Convention on the Rights of Persons with Disabilities

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Committee on the Rights of Persons with Disabilities

Report on the investigation into Mexico conducted pursuant to Article 6 of the Optional Protocol to the Convention *, **, ***

I. Introduction[1]

1. This report contains the conclusions, observations, and recommendations adopted by the Committee on the Rights of Persons with Disabilities regarding the procedure for investigating serious or systematic violations established in Article 6 of the Optional Protocol to the Convention.

2. In its conclusions, observations, and recommendations, the Committee addresses the legislation, policies, and practices regarding the institutionalization of persons with disabilities in the State Party, as well as its multidimensional causes, including the deprivation of legal capacity, coercion in mental health settings, and institutionalization in social services. The Committee addresses the heightened risks of institutionalization for persons with disabilities who face multiple and intersectional discrimination, as well as the negative impacts of institutionalization on the personal integrity and rights of persons with disabilities, particularly independent living and inclusion in the community.

3. The Committee also analyzes mechanisms for individual and collective redress for the harm caused, including access to justice and strategies for de nd deinstitutionalization. The Committee issues recommendations to address these issues.

*** Due to the word-count limitations on reports established by General Assembly resolution 68/268, the factual findings of the inquiry into Mexico conducted under Article 6 of the Optional Protocol to the Convention can be found in the conference room paper available on the Committee's website. That document describes the procedure followed in the investigation, the information provided by the source, the observations and information provided by the State Party, the analysis of the legal and public policy framework, and the Committee's factual findings.

** This report was released after the expiration of the six-month period provided for in article 6, paragraph 4, of the Optional Protocol to the Convention.

* Adopted by the Committee at its 33rd session (August 11–26, 2025).

[1] When the Committee refers to institutions, it means both public and private ones, including unregistered ones, and all types of collective social welfare facilities such as group homes, shelters, centers or residences, refuges, rehabilitation centers, and/or mental health services, including psychiatric hospitals, centers or residences for persons with "mental disorders or mental disabilities," and hospitals or residences for persons with incurable or terminal illnesses .

II. Conclusions and observations

A. Violations of the rights enshrined in the Convention

4. The investigation concerns the following provisions of the Convention: general obligations (Art. 4), equality and non-discrimination (Art. 5), equal recognition of persons with disabilities before the law (Art. 12), access to justice (Art. 13), liberty and security of the person (Art. 14), protection from torture or other cruel, inhuman, or degrading treatment or punishment (Art. 15), protection from all forms of exploitation, violence, and abuse (Art. 16), the right to live independently and be included in the community (Art. 19), respect for home and family (Art. 23), and health (Art. 25).

5. The Committee will assess the findings of the investigation in light of the State Party's legal obligations. It will also assess the serious or systematic nature of the violations.

1. Persistence of institutionalization (art. 14)

6. Under Article 14 of the Convention, the State Party must repeal all laws and abolish all practices that permit the deprivation of liberty of persons with disabilities based on an actual or perceived disability, whether such deprivation of liberty is based solely on the disability or also on grounds such as therapeutic necessity or the perceived danger they might pose to themselves or to others[2] .

7. The Committee notes that:

a) The amendments introduced in 2013 and 2022 to the General Health Law regarding mental health and addictions, which applies at the federal level, establish informed consent as the general rule for medical treatments. However, this legislation continues to permit the practice of treatment without informed consent in circumstances where "[a person's] life would be exposed to imminent risk or their physical integrity to irreversible harm" (Art. 51 Bis 2), without clarifying these criteria. Institutionalization continues to be accepted as a last therapeutic resort (Art. 75). The Committee notes that this therapeutic justification has been used with broad discretion for involuntary institutionalization and the application of forced treatments to persons with disabilities;

b) Many state laws continue to authorize involuntary commitment and forced treatment on the basis of therapeutic justifications and the alleged dangerousness of persons with disabilities. Psychiatric crises frequently result in involuntary commitments and forced treatments;

c) People with disabilities continue to be involuntarily institutionalized in public and private facilities based on decisions made by third parties, including their families, and this practice primarily affects people with actual or perceived intellectual and/or psychosocial disabilities;

d) Many unregistered private institutions operate irregularly and continue to admit persons with disabilities under the pretext of rehabilitation;

e) Mental health approaches remain predominantly medical and pharmacological, and efforts to expand community-based mental health services are limited due to the lack of regulations that implement the mandate of the General Health Law and allocate budgets for community mental health;

f) Many people with disabilities are subject to involuntary transfers, reinstitutionalization, or prolonged or indefinite institutionalization, which violate their dignity and prevent them from developing as individuals;

[2] A/72/55, annex, paras. 6, 10, and 13.

g) Reinstitutionalization prevents people with disabilities from leaving institutions and choosing community-based housing options. Transfers are used as a substitute for an individualized deinstitutionalization plan and the provision of support for independent living and community inclusion;

h) Declarations of lack of criminal responsibility in proceedings involving persons with disabilities frequently result in involuntary and prolonged detentions, without the guarantees of due process and a fair trial. Such detentions occur in prisons and their annexes.

a) Institutionalization and lack of recognition as a person before the law (arts. 12 and 14)

8. In accordance with Article 12 of the Convention, the State Party must recognize the legal capacity of all persons with disabilities, repealing all provisions that authorize the substitution of their decision-making and adopting a system of supported decision-making. This system must respect the autonomy, will, and preferences of persons with disabilities and include safeguards to prevent conflicts of interest with those providing support.

9. The Committee notes that:

a) Full recognition of legal capacity remains incomplete. Although the National Code of Civil and Family Procedure was amended in 2023, a significant number of states maintain provisions in their civil or family procedure codes that restrict capacity on the basis of a disability;

b) People with disabilities continue to be deprived of their legal capacity through legal procedures and in practice. *De facto* incapacitation affects a significant proportion of people with disabilities, including those who are institutionalized. The bimonthly payments derived from the Welfare Pension for Persons with Permanent Disabilities are, in most cases, delivered to the directors of the institutions or to family members of the persons with disabilities;

c) Only Mexico City has laws recognizing supported decision-making. However, regulations to implement such supports are still pending.

b) Institutionalization and its impact on high-risk groups (arts. 5 and 14)

10. The Convention obliges the State Party to eliminate legislation, policies, or practices that are discriminatory on the basis of disability[3] . Anti-discrimination legislation must address discrimination on the basis of disability, such as institutionalization, the denial or limitation of legal capacity, or forced mental health treatment[4] . The State Party must identify and address the multiple and intersectional discrimination affecting women and girls with disabilities.

11. The Committee notes that, while laws and public policies provide for differentiated approaches regarding women, children, older persons, migrants, and indigenous peoples, gaps persist in the implementation of such laws and policies that do not mainstream disability, particularly with respect to persons with disabilities who remain institutionalized.

12. With regard to children and adolescents with disabilities, the Committee notes that:

a) Despite the legal recognition of multiple and intersectional discrimination, there are no measures in place to identify and combat it;

b) Due to a lack of support and factors such as poverty, neglect, stigma, prejudice, parental disability, and the prevalence of discourses and rhetoric regarding

[3] General Comment No. 6 (2018) of the Committee on Equality and Non-Discrimination, paras. 30 and 38.

[4] *Ibid*., para. 73(c).

protection and care rooted in medical and paternalistic models, children with disabilities face a higher risk of being separated from their families and institutionalized. Families face legal barriers to regaining custody of their children;

c) Institutionalization exposes children with disabilities to significant and irreversible harm to their cognitive development and their social interaction