investigatory team asked a resident named E. at Sáyago what she did during the day. E. replied, "I walk around. That's all."

Long-term residents of institutions inevitably lose social and psychological functioning as a result of the lack of activity. At Samuel Ramírez Moreno, we observed men who were half naked, urinating and defecating on the ground of the cement courtyard, and then stepping in their own urine and feces. One man was sitting in it. Another man was completely naked, rocking back and forth in a wheelchair. The director told us that some of these men had grown up in institutions, not receiving any rehabilitation services and not participating in the community. Even those that had not grown up in an institution had

regressed over the years. After 10 years, no one had improved. Rather, the director said "patients are the same with more deterioration – mental deterioration." The director added that "doing nothing makes them become savage people" and that "no one" would be able to live with support in the community.

A psychologist at CAISAME E.P. Guadalajara echoed the sentiments of the director of Samuel Ramírez Moreno. Gesturing at the long-term ward for "crónicos" or "abandonados," he said "these people have no abilities," citing this as the reason for lack of rehabilitation programs for most residents. Like Sáyago, the institution provided limited rehabilitation in the form of crafts and painting for some of its patients, as well as several villas where the living conditions were cleaner and more personable for 28 residents. For the other 175 residents, however, there were no habilitative or rehabilitative programs. These residents were left to wander the grounds like the residents at Samuel Ramírez Moreno.

At Sáyago the investigative team observed a patient whose hands and feet had been wrapped in gauze. The patient was strapped in a wheelchair. The psychiatrist said that the patient was aggressive and that the gauze and restraints were for her own safety. When asked about a treatment plan, however, the psychiatrist explained that the patient was being given medication, but that was the extent of the patient's "treatment." In the absence of meaningful rehabilitation, almost all adults in long-term care receive psychotropic medications. Without adequate patient records or monitoring of side-effects, these medications can cause irreversible nerve damage or death. In addition to the misuse of medication, the misuse of wheelchairs also creates a life-threatening danger in psychiatric hospitals.

D. Dangers caused by lack of care or inappropriate treatment

One of the impacts of long-term institutionalization with little stimulus or opportunities to develop emotional attachments is the development of self-abusive behavior or aggression on the part of patients. Behavioral and disability specialists believe that one cause of such extreme, self-abusive behaviors is the inability to communicate unmet needs and pain.[59] This is particularly serious for people who have been detained since they were children. The lack of specialists and behavioral programs to assist people who become aggressive or self-abusive presents serious health risks to people detained in facilities. At Conecalli, Fraternidad sin Fronteras, La Salud, CAISAME E.P. Guadalajara, Samuel Ramírez Moreno, and Shelters # 1 and 2, we observed children and adults hitting themselves, biting themselves, or engaging in other "self-abusive" behavior.

Children and adults that engage in self-abusive behaviors are usually restrained or given high levels of medications as treatment to control the behavior. These forms of control or management, however, do not stop the self-abuse and only lead to additional abuses (see below). Staff members at these institutions have told DRI and the CMDPDH investigators that they have no other way of stopping the self-abuse. However, behavior and disability specialists overwhelmingly agree that these behaviors can be stopped through "functional assessment, non-aversive applied behavior analysis, positive behavior support, individualized curriculum development, and other systems."[60]

In the absence of rehabilitation or habilitation programs, institutions rely almost exclusively on psychotropic medications. At Sáyago, Samuel Ramírez Moreno, Nieto, El Batam, Concha Vasquez**,** Cruz del Sur, and Nuestra Señora de Guadalupe, DRI and the CMDPDH investigators observed individuals showing apparent signs of either akathisia (restless legs and jitters), akinesia (weakness, fatigue, painful muscles, lack of movement), dystonias or dyskinesias (grimacing, head and neck stiffness), Parkinsonian effects (muscle stiffness, shuffling gait, stooped posture, drooling) and tardive dyskinesia (abnormal, involuntary, and irregular movements of the head, limbs and trunk about 6 months after treatment with psychotropic medications).[61] These symptoms could easily have been identified as part of routine monitoring of psychotropic medications. At each of these facilities, many people appeared highly sedated, suggesting that high dosages of psychotropic medications are common. In short-term facilities, such as Fray Bernardino, our observations of these symptoms were notably absent. The exclusive, long-term reliance on psychotropic medications – particularly without very careful patient records and monitoring of side-effects – can lead to disabling side-effects, irreversible nerve damage and sudden death.[62]

At Concha Vásquez psychiatric hospital in the State of Veracruz, we saw a large number of women with major side-effects of psychotropic medications. One woman had difficulty speaking because she was shaking so hard. Her teeth were clicking repeatedly and the few words that she managed to get out were slurred. We reviewed her medical record and confirmed that she was on high levels of multiple neuroleptics.

> *I observed high levels of tardive dyskenesia, an irreversible degeneration of the nerves that results from neuroleptics. Many patients had uncontrollable rhythmic movements of their hands, protruding tongues, and shuffling gaits – signs of overmedication. I reviewed patient records at the Concha Vazquez psychiatric facility and found that most patients had dangerously high levels of neuroleptics that would be considered excessive anywhere in the world. I saw two or three individuals on fifteen different medications.* **– Karen McGowan Green, a developmental disabilities nurse**

While physical conditions were much better at the one private facility we visited, the Sanitorio Psiquiátrico de Nuestra Senora de Guadalupe, we also observed serious side-effects from psychotropic medications in this facility. We saw many residents with tongues protruding from their mouths, slurred speech and shaking hands. Several were lying on the ground during the middle of the day, indicating very high levels of sedation. The director of the institution explained that the people were not required to take psychotropic medications, but that the institution only admitted patients who needed it. Thus, everyone in the facility receives psychotropic medications. She also explained that psychotropic medications are very helpful for use in controlling unruly patients.

The use of chemical restraints for long-term maintenance of behavioral problems can be extremely dangerous. It is a practice that is avoidable where appropriate supportive services and habilitation programs are available. In the absence of behavioral programs or meaningful activity, however, long-term use of chemical restraints is almost inevitable.

E. Psychosurgery

For self-injurious or aggressive behavior, many staff members at the institutions told us that the only thing to do is to increase a resident's medication or tie him down. However, in some extreme cases, DRI and the CMDPDH investigators discovered that some institutions will occasionally resort to lobotomies or other forms of psychosurgery.

> **There are patients where medication does not work. For them, we have brain surgery. They remove the part of the brain that causes aggression. One woman, Pancha, was tied up in the hospital for months but was still aggressive. So we sent her for brain surgery. The doctors in the hospital decided she needed this. Her legal representative, the director of this institution, had to approve.** – *Director of Fraternidad sin Fronteras*

The directors of Fraternidad sin Fronteras and La Salud both said that they had sent patients for psychosurgery. The director of El Batam also mentioned that in the past patients had been sent away for psychosurgery, but not within the last six years. At La Salud, DRI and the CMDPDH investigators observed a man who had received brain surgery. He was slumped over in a wheelchair, and his speech was slow and slurred. The director said that the man had been aggressive in the past, but that since the surgery, he was entirely passive. According to the director, four patients have had lobotomies in the last four years.

In order to subject a patient to a lobotomy or psychosurgery, the authorities at La Salud reported that an independent team must approve the surgery. At Fraternidad sin Fronteras, the authorities reported that psychosurgery needs only to be approved by the director of the facility who also acts as a guardian. However, both these procedures are insufficient and inadequate according to international health authorities. The World Health Organization has stated that because of the "irreversible nature" of psychosurgery, psychosurgery should not be performed on people who are unable to give "informed consent."[63] This consent must be "genuine" as determined by an independent review body.[64] Moreover, according to the MI Principles, "Psychosurgery […] shall never be carried out on a patient who is an involuntary patient in a mental health facility."[65] At La Salud and at Fraternidad sin Fronteras, none of these safeguards or standards were being followed. Indeed, the lack of protections and safeguards for legal capacity in Mexico make the implementation of these standards impossible.

III. Segregation of Children with Disabilities

Article 19 of the CRPD establishes that all persons with disabilities – children and adults – have a right to live in the community. For children with disabilities, this right is strengthened by a recognition, in CRPD article 23(5), that "where the immediate family is unable to care for a child with disabilities [governments shall]"undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting."

There is particular urgency in protecting children with disabilities from improper segregation from society. Psychiatric and psychological research has demonstrated that *any* child placed in an institution is at risk of becoming disabled – whether or not that child had a disability at the time of placement.[66] Children placed in institutions under the age of four are at particularly high risk of cognitive and psychological damage – such as "attachment disorders"— that come from being raised in a congregate care facility where they cannot establish loving bonds with a parent or consistent care-giver.[67] Children and adolescents are subject to increased developmental delays the longer they are placed in institutions.[68] Without the protection of families or the watching eyes of the community, girls and young women are at particular risk of sexual abuse in institutions.[69] Children who are born with a disability and who need specialized care and protection are also at particular risk of health-related dangers, physical and sexual abuse, and increased disability in institutions.[70] Even in well-funded and well-staffed orphanages, the risks to children with disabilities are even greater than they are for other children.[71] Orphanages or other institutions are also inappropriate placements for children who have experienced abuse in their family as such placement "can compound the effect of abuse and neglect…."[72]

There is no registry of children sent to institutions….DIF has no idea how many children are in institutions – no idea. – *Official from the Federal District Human Rights Commission*

Mexico's system of institutions for children consists of an array of small, privately-run residential facilities. These facilities are under the control of states or local governments, though the federal government funds facilities in Mexico City. Some facilities include children and adults, and some are just for children. In theory, all institutions for children in Mexico are regulated and monitored by the DIF Federal.

On July 30, 2010, Mexico passed a decree that reforms several provisions of the Law on the Rights of the Boys and Girls of the Federal District.[73] It creates a Child Ombudsman's Office headed by the Executive Director of DIF for the Federal District. The Child Ombudsman's Office stated functions are to track children, monitor conditions, and protect children's rights.[74] Although it permits people to intervene to "competent authorities" in the case of suspected child abuse, it does not require it, nor does it state who the competent authorities are, and what process will be put in place to follow up on a report. In practice, as described below, there is currently little oversight, no national standards for

quality of care, and no prevention of exploitation, violence, and abuse in the facilities. **Without such monitoring or oversight, it is impossible to say how many children with disabilities are languishing in Mexican institutions.**

A. Gateway to life-time of institutionalization

> **They arrive here. They grow up here. And then they die here. –** *Director of Fraternidad sin Fronteras*

Our investigative team visited several residential facilities that housed both children with and without disabilities: Fraternidad sin Fronteras (a mixed facility with 52 adults and 28 children) in the Federal District; Conecalli (91 children) in the State of Veracruz; Casa Hogar de Coapexpan (15 children and 2 adults) in Xalapa; and Shelters # 1 and # 2 (63 and 83 children, respectively) in Oaxaca. We also visited CAISAME E.P. Guadalajara, a psychiatric institution that used to house children with disabilities, as well as adults with disabilities. Although the hospital no longer admits children, the children who were admitted over 10 years ago are still there. We visited CAISAME E.B. Guadalajara, as well, which provides short-term stays and out-patient services for children with psychosocial disabilities. While these facilities were supposed to provide temporary or provisional care for children, we found that the children may grow up and remain in them for a lifetime.

Children's institutions are a gateway to lifelong institutionalization. Individuals with disabilities who grow up in orphanages often live the rest of their lives in adult facilities. At Fraternidad sin Fronteras in Mexico City and Conecalli in Veracruz, we found a similar story. Authorities reported that, once placed in the institution, children with disabilities are expected to remain in the facility for life due to a lack of programs for community placement.

At both Conecalli and Fraternidad sin Fronteras, children with disabilities who reach eighteen have no place to go. Without supportive services for adults with disabilities, they are forced to remain in the facility. Fraternidad sin Fronteras has a section designated for adults, and children who reach eighteen are simply shifted from the children's wing to the adult area. Conecalli is, theoretically*,* a facility designated only for children. But there is no place for individuals to go when they become adults. The facility is not equipped to house or respond to the needs of adults, and it has no specialized living areas for this population. As a result, the young adults living at the facility are simply mixed in with the other children. During our visit, staff introduced DRI and the CMDPDH investigators to a twenty-year old young man who had lived in the facility since he was five years old. According to staff, there are no plans to integrate him into society, and there are no services available to help him live independently in the community. Seven other young adults live in the same situation at Conecalli.

The director of a girls' residential facility, Casa Hogar de Coapexpan, in Xalapa told the same story. Two girls who grew up in the institution had no place to go once they reached eighteen, so they are still there. They do chores and help out, but they are not paid and are unable to leave due to the lack of support in the community. The director said that they will remain indefinitely in the institution.

By returning to some of the same institutions we visited in the 1990's, we could observe this pattern over ten years. DRI (then Mental Disability Rights International or MDRI) visited the long-term facility in Guadalajara in 1999, and we observed about two dozen children detained in the facility. Most of these children were lying on mats on the floor or wandering around the barren halls or rooms of the facility in total inactivity. When we returned to the facility, we observed many of the same children ten years later – now young adults -- on the same mats, in the same room – still doing nothing. Staff reported that these children had no place else to go and were expected to remain in the facility for life.

It is a positive development that the long-term facility in Guadalajara no longer admits children. Yet staff at the facility was unaware of any new community alternatives for children. Some children with disabilities may be served in an acute-care residential unit. But at that unit, authorities explained that children needing long-term care were sent to another long-term residential orphanage operated by DIF.

B. Lack of community support

> **Giovanna is a girl with a very severe disability. She has a mother and a brother. The mental disability affected her whole family. They didn't have enough money to buy food and medications. The mother was desperate, so she tried to kill her daughter. –** *Director of Fraternidad sin Fronteras*

> **We have a boy here named Israel. He lived in a trash can until he was twelve. He lost an eye. He was sent here to this institution when authorities found him. Now he's autistic.** – *Director of Fraternidad sin Fronteras*

According to the director of an institution in Veracruz, Conecalli, "true orphans" without parents make up just a small percentage of all children in institutions. She said that most children with or without disabilities are placed in the institution because parents do not have the resources to take care of them. Many children are placed in institutions because they are found living in the streets or because their parents are too poor to take care of them. Some children are placed in the institution by the *Procuraduria* (prosecutor's office) because the family is believed to be abusive. Children born with a disability too "severe" to be handled by the family alone, she explained, must be placed in the institution. The director of Fraternidad sin Fronteras made a similar observation.

In practice, what is considered a "severe" disability justifying institutionalization in Mexico may be an extremely minor disability that would require very limited support to families to enable them to keep their children in the community. At Conecalli*,* a facility now housing 91 girls and boys, we found infants and toddlers placed in the facility because of Down syndrome or cleft palate. These are children who, in most countries, can live in the community with little or no support services.

C. Discrimination against children with disabilities in out-placement

While efforts are made on behalf of non-disabled children to reunify them with their families, or arrange for adoptions, children with disabilities are left behind. There is no system of foster care in Mexico for children with or without disabilities. As a result, the only hope of return to the community for any child is family reunification or adoption.

> **There is no adoption of children with disabilities within Mexico. I have seen only one case in seven years. So children with disabilities remain here for life. –** Director of Conecalli

A representative of the DIF Federal, reported that she had not seen a case of a child with a disability adopted from an institution in her eight years in the department.[75] At Conecalli and Fraternidad sin Fronteras, authorities reported that the lack of adoption is, in part, a cultural problem as Mexicans are not accustomed to adopting children with disabilities. The director of Fraternidad sin Fronteras also said that it was a "bureaucratic problem," as they have a long list of parents who desperately want to adopt children. In practice, she said, no efforts are made to place children with disabilities.

D. Lack of care and habilitation leads to increased disability in children

> **There were almost two dozen children with disabilities sitting on mats on the floor or on benches in total inactivity, practically motionless. Some were covered in blankets. Some sat staring at the walls. A few sat rocking back and forth or biting their fingers. Staff just looked on. –** *DRI investigator at Fraternidad sin Fronteras*

The investigative team observed a lack of care and habilitation in the residential facilities we visited. There is a shortage of habilitation programming for children with intellectual disabilities to allow them to preserve and maintain basic living skills, and a near-total lack of psychosocial rehabilitation programs to assist children in returning to the community. Therapy for children with physical disabilities is also limited. As a result, placement for children with disabilities in long-term facilities can be dangerous and leads to increased disabilities.

While the residential facilities for children that we visited were clean, the environment is bleak and barren and denies children of the sensory stimulation and human contact needed for normal growth and development. The sections of Fraternidad sin Fronteras for children include dormitories, two indoor play areas, and two cement courtyards. While there is a lawn outdoors and a garden with chickens, we did not observe any children in these areas. There are no toys visible in the play areas. The living areas have no decorations or space for personal possessions.

While DRI and the CMDPDH investigators were at the Fraternidad sin Fronteras*,* the children did not appear to be engaged or enjoying meaningful relationships. In the indoor play area, 14 children lay in a state of motionless lethargy on the floor or bench, listless and unresponsive. Although it was 4pm, many were slumped over and covered in blankets. Most of the children did not react when our group came into the room. One boy, who we were told was 4 years old, sat in the middle of the room on a rubber mat, rocking back and forth and resorting to self-stimulatory behaviors. In the background, a

television blared and flashed bright colors, but the room was otherwise void of stimulation. From all appearances, this was how the children spent most of their time.

The living areas of the Conecalli were brighter, cleaner, and better decorated than the other institutions we visited. But even in this facility, the staff was overwhelmed by the number of children they needed to attend, and children without disabilities live in much better conditions than children with disabilities. The children were divided into dorms by age, gender, and disability. In the infant area, there were babies from 0 to 2 years old; in the toddler area, there were 16 boys and girls from ages 2 to 4; in the girls area, there were 33 girls age 5 and up; in the boys area, there were 16 boys age 5 and up; and finally, there was an area for the 7 children and young adults with severe disabilities.

At Conecalli, we observed infants – including a two month old child – lying in cribs with little attention. These children, who may have lacked any disability when they were placed in the institution, are likely to become disabled unless they are quickly adopted.

In stark contrast to the nicely decorated areas for children *without* disabilities, the children and young adults with severe disabilities at the Conecalli lived in conditions similar to those of Fraternidad sin Fronteras, where children with disabilities were lying in beds or cribs without any activities or stimulation. In the dorm for those with disabilities, there were no pictures on the drab walls or toys to play with. Some children with disabilities were living on mattresses on the floor.

> **I saw two children at Conecalli with cerebral palsy sitting in cribs, unable to move their arms and legs. They will inevitably lose functioning if left in that manner. Staff tried their best and was able to give them short bursts of attention – but not the physical management they need to avoid increased disability. –** *Karen Green McGowan, developmental disabilities nurse*

Protracted inactivity of remaining in a crib can be dangerous for any child in terms of their physical development, as well as their psychological health.[76] It is detrimental for children to lie on their backs in a crib for prolonged periods of time. When this happens, their heads flatten and their bones don't grow properly because gravity does not pull on them at the proper angle. As such, many children who grow up in cribs remain small.[77] Children with abnormal movement or children with limited movement only degenerate in cribs without constant therapy. According to developmental disabilities nurse Karen Green McGowan, these children need constant care, so that on a neurological level their brains will develop healthy movement patterns and on a physical level, they will develop the muscle tone and bone for actual movement. To maximize growth and development, it is recommended that children have a care plan that consists of "feeding, sleeping, physical therapy, play, other ways to foster growth and development, medications, psychosocial needs, family needs, and pain assessment/management."[78] This level of care is a level that most institutions cannot provide. Rather, it is the level of care that parents or other consistent care-givers provide their children 24 hours a day.

At Conecalli, DRI and the CMDPDH investigators observed two older children lying in cribs. The director said that these children stay in bed 24 hours a day. One of these children was an adolescent girl with cerebral palsy. She was engaging in repeated abnormal movement patterns in a crib – a dangerous pattern of behavior resulting from a lack of appropriate care (as described above). We also observed a

five-year old in a crib whose arms and legs are deformed from being in the crib. Karen Green McGowan said that this child will never learn how to stand up and walk if he is not given the physical therapy and support he needs to do so.

Staff on the ward for children with cerebral palsy at Conecalli told investigators that they are not aware of techniques for preventing the degeneration of children into further disability. Programs they reported were based on regularly scheduled sessions of physical therapy rather than consistent positioning and management at the facility. As indicated above, however, individuals with cerebral palsy require constant support to change neurological patterns and teach them regular movement patterns.[79] Without these programs in place, a child may develop contractures (shortening of muscle or joint), hip dislocations or semi-dislocations, malnutrition, and scoliosis.[80]

While non-disabled children go to school in the vicinity of Conecalli, children with disabilities do not go to school. The one exception was a boy who attends a school for blind children with behavioral issues in Xalapa. However, when DRI and the CMDPDH investigators interviewed staff at this school, they found that the facility lacked any specialized support or training for children with intellectual disabilities. The child living in Conecalli had experienced serious psychological trauma and had stopped talking, but no psychologist was available at the school.

IV. Disappearances, Exploitation and Trafficking

We are legally obligated to regulate all institutions for children – where they are, how many are in the institution, and what treatment they get. This is the goal. But the actual system is a black hole. – *Chief of Social Assistance and Integration Unit DIF Federal*

It is well established that children and adults with disabilities in any country are especially vulnerable to abuse in institutions and in the community.[81] This includes increased risk of gender-based violence.[82] In Mexico there are a "huge number of street children," with approximately 25,000 in the Federal District alone.[83] An estimated 20,000 children are victims of trafficking each year, according to the Mexican government.[84] The lack of assistance to families to keep children with disabilities at home, which results in the institutionalization of children, also creates an especially high risk of abuse and a special vulnerability to being caught up in trafficking. In Mexico, children with disabilities have been allowed to literally disappear into the social service system, at best, or at worst a world of exploitation and abuse.

Article 16(1) of the CRPD requires governments to establish mechanisms to protect children or adults with disabilities from "all forms of exploitation, violence, and abuse…."[85] This includes the establishment of "gender and age-sensitive assistance and support for persons with disabilities and their families and caregivers."[86] To prevent such abuse, governments must ensure that "all facilities and programs designed to serve persons with disabilities are effectively monitored by independent authorities." Mexico City has recently established a new Children's Rights Ombudsman – a positive

development.[87] However, the Ombudsman has yet to have the resources or authority that would be needed to monitor and protect children in the country's vast network of institutions.

A. Danger of abuse and trafficking

It is like ethnic cleansing – *Federal District Human Rights Commission official, referring to the official practice of sweeping children with and without disabilities into institutions known to be dangerous*[88]

The lack of oversight, regulation, or monitoring of orphanages puts *all* children – especially children with disabilities – in great danger. This danger is demonstrated by the widely publicized case of children's disappearances from La Casita del Sur, in Mexico City, and other such facilities run by the organization "Iglesia Cristiana Restaurada" (the Restored Christian Church).

The United Nations Special Rapporteur on the sale of children has sent an urgent appeal to the Government of Mexico concerning children missing from institutions run by Iglesia Cristiana Restaurada.[89] According to the UN report, children who were 1 and 2 years old were placed in institutions by Mexican authorities, in some cases because their mothers were begging on the street and had no other means to support their children.[90] When their mothers sought to visit their children, authorities were not able to find them.[91]

After a raid in January 2009 on two institutions run by the religious order, 126 children were rescued but 11 children remained missing. Some of the children rescued in this raid were later placed by authorities back into the Casita del Sur, run by the same religious order.[92] When authorities looked into conditions at Casita del Sur, they found that children had been beaten, left without food for days, closed in dark rooms or closets for up to two days, and prevented from seeing their parents.[93] Staff at the facility had been previously implicated by Mexican authorities in the disappearance and trafficking of 14 children.[94]

Our investigative team interviewed authorities at the Federal District Human Rights Commission, who also conducted the investigation into disappearances and abuses at this facility.[95] According to these authorities, they "strongly suspect" that girls in the facility were sexual abused and this matter is currently under investigation.

Children's rights groups in Mexico have also expressed concern about of the dangers of abuse and trafficking of children in institutions. According to a statement by the Children's Rights Network and newspaper reports, minors have reported to have been sexually abused and forced into labor by members of an organized crime ring at children's home called Casa Adulam AC.[96]

In 2010, Mexican authorities identified another institution, the Drug and Alcohol Rehabilitation Institute Hospital Center "Saint Tomás, Los Elegidos de Dios," where women and girls were subject to sexual abuse and trafficking. The Special Prosecutor for the Abduction Office of the District Attorney of the Federal Disctrict, reportedly found 107 people, from 14 to 70 years old, living in "overcrowded

facilities" in "extreme conditions of abuse and sexual exploitation."[97] At another shelter, there have been reports of children being detained until age 18 and abused and reports of authorities failing to respond to the situation.[98] A local newspaper also reported on these allegations, stating that there have been women who claim to have been raped and forced to give up their babies, while another woman has said that she was forced to abort.[99]

Based on findings of sexual abuse and trafficking at Casa Adulam and Los Elegidos de Dios, an official of the Mexico City Human Rights Commission reported to DRI that "we do not yet face a scenario that what happened at Casita del Sur could not happen again….The Recommendation of the La Casita del Sur case was issued in April 2009, and we found what was happening in the Casa Adulam and Casa de los Elegidos de Dios this year." As a result of these cases, the Mexico City government has passed legislation to create a new Children's Rights Ombudsman. But this program has not yet been established. Most important, there is still a lack of community-based alternatives to institutions. There remains no alternative to institutionalization for children who face abuse in their homes or whose parents simply cannot keep them because of the lack of disability-related supports.

B. Lack of monitoring and oversight

When the Human Rights Commission of Federal District investigated the Casita del Sur case, they found that there was "no supervision or monitoring of conditions" in the facility.[100] Even though some of the children had been sent to the facility by the *Procuraduría del Distrito Federal* (Prosecutor's Office) because they were allegedly victims of crimes, the office failed to check on their whereabouts. Neither the local children's authority, Federal District DIF, nor the Ministry of Social Development of the Federal District had met their legal obligation to monitor the facility under Mexican law.[101] The Federal District Human Rights Commission found that the various local authorities responsible did not coordinate their efforts or share information amongst themselves, that they did not check on the suitability of placements, and that they did not follow up to determine whether there was a chance at family reunification.[102] While the Federal District Human Rights Commission found some "isolated cases" of follow-up in individual cases, there was no plan to ensure follow-up for all children. [103] In some cases where children had been taken from abusive homes, they were returned to those homes without a psychological evaluation.[104]

The situation at Casita del Sur provides a window into the so-called child protection system. The network of small private institutions for children with disabilities is the same as the system that Mexico uses to house street children or any other child not taken care of by their family. While many children are placed in these institutions for reasons other than disabilities, there is certain to be a high level of mental disability among this population. According to authorities at the Federal District Human Rights Commission, most of the children in these facilities have suffered from the psychological trauma of abuse in the family or in the institutions themselves. The great majority of these children are substance abusers.

In theory, the DIF Federal is responsible for monitoring the system of institutions for children. Our investigative team asked the Head of Social Assistance and Integration Unit of the DIF Federal

whether they are responsible for monitoring and enforcing rights throughout Mexico, they answered "formally it is like this, but in reality it is not." According to him, the law is unclear as to which authority is truly responsible. DIF Federal authorities must rely on state authorities to report on institutions, but they have no way to require reporting and, in practice, many states simply do not respond to questions from the federal authorities.

> **We can pay visits by surprise. But I don't have the personnel. So we have to believe what they say is happening.** – *DIF Federal official*

There is a particularly serious lack of data about children with disabilities. DIF Federal informed our team that it has no data on institutionalization of children with so-called "severe disabilities," as this is the authority of the Ministry of Health. The Chief of Mental Health Services at the Ministry of Health, however, informed DRI and the CMDPDH that all information about children with disabilities is the responsibility of DIF.

> **There is a girl named Lisbeth in this institution. She's eight years old now. The previous director of this institution found her in an institution for adults with AIDS. She had been sent there by DIF. We took the girl and found that she never had AIDS. She had autism. There was no reason to put the child in that other facility. But DIF does not have enough resources to track cases or to send [kids] to the right place. She was four years old when we brought her here**. – *Director of Fraternidad sin Fronteras*

Our investigative team found a lack of government oversight and monitoring at Fraternidad sin Fronteras. This lack of oversight is striking, since this is a facility that is funded by Mexican federal authorities.[105] The director of Fraternidad sin Fronteras stated that, despite getting government funding, the facility does not have to abide by any government standards for care, is under no obligation to provide specialized rehabilitation or other services, and is not subject to regular monitoring visits. DIF authorities occasionally follow up on the whereabouts of a particular child, but this is not systematic. As she stated, "DIF is a huge institution and has millions of kids. It can't follow-up on all of them."

C. Forced labor

> **We do not know their name or their age. They came here without papers.**
> – *Director of Casa Hogar de Coapexpan in Xalapa, Veracruz*

Our investigative team visited one small, private facility for children with disabilities in Xalapa, where we observed the exploitation of children and total failure of government oversight. Casa Hogar de Coapexpan houses fifteen children and two adults. The director of the facility reported that children with intellectual disabilities were abandoned to the facility without documents. In some cases, the facility never knew their name or age, and they never even obtained a diagnosis for their mental condition. Authorities at this facility reported that no legal process was needed to detain these children.

Many of the children were never sent to school. When two of the children became eighteen years old, the facility chose to keep them. Our investigative team interviewed these two girls who reported that they work entirely without pay. Apart from their work, they spend their day in inactivity and rarely leave the grounds of the home. These girls clearly had no other place to go, and no assistance was available from the local government to help them find jobs or opportunities for independent living. While there is no reason to believe this facility has any improper motive in keeping these girls, they are exploiting their labor at no cost. By making all life decisions for these women with no legal authority, this facility is effectively depriving these women of any practical opportunity to exercise their rights to make any choices about their lives.

D. Failure to protect against violence and trauma

We have one child who lives in Conecalli and came from a very bad background. He was kept in a small room naked. He urinated and defecated in the same room where they brought him food. After the family was reported to DIF, he was brought to the institution. The child stopped talking and bites. – *Teacher at special school for the blind in Xalapa, Veracruz*

In any social service system designed to protect children or adults who have been subject to emotional abuse or physical violence, specialized services are needed to help children and adults cope with the dangerous emotional impact of trauma.[106] Girls and women are particularly vulnerable to such abuse.[107] Failure to do so can lead to increased psychological damage.[108] It is particularly important that special care be taken to ensure that children are not returned to situations where they may re-experience trauma.[109] Re-traumatization can be particularly dangerous for children who have already been exposed to such abuse.

Our investigative team received numerous reports of children being placed in institutions because they had been subject to violence and abuse in their families. Yet none of the programs we visited had specialized psychological counseling or support for children who had been subject to violence. Officials at the Human Rights Commission of the Federal District reported to us that they suspect and are investigating allegations of sexual abuse among children found at Casita del Sur and other institutions for children. [110] Despite this, children from these facilities were returned to families without a psychological evaluation. There was no care to determine whether they had been placed in the facility originally because of an abusive family situation.[111]

At Centro de Educación Para Niños con Discapacidad Múltiple, a special school for the blind in Xalapa, Veracruz, there are a number of children who come from "difficult backgrounds" as described above. Some of these children cannot go to mainstream schools, according to staff for such reasons as "they do not follow orders," "they do not pay attention," or "they have violent reactions." While the school is prepared to respond to their sensory disabilities, they do not have programs for psychological support or response to any trauma they have experienced.

V. Hidalgo Model of Reform

A. Closure of Ocaranza and creation of villas in Hidalgo

Ten years ago, **Disability Rights International** (then Mental Disability Rights International or MDRI) documented a broad array of serious human rights abuses against children and adults with disabilities in Mexico's mental health system. One of the worst facilities documented in our report was the Ocaranza psychiatric facility in the state of Hidalgo.[112] In response to the report, ***Human Rights & Mental Health: Mexico*** and outspoken advocacy of Mexican activists, the Secretary of Health promised major changes in the mental health system.[113] The Mexican news magazine, Proceso, ran a story about the situation of people with disabilities in psychiatric institutions in Mexico in which Secretary Gonzalez Fernandez said the following:

> The Health Ministry also approved financial support to all psychiatric hospitals. For Ocaranza, it authorized an additional investment of 12 million pesos. "The new hospital Villa Ocaranza," said Manuel Urbina, "will set a precedent in Mexican psychiatric treatment. Now: the purpose is to provide guidance to hospitals for their patients to be reintegrated into the community […]."[114]

In the Spring of 2000, the Ministry of Health engaged Dr. Robert Okin, then Chief of Psychiatry at San Francisco General Hospital, to assist in reforming the care for patients at Ocaranza. While Dr. Okin was a co-author of the DRI report in 2000 (then MDRI), he also agreed to serve the Mexican government on a volunteer basis as a consultant in his individual capacity. He did not represent DRI in his work with the Mexican government.

Dr. Okin brought a multi-disciplinary team of mental health professionals from San Francisco General Hospital to Ocaranza in Mexico. He and his team concluded that the infrastructure of the institution was so old, dysfunctional and inhospitable, it would be impractical to repair. Moreover, he concluded that the physical structure, particularly the lack of privacy intrinsic to the large open plan of the wards, was such as to make it impossible to correct many of the abusive conditions of the institution, even if large sums of money were appropriated to attempt this.

Thus, for therapeutic and financial reasons, Dr. Okin recommended that the entire institution be abandoned and replaced by small homes in the community for long-term patients. For acute psychiatric patients, he recommended that a ward be opened in the general hospital in Hidalgo. The latter would enable people with psychiatric crises to be hospitalized in a less stigmatizing context, closer to where they lived, with the rights and privileges of other medical patients. The following is a description of the process that followed in Dr. Okin's recollection:

> Because of the inhumane nature of the existing institutional conditions, and the impracticality of immediately creating homes in the community, my team and I conceded that as a temporary measure, twelve homes would be built on the grounds of

the institution, while two would be quickly opened in the community. The government agreed that this was to be a temporary solution until other homes could be created in the community. According to Virginia Gonzales Torres,[115] one of the original advocates of reform in Hidalgo, the model was a compromise necessitated by the political opposition to integrating people with disabilities into the community. In a more recent conversation with Dr. Campillo, the current director of the federal mental health authority, the plan for community integration was held back by political opposition from staff labor unions that feared for the loss of institutional jobs.

With remarkable speed, the government transferred 32 residents into two group homes in the community, moved approximately 100 others into institutions in Mexico City, and built 12 homes (the so-called "Ocaranza villas") on the grounds of Ocaranza for the remaining 144 residents, promising to quickly create additional group homes in the community for these 144 residents. Within 4-6 months, what became known as the Hidalgo model (small transitional homes on the grounds of the institution to be used while community homes were established) was created, the institution closed, and patients transferred.

I was present during the first week after the residents were transferred. The effects on those people who moved into both community and institutional "villas," were immediate and dramatic. People who had lived for years in the most barren, dehumanizing institutional conditions, with nothing to do but wait out their lives in a state of complete boredom and inactivity were now participating in the life of the home, cooking, cleaning, doing their laundry. People who had clothes or shoes of their own, who often walked around naked and barefoot through urine and feces were suddenly attired. People who had no privacy in their sleeping spaces, who had always showered in groups, who had never had the privacy of a door on their toilet stalls, who often had to do without toilet paper to wipe themselves, who were forced to live without a shred of dignity – these people were now living in small 12 person homes, three people to a room, with a living room, dining room, and kitchen. They now had their own clothes, their own shoes, their own bedcovers.

The behavior of the staff also seemed transformed. When people lived in wards as "patients," the staff spent most of their time guarding, "supervising," and controlling them. The physical structure of the wards, the centralization of certain institutional functions made it almost impossible for staff to teach or assist them in ordinary living skills that they had either never learned or had forgotten after years of hospital life. Once patients were transferred to the more normal environment of a group home, the staff immediately started to involve themselves in patients' daily lives, teaching them how to tie their shoes, sort out their clothes, cook, clean, and do laundry. It seemed that the new environment in a sense pulled new behavior from both staff and residents.

Whether these changes persisted today, we cannot be certain because we were denied access to the program. Second hand reports indicate that they have. If so, then there is no question that the lives of people have improved. But, disappointingly, the original promise of the "Hidalgo model" has still not been realized – that of community integration. The "Hidalgo model" of institutional villas was never meant to be permanent. What was explicitly conceptualized as a temporary, emergency intervention for the 144 residents of Ocaranza pending the rapid establishment of supported, rehabilitation-oriented community services, appears to have become a permanent fixture.

B. Current operation of the Hidalgo model

The federal official now in charge of the Hidalgo model explained to DRI and the CMDPDH in March 2010 that, over the last ten years, it has been impossible to gain the political support from mental health authorities necessary to allow Hidalgo model programs to move fully into the community.

DRI and the CMDPDH investigators requested access to the Villas Hidalgo to examine the current operation of the original Hidalgo model program. This is the only program in Mexico to which we were denied access. Federal mental health authorities told us that the Villas Hidalgo were locked and we could not gain access without permission. We were able to visit two other programs where so-called Hidalgo model programs were established – at Sáyago and CAISAME E.P. Guadalajara. At various other programs in the country, small homes were built on the grounds of existing institutions.

There are a number of different versions of the Hidalgo model program in Mexico in development. At Cruz del Sur in Oaxaca, for example, Hidalgo model villas were built but never fitted with water and electricity and are sitting empty for years on the grounds of the facility. At Concha Vásquez in Orizaba, the current institution is being replaced with a new one located outside of town several miles away. According to the blueprints we were shown, the new institution will include several villas on its grounds that are referred to as the Hidalgo model. While these were referred to as Hidalgo model programs, our analysis here is limited to Sáyago and CAISAME E.P. Guadalajara, which appear to be the only fully realized versions of the Hidalgo model we observed.

The Hidalgo model programs at the Sáyago institution in Mexico City were the most developed programs we visited. Of the 255 people at CAISAME E.P. Guadalajara, there are approximately 28 people living in the villas that are located on the grounds of the institution. During our March 2010 visit to Sáyago, we found that 144 residents out of 280 residents live in the villas within the institution. We were informed that plans called for all Sáyago patients in the facility to be moved to Hidalgo model programs by June 2010. We were not permitted access to Sáyago in September 2010 to verify whether this transition had taken place or to observe the new programs.

In March 2010, conditions in the Sáyago villas were much better than in the rest of the facility – which still resembled a typical *granja*. Each villa we observed is shaped like a hexagon with three bedrooms with three beds each. The villa also includes an office for hospital staff, and a collective

kitchen. At the center of the villa there is a common area that contains a couch and television. Within the bedrooms, residents have their own dresser and space for personal possessions. At Sáyago, there were 12 villas in operation at the time of our visit.

At CAISAME E.P. Guadalajara there are five villas, although only three are in use. The other two are being used as an administration office and a multi-purpose room. As at Sáyago, there is a stark contrast between conditions for individuals in the three villas and the rest of the institution. All of the other residents in these institutions live in large, dorm-like wards. In both Sáyago and CAISAME E.P. Guadalajara, the villas are much cleaner, better staffed, and residents receive more personalized care and interactions with the staff.

The director of Sáyago told us that some residents have jobs in the community that they go to and return from each day. She also said that others do odd jobs within the institution and earn 140 pesos each week. Most residents of the villas do crafts four times a week, making paper flowers or painting vases. In Sáyago, the director told us that the purpose of its rehabilitation programs were to get people jobs in the community, to live independently, or to handle money. At Sáyago, the most impressive program we observed is a hair styling studio serving residents of the facility. It is operated entirely by other residents of the villas. The women working in the salon program clearly had skills that they could use at jobs in the community. The salon could serve as a model for rehabilitation programs that could be widely replicated in the community.

At CAISAME E.P. Guadalajara, a social worker is employed to find people jobs in the community. Of the 28 people in the Guadalajara villas, eight of them are working outside of the psychiatric hospital in real jobs. One woman from Guadalajara has graduated from the program and is now living in the community. According to the director, this woman is living in a rented apartment in town and has a job. The institution supported her to get furniture, etc., but there are no funds for community service. The woman returns to the hospital for psycho-therapy.

The director of Sáyago said that a small number of people have left Sáyago entirely and that institution had helped pay for rent for six months. If the person is unable to get or maintain a job to pay rent after that time, however, the person must return to Sáyago.

At Sáyago and CAISAME E.P. Guadalajara, we met residents of the villas who seemed fully capable of living in the community but who lacked the housing or job opportunities to do so. As is the case for many people in Mexico’s long-term asylums, mental health care is available only in the institution and people are forced to come live in the Hidalgo model villas because a lack of mental health care and supportive services that they can access from their home in the community. We should also highlight a new program of supervised residences about to be implemented by the CAISAME E.P. Guadalajara, that offers up to ten very “functional” residents of the villas an opportunity to live in the near by community with a daily supervision from the hospital’s staff and more chances to start earning their own money and living in a more autonomous way.

We interviewed a woman at Sáyago named X. who was well dressed and had just returned from her job in the community. She explained that she had previously lived in the community with family

members. But when her psychiatric symptoms returned, her family insisted that she return to Sáyago. Even though she exhibited a great deal of independence and appeared very capable of living in the community, this woman said that the only place she could receive mental health services was at Sáyago. Despite the long and difficult commute to Sáyago, she said she was forced to live in the facility because of lack of housing and treatment in the community.

At CAISAME E.P. Guadalajara, a member of the investigative team met a woman who appeared very capable of living in the community. The woman's name was V., and she gave the investigator a tour of her villa. She showed the investigator her room, her bed, and her dresser, which contained a zip-lock bag full of make-up, as well a notebook with the alphabet she was studying and names and pictures of her family. V. took the investigator to the kitchen and offered her juice and lunch. V. reported that there were no plans or opportunities, however, to move out of the villas and into the community. She said that the limitation was that she had no opportunity to find a job in town on her own.

Conditions in the Hidalgo model villas are an improvement over those in other parts of the same facilities. When we visited the residents living in the villas at Sáyago and CAISAME E.P. Guadalajara, they nearly all said that they would much rather live in the villas than in the general wards of the institutions. As a short-term stepping-stone to community integration, the Hidalgo model villas could be important. The limitations on the program we observed are as follows:

- **Not a transition to the community** – For most residents, the Hidalgo model is not a stepping-stone to community integration. It is merely a more humane version of segregated living in the institution.
- **People still segregated because of a lack of community services** – People capable of living in the community are held back and kept from leaving the institution because of a lack of housing or mental health services outside the facility.
- **Remoteness of programs a barrier to integration** – Since the Hidalgo model villas are based in institutions located in remote areas, transportation to and from the programs is very difficult and expensive. Except for people who happen to live very close by to the institution, the Hidalgo model is not a practical model for people who might be able to work and live in the community but need some support. Difficulties with transportation were the most common complaint we heard from residents of the villas.
- **Freedom of movement and choice denied to people in Hidalgo programs** - People living in the Hidalgo model programs do not have "choices equal to others" in the community. Doors are locked and people cannot come and go except as permitted by institutional authorities. When DRI and the CMDPDH investigators wanted to visit the Villas in Hidalgo, we were told by mental health authorities that the facilities were locked and surrounded by armed guards. The ability to make choices – including the ability to come and go – is an essential aspect of community life, and it is recognized as a core requirement of article 19 of the CRPD.
- **Rehabilitation is inadequate and people are subject to abusive restraints** – Many of the rehabilitation programs offered in the Hidalgo model programs (e.g. arts-and-crafts)

did not seem to be tailored to the needs of people with more severe disabilities. The exception we observed is the hair salon which offers an important range of skills-building opportunities. For people with more severe disabilities, however, behavioral support programs are not available. We observed a man who had been experiencing behavior problems in the Sáyago villas, and he was left in the medical area tied down from head-to-toe to a chair. We were told he was kept there for days. As in other parts of Sáyago, restraints and psychotropic medications seem to be the only techniques the staff uses to control people who have behavioral difficulties.

- **Programs discriminate against more disabled individuals** – People with more severe disabilities are excluded from the Hidalgo model programs. At both Sáyago and Guadalajara, authorities reported that the less disabled, higher functioning, and more compliant people were selected for the program.

VI. Violations of International Law

The new UN Convention on the Rights of Persons with Disabilities (CRPD) provides a valuable new framework to assess the protection of the basic human rights of children and adults with disabilities who are being detained in Mexican institutions. The CRPD does not create new rights, but it does establish how existing rights apply to people with disabilities.[116] As stated in article 1 of the CRPD, the "purpose of the present Convention is to promote, protect, and ensure the full and equal enjoyment of all rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[117] It establishes that "discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person."[118] Under article 3, the core principles underlying the convention's protections include:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
(b) Non-discrimination;
(c) Full and effective participation and inclusion in society;
(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
(e) Equality of opportunity;
(f) Accessibility;
(g) Equality between men and women;
(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

The Convention underscores the principle – established by international law, but often overlooked in practice – that people with disabilities enjoy the same basic rights as all other people under existing human rights conventions. This includes such key conventions ratified by Mexico as the American Convention[119] and United Nations conventions, such as the Convention on the Rights of the Child[120] the Convention against Torture and Other Cruel, Inhuman or Degreating Treatment or Punishment,[121] the International Covenant on Economic, Social, and Cultural Rights (ICESCR),[122] and the International Covenant on Civil and Political Rights.[123] The CRPD builds on protections already established in the Americas by the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities.[124]

The CRPD creates a Committee on the Rights of Persons with Disabilities to provide authoritative interpretation of the broad, general rights established under the Convention. Until such time as the CRPD Committee issues general comments on the Convention, some of the most useful guidance available comes from the UN High Commissioner on Human Rights, which has issued a directive to governments who have recently ratified the CRPD. This directive explains how governments may meet their obligation to reform laws, policies, and program for compliance with the CRPD.[125] The

High Commissioner recommends reviewing both laws and policies for compliance with the CRPD and notes that the CRPD requires governments not just to change laws, policies and practices, but also to fully enforce them.[126]

A. Discrimination on the Basis of Disability

The protection against discrimination is one of eight principles underlying the convention, but it has been described as the unifying principle behind the CRPD.[127] The broad denial of rights on the basis of disability is core to the definition of discrimination as defined in the CRPD:

> "Discrimination on the basis of disability" means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.[128]

The protection against discrimination is also a fundamental right protected by the American Convention on Human Rights.[129] While the CRPD provides much more detailed protections for persons with disabilities than does the American convention, the protection against discrimination is a link between the two conventions. Extensive violations of the rights of people with disabilities under the CRPD can be used as evidence to demonstrate discrimination under the American Convention.

This report provides evidence of the fact that segregation from society on the basis of disability also entails the denial of a broad deprivation of a person's ability to exercise all other rights – the right to life (art. 10), right to health (art. 25), right to habilitation and rehabilitation (art. 26), and the right to live in the community with choices equal to others (art. 19).[§] Mexico's mental health and social service systems consistently subject adults and children with disabilities to discrimination by providing them with care in a manner that leads to their segregation from society.

Now that Mexico has ratified the CRPD and committed itself legally and politically to the enforcement of disability rights, immediate action is necessary to integrate children and adults with disabilities fully into society.

B. Segregation from Society and the Right to Community Inclusion

One of the most important and innovative provisions of the CRPD is article 19, which establishes the right of "*all* persons with disabilities to live in the community, with choices equal to others…"[130] The reference to "all" persons with disabilities includes all children and adults with intellectual or psychosocial disabilities. **This means that no person is considered too disabled to enjoy and benefit**

[§] Note: Each of these rights is described in more detail later in these sections.

from the right to live as a full member of the community. Any limitation of this right cannot be justified on the basis of a person's disability but must be based on a disability-neutral basis, such as actions that threaten the safety of others (*see* protections against arbitrary detention below).

In order to implement the right to live in the community, governments agree to "take effective and appropriate measures to facilitate the full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community."[131] This includes the right to "community support services […] necessary to support living and inclusion in the community […]."[132] If people with disabilities lack a home in the community or a family to take care of them, they have a right to "a range of in-home, residential, and other community support services […] to prevent isolation or segregation from the community."[133]

With the adoption of the CRPD, the obligation to reform mental health systems and create community-based support services is not just a matter of good social policy – it is a recognized, fundamental human right. This new recognition clarifies the requirements of international human rights law, but the concepts represented in the CRPD are not new. There is a growing worldwide consensus that people with a diagnosis or history of mental illness, as well as individuals with intellectual disabilities, benefit from being part of society.[134] Of course, the rest of society benefits as well from the inclusion of people with disabilities. The United Nations Special Rapporteur on Health has observed that:

> As a result of increased knowledge about mental disabilities and new models of community-based services and support systems, many people with mental disabilities, once relegated to living in closed institutions, have demonstrated that they can live full and meaningful lives in the community. People once thought incapable of making decisions for themselves have shattered stereotypes by showing that they are capable of living independently if provided with appropriate legal protections and supportive services. Moreover, many people once thought permanently or inherently limited by a diagnosis of major mental illness have demonstrated that full recovery is possible.[135]

These ideas have been endorsed by the Pan American Health Organization (PAHO) and have gained support throughout the Americas. NOM-025-SSA2-1994rth, Central and South America, convened by the PAHO, adopted the *Declaration of Caracas.*[136] The *Declaration of Caracas* recognized that psychiatric hospitalization "isolates patients from their natural environment…generating greater social disabilities."[137] The international consensus reflected by the *Declaration of Caracas* is that governments should restructure mental health care systems to "promote alternative services models that are community-based and integrated into social and health care networks."[138] Governments throughout the Americas and the PAHO gathered in Panama in October 2010 to celebrate the 20th anniversary of the *Declaration of Caracas*.

The CRPD provides stronger protection and a clearer mandate than the UN Convention on the Rights of the Child (CRC) for ensuring that all children with disabilities have the opportunity to live and grow up with a family.[139] Under article 19, the CRDP recognizes a right of "all persons with disabilities"

to "live in the community," whereas the CRC establishes no such individual right. The CRC states more broadly that "a mentally or physically disabled child should enjoy a full and decent life, in conditions which…promote self-reliance and facilitate the child's active participation in the community."[140] To implement this right, Article 23(3) establishes that children with disabilities should receive "education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development."[141] The Committee on the Rights of the Child has called on governments to "to set up programmes for de-institutionalization of children with disabilities, re-placing them with their families, extended families or foster care system." [142] While the CRC creates a clear mandate to all governments to move toward de-institutionalization, article 19 of the CRPD provides an unqualified right to the ultimate outcome of this process: full community integration. The new UN Guidelines for the Alternative Care of Children, adopted by the UN General Assembly in 2010, support this shift. The Guidelines require that alternatives to institutions must be developed "with precise goals and objectives, which will allow for *their progressive elimination*."[143]

For children with disabilities, the provisions of article 19 are strengthened by an explicit right of children to grow up with a family under CRPD article 23. Article 23(5) states that "where the immediate family is unable to care for a child with disabilities, [States Parties shall] undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting." Thus, under the CRPD and the subsequent UN Guidelines, institutions and orphanages are no longer acceptable as a "last resort" for children with disabilities who lack services in the community. The continued existence of such institutions represents evidence that a country has not yet fully implemented the right to live in the community with a family as established in CRPD articles 19 and 23.

The clear mandate of international law is that governments must work toward the elimination of institutions for children rather than simply bringing about their improvement. According to UNICEF, "it has become widely accepted that institutional care for children whose needs cannot be met within their own family is highly detrimental to their well-being and development…. Research has demonstrated that children experience developmental delays and potentially irreversible psychological damage by growing up in such environments. Even in a well-staffed institution, a child rarely gets the amount of attention he or she would receive from their own parents, or from substitute caregiver families in the community. In addition, children in these settings are denied the important benefit of modeling by other children, which is critical for learning."[144]

The United Nations High Commissioner on Human Rights has identified key elements to the obligations of governments under CRPD article 19.[145] The right to community integration must be:

(1) **Legally recognized and enforceable through meaningful choices –** According to the UN High Commissioner, "[t]he key element of any intervention aimed at giving effect to the right to independent living and community inclusion is the *explicit legal recognition* of the right of persons with disabilities to determine where and with whom to live. This recognition should also openly

reflect the unlawfulness of arrangements for residential care made against the wishes of a person with disabilities."[146] In order to implement the right to live "with choices equal to others" under article 19, a government must also protect the right to make choices about all other aspects of life – not just choices about place of residence. (This right to make choices is also protected by article 12 of the CRPD and is discussed further in Section VI (G) below.)

(2) Included in national policies and planning – For countries that have traditionally relied on placing people with disabilities in institutions, psychiatric facilities, or orphanages, a policy of "[d]e-institutionalization is necessary but not sufficient to achieve the goal of independent living."[147] Planning for "a national strategy that integrates interventions in the area of social services, health, housing and employment, at a very minimum, will be required."[148]

(3) **Implemented through the creation of community-based services –** Perhaps most importantly, implementation of CRPD article 19 will be evaluated by the United Nations based upon the actual provision of community-based services. Thus, funding is required to implement policies of deinstitutionalization such that people with disabilities can "access the support services required to enable independent living and inclusion in community life….."[149] This includes "the guarantee that independent living support should be provided and arranged on the basis of the individual's own choices and aspirations, in line with the principles of the Convention."[150]

Mexico has three relevant laws that relate to the community integration of people with disabilities: (1) Ley General de Salud (Federal Health Law), (2) Ley General de Las Personas Con Discapacidad (Federal Law for Persons with Disabilities), and (3) Norma Oficial Mexicana "NOM-025-SSA2-1994" (Official Mental Health Standard).[**] With regard to the right to community integration, the Federal Health Law states that "The confinement of Persons with mental disabilities in mental health facilities must be in accordance with the ethic and social principles, and with the scientific and legal requirements determined by the Ministry of Health and by other applicable legal provisions."[151] However, the law does not establish a right to community integration or state that the purpose of rehabilitation should be community integration.

The Federal Law for Persons with Disabilities, meanwhile, specifies that the principle of "integration through participation and full and effective inclusion in society" should be observed as a matter of "public policy."[152] However, this is merely a matter of public policy, and not enforceable law. Article 7 of this law provides people with disabilities rehabilitation services, but there is no mention of community integration here or anywhere else in the law.[153]

[**] In Mexico, the Constitution is the leading legal authority followed by laws, then regulations, and finally by standards. Standards have the force of law and "detail the form, format, documentation that must be maintained for laws and regulations," as well as fines and sanctions. *See* WHAT IS THE DIFFERENCE BETWEEN A LAW, A REGULATION, A NOM, AND A NMX?, http://www.mexicanlaws.com/what_is_the_difference.htm (last visited Nov. 3, 2010).

The right to community integration is stated most explicitly in the Official Mental Health Standard NOM-025-SSA2-1994 (NOM-025).[154] The mental health standard establishes that it is the responsibility of government to provide community-based services for people with disabilities.[155] Under Section 7.1.3, hospitals have the duty to promote the creation of community-based programs in order to facilitate the reintegration of people with mental illnesses into the community.[156] To achieve successful transitions into the community, hospitals must provide comprehensive rehabilitation programs. Section 3.5 of the NOM-025 identifies comprehensive rehabilitation as a group of activities aimed at the maximization of the development of the individual to overcome or diminish the disadvantages acquired as a result of their mental illness. Under the standard, rehabilitation programs must educate service system users to care for themselves in their daily lives so that they can participate in community activities and engage in a full social and cultural life in the community.[157]

Article 4(5) of the CRPD requires the Convention to be implemented at "all parts of federal states without any limitations or exceptions." No Mexican law, including the Official Mental Health Standard, creates a systemic mandate on states to create community-based mental health services systems. In the absence of a mandate for services at the state or local level that would allow for the implementation of Mexico's mental health law, Mexico's Official Mental Health Standard is further limited by the fact that it cannot be enforced at the individual level to protect an individual's right to community integration. It is not associated with a right to a package of actual services that would allow a person with a disability to exercise his or her right to live in the community.

June 2011 update: On May 31, 2011, Mexico's "Law for the Inclusion of People with Disabiities" entered into force.[158] The stated goal of Mexico's new Law for the Inclusion is to bring about compliance with the CRPD. Despite the stated purpose of the law, however, the new legislation fails to provide any actual right to live or receive services in the community.

The new Law for Inclusion establishes that the Public Administration will establish measures against discrimination and will take affirmative action to allow the integration of people with disabilities into the society. Article 6.IX states that the Federal Executive Branch should promote the integration of people with disabilities. Like in the current Federal Law for Persons with Disabilities, however, these provisions are merely a statement of public policy. This is not enforceable law.

The Law for Inclusion does not have any provision that would create community services. On the contrary, under article 4.V, the Ministry of Health has as duty to promote the creation of long-term institutions for people with disabilities in distress; Under article 6.III, the Ministry of Social Development will also promote the establishment of specialized institutions to "care," "protect" and "house" people with disabilities in poverty, neglect or marginalization. Instead of establishing new opportunities for community integration, the new Law for Inclusion reinforces Mexico's existing segregated system of care for people with disabilities.

Considering all current Mexican law, including the national Law for Inclusion of People with Disabilities that will soon enter into force, Mexico fails at the systemic and individual levels to meet the first criterion for implementation of article 19: an enforceable right to community integration. Mexico

also fails to fulfill the second element of article 19 – the inclusion of the right to community integration in national policies or planning. As the director of the Psychiatric Services System explained to DRI and the CMDPDH investigators, the federal government of Mexico has not allocated the funds necessary to implement the mental health law that provides a right to care in the community. Mental health authorities report that none of the mental health budget is specifically designated for community mental health. In practice, the government's so-called "plan" for mental health services and community care is no more than of a statement of values than an actual policy or program. ***Despite the government's claims, there is no real plan for the creation of community-based services.***

Finally, as the observations in this report indicate, Mexico has failed to meet the third criterion for implementation of article 19 – the actual provision of services in the community. In practice, our report finds that thousands of individuals with disabilities are segregated from society because of the lack of community-based services. Until community services are established, there are no meaningful "choices" available to people with disabilities.

C. Lack of Habilitation and Rehabilitation

CRPD article 26(1) recognizes the right of persons with disabilities to receive "comprehensive habilitation and rehabilitation services and programs." The purpose of such programs is "to enable persons with disabilities to attain and maintain maximum independence, full physical, mental and social and vocational ability, and inclusion and participation in all aspects of life." Thus, the CRPD's protection under article 26 is more than a right to specific services – it is more broadly a right to support in exercising the right to personal autonomy and liberty, including full inclusion and participation in society.[159]

While isolated habilitation and rehabilitation programs exist in Mexico's long-term facilities, the great majority of people with disabilities do not have access to these services. Even when habilitation and rehabilitation are provided, the context in which they are provided undermines their effectiveness. During our visits to seven long-term facilities in Mexico City, the State of Mexico, Puebla, Veracruz, and Jalisco, we observed thousands of individuals languishing in near-total inactivity – crowded onto benches of barren rooms, lying on the grass or the concrete floor of institutions, or sitting on beds. These environments are totally unsuitable to rehabilitation and regaining the skills needed to reintegrate people into the community. In practice, life in an institution does not give anyone the skills or experiences they would need to make the transition back to society.

As described in sections II-C and III-D of this report, the lack of stimulation, social interaction, and opportunities for using and maintaining skills leads to deterioration in social and psychological functioning for people who are held in institutions for long periods of time. For the *abandonados* who remain in the institution for life, rehabilitation is essentially impossible, even when so-called rehabilitation programs are made available. As article 26(1)(b) of the CRPD makes clear, the purpose of these programs is to "[s]upport participation and inclusion in the community and all aspects of society." Where institutions lead to a dead-end and there is no hope for community integration, the efforts of even the most well-meaning program and staff are undermined.

D. Threats to Life and Health

Under the CRPD, people with disabilities are entitled to the right to life and the right to health. The CRPD provides valuable guidance to governments as to how the broader right to ensure that persons with disabilities can enjoy the "highest attainable standard of physical and mental health" as protected by previously existing human rights instruments, such as article 12 of the ICESCR.[160]

Article 10 of the Convention recognizes "the inherent right to life" and the obligation of States Parties to "ensure its effective enjoyment by persons with disabilities on an equal basis with others."[161] Article 25 recognizes that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability"[162] and, specifically, "health services as close as possible to people's own communities, including in rural areas."[163]

This report documents a broad array of health risks in Mexico's psychiatric institutions and long-term care facilities, including: (1) lack of basic medicine and health care, (2) overuse and high dosages of psychotropic medications, (3) lack of dental care, (4) use of long-term restraints in both beds and wheelchairs, (5) lack of physical therapy, especially for people with cerebral palsy, (6) unhygienic and unsanitary living conditions, and (7) lack of social stimulation. The lack of loving attention and social stimulation is particularly dangerous for children – which may lead to a "failure to thrive" that can be life-threatening.

At the institutions that DRI and the CMDPDH visited, we observed people restrained in beds, wheelchairs, and other methods, even though these practices are extremely dangerous and are likely to cause medical complications that can be life-threatening. From a strictly medical perspective, the long-term use of restraints constitutes a serious danger to life and health. People who are put in long-term physical restraints may suffer from muscular and skeletal atrophy, swollen and discolored limbs, gangrene, and pneumonia. Bed sores from physical restraints can easily become dangerous and infected – particularly when people are left covered in their own feces. The dangers of physical restraints include a risk of "serious injury or death, retraumatization of people who have a history of trauma, and loss of dignity and other psychological harm."[164] The World Health Organization has singled out "long-term bodily restraint" as "a cruel treatment often leading to muscular atrophy and skeletal deformity."[165] The Inter-American Court on Human Rights, in the case of *Ximenes-Lopes v. Brazil*, pointed out that "the use of restraint poses a high risk of doing harm to the patient or causing his or her death and that falls and lesions during such procedure are quite common."[166]

At Cruz del Sur, a nurse told DRI and the CMDPDH investigators that the institution lacked some of the most basic medicines, including those for heart attacks and other illnesses that can be fatal. At night and in the evening, there are not even psychiatrists or doctors to administer the medicine that is available in the event someone becomes ill. In some institutions, there is no way to easily transfer residents to a general hospital for somatic health care.

In addition to the lack of basic medication, DRI and the CMDPDH investigators found residents suffering from overuse and high dosages of psychotropic medications at all of the institutions we visited. We were told that psychotropic medications are used to control difficult behaviors instead of less invasive and more specific forms of behavioral therapy. Additionally, residents were receiving high doses of these psychotropic medications. At Samuel Ramírez Moreno, the subdirector reported that due to budget constraints, they have had to use less expensive medications even though they have more disabling side effects. High doses of these medications can result in tardive dyskinesia, which manifests itself through rhythmic movements of the lips and tongue, teeth grinding, shifting back and forth on the feet, and twisted movements of hands. It can also lead to disabling side-effects, such as irreversible nerve damage and sudden-death.[167]

Many of the residents that we observed in every institution that we visited had dental problems, such as missing teeth and decay. Loss of teeth and decay can create discomfort and other serious health risks (in addition to toothaches, loss of teeth may lead to decreased saliva production, muscle spasms, and chronic headaches).[168] People who lose their teeth and lack replacements must eventually limit themselves to soft foods, which may lead to malnutrition and a general decline in health.

For people with cerebral palsy or other forms of disability that limit movement, it is crucial that they receive physical therapy and daily exercise. Otherwise, they will suffer from the same symptoms that people who are placed in long-term restraints suffer from. DRI and the CMDPDH found that many institutions had no physical therapists on staff and that most patients received little to no physical therapy. Exercise machines collected cobwebs and dust, while people lay in bed having lost the ability to move.

DRI and the CMDPDH found that many residents in the institutions we visited lived in extraordinarily unhygienic and unsanitary living conditions (with the exception of La Salud, a social security psychiatric institution; Hospital Psiquiátrico de Nuestra Señora de Guadalupe, a private institution; Fraternidad sin Fronteras; Conecalli; and Fray Bernardino). At Samuel Ramírez Moreno, water is only available for a three-hour period in the morning – after that, there is no water for bathing or washing clothes. There, as well as at El Batam and CAIS Villa Mujeres, we saw people sitting, walking, and eating in their own urine and feces. At many institutions, the smell of human waste permeated the entire institution and the bathrooms were covered in waste. At CAISAME E.P. Guadalajara, DRI and the CMDPDH investigators observed approximately 30 residents taking their medicine from a single cup. Such unhygienic and unsanitary conditions pose a significant risk of disease and infection.

Finally, DRI and the CMDPDH investigators observed a total lack of social stimulation for both adults and children at psychiatric institutions and long-term facilities. At every single place we visited, adults and children were segregated from the rest of society. Their days are marked by pervasive inactivity and isolation. People lose social skills rapidly, and children, in particular, experience potentially irreversible psychological deficits, as well as developmental delays.

E. Cruel, inhuman or degrading treatment and torture

> **..The Special Rapporteur draws attention of the General Assembly to the situation of persons with disabilities, who are frequently subjected to neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence. He is concerned that such practices, perpetrated in public institutions, as well as in the private sphere remain invisible and are not recognized as torture or other cruel, inhuman or degrading treatment or punishment. The recent entry into force of the Convention on the Rights of Persons with Disabilities and its Optional Protocol provides timely opportunity to review the anti-torture framework in relation to persons with disabilities. By reframing violence and abuse perpetrated against persons with disabilities as torture or a form of ill-treatment, victims and advocates can be afforded stronger legal protection and redress for violations of human rights –** *UN Special Rapporteur on Torture, Manfred Nowak*[169]

Article 15 of the CRPD guarantees the following: "No one shall be subjected to torture or cruel, inhuman, or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation." The words of the CRPD were chosen to match the protection provided under article 7 of the International Covenant on Civil and Political Rights (ICCPR).[170] These protections are very similar to the terms of American Convention article 5(2) and the Convention against Torture. The UN Special Rapporteur on Torture has stated that the application of CRPD article 15 "can be informed by the definition of torture contained in article 1 of the Convention against Torture."[171] In December 2006, the UN Special Rapporteur on Torture convened a meeting of disability and torture experts to examine the ways that the Convention against Torture can be applied to protect persons with disabilities.[172]

Under all these conventions, governments are required to ban torture or cruel, inhuman or degrading treatment or punishment (known collectively as "ill-treatment") and to take pro-active measures to ensure that these practices do not take place. The failure to protect people from ill-treatment or torture is among the most serious human rights violations under international law. These are considered "non-derogable" rights – meaning that there are no exceptions to the obligations of governments to protect against such abuses, including in circumstances of national emergency.

For a practice to constitute torture or ill-treatment, the pain inflicted on a person must rise to a level of severity to violate international human rights law. The CRPD does not change the existing definition of cruel, inhuman or degrading treatment or torture, but it makes clear that the protections apply to individuals with disabilities. The UN Special Rapporteur on Torture, Manfred Nowak, has explained that abuses perpetrated in institutions or other contexts of care have not been traditionally identified with the protections against torture or ill-treatment. With the ratification of the CRPD, governments are obliged to ensure that people with disabilities are guaranteed these protections, even if the abuses take place under the guise of "medical treatment" or in an environment that is intended for their medical care or protection. Due to the "growing demand for the protection of fundamental

rights and freedoms," treatment that may not have been considered torture in the past may be considered torture now or in the future.[173]

Thousands of individuals with disabilities in Mexican institutions are subject to severe emotional and physical pain and suffering that constitutes ill-treatment under international law. In some cases, the abuses we observed may rise to the level of torture. In a number of institutions – CAISAME E.P. Guadalajara, Sáyago, Ramírez Moreno, and El Batam, we observed people who had been tied permanently to wheelchairs or beds. We observed children left in long-term detention in Children's homes #1 and #2 in Oaxaca. In Guadalajara, we observed a man wrapped from head to food in gauze bandages that do not permit any movement throughout his body. As described further below, the use of long-term restraints in Mexico's institutions may constitute nothing less than torture.

1. Cruel, inhuman or degrading treatment

While article 1 of the Convention against Torture defines torture, article 16 defines cruel, inhuman or degrading treatment or punishment. It states that cruel, inhuman or degrading treatment or punishment are those acts or omissions that "do not amount to torture under article 1." Both torture and cruel, inhuman or degrading treatment or punishment require "the infliction of severe pain or suffering."[174] While there is little to distinguish between cruel and inhuman acts, degrading acts may forego the "severity" requirement if the treatment is "particularly humiliating."[175] Degrading treatment is "characterized by the fear, anxiety and inferiority induced for the purpose of humiliating and degrading the victim and breaking his physical and moral resistance."[176] In order to constitute a violation of the right to protection against torture or ill-treatment, a practice must be "severe."

There is extensive practice that makes clear that practices commonly found in Mexico's institutions meet the level of severity required to constitute ill-treatment. The UN Special Rapporteur on Torture has "expressed concerns about poor living conditions in psychiatric institutions and homes for persons with disabilities" as violations of the Convention against Torture.[177] "Poor conditions in institutions" that may violate the Convention against Torture include a failure on behalf of the government to provide "adequate food, water, medical care and clothing."[178]

The lack of financial resources does not excuse these human rights violations. In its recent summary of international human rights law, the World Health Organization has stated that "the lack of financial or professional resources is not an excuse for inhuman and degrading treatment."[179] Governments are required to provide adequate funding for basic needs and to protect the user against suffering that can be caused by a lack of food, inadequate clothing, improper staffing at an institution, lack of facilities for basic hygiene, or inadequate provision of an environment that is respectful of individual dignity.[180]

The denial of appropriate medical care, rehabilitation, and habilitation in institutions (described in part C above) also results in avoidable pain and suffering that constitute cruel, inhuman or degrading treatment. Being left in a room for a life-time in near total inactivity with no stimulation, no contact

with the outside world, and no hope of return to the community may also rise to the level of severity necessary to qualify as inhuman and degrading treatment. Investigators also observed conditions that clearly violate the prohibition on ill-treatment: people living in filthy, unhygienic conditions; people subject to the horrendous smells of urine and feces spread about the floors of the institutions; the use of a single drinking glass to dispense medication to 30 people; lack of water for bathing or washing clothes; open showers and toilets with no privacy; lack of space for personal possessions; sexual abuse; and violence.

In the case of *Ximenes-Lopes v. Brazil*, the Inter-American Court incorporated the standards of the United Nations "Principles for the Protections of Persons with Mental Illness"[181] to determine whether the use of restraints violates article 5 of the American Convention, which prohibits torture or ill-treatment.[182] *Ximenes-Lopes* did not address the issue of long-term restraints (described further below), but it did state that any use of restraints "should be used as a last resort and with the only purpose of protecting the patient…"[183] The Court also stated that "health care staff should apply the least restrictive possible restraint techniques and only for such period of time as is absolutely necessary and under conditions which respect the patient's dignity and minimize the risks of impairing his or her health."[184] At many facilities, there are no procedures for monitoring restraints to ensure that they are used in as limited a manner as possible. Physical restraints are frequently used for administrative convenience where adequate staff is not available to supervise patients. In Cruz del Sur, for example, we observed a woman who could not speak Spanish held indefinitely in restraints until family members could be identified. In many facilities, restraints are used as the primary response to "aggression" or "self-abuse" because no other treatment is available. At the Oaxaca Shelter #2 for children, we observed a girl left with her arms tied inside her shirt so she was unable to use her hands. Such practices subject people to unnecessary danger and loss of autonomy and must be considered, at minimum, inhuman and degrading treatment.

2. Long-term Restraints as Torture

When people are held in a permanent condition of long-term physical restraint, DRI contends that this practice may rise to the level of torture. The UN Special Rapporteur on Torture has stated that "there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment."[185] When DRI (then Mental Disability Rights International or MDRI) found that children were tied to the bars of cribs in Serbian orphanages, the UN Committee on the Rights of the Child expressed concern that "long-term forms of restraint and seclusion…could amount to ill-treatment or even torture."[186]

We observed the extensive use of physical restraint in Mexican institutions as a permanent form of behavior control. While some staff observed that people may be temporarily released from restraints for cleaning or other reasons, they also commented that certain individuals considered "difficult" by the staff are continually tied up again and again. At CAISAME E.P. Guadalajara, we observed a young man tied to a wheelchair from head-to-toe so that he was not able to move any part of his body. This young man is the same individual who DRI observed as a boy tied to a wheelchair when we visited the institution in 1999. Staff on the ward told us that this young man is permanently held in a wheelchair.

We photographed a woman in Ocaranza whose upper body was held in restraints in 1999. We photographed the same woman at the Sáyago facility tied to a wheelchair in March 2010.

The practice of torture is subject to the highest level of international recrimination, and torture is carefully defined under article 1 of the Convention against Torture. For a practice to constitute torture, it must meet all four elements of the definition. The practice must entail (1) severe emotional or physical pain or suffering; (2) it must be inflicted intentionally; (3) it must be inflicted for a purpose; and (4) there must be State involvement. An act falling short of these four elements may constitute cruel, inhuman, or degrading treatment, in violation of article 16 of the Convention against Torture.

The use of long-term physical restraints can meet all the elements of the torture definition. Some human rights authorities, such as the European Court of Human Rights, have viewed the critical factor in distinguishing between ill-treatment and torture as the intensity of suffering inflicted.[187] While the short-term use of physical restraints can be extremely painful, the prospect of facing a lifetime largely tied down to a bed is a practice that causes an intensity of mental and physical suffering that no person could be expected to endure. Having one's arms and legs tied to a wheelchair or the corners of a bed removes all control of the most basic of bodily functions, including the ability to feed oneself or eliminate bodily waste. The prospect of facing a life-time of restraints on a daily basis without hope or opportunity for any form of movement or individual autonomy causes profound levels of pain and suffering.

Other human rights authorities have focused on other elements of the definition to determine whether a practice rises to the level of torture. The UN Commission on Human Rights has seen the purpose of the conduct as the key factor in distinguishing ill-treatment from torture.[188] The Special Rapporteur on Torture has observed that a key factor to be taken into consideration is the powerlessness of the victim:

> **The powerlessness of the victim is the essential criterion which the drafters of the Convention had in mind when they introduced the legal distinction between torture and other forms of ill-treatment**.[189] – *UN Special Rapporteur on Torture Manfred Nowak*

In the case of the children or adults with disabilities we observed in Mexico, the special vulnerability of being detained in an institution must also be taken into consideration. The UN Special Rapporteur on Torture has pointed out that, "[a]ssessing the level of suffering or pain […] requires considering the circumstances of the case, including the existence of a disability, as well as looking at the acquisition or deterioration of impairment as result of the treatment or conditions of detention in the victim."[190] As observed above, the use of long-term restraints is physically dangerous and likely to lead to increased disability. Children and adults with disabilities detained in institutions are extremely vulnerable to abuse because of their powerlessness and because they are subject to the total control of an institution. No one is

subject to so much powerlessness as individuals who are subject to the long-term use of physical restraints.

The next factor to be considered in determining whether a practice is torture is whether an act is inflicted with intent and purpose. One of the reasons that abuses in a medical context have not been widely understood as torture is because mental health professionals are generally assumed to be motivated by a desire to help or protect a patient. Yet the UN Committee against Torture has stated, in General Comment #2, that "*elements of intent and purpose in article 1 do not involve a subjective inquiry into the motivations of perpetrators*."[191] Thus, a practice that induces severe pain may constitute torture even if the health care worker who places a person in restraint is attempting to provide treatment. A motivation to cause suffering is not required. Whatever the motivation, the "intent" requirement of the Convention against Torture is important because it requires that the act be knowing and intentional. The placement of a person in long-term restraints over a life-time can meet the intent requirement because staff knowingly places a person in this condition. Indeed, in all the institutions we visited, authorities reported that an order by a physician or psychiatrist is needed to place a person in restraints.

The UN Special Rapporteur on Torture has explained that "intent" to cause pain "can be effectively implied where a person has been discriminated against on the basis of disability."[192] At the Expert Seminar on Freedom from Torture and Ill-Treatment and Persons with Disabilities convened by the UN Office of the High Commissioner on Human Rights (OHCHR) in December 2007, DRI presented video from Serbia showing people with disabilities held in long-term restraints. The OHCHR summarized the discussion of this as follows:

> Many participants agreed that the situation presented in the video constituted torture as provided in article 1 of CAT. Further, some noted that situations like the one in the video were not exclusive to Serbian institutions and that it was important to start applying the torture protection framework fully to the treatments and conditions inflicted on persons with disabilities.
>
> During the discussion, the elements of torture - as foreseen in article 1 of CAT- were clarified and applied to the situation described in the presentation…the intent and … purpose element are related, and therefore one doesn't need to prove the existence of intent, when the purposive element is clear, (e.g. it was noted that in the context of institutionalization of persons with disabilities like the one in the video, the purpose of discrimination was present).[193]

The Convention against Torture requires that pain be inflicted for a purpose. The UN Special Rapporteur on Torture makes clear that "purely negligent conduct" cannot constitute torture.[194] The practice of long-term restraints because of their disability constitutes torture because it is much different than mere negligence. Whether the stated "purpose" is treatment or the control of behavioral disorders – or whether it is actually used for the administrative convenience of staff that is

not able to control a patient – it can carry the intent and purpose required to meet the definition of torture.

The Convention against Torture prohibits the infliction of pain or suffering for the purpose of "coercion" or "discrimination."[195] The adoption of the Convention on the Rights of Persons with Disabilities (CRPD) underscores the fact the international community no longer tolerates discrimination on the basis of disability, nor does it tolerate the deprivation of liberty on the basis of disability. The deprivation of liberty entailed by the long-term use of physical restraints without legal protections is total. Relegating a child or adult with a disability to a lifetime of being tied down is torture and should not be tolerated in any society and is deserving of the highest level of international recrimination.

The final element necessary to meet the definition of torture, under the Convention against Torture, is the requirement of State action. Most of the institutions we observed in Mexico are operated, funded, and regulated by the government. DRI recently documented the use of long-term restraints and electric shocks in a private facility receiving government funds and regulated by the State of Massachusetts in the United States. The UN Special Rapporteur on Torture stated on US television that practices documented in the report constitute torture.[196] At the UN Expert Seminar on Torture, participants concluded that "[s]tates have the obligation to ensure that public and private health institutions don't inflict torture and ill-treatment."[197] In the case of Ximenes-Lopes, the Inter-American Court similarly found that governments can be held accountable for the protection against torture in a private psychiatric facility.[198]

The practice of long-term physical restraints, as practiced in Mexican institutions, can rise to the level of the strictest definitions of torture. The use of long-term restraints is a practice that brings about great intensity of suffering and is also likely to bring about or result from total powerlessness of a victim. Long-term restraints cannot take place without a purposeful act perpetrated over days, months, or years. At minimum, the long-term use of physical restraints constitutes inhuman and degrading treatment in violation of the Convention against Torture. When such practices meet all four criteria required by the Convention against Torture, the use of long-term physical restraint on institutionalized children or adults with disabilities may constitute nothing less than torture.

F. Arbitrary Detention

Mexican law does not provide international human rights standards necessary to protect individuals against arbitrary detention. In the absence of these legal protections, every person subject to involuntary detention in Mexico's institutions is subject to arbitrary detention in violation of CRPD article 14 and article 7(3) of the American Convention. In practice, a large number of people who are designated as "voluntary" are also subject to arbitrary detention. We found that many people whose detention is regarded as "voluntary" are merely signed in by family members. This widespread practice violates even the basic requirements of Mexico's mental health law.

One of the core principles of the CRPD is the recognition of principles of "individual autonomy, including the freedom to make one's own choices,"[199] and one of the most fundamental choices a

person can make is the choice of where he or she lives and receives treatment. This is linked to another core provision of the CPRD, the right to "full and effective participation and inclusion in society."[200]

Under CRPD article 14, governments must "ensure that persons with disabilities, on an equal basis with others, are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law…."[201] Most important, article 14 establishes that "the existence of a disability shall in no case justify a deprivation of liberty."[202] The UN High Commissioner on Human Rights has stated that the CRPD does not prohibit involuntary detention as long as the standard for detention is disability neutral (i.e. the same for disabled and non-disabled individuals):

> Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. […] This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventative detention, but the legal grounds upon which restriction of liberty is determined must be de-linked from disability and neutrally defined so as to apply to all persons on an equal basis.[203]

In so doing, the CRPD provides a stricter standard for psychiatric commitment than was previously allowed under the United Nations' "Principles for the Protection of Persons with Mental Illness" (the "MI Principles").[204]

Article 14 of the CRPD does make clear that "if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the Convention […]."[205] While the CRPD requires a disability neutral standard for commitment, it does maintain previously existing procedural protections to avoid arbitrary detention. As established under international human rights law, this includes a right to a hearing by an independent and impartial authority before a person can be committed, the right of a person to counsel to challenge his or her commitment, and the right to present evidence such as the view of an independent mental health professional.[206]

The protections established under article 12 of the Convention must also be taken into consideration when considering any process of psychiatric commitment. As described further below, article 12 requires recognition of a person's right to make choices for him or herself. When a disability limits a person's ability to make choices, the CRPD requires affirmative steps to assist with "the support they may require in exercising their legal capacity."[207] This may entail helping a person to identify meaningful alternatives to institutionalization – and respecting his or her right to make such choices.

The NOM-025 governs all psychiatric commitment throughout the country.[208] The law was specifically modeled after the UN's MI Principles.[209] Now that standards for psychiatric commitment have been made even stricter than the MI Principles, the new CRPD standard supersedes those previously allowed. Yet, as DRI found in our 2000 report, Mexico's mental health law never met the requirements of international law under the old UN standards.[210] The Mexican *Norma* does not include

requirements that the legal capacity of individuals with disabilities be respected or that support be provided in a decision-making process.

Mexican law does not include requirements for independent review and oversight of psychiatric commitment. Under the *Norma Oficial Mexicana,* involuntary commitment requires only the written approval of a psychiatrist and a family member or legal guardian.[211] The *Norma Official Mexicana* does not require judicial oversight of the civil commitment process. There is no mechanism requiring any review of the initial commitment, and there is no process for period review of commitment. Once a person is detained by family and a psychiatrist, they may remain in an institution for life.

> **I took my wife to San Rafael hospital. I needed to go to the Ministerio Público. They asked for a signature from a psychiatrist with a diagnosis. They did not ask for any other explanation of what happened. They just wanted to show that I brought my wife to the hospital and that the doctors signed the papers. I guess they needed to show that it was not a kidnapping**. *– Member of Voz Pro Salud, October 2009*

The *Norma Oficial Mexicana* requires a hospital to inform the *Ministerio Público* (an investigating judge) of the admission and "development" of the case, but it does not require that the *Ministerio Público* review or approve the commitment.[212] Mental health authorities told us that the notification of the *Ministerio Público* is done to help locate individuals under suspicion of criminal behavior. In practice, authorities at institutions explained that no details of a case are provided to the *Ministerio Público* that would allow them to come up with an independent opinion and updates are not routinely provided. The director of Samuel Ramírez Moreno informed DRI and the CMDPDH investigators that, in his experience, no official from the *Ministerio Público* has ever asked for additional information or challenged his judgment about an involuntary psychiatric commitment.

Mexican law does require periodic clinical review of each case by medical authorities at the institution.[213] This review is not conducted by an independent authority as required by international law. The review is entirely medical in nature and does not require any assessment of dangerousness or other standards relating to involuntary detention.

> **Voluntary treatment is not the main way we admit patients because they do not want to be here. Usually, the family signs them in. No other authority is involved in admission. It is family plus psychiatrist or a doctor.** – *Authorities at CAISAME E.P. Guadalajara*

Authorities at Fray Bernardino (a short-term facility) and many of the long-term facilities we visited reported that the majority of the individuals detained in the institution were considered "voluntary." Except at Fray Bernardino, which requires the signature of a person being committed as a voluntary patient, many of the institutions accept individuals as voluntary if they are brought by family members. This common practice violates the basic terms of Mexican mental health law. The *Norma Oficial Mexicana* permits voluntary admission to an institution "at the user's request."[214] In practice,

authorities at long-term facilities explained that people brought by relatives and detained as "voluntary" are not free to leave.

The failure to respect a person's choice about admission and the acceptance of family consent creates enormous dangers for individuals with disabilities. At Fray Bernardino, authorities report that they can over-ride the objections of one family member if they are able to find another who agrees to involuntary detention. At El Batam, the director expressed grave concern about people detained at facilities over the objections of his medical or psychiatric staff. "We explain to the families that the law does not allow us to admit certain patients," he explained, "but the family complains to the local government. The authorities then order us to admit patients. We can't say no." In certain cases, the director of El Batam said that the authorities order them to admit *abandonados* without families purely because they had no other place to go – irrespective of whether they needed psychiatric treatment.

G. Guardianship, Legal Capacity and Choice

> **For the abandonados, the states make all decisions. It is up to the director of the hospital. I am responsible.** – *Director of El Batam*
>
> **Once in the hospital, the doctors make all the decisions about patients. Patients have to collaborate with us. It sounds a little autocratic, but it is an institution.** – *Director of Samuel Ramírez Moreno Hospital*
>
> **We are legal guardian of everyone here….We do not have to go through any legal process.** – *Director of Fraternidad sin Fronteras*
>
> **If any person living in Mexico City's shelter system wants to have sex, I have to decide if it is safe and consensual. It's up to me to decide for everyone. They have disabilities, so it is very hard**. – *Operations Coordinator of the shelter system for 2,700 people*

Mexico's law on guardianship and legal capacity falls well short of the requirements of international human rights law. In practice, our observations in institutions reveal that even the minimum protections afforded under Mexican law are routinely ignored for people detained in institutions. Whether a person is technically admitted as a "voluntary" or "involuntary" patient, placement in an institution in Mexico, for the vast majority of individuals, carries with it a total loss of rights guaranteed under article 12 of the CRPD.

The ability of a person to make choices about his or her life is so fundamental that it is linked in the CRPD under article 12 with "the right to recognition everywhere as persons before the law." The CRPD recognizes that "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."[215] The traditional view of legal capacity is that some people with mental disabilities are

unable to make *any* choices about their lives. Traditional legal systems put people under so-called "plenary" guardianship where another person is appointed to make choices about their lives. When this is done, people are sometimes then deprived of their liberty and placed in an institution, and the result is that the placement is considered "voluntary" because the guardian approved of the placement. For this reason, article 12 and article 14 of the CRPD are so closely linked. The European Court of Human Rights has emphasized the need for procedural safeguards to protect against deprivation of both legal capacity and liberty.[216] Article 12 of the CRPD is designed to allow people with disabilities to maintain maximum possible control of their lives, even if they have some limitations on their ability to understand or communicate their choices.

The CRPD recognizes that even people with severe mental impairments retain some abilities to make choices. Individuals with psychiatric disabilities, for example, may go through brief periods during a crisis when they have difficulty making decisions, but they almost always return to a mental state where they can make decisions that they would like to be enforceable later during a crisis. Even if a person has an intellectual disability that limits his or her understanding of complex matters, almost all people with disabilities retain some ability to make decisions and express their choices if they receive assistance in understanding issues and communicating their point-of-view.

The CRPD supports an innovative approach that is new to many legal systems of the world. When a person has difficulties making choices, the CRPD requires an alternative to having a court simply appoint a guardian to make a decision in place of the individual. The Convention requires governments to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."[217] This may mean that a person with a disability may choose a friend, a relative, or even a trusted member of an institutional staff to help them make a decision. To avoid conflict of interest or coercion, the Convention requires "appropriate and effective safeguards."[218] These safeguards are to be "proportional and tailored to the person's circumstances" so that a very important decision, for example, may be subject to review by "a competent, independent and impartial authority or judicial body."[219] If the individual is not able to make a decision independently, any restrictions on their right to exercise legal capacity must "respect the rights, will and preferences of the person…"[220]

In Mexico, however, the federal government does not have the power to regulate legal capacity or guardianship, since they are considered domiciliary matters and thus governed by the state.[221] Each state has its own laws regarding legal capacity and guardianship.[222] In many respects, however, many of the states share similarities with the legal capacity and guardianship laws of the Federal District. The laws of Mexico's thirty-two states have recently been reviewed by Rehabilitation International and others, which found many flaws in Mexican laws on guardianship. The study found that the laws and regulations throughout Mexico contain "broad and discriminatory language" that aims at limiting legal capacity.[223] The definition of capacity varies throughout the states, but the language used is generally "broad and discriminatory."[224] The definition also varies depending on whether the person's disability is psycho-social, intellectual, sensory, or physical.[225]

Under Mexican law, an "interdiction trial" is the legal procedure for declaring and appointing a guardian for a person with a disability.[226] In most cases, according to the study by Rehabilitation International et al., the interdiction trial only occurs after a guardian has already been appointed and when the person with a disability objects to the appointment of the guardian.[227] Thus, the appointment of a guardian and the subsequent denial of legal rights require almost no procedural due process until after the fact. Moreover, even if the person with a disability does object to the appointment of a guardian and receives a formal "interdiction trial," he or she is given very little opportunity to participate in the procedure and sometimes does not even know that he or she has been subjected to guardianship.[228] According to the legal review by Rehabilitation International, a guardian is nearly always appointed for a person with a disability during the "interdiction trial" without first resolving the issue of whether guardianship is even appropriate in the first place.[229]

According to the RI analysis, when a person is placed under guardianship in most Mexican states, "all legal acts carried out by persons with disabilities under guardianship are null and void" and "all legal decisions must be adopted by the Guardian."[230] Under most state laws, "the Guardian must request permission to the applicable Judge to carry out certain legal acts, but the will of the person with disabilities in question is not consulted or requested at any time."[231] As Rehabilitation International has concluded, Mexican state laws do not provide the protections required by the CRPD.

When Mexico ratified the CRPD, it did so with a "declaration" stating that, if Mexican law provides greater protections than are required by international law, Mexican law would be binding.[232] As some commentators have pointed out, the Mexican declaration provides no more than the guarantee, already established under the CRPD, that "[n]othing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party…in force for that State."[233]

In reality, however, Mexican practice falls well short of the CRPD and the country's own domestic law. Our findings were similar in Mexico City and at institutions in the State of Mexico, Puebla, Veracruz, Jalisco, and Oaxaca. Once a person is detained in a psychiatric facility or other institution, DRI and the CMDPDH investigators found that this entails a nearly total denial of rights to make any other choices – about medical care or about any of the other basic activities of daily living. The greatest complaint we received from patients was that they were locked in and unable to leave – whether or not they were deemed "voluntary" or had gone through any form of legal process in being detained. Once in the institution, people reported to DRI and the CMDPDH investigators that they are not allowed to choose when to get up and out of bed, when to eat, or what to do with their day. People are not given choices with regard to medical or psychiatric treatment. In the vast majority of cases, it seems never to have occurred to either patients or mental health care providers to inform or ask the patients themselves about treatment decisions.

> **The institution makes the decisions about medical care. We have a committee… but no one other than medical authorities is involved in decisions that relate to medical treatment. Family signs a form on**

admission that lets us manage all care. – *Director of CAISAME E.P. Guadalajara*

In many cases, the act of being placed in an institution can result in irreversible losses. Two women detained in institutions reported to investigators that they had lost contact with their children as a result of detention in an institution. At Nieto, the director of a facility reported to DRI and the CMDPDH investigators that a pregnant woman will have her child taken away from her and put up for adoption because she is detained at the facility. When investigators pressed the director as to whether any improvement in her condition might make a difference to the outcome of this case, the director made clear that the decision was entirely in the hands of the institution authorities. He also made it clear that her current placement in the facility was adequate basis for having the child taken away – whether or not her mental condition improved by the time the baby was born.

The director of Fraternidad sin Fronteras reported that when children are abandoned at the institution, the director becomes the guardian. When children have families, but they are too poor to care for them, then the parents retain guardianship of their children. Adults without families or *abandonados* become wards of the institution.

In practice, the ability of authorities to make any decision about a patient's life is based on the perception and the reality that medical and psychiatric authorities can determine that *anyone* in the facility is incompetent and lacks the legal right to choices.

H. Access to Justice

CRPD article 13 requires governments to "ensure effective access to justice for persons with disabilities on an equal basis with others."[234] The right to access to justice plays a critical role in a person's right to legal capacity and right to liberty and security under the CRPD. When a person's legal capacity is being assessed or a person is being placed in a psychiatric hospital involuntarily, international law requires that it is done in accordance with the law and procedural safeguards. As such, people with disabilities must have the same access to justice as those people without disabilities. The failure to enforce even the minimum protections of Mexico's own guardianship law, not to mention the lack of safeguards to protect legal capacity as required by CRPD article 12, leaves people detained in institutions vulnerable to a much broader range of abuses.

Access to justice is also especially important for people detained in institutions, because they are particularly at-risk of experiencing abuse or having other rights violated. In order to facilitate this right, affirmative steps are necessary to promote training and awareness of administrators and staff.[235] People with disabilities must be able to report instances of abuse and neglect both within institutions and within the community. Instead of taking the precautions to ensure access to justice for persons detained in Mexico's facilities, the right of access to justice is systematically denied.

VII. Mexico's Obligations under International Law

As a country that has ratified the American Convention, the Convention on the Rights of Persons with Disabilities (CRPD), and the UN Convention against Torture, Mexico has agreed to legally binding enforcement of international human rights law. Under the American Convention, governments commit to "respect" international law and to "ensure" its enforcement through "legislative or other measure as may be necessary to give effect to those rights or freedoms."[236] Protections under the American Convention against discrimination, arbitrary detention, torture, inhuman and degrading treatment or punishment are subject to immediate and full enforcement. Where rights are abused, individualized remedies must be established. Where abuses rise to the level of torture, the UN Convention against Torture requires that violations be punishable under criminal law.

The CRPD requires governments to "ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities…"[237] This includes "all appropriate legislative, administrative and other measures for the implementation of the rights recognized" in the CRPD.[238] In addition to passing new laws, the CRPD requires Mexico to "modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities."[239]

Under the American Convention and the CRPD, Mexico is obligated to take immediate action to end the abusive and dangerous conditions we observed within institutions. The enforcement of these rights will entail the investment of new resources, and international law requires Mexico to dedicate the funding necessary for full enforcement of these rights.

Mexico must recognize the right of all persons with disabilities to exercise legal capacity and make basic choices about their lives, as required by CRPD article 12. The principle of individual choice and autonomy established under article 12 of the CRPD requires a fundamental change in the perception of people with disabilities. Rather than being merely subjects to be protected by the law, or the recipients of services, individuals with disabilities are the bearers of rights with the responsibility and opportunity to make choices about their lives. Instead of assuming that individuals with disabilities are unable to make choices or exercise their rights, the government is under an affirmative obligation to provide the support necessary to help people with disabilities make choices about their lives.

The protection against discrimination under the American Convention and the right to community integration under article 19 of the CRPD requires a broad transformation of Mexico's mental health and social service system to ensure that children can grow up in the community with their families and adults with disabilities are not relegated to a life-time of segregation from society. International law recognizes that resources are limited in any society and implementation of plans for reform may take time. Even where governments must take steps toward the "progressive

achievement" of rights,[240] they are under an immediate "obligation of conduct" to take "deliberate, concrete, and targeted" action towards full realization of rights.[241]

The provisions of the CRPD requiring accountability and public participation in national implementation have been heralded as some of the most important elements of the new convention.[242] The CRPD Committee has not yet established detailed guidelines for steps governments can take toward their fulfillment of the obligation to plan and implement the right to community integration – though such guidelines and detailed benchmarks would be helpful. Guidance is available from other treaty-bodies about governments' obligations to plan and implement the right to health. [243]

Recommendations

DRI's recommendations are posted at www.disabitiyrightsintl.org. Recommendations from the Mental Disability Rights International Report in 2000 are also posted on our website, providing more detailed advice on mental Health system reform.

For Mexico to meet its legal obligations under international law, we recommend the following:

1. **The right to community integration must be established under Mexican law, consistent with the requirements of CRPD article 19.** This law must bind authorities to the creation of a community-based service system to allow meaningful choices by people with disabilities to live in the community with choices equal to others. As required by the CRPD, this law must obligate state and local governments to implement these rights.[244]

2. **Comprehensive plans should be drawn up to integrate and include all people with disabilities into the community.** Mexico's reform plans must be accompanied by action-steps, time-tables, and financing. Abstract rights or plans for reform are meaningless unless they are accompanied by clear action-steps that can be monitored over time (see CRPD art. 33). As required by article 4(3) of the CRPD, organizations made up of people with disabilities should be actively involved in developing, implementing, and monitoring reform plans (this should specifically include participation by organizations made up of people with psychosocial and intellectual disabilities which are the groups most often segregated from society in institutions). Reform plans must identify which authorities are responsible for taking action to create community-based programs. These plans must come with time-tables for action. The cost of each step should be set forth and the government should identify sources of funds to pay for services at each step. Community-based support should include:

   a. Support for families of children with disabilities and adults who choose to remain living with families;
   b. Appropriate education in an integrated environment for children with disabilities;
   c. Supported independent living for adults, including housing for people with disabilities;
   d. Income support at a level that permits humane and decent independent living;
   e. Mental health services in the community – individuals should not have to travel far to receive mental health services or check into institutions for care they can receive in the community;
   f. Community-based medical and social services;
   g. Peer support;
   h. Rights protection and advocacy in the community;

i. Support for decision-making by people with disabilities in the community. In addition to providing individuals receiving services with the support they may need to make decisions about their care, the services themselves must be carefully planned to respond to the needs and wishes of individuals who are served.

The lack of a family to support a person with a disability in the community should no longer be accepted as the reason for relegating a person to segregation from society.

As Mexico creates new community services, it should not make the mistake of simply moving from larger to smaller institutions, or new homes within the grounds of existing institutions. Research has shown that, even when they are cleaner and newer, smaller institutions do not confer the benefits of the most integrated and inclusive environments.[245] In addition to being consistent with the requirements of articles 19 and 12, social services in a more inclusive environment that reflect choices by participants have been shown to provide better outcomes for persons with disabilities.[246]

There is extensive international expertise and guidance available to Mexico about how to plan and implement reform of its mental health and social service system to move toward full community integration of adults with disabilities.[247] The World Health Organization has recently compiled information about best practices from international experience that provide guidance to countries at all levels of development about steps they can take to bring about mental health system reform.[248] Given Mexico's limited financial and professional resources in much of the country, models of mental health care that emphasize peer and other social supports may be particularly valuable.[249] In recent years, advances have been made in the development of "recovery-oriented" models of community based care that emphasize the importance of free choice and self-determination by people receiving such services.[250]

3. **New placements of children in institutions should be brought to an end** – In order to implement CRPD 23(5), plans for the elimination of institutions for children and the support of alternatives for children with disabilities in the community must be established. As a strategy for bringing about the full realization of the right to protect all people with disabilities from improper segregation from society under article 19, we also recommend prioritizing children with disabilities. If Mexico can shut the door to any new placements in institutions for children, the country will be taking an important strategic step towards its broader reliance on a segregated system of treatment for all persons with disabilities. Mexico should adopt legislation that will end any new placements of children with disabilities by a specific, publicly declared target date, by which time safe and humane, family-based support should be available for all children with disabilities. If biological or extended families are not available for children, supported foster care (substitute family) programs should be established. Children are extremely vulnerable to abuse and increased disability from placements in institutions. Once family bonds are broken, future reintegration of children with families will be more difficult. To

avoid these dangers, Mexico should immediately create family-based alternatives to institutions.

Extensive resource material exists to guide Mexico to create community services, support families of children with disabilities, and plan for closure of institutions for children with disabilities.[251] The UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children provide a framework of principles and objectives for the reform of children's services.[252]

4. **Safeguards and oversight mechanisms should be established to protect the rights of children and adults detained in institutions or receiving support from community programs** – Article 16 of the CRPD requires governments to create independent oversight mechanisms to protect against exploitation, violence and abuses. These oversight mechanisms are important to protect children and adults in community-based services and foster care as well as in institutions. As required by CRPD article 16(2), oversight mechanisms should be age, gender, and disability sensitive. In order for effective oversight:

    a. A registry of children in institutions should be created. Also, a system for tracking admissions, discharges, and transfers of children and adults at and between institutions or from institutions to other placements should be created, so that they cannot disappear from society; information about the total number and characteristics of persons receiving services should be published (this will also greatly assist in planning for improved services and reform).
    b. Monitoring and oversight systems should operate independently of the social service system.
    c. A system of registration and certification should be established to ensure that no one is placed in any institution or community program that does not meet minimum standards of care and full compliance with monitoring. Clearly stated rights should be adopted for all persons receiving care in institutions or community programs. These rights should be posted in all institutions and programs in prominent locations in a language and a manner that can be understood (including alternative formats for people with sensory impairments). These rights should be explained to service system users.
    d. Grievance and complaint procedures should be established for people receiving services or personal representatives that may be appointed by such individuals. The system must ensure a fair and impartial investigation into complaints in a manner that protects against reprisals. One model is to create an independent ombudsman with responsibility for managing the grievance/complaint function; access to legal or non-legal advocates should be available when other means of resolving complaints prove unsuccessful.
    e. Develop a process for independent, professional and thorough investigations of reports of physical and sexual abuse and for monitoring and follow-up on serious injuries, including injuries of unknown origin, illness, and all deaths.

f. All information about rights, grievance procedures, and advocacy services should be accessible and appropriate for people with physical, sensory, or mental disabilities.
g. Independent oversight bodies should be empowered to conduct regular, unannounced visits to facilities and programs.
h. Specialized age and gender specific programs should be established that are sensitive to the particular concerns of children and women with disabilities; services should be "trauma-informed" and sensitive to the needs of survivors of abuse.
i. Reports of findings of oversight bodies should be made public.
j. People with disabilities and their representative organizations should receive training and funding to participate in independent monitoring programs; to ensure stakeholder inclusion, programs should especially reach out to people with specific kinds of disabilities served by particular programs.
k. To prepare its report to the CRPD Committee, representatives of the national or state human rights commissions should endeavor to visit all institutions in Mexico.

We recommend the creation of specialized independent oversight systems at the national and state levels.

5. **Avoid dumping people into the community with no services** – In many parts of the world, governments have used the mandate for reform as an excuse to close institutions and save money without creating community-based alternatives. Abrupt closures of institutions or "patient dumping" can create life-threatening dangers that should be avoided. During the transition to a community-based service system, the government will have to maintain institutions until alternatives are created. While savings may be possible when institutions are closed, governments should not expect such savings during the early years of reform.

6. **Life-threatening abuses and torture, including the abuse of restraints, must be brought to an immediate end** – Urgent action is needed to protect individuals detained in institutions from life-threatening dangers and torture. Enforceable legislation should be adopted to ensure minimum standards of care and protection from harm in institutions and community programs. The use of physical and chemical restraints should be strictly regulated according to internationally accepted standards as a temporary safety measure to protect against immediate and imminent harm. Restraints should never be used for treatment or the administrative convenience of staff. Professional staff must be trained in the treatment and care needed to avoid the use of physical restraints. This may mean increased staffing within institutions in the short-term, but such reforms do not justify new investments in the infrastructure of institutions. Individuals who have been subject to torture through the use of long-term restraints are entitled to reparations under international law. The government of Mexico should set aside priority funding for these individuals to receive the housing and services in the community that will allow them to live safely and independently.

7. **New investments in infrastructure or building of institutions should be avoided** – If institutions are unsafe immediate, life-saving measures are essential. Major capital investments in new infrastructure, however, cannot be justified. Instead, governments should provide the support necessary for transfer of individuals to safe environments in the community. Major new building programs on the grounds of institutions that keep people segregated from society are not consistent with CRPD article 19.

> **Four decades of work to improve the living conditions of children with disabilities in institutions have taught us one major lesson: there is no such thing as a good institution.** – *Gunnar Dybwad, founding father of the international movement for inclusion*

   International experience has demonstrated the dangers of continuing to invest in institutions.[253] As described by Save the Children: "[t]he very existence of institutions encourages families to place their children into care, and draws funding away from services that could support children to thrive within families and communities."[254]

8. **Legal reforms and broad changes in attitude and practice are needed to protect the right of people with disabilities to exercise legal capacity, provide supported-decision making, and protect against arbitrary detention** – The right of all people with disabilities to enjoy legal capacity should be protected by Mexican law, consistent with CRPD article 12. To maximize the potential for individuals with disabilities to make meaningful choices, programs to provide support for supported decision-making should be established. This should include training for mental health and social care service workers at all levels – from policy makers to staff in institutions and community programs. Mexico's mental health law and psychiatric commitment procedures should be revised to bring them into compliance with CRPD articles 12 and 14 to ensure that people are not arbitrarily detained in institutions.

9. **Access to justice must be ensured** – People with disabilities, especially people detained in institutions, should receive the individual support and legal representation they need to ensure that their right of access to justice is protected as required by CRPD article 13. In practice, the right to exercise choice and legal capacity, as required by CRPD article 12, is essential for people with disabilities to be able to benefit from all other rights. Support to individual decision-making as well as resources to provide individuals with advocacy and legal representation is critical to ensure access to justice for people detained in institutions. In order to ensure access to justice for persons with disabilities, Mexico can draw on proven models of best practices to ensure access. [255]

10. **Full participation by people with disabilities must be ensured in human rights oversight, planning for reform, and program implementation.** Article 4(3) of the CRPD introduces an innovative new obligation on governments to "consult with and actively involve persons with

disabilities, including children with disabilities, through their representative organizations" in the development and implementation of programs to implement the CRPD. Article 33 calls for participation in national planning, implementation, and human rights monitoring.

People with intellectual and psychosocial disabilities are key stakeholders in protecting these rights – as they are the most likely groups to be segregated from society and to have their right to make choices about their lives taken away. Governments should not assume that family members or even other disability activists can speak on behalf of individuals with intellectual or psychosocial disabilities. Due to their experience of discrimination and marginalization, these groups may not have experience in self-advocacy or participation in decision-making about matters that directly affect their lives. In order for Mexico to fulfill its obligations under articles 4(3) and 33 of the CRPD, support and capacity-building for key stakeholder groups made up of individuals with intellectual and psychosocial disabilities is essential.

11. **Effective and thorough reporting to the UN CRPD Committee should include detailed information on human rights of children and adults detained in institutions and steps being taken to end segregation** – Mexico's official report to the UN Committee on the Rights of Persons with Disabilities should describe the action steps that the government is taking to respond to the human rights violations documented in this report. Mexico should supplement this report with information we were unable to acquire about people with disabilities throughout the country. To begin with, Mexico should identify national data on the number of children and adults detained in institutions. **June 2011 update**: On April 27, 2011, Mexico submitted its official report to the UN CRPD Committee. It failed to provide any of the essential data on children and adults detained in institutions. We call on the government of Mexico to submit this information without delay.

Appendix 1: List of Mexican Institutions visited by DRI and CMDPDH

- **Centro de Asistencia e Integración Social Azcapotzalco ("CAIS Azcapotzalco")**
    - Size: 28 people
    - Gender: Male and female
    - Age: Children
    - Funding: Public
    - Jurisdiction: Federal District
    - Date visited: September 10, 2010

- **Centro de Asistencia e Integración Social Coruña Hombres ("CAIS Coruña")**
    - Size: 100
    - Gender: Male
    - Age: Adults
    - Funding: Public
    - Jurisdiction: Federal District
    - Date visited: September 6, 2010

- **Centro de Asistencia e Integración Social Villa Mujeres ("CAIS Villa Mujeres")**
    - Size: 450 people (380 permanent)
    - Gender: Female
    - Age: Adults
    - Funding: Public
    - Jurisdiction: Federal District
    - Date visited: September 11, 2010

- **Casa Hogar de Coapexpan**
    - Size: 17 people (2 adults and 15 children)
    - Gender: Female
    - Age: Children and young adults
    - Funding: Private
    - Jurisdiction: State of Veracruz
    - Date visited: March 4, 2010

- **Casa Hogar 1 ("Shelter # 1")**
    - Size: 63 people
    - Gender: Male and female
    - Age: 0-8 years old (with some exceptions)
    - Funding: Public
    - Jurisdiction: State of Oaxaca
    - Date visited: September 8, 2010

- **Casa Hogar 2 ("Shelter # 2")**

  - Size: 83
  - Gender: Male and female
  - Age: 8-18 years old (with some exceptions)
  - Funding: Public
  - Jurisdiction: State of Oaxaca
  - Date Visited: September 8, 2010

- **Centro de Atención Integral de Salud Mental de Estancia Breve Guadalajara ("CAISAME E.B. Guadalajara")**
  - Size: 50 people
  - Gender: Male and female
  - Age: Adults and children
  - Funding: Public
  - Jurisdiction: State of Jalisco
  - Date visited: January 14, 2010

- **Centro de Atención Integral de Salud Mental de Estancia Prolongada Guadalajara ("CAISAME E.P. Guadalajara")**
  - Size: 255 people (200 chronic patients; 55 acute patients)
  - Gender: Male and female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: State of Jalisco
  - Date visited: January 14, 2010

- **Centro de Educación para Niños con Discapacidad Múltiple**
  - Size: 20 people (?)
  - Gender: Male and female
  - Age: Children
  - Funding: Public (?)
  - Jurisdiction: (?)
  - Date visited: March 4, 2010

- ***Centro Femenil* de *Readaptación* Social en el T*epepan***
  - Size: 72 people
  - Gender: Female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: Federal District
  - Date visited: January 12, 2010

- **Ciudad Asistencial Conecalli ("Conecalli")**
  - Size: 91 people
  - Gender: Male and female
  - Age: Children and young adults
  - Funding: Public
  - Jurisdiction: State of Verazcruz

  - Date visited: March 4, 2010

- **Fraternidad sin Fronteras**
  - Size: 80 people (52 adults, 28 children)
  - Gender: Male and female
  - Age: Adults and children
  - Funding: Private and public
  - Jurisdiction: Federal District
  - Date visited: January 11, 2010
  -
- **Hospital Psiquiátrico Fray Bernadino Álvarez**
  - Size: 300
  - Gender: Male and female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: Federal District
  - Date visited: September 9, 2010

- **Hospital Psiquiátrico Dr. Adolfo M. Nieto ("Nieto")**
  - Size: 260 people
  - Gender: Female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: State of Mexico
  - Date visited: March 5, 2010

- **Hospital Psiquiátrico Cruz del Sur ("Cruz del Sur")**
  - Size: 120 people
  - Gender: Male and female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: State of Oaxaca
  - Date: September 8, 2010

- **Hospital Psiquiátrico José Sáyago ("Sáyago")**
  - Size: 280 people
  - Gender: Female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: State of Mexico
  - Date visited: March 5, 2010

- **Sanatorio Psiquiatrico de Nuestra Señora de Guadalupe**
  - Size: 96 people
  - Gender: Male and female
  - Age: Adults
  - Funding: Private

- Jurisdiction: State of Puebla
- Date visited: January 15, 2010

- **Hospital Psiquiátrico Campestre Dr. Rafael Serrano ("El Batam")**
  - Size: 300 people (240 chronic patients; 60 acute patients)
  - Gender: Male and female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: State of Puebla
  - Date visited: January 15, 2010

- **Hospital Psiquiátrico La Salud Tlazo Lteotl ("La Salud")**
  - Size: 150 people
  - Gender: Male
  - Age: Adults
  - Funding: Social Security
  - Jurisdiction: State of Mexico
  - Date visited: January 13, 2010

- **Hospital Psiquiátrico Dr. Samuel Ramírez Moreno ("Samuel Ramírez Moreno")**
  - Size: 200 people
  - Gender: Male
  - Age: Adults
  - Funding: Public
  - Jurisdiction: Districto Federal
  - Date visited: March 1, 2010

- **Hospital de Salud Mental Dr. Victor Manuel Concha Vásquez ("Concha Vásquez")**
  - Size: 69
  - Gender: Male and female
  - Age: Adults
  - Funding: Public
  - Jurisdiction: State of Veracruz (State Government)
  - Date visited: March 3, 2010

Endnotes

[1] Convention on the Rights of Persons with Disabilities, G.A. Res. 60/106, U.N. Doc. A/Res/61/106, *entered into force May 3, 2008* (December 13, 2006) [hereinafter CRPD], ratified by Mexico December 17, 2007. The CRPD text, related UN resolutions, and an updated list of signatories and States Parties is posted on the United Nations Enable website at http://www.un.org/esa/socdev/enable/rights/ convtexte.htm (last visited May 18, 2011).

[2] American Convention on Human Rights, Nov. 22, 1969, 1144 U.N.T.S. 123, O.A.S.T.S. No. 36, at 1, OEA/Ser.L/V/II.23 doc. Rev. 2, 9 I.L.M. 673 (1970), *entered into force* March 23, 1976, [hereinafter American Convention]. Mexico ratified the American Convention on March 2, 1981.

[3] International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, UN Doc. A/6316 (1966). Mexico ratified the International Covenant on Civil and Political Rights on March 23, 1981.

[4] International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3, 8 (entered into force Jan.3, 1976) [hereinafter ICESCR].

[5] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46, U.N. GAOR, 39th Sess. Supp. No. 51, U.N. Doc. A/39/46 (Dec. 10, 1984) [hereinafter Convention Against Torture], *entered into force June 26, 1987*. Mexico ratified the Convention against Torture on Jan. 23, 1986**.**

[6] The Court determined that the operating conditions of *Casa de Reposo Guararapes*, both regarding the general conditions of the place and the medical care provided therein, were quite far from being adequate to administer a decent health treatment and were in and of themselves incompatible with the appropriate protection of personal integrity and life, particularly as they affected persons who were extremely vulnerable due to their mental illness. Ximenes-Lopes v. Brazil**.** Preliminary Objection, Judgment of Nov. 30, 2005, Inter-Am. Ct. H. R. (ser. C) No. 139, p. 132.

[7] Articles in the New York Times and the Washington Post in January 2000 brought international attention to the coming release of the report. Michael Winerip, *The Global Willowbrook,* N.Y. Times Magazine, January 16, 2000 at 53; Stacy Weinter, *Speaking up for the Mentally Disabled: Eric Rosenthal Brings their Plight to the World*, Washington Post, January 18, 2000. The following is a partial list of articles and broadcasts about the MDRI report: Michael Winerip, *The Global Willowbrook*, N.Y. TIMES MAGAZINE, January 16, 2000, at 53; Stacy Weiner, *Speaking Up for the Mentally Disabled: Eric Rosenthal Brings Their Plight to the World*, WASHINGTON POST, January 18, 2000 at C1; Michael Winerip, *Study Finds Abusive Conditions in Mexico's Mental Hospitals*, N.Y. TIMES, February 18, 2000 at A1; John Hecht, *Nation's Mental Care 'Shocking': Rights Group Rips Mental Health Care*, THE NEWS: MEXICO, February 18, 2000, at 1; *Abuse of Mental Patients Alleged*, TORONTO STAR, February 18, 2000; Jan McGirk, *Thousands in Mexican asylums are subjected to 'barbaric conditions,'* THE INDEPENDENT OF LONDON, February 19, 2000 at 17; *Groups assails mental health-care system in Mexico*, SAN DIEGO UNION-TRIBUNE, February 19, 2000 at A8; *Mental Health Care Blasted*, THE NEWS: MEXICO, February 20, 2000 at A4; Howard LeFranchi, *Bringing dignity to health care: A three-year study spotlights horrific conditions in Mexico's mental institutions*, THE CHRISTIAN SCIENCE MONITOR, February 23, 2000 at A1; *Q&A interview with Eric Rosenthal* (CNN International television broadcast, Feb. 25, 2000)(video copy on file with Disability Rights International); *20/20 report on abuses in Mexican psychiatric institutions* (ABC television broadcast March 8, 2000)(video copy on file with Disability Rights International); *Weekend All Things Considered with Jackie Lyden, Eric Rosenthal, Executive Director of Mental Disability Rights International, discusses a report which outlines abuses in Mexico's government-run mental health facilities* (National Public Radio broadcast, March 5, 2000)(audiotape on file with Disability Rights International).

[8] María Scherer Ibarra, *En Mexico, el peor trato del mundo a los enfermos mentales: Miseria abandono y derechos humanos conculcados, en los hospitales psiquiátricos*, PROCESO, January 2000 at 10 (cover story); Maria Scherer Ibarra, *La accidenta visita de Gonzalez Fernandez al psuquiatrico Ocaranza*, PROCESO, February 18, 2000; Maria Scherer Ibarra, La Secretaría de Salud cerrará el psiquiátrico. Los internos del Ocaranza se preparan para la libertad, Proceso (No. 1225), April 22, 2000 at http://www.proceso.com.mx/rv/ hemeroteca/detalleHemeroteca/123194; Monica Livier Gomez, *Condiciones inhumanas en Psiqiatrico Ocaranza*, PROCESO (No. 1214), February 6, 2000; Reuters, *Los Hospitales psiquiátricos de Mexico, de los peores del mundo: Robert Okin*, NOVEDADES, February 18, 2000 at A16; *En Mexico se violan los derechos humanos de enfermos mentales*, LA JORNADA, February 18, 2000 at 16.

[9] Special Rapporteur on the sale of children, child prostitution and child pornography, *Promotion and Protection of all Human rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development, Mission to Mexico*, ¶ 37, U.N. Doc A/HRC/7/8/Add.2 (Jan. 28, 2008) (by Juan Miguel Petit) [hereinafter Special Rapporteur on the sale of children].

[10] United States Department of State, *Trafficking in Persons Report 2009 - Mexico*, 16 June 2009, available at: http://www.unhcr.org/refworld/docid/4a4214a32d.html [accessed 29 October 2010]

[11] *See* analysis in section VI-D of this report. *See also* Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Note transmitted by Note of the Secretary-General*, ¶ 37-41, U.N. Doc. A/63/175 (Jul. 28, 2008) (by Manfred Nowak) [hereinafter Special Rapporteur on Torture]; U.N. Comm. on the Rights of the Child, Consideration of Reports Submitted by States Parties under Article of the Convention, Concluding observations: Serbia, ¶ 35, U.N. Doc CRC/C/SRB/CO/1 (June 20, 2008).

[12] WORLD HEALTH ORGANIZATION, WHO RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS LEGISLATION 63 (2005).

[13] *Id*.

[14] Protection of Persons with Mental Illness and the Improvement of Mental Health Care, G.A. Res. 46/119, U.N. GAOR 75th Plenary Meeting, U.N. Doc. A/Res/46/119, at Principle 11(14) (Dec. 17, 1991) [hereinafter MI Principles].

[15] CRPD, *supra* note 1, art. 4(1)(a).

[16] Dis-Capacidad, "México podría fortalecer la Convención con el retiro de la Declaración Interpretativa," http://www.dis-capacidad.com/nota.php?id=1498 (last visited June 2, 2011).

[17] U.N. ENABLE, THE SPECIAL RAPPORTEUR ON DISABILITY OF THE COMMISSION FOR SOCIAL DEVELOPMENT, http://www.un.org/esa/socdev/enable/rapporteur.htm (last visited Oct. 22, 2010). Mexico's proposed resolution was adopted by the UN General Assembly in February 2002. Comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities, G.A. Res. 56/168, U.N. Doc A/Res/56/168 (Feb. 26, 2002).

[18]CRPD, supra note 1.

[19] UN Department of Economic and Social Affairs (UN-DESA), Office of the High Commissioner for Human Rights (OHCHR) and the Inter-Parliamentary Union (IPU), From Exclusion to Equality: Realizing the Rights of Persons with Disabilities iii (Andrew Byrnes, Jean-Peierre Gonnot, Linda Larsson, Thomas Schindlmayr, Nicola Shepher, Simon Walker, and Adriana Zarraluqui, 2007) (this manual provides a helpful overview of the CRPD).

[20] U.N. ENABLE, CONVENTION AND OPTIONAL PROTOCOL SIGNATURES AND RATIFICATIONS, http://www.un.org/disabilities/countries.asp?navid=12&pid=166 (last visited May 18, 2011).

[21] U.N. ENABLE, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES, http://www.un.org/disabilities/default.asp?id=150 (last visited Oct. 13, 2010).

[22] CRPD, *supra* note 1; Optional Protocol to the Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, U.N. Doc. A/Res/61/106 (December 13, 2006) [hereinafter Optional Protocol], *ratified by Mexico December 17, 2007.*

[23] CRPD, *supra* note 1, at art. 4(1).

[24] *Id*. at art. 35(1).

[25] *Id*. at art. 35(1)(2).

[26] U.N. Comm. on the Rights of Persons with Disabilities, *Guidelines on treaty-specific document to be submitted by states parties under article 35, paragraph 1, of the Convention on the Rights of Persons with Disabilities, transmitted by note of the Secretary General*, U.N. Doc. CRPD/C/2/3 (Nov. 18, 2009).

[27] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 35(4).

[28] *Id.* at art. 4(3).

[29] State Population Council, Government of the State of Mexico, Mexico City Metropolitan Areas available at http://qacontent.edomex.gob.mx/coespo/indicadoressociodemograficos/zonasmetropolitanas/index.htm (last visited April 25, 2011).

[30] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Report*, Econ. & Soc. Council, Comm'n on Human Rights, 61st Sess., ¶ 54, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005) (by Paul Hunt) [hereinafter Special Rapporteur on health].

[31] WORLD HEALTH ORGANIZATION, TREATMENT OF MENTAL DISORDERS: A REVIEW OF EFFECTIVENESS 19 (Norman Sartorius et al., eds., 1993) [Hereinafter "World Health Organization Review of Effectiveness"]. The classic sociological documentation of the "institutionalized mentality" is described in ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1996).

[32] Declaration of Caracas (1990), available at http://new.paho.org/hq/dmdocuments/2008/DECLARATIONOFCARACAS.pdf. In 1990, the Pan American Health Organization and World Health Organization (PAHO/WHO) convened mental health organizations, associations, professionals and jurists to the Regional Conference on Restructuring Psychiatric Care in Latin America, held in Caracas, Venezuela. The Declaration of Caracas was adopted in the framework of that Conference.

[33] SECRETARIA DE SALUD, PROGRAMNA DE ACCIÓN ESPECÍFICO 2007-2012, ATENCIÓN EN SALUD MENTAL [SPECIFIC ACTION PROGRAM 2007-2012, Mental Health Care] 51 (2008).

[34] *Id*.

[35] *Id*.

[36] *Id*. at 57.

[37] PAN AM. HEALTH ORG., EVALUACIÓN DE SERVICIOS DE SALUD MENTAL EN LA REPÚBLICA MEXICANA 30 (2004).

[38] *Id.*at 19-20.

[39] *Id.* at 24.

[40] *Id.* at 19.

[41] *Id.* at 23.

[42] Sanda M. Nettina, Lippincott Manual of Nursing Practices 194 (9th ed., 2010).

[43] Special Rapporteur on Torture, *supra* note 11, at ¶55.

[44] Gregory M. Smith et al, *Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Program* 56 PSYCHIATRIC SERVICES 1115 (2005); US DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES FOR ADMINISTRATION, http://www.samhsa.gov/ (last visited Nov. 5, 2010); CENTER FOR MENTAL HEALTH SERVICES, ENDING HARM FROM RESTRAINT AND SECLUSION: THE EVOLVING EFFORTS (2005); Alisa B. Busch & Miles F. Shore, *Seclusion and Restraint: a review of recent literature* 8 HARV. REV. OF PSYCHIATRY 261, 265 (2000).

[45] WORLD HEALTH ORGANIZATION REVIEW OF EFFECTIVENESS, *supra* note 31, at 349, 345.

[46] Sanda M. Nettina, *supra* note 42, at 195, *citing* the 1987 Omnibus Budget Reconciliation Act.

[47] *Id*.

[48] *Id*. at 293.

[49] *Id*. at 687.

[50] *Id*.

[51] *Id*. at 186.

[52] *Id*.

[53] *Id*. at 187.

[54] *Id*. at 1544.

[55] *Id*.

[56] *Id*.

[57] WORLD HEALTH ORGANIZATION REVIEW OF EFFECTIVENESS, *supra* note 31, at 19.

[58] A new hospital is currently being built to replace the old Hospital Mental "Dr. Victor M. Concha Vazquez." The current hospital is attached to the historic church and abuts the town square and a park at the heart of the town. Unfortunately, the new institution is located outside of the town Orizaba at the end of a bumpy dirt road and surrounded on all sides by open fields and mountains. The directors of the institution showed DRI the blueprints for the new institution. Like Sáyago and CAISAME Guadalajara, the new hospital will include an area for three or four little villas, but no real community integration.

[59] Lou Brown, *Thoughts About Aversive Treatments of Children With Disabilities* 36 TASH CONNECTIONS 29, 29 (Summer 2010).

[60] *Id*. at 30.

[61] Sandra M. Nettina, *supra* note 42, at 1819.

[62] We conducted a more in-depth analysis of the practices of record-keeping and monitoring of psychotropic medications in our 2000 report. The conditions of people we observed at institutions were strikingly similar to what we observed ten years ago. *See* Mental Disability Rights International, Human Rights & Mental Health: Mexico 26-31 (2000).

[63] WORLD HEALTH ORGANIZATION, WHO RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS LEGISLATION 63 (2005).

[64] *Id*.

[65] Protection of Persons with Mental Illness and the Improvement of Mental Health Care, G.A. Res. 46/119, U.N. GAOR 75th Plenary Meeting, U.N. Doc. A/Res/46/119, at Principle 11(14) (Dec. 17, 1991) [hereinafter MI Principles].

[66] Save the Children, The Risk of Harm to Young Children in Institutional Care 1 (2009); Save the Children, Keeping Children Out of Harmful Institutions (2009); Su-chin Serene Olin & Sarnoff A. Mednick, *Risk Factors of Psychosis: Identifying Vulnerable Populations Premorbidly,* Schizophrenia Bulletin 22(2), 240 (1996); Dana Johnson, *Medical and Developmental Sequelae of Early Childhood Institutionalization in Eastern Europe Adoptees*, in The Effects of Early Adversity on Neurobiological Development 1426 (C. Nelson, ed., 2000); Charles H. Zeanah et. Al. *Designing research to study the effects of institutionalization on brain and behavioral development: The Bucharest Early Intervention Project,* 15 DEVELOPMENT AND PSYCHOPATHOLOGY 885, 886 (2003) (reviewing five decades of research literature on the damaging effects of institutionalization); Georgette Mulheir et. Al. *De-institutionalizing and Transforming Children's Services: A Guide to Good Practice, 28-33 (2007)*

[67] Deborah A. Frank et. al., *Infants and Young Children in Orphanages: One View from Pediatrics and Child Psychiatry*, 95 PEDIATRICS (1996). Megan Gunnar, Jacqueline Bruse, and Harold Grotevant, *International adoption of institutionally reared children: research and policy,* 12 DEVELOPMENT AND PSYCHOPATHOLOGY 677 (2000); Dana Johnson, *Medical issues in international adoption: Factors that affect your child's pre-adoption health,* 30 ADOPTIVE FAMILIES 18 (1997). Michael Rutter, et. al., *Quasi-Autistic patterns following early global deprivation, 40* JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY AND ALLIED DISCIPLINES 547 (1999); Save the Children, *supra* note 66, at 6.

[68] James Conroy & Valery Bradley, *The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis* (1985).

[69] Dana Johnson, *supra* note 66, at 142.

[70] *Id.* at 147.

[71] Alexandra Trout, Kathryn Casey, M. Beth Chmelka, Catherine DeSalvo, Robert Reid, and Michael H. Epstein, "Overlooked: Children with Disabilities in Residential Care, 88 Child Welfare 111 (2009).

[72] Save the Children, *supra* note 66, at 7.

[73] Decree that Reforms Several Provision of the Law in Regard to the Rights of Boys and Girls of the Federal District [Official Citation , Graceta Oficial del Distrito Federal (July 30, 2010).

[74] *Id*.

[75] Interview by Sofia Galvan Puente with the Supervisor of Social Workers, General Direction of Rehabilitation and Legal Aid, in Mexico City, Mexico (2010).

[76] Deborah A. Frank, *supra* note 67, at 570-574.

[77] Charles H. Zeanah et. al., *supra* note 66.

[78] Sandra M. Nettina, *supra* note 42, at 1545.

[79] *Id*.

[80] *Id*.

[81] Special Rapporteur on Torture, *supra* note 11, at ¶ 50.

[82] KAREN RAYE, VIOLENCE, WOMEN AND MENTAL DISABILITY 2 (Mental Disability Rights International, 1999).

[83] Special Rapporteur on the sale of children, child prostitution and child pornography, *Promotion and Protection of all Human rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development, Mission to Mexico*, ¶ 37, U.N. Doc A/HRC/7/8/Add.2 (Jan. 28, 2008) (by Juan Miguel Petit) [hereinafter Special Rapporteur on the Sale of Children].

[84] United States Department of State, *supra* note 10.

[85] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 16(1).

[86] *Id*. at art. 16(2).

[87] Decree that Reforms Several Provision of the Law in Regard to the Rights of Boys and Girls of the Federal District, *supra* note 73.

[88] The Centro Nacional de Comunicacion Social has also documented the allegations of "social cleansing," saying that police and public officials may be involved of recruiting people living on the street to place them in private welfare detention centers where they forced labor and sexual abuse occurs. *STREET POPULATION, VICTIMS OF "SOCIAL CLEANSING" REPORTED OSC*, CENTRO NACIONAL DE

COMUNICACION SOCIAL (DEC. 14, 2009). *See also*, *NGOs demand a halt in "social cleansing" in the Federal District,* Proceso (Dec. 14, 2009).

[89] Special Rapporteur on trafficking in persons, especially women and children, *Promotion and Protection of all Human rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development, Addendum, Communications to and from Governments*, U.N. Doc. A/HRC/14/32/Add. 1 (May 31, 2010) (by Joy Ngozi Ezeilo) [hereinafter Special Rapporteur on Trafficking in Persons].

[90] *Id.* at ¶ 43.

[91] *Id.*

[92] *Id. at ¶. 48.*

[93] *Id.* at ¶46.

[94] *Id.* at ¶50.

[95] Distrito Federal Human Rights Commission, Recommendation 4/2010, 1121 (April 20, 2009).

[96],The Children's Rights Network in Mexico expresses its concern about the lack of guarantees for the protection of the rights of children with parental care, Statement*, Children's Rights Network of Mexico* (May 28, 2010). *See also 37 victims of trafficking rescued in Mexico City, 27 are Under Age*, Proceso (May 20, 1010).

[97] *A horror house discovered in Iztapalapa; 107 people were released*, Proceso (Dec. 2009).

[98] The Children's Rights Network in Mexico expresses its concern about various events that evidence the weaknesses of public institutions to ensure the rights of children without parental care*,* Statement, *Children's Rights Network of Mexico* (Aug. 9, 2010), *available at* http://www.derechosinfancia.org.mx/Especiales/pronunciamientodifcancun.html (last visited Nov. 15, 2010).

[99] *PGJ dismantles another house of "slaves,"* El Universal (May 21, 2010), *available at* http://www.eluniversal.com.mx/notas/682100.html. *See also PGJDF investigates foster homes links within states*, El Universal (May 21, 2010), *available at* http://www.eluniversal.com.mx.notas/682233.html.

[100] *Id.* at ¶ 5.1 (b).

[101] *Id.* at ¶ 5.1 (c).

[102] *Id.* at ¶ 5.28.

[103] *Id.* at ¶ 5.30.

[104] *Id.*

[105] In addition to private donations and donations from charitable institutions, Fraternidad Sin Fronteras receives funding from three different federal authorities (DIF Federal, Instituto Naciónal de Desarrollo Social, and Insituto de Asistencia e Integracion Social), as well as on local authority (DIF DF). FUNDACION FRATERNIDAD SIN FRONTERAS, INFORME DE ACTIVIDADES (2007).

[106] Maxine Harris and Roger D. Fallot, *Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift, in* 2001 NEW DIRECTIONS FOR MENTAL HEALTH SERVICES 3 (Maxine Harris and Roger Fallot, eds., 2001).

[107] Maxine Harris, *Modifications in Services and Clinical Treatment for Women Diagnosed With Severe Mental Illness Who Are Also Survivors of Sexual Abuse Trauma, in* WOMEN'S MENTAL HEALTH SERVICES 309 (Bruce Levin, Andrea Blanch & Ann Jennings, eds., 1998).

[108] *Id*. at 315.

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[109] *Id*.

[110] Districto Federal Human Rights Commission, *supra* note 95, at ¶ 5.33.

[111] *Id.* at ¶ 5.30.

[112] MENTAL DISABILITY RIGHTS INTERNATIONAL, HUMAN RIGHTS AND MENTAL HEALTH: MEXICO 15 (2000).

[113] The immediate follow-up to our report and the original thinking behind the Hidalgo model are described in the Afterward of our report on Mexico from 2000. *See* MENTAL DISABILITY RIGHTS INTERNATIONAL, *supra* note 112, at 58.

[114] María Scherer Ibarra, *La Secretaría de Salud cerrará el psiquiátrico. Los internos del Ocaranza se preparan para la libertad* [*The Ministry of Health will close the psychiatric hospital. Ocaranza inmates are getting prepared for freedom*], PROCESO No. 1225 (April 22, 2000), http://www.proceso.com.mx/rv/hemeroteca/detalleHemeroteca/123194

[115] Virginia Gonzalez Torres currently holds the position of Technical Secretariat of the National Mental Health Council of the Ministry of Health (Secretaria Técnica del Consejo Nacional de Salud Mental de la Secretaría de Salud).

[116] Gerard Quinn, *A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities*, 1 EUROPEAN YEARBOOK OF DISABILITY LAW 89, 100 (2009) (describing the background and history of United Nations process of drafting the CRPD).

[117] Convention on the Rights of Persons with Disabilities, *supra* note 18, art. 1

[118] *Id*. at Preamble(h).

[119] American Convention, *supra* note 2.

[120] Convention on the Rights of the Child, *supra* note **Error! Bookmark not defined.**.

[121] Convention against Torture, *supra* note 5.

[122] International Covenant on Economic, Social, and Cultural Rights, *supra* note 4.

[123] International Covenant on Civil and Political Rights, *supra* note 3.

[124] Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities, OAS AG/Res 1608 (XXIX-0/99) (June 7, 1999). Mexico ratified the Convention on June 12, 2000.

[125] U.N. High Comm'r for Human Rights of the Human Rights Council, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and Secretary-General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities,* 10th Sess., ¶ 46, U.N. Doc. A/HRC/10/48 (Jan. 29, 2009) [hereinafter U.N. High Comm'r for Human Rights of the Human Rights Council].

[126] *Id*.

[127] Janet Lord, David Suozzi, and Allyn Taylor, *Lessons from the Experience of the UN Convention ont he Rights of Persons with Disabilities; Addressing the Democratic Deficit in Global Health*, 38 LAW, MEDICINE, AND ETHICS, 564, 572 (2010).

[128] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 2.

[129] American Convention on Human Rights, *supra* note 2, at art. 1.

[130] *Id*. at art. 19.

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[131] *Id.*

[132] *Id*. at 19(a).

[133] *Id*. at art. 19(b).

[134] WORLD HEALTH ORGANIZATION, WORLD HEALTH REPORT 89-91 (2001).

[135] Special Rapporteur on Health, *supra* note 30, at ¶15.

[136] *See* Itzhak Levav, Helena Restrepo, & Carlyl Guerra de Macedo, *The Restructuring of Psychiatric Care in Latin America*: *A New Policy for Mental Health Services*, 15 J. PUB. HEALTH AND POLICY 71 (1994) (describing developments in mental health, policy, and law, underlying the *Declaration of Caracas*). For a Spanish-language history of the rights of persons with disabilities before the adoption of the UN CRPD, *see* ILANUD, *Los Derechos Humanos de Las Personas con Discapacidad* (complied by Rodrigo Jiménez, 1996). *See also*, Declaration of Caracas, *supra* note 32.

[137] Declaration of Caracas, *supra* note 32, at Declare 4(b).

[138] *Id*. at Declare (1).

[139] UNICEF, *The Rights of Children with Disabilities in Viet-Nam: Bringing Vietnam's Laws into compliance with the UN Convention on the Rights of Persons with Disabilities* 20 (Eric Rosenthal and Arlene Kanter, December 2009) (describing the way CRPD's protection of the right to live in the community is more effective than the right to services to promote integration under the CRC).

[140] CRC, art. 23(1).

[141] *Id.*, art. 23 (3).

[142] U.N. Comm. on the Rights of the Child, General Comment 9, the rights of children with disabilities, Sept. 11, 2006—Sept. 29, 2006, ¶ 49, U.N. Doc. CRC/C/GC/9 (Feb. 27, 2007).

[143] Guidelines for the Alternative Care of Children, G.A. Res. 64/142, U.N. GAOR, 64th Sess., U.N. Doc A/Res/64/142, at 23 (Feb. 24, 2010).

[144] UNICEF, Promoting the Rights of Children with Disabilities: Innocenti Digest No. 13, 18 (2007), *citing* Eric Rosenthal, *et al* Children in Russia's Institutions: Human Rights and Opportunities for Reform (1999).

[145] U.N. High Comm'r for Human Rights of the Human Rights Council, *supra* note 125, at ¶45.

[146] *Id.* at ¶ 50 (emphasis added).

[147] *Id*. at ¶51.

[148] *Id*.

[149] *Id*.

[150] *Id*.

[151] Ley General de Salud, Diario Oficial de la Federación 02.07.1984, art. 75 (1984).

[152] Ley General de las Personas con Discapacidad, Diario Oficial de la Federación of 05.10.2005, art. 5(f) (2005).

[153] *Id*.

[154] Norma Oficial Mexicana, *Para le prestación de servicios de salud en unidades de atención integral hospitalaria medico-psiquiatrica* (Official Mexican Standard, NOM-0250SSA2-1994) (For the provision of health services in integrated hospital attention, medical-psychiatric units),NOM 025-SSA2-1994, Diario Oficial de la Federación 11.16.1985 (1994) [hereinafter "NOM-025-SSA2-1994"].

[155] *Id*. at §7 (describing integrated rehabilitation programs, "*Actividades de Rehabilitatión Integral").*

[156] *Id.* at §7.1.3.1 (community-based services should be provided, including services in mental health community centers, day centers, half-way houses, and other outpatient programs).

[157] *Id.* at §3.5 (describing integrated rehabilitation programs, or "*rehabilitación integral").*

[158] Ley General para la Inclusión de las Personas con Discapacidad, Diario Oficial de la Federación of 05.30.2001, http://www.dof.gob.mx/nota_detalle.php?codigo=5191516&fecha=30/05/2011 (last visited June 2, 2011).

[159] Gerard Quinn, *supra* note 116, at 106.

[160] ICESCR, art. 12, *supra* note 4. *See* Eric Rosenthal and Clarence J. Sundram, "International Human Rights in Mental Health Legislation," 21 New York Journal of International & Comparative Law 469, 494 (describing the right to health for persons with disabilities under international law as it stood before the adoption of the CRPD).

[161] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 10.

[162] *Id*. at art. 25.

[163] *Id*. at art. 25(c).

[164] K. Huckshorn, *Re-designing state mental health policy to prevent the use of seclusion and restraint*, 33 ADMIN. & POL. IN MENTAL HEALTH 482 (2006).

[165] World Health Organization Review of Effectiveness, *supra* note 31, at 19.

[166] Ximenes-Lopes v. Brazil, *supra* note 6, at ¶ 133.

[167] We conducted a more in-depth analysis of the practices of record-keeping and monitoring of psychotropic medications in our 2000 report. The conditions of people we observed at institutions were strikingly similar to what we observed ten years ago. *See* Mental Disability Rights International, Human Rights & Mental Health: Mexico 26-31 (2000).

[168] CAROLYN JARVIS, PHYSICAL EXAMINATION AND HEALTH ASSESSMENT 415 (1992).

[169] MANFRED NOWAK & ELIZABETH MCARTHUR, THE UNITED NATIONS CONVENTION AGAINST TORTURE: A COMMENTARY 77 (2008).

[170] The protection under the ICCPR was chosen over the UN Convention Against Torture because it was thought to provide broader protections in the setting of private institutions. Stefan Tromel, *A Personal Perspectie on the Drafting History of the United Nations Convention on the Rights of Persons with Disabilities*, 1 EUROPEAN YEARBOOK OF DISABILITY LAW 115, 130 (2009).

[171] Special Rapporteur on Torture, *supra* note 11, at ¶ 46.

[172] Office of the High Comm'r for Human Rights, *Expert Seminar on Freedom from Torture and Ill Treatment and Persons with Disabilties: REPORT*, Dec. 11, 2007, *available at* http://www2.ohchr.org/english/issues/disability/torture.htm.

[173] Cantoral-Benavides v. Peru, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 69, ¶99 (Aug. 18, 2000), *citing Selmouni v. France*, App. No. 25803/94, ECHR 1999.

[174] Manfred Nowak, *What Practices Constitute Torture?* Hum. Rts. Q. 809, 822 (2006).

[175] *Id*.

[176] *Loayza Tamoya v. Peru,* Judgement, Inter-Am. Ct. H.R. (ser. C) No. 33, ¶57 (Sept. 17, 1997), citing *Ireland v. The United Kingdom* , App. No. 5310/71, ECHR 1978.

[177]Special Rapporteur on Torture, *supra* note 11, at ¶ 52.

[178] *Id*.

[179] WORLD HEALTH ORGANIZATION, WHO RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS, AND LEGISLATION 11 (2005).

[180] *Id*.

[182] Ximenes-Lopes v. Brazil, *supra* note 6, at ¶ 134.

[183] *Id.*

[184] *Id. at* ¶ 135.

[185] Special Rapporteur on Torture, *supra* note 11, ¶ 55.

[186] U.N. Comm. on the Rights of the Child, *supra* note 11, at ¶ 35.

[187] According to the European Court of Human Rights the distinction between inhuman and degrading treatment and torture "derives principally from a difference in the intensity of the suffering inflicted." Ireland v. United Kingdom, ¶ 167, App. No. 5310/71, Judgmente Ser. A., No. 25, Jan. 18, 1978.

[188] Manfred Nowak, *supra* note 174, at 820, *citing* The Greek Case, 1969 Y.B. Eur. Conv. On H.R. 461, 186 (Eur. Comm'n on H.R.).

[189] Nowak & MacArthur, *supra* note 169, at 77.

[190] Special Rapporteur on Torture, *supra* note 11, at ¶ 47.

[191] Comm. Against Torture, *General Comment 2, Implementation of article 2 by States Parties*, U.N. Doc. CAT/C/GC/CRP.1/Rev.4 (2007).

[192] Special Rapporteur on Torture*, supra* note 11*,* at ¶ 49.

[193] Office of the High Comm'r for Human Rights, *supra* note 172, at 5.

[194] *Id.*

[195] Convention Against Torture, *supra* note 5, at art. 1.

[196] The video of the television broadcast is posted on DRI's website at www.disabilityrightsintl.org.

[197]Office of the High Comm'r for Human Rights, *supra* note 172, at 5.

[198] Ximenes-Lopes v. Brazil, Merits, Reparations and Costs, supra note 6, at §VII, ¶ 112(55).

[199] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 3(a).

[200] *Id*. at art. 3(b).

[201] *Id*. at art. 14.

[202] *Id*. At art. 14(1)(b).

[203] U.N. High Comm'r for Human Rights of the Human Rights Council, *supra* note 125, at ¶ 49.

[204] Prior to the CRPD, the United Nations adopted a series of principles, known as the MI Principles, to better protect the rights of mental disabilities. Under the MI Principles, "A person may be admitted involuntarily to a mental health facility […] if […] that person has a mental illness […]." MI Principles, supra note 65, at Principle 16(1)(a)-(b).

[205] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 14(2).

[206] MI Principles, *supra* note 65, at Principles 16-17. In the case of Victor Rosario Congo, the Inter-American Commission found that the MI Principles are an authoritative guide to the requirements of the American Convention with regard to psychiatric commitment. Victor Rosario Congo v. Ecuador, Inter-Am. Ct. H.R., Case 11.427, Report No. 63/99 (April 13, 1998).

[207] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 12(3).

[208]NOM 025-SSA2-1994, *supra* note 154.

[209] *Id*. at §11.

[210] Mental Disability Rights International, *supra* note 112, at 31-34.

[211] NOM 025-SSA2-1994, *supra* note 154, at §4.4.2.

[212] *Id.*

[213] *Id.* at §6.4.3.1.

[214] *Id.* at §4.4.1.

[215] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 12(2).

[216] See *Varbanov v. Bulgaria*, App. No. 31365/96, ECHR 2000-IV; *Shtukaturov v. Russia*, App. No, 44009/05, ECHR 2008-I; and *Salontaji-Drobnjak v. Serbia*, App. No. 36500/05, ECHR 2009-II.

[217] *Id*. at art. 12(3).

[218] *Id.* at, art. 12(4).

[219] *Id. at a*rt. 12(4).

[220] *Id.*

[221] REHABILITATION INTERNATIONAL ET AL., LEGAL CAPACITY AND GUARDIANSHIP OF PERSONS WITH DISABILITIES IN MEXICO 15 (2010).

[222] *Id*.

[223] *Id.* at 11.

[224] *Id*.

[225] *Id*. at 11-12.

[226] *Id*. at 11.

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[227] *Id*. at 21.

[228] *Id*. at 21-22.

[229] *Id*. at 23.

[230] *Id*. at 15.

[231] *Id*.

[232] UN ENABLE, DECLARATIONS AND RESERVATIONS, MEXICO, http://www.un.org/disabilities/default.asp?id=475 (last visited Nov. 5, 2010).

[233] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 4(4). *See also*, Gerard Quinn, *Resisting the 'Temptation of Elegance'* in THE UN CONVENTION ON HUMAN RIGHTS, SCANDINAVIAN AND EUROPEAN PERSPECTIVES (Oddný Mjöll Arnardóttir & Gerard Quinn, eds., 2009).

[234] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 13(1).

[235] *Id.* at a*rt. 13(2).*

[236] American Convention, *supra* note 2, at art. 1 and 2.

[237] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 4(1).

[238] *Id.* at art. 4(1)(a).

[239] *Id.* at art. 4(1)(b).

[240] *Id.* at art. 4(2).

[241] Committee on Economic, Social, and Cultural Rights, General Comment 3, ¶ 2, U.N. Doc. 12/14/1990. General Comment #3 provides valuable detail about the nature of governments obligations to take action toward their obligations of "progressive enforcement."

[242] Lord, Suozzi, and Taylor, *supra* note 127, at 575.

[243] While detailed standards for national planning under the CRPD have yet to be established, guidance can be found under the general comments to other conventions. *See, e.g.* United Nations Committee on Economic, Social, and Cultural Rights, General Comment 14 on the Right to Health, U.N. Doc. E/C, 12/2000/4, ¶43f. *See., e.g.* Alicia Ely Yamin, "Toward Transformative Accountability: Applying a Rights-Based Approach to Fulfill Maternal Health Obligations," in 12 Sur: International Journal on Human Rights 95, 99 (describing international standards for public participation in national planning for maternal health obligations). This article is published in Spanish at www.surjournal.org [check for Spanish citation].

[244] Convention on the Rights of Persons with Disabilities, *supra* note 18, at art. 4(5).

[245] Jim Mansell and Julie Beadle-Brown, Deinstitutionalization and Community Living: Position Statement of the Comparative Policy and Practice Special Interest Research Group of the International Association for the Scientific Study of Intellectual Disabilities 54 Journal of Intellectual Disability Research 104 (2010); Many countries have made similar mistakes in investing in smaller institutions. In Romania, for example Mental Disability Rights International (now DRI) documented the human rights violations that took place in such facilities. Mental Disability Rights International, Hidden Suffering: Romania's Segregation and Abuse of Infants and Children with Disabilities (2006).

[246] Mansell & Beadle-Brown, *supra* note 245*, at 109.*

[247] Organización Panamericana de la Salud, Reestructuración de la Atención Psiquiátrica: Bases Conceptuales y Guías Para su Implementación, Memorias de la Conferencia Regional Para La Reestructuración de la Atención Psiquiátrica (1991); Loren Mosher & Lorenzo Burti, Community Mental Health: A Practical Guide (1994) (summarizing lessons from the experience with mental health system reform in the United States and Italy); Robert Okin, *Testing the Limits of Deinstitutionalization*, 46 Psychiatric Services 569 (1995) (describing the transition to a completely community-based mental health system in Western Massachusetts); Robert Desjarlais, Leon Eisenberg, Byron Good and Arthur Kleinman, World Mental Health (1995).

[248] World Health Organization, Planning and Budgeting to Deliver Services for Mental Health (2003)**.** Extensive resources on mental health system reform are available on the WHO website. *See, e.g.* World Health Organization, Improving Health Services and Systems for Mental Health, http://www.who.int/mental_health/policy/services/mhsystems/en/index.html (last visited May 18, 2011).

[249] Laurie Ahern & Daniel Fisher, Personal Assistance in Community Existence: A Recovery Guide (2003); National Empowerment Center, A PACE/Recovery Reader (Daniel B. Fisher, Tom Langan, Laurie Ahern, eds. 2003).

[250] Extensive resources on psychiatric recovery are available at the website of the National Empowerment Center. http://www.power2u.org/index.html (last visited May 18, 2011). *See, e.g.* Enhancing the Effectiveness of Psychiatric Care and Other Services and Supports: Guidelines for Promoting Recovery Through Choice and Alternatives **http://www.power2u.org/articles/recovery/ncmhr-guidelines.html** (last visited May 18, 2011); United States National Council on Disability, From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves" (January 2000).

[251] UNICEF (2007), *supra* note 144; Save the Children, Keeping Children Out of Harmful Institutions (2009); EveryChild, Scaling Down: Reducing, reshaping and improving residential care around the world (2011).

[252] Guidelines, *supra* note 143.

[253] UNICEF, *supra* note 144, at 17; Eurochild, *supra* note 251, at 24-25.

[254] Save the Children, *supra* note 251, at 2.

[255] BIZCHUT, Due Process for People with Disabilities, http://www.bizchut.org.il/eng/upload/activities/people.html (last visited June 2, 2011) (Procedural accommodations to enable access to justice for persons with disabilities). Neta Ziv, Witnesses with Mental Disabilities: Accommodations and the Search for Truth — The Israeli Case, http://www.dsq-sds.org/article/view/51/51 (last visited June 2, 2011) (Procedural accommodations to enable access to justice for persons with disabilities). Speak Up, The Justice System, http://www.accpc.ca/Speak_Up/bestpractices-justicesystem.htm (last visited June 2, 2011) (Augmentative and alternative communication). Speak Up, Sexual Health and Safeguarding Communication Displays, http://www.accpc.ca/Speak_Up/vocabulary-intro.htm (last visited June 2, 2011) (Augmentative and alternative communication). UNICEF, Violence against Disabled Children, http://www.unicef.org/videoaudio/PDFs/UNICEF_Violence_Against_Disabled_Children_Report_Distributed_Version.pdf (last visited June 2, 2011) (Violence and abuse in hospitals and institutions). Laurie E. Powers and Mary Oschwald, Violence and Abuse against People with Disabilities: Experience, Barriers and Prevention Strategies, http://www.directcareclearinghouse.org/download/AbuseandViolenceBrief%203-7-04.pdf (last visited June 2, 2011) (Exposure of persons with disabilities to violence and abuse). Mary Ann Curry, Laurie E. Powers, and Mary Oschwald, Development of an Abuse Screening Tool for Women with Disabilities, http://disabilities.temple.edu/programs/justice/docs/bibliographyScans/Curry%201.pdf (last visited June 2, 2011)(Exposure of persons with disabilities to violence and abuse).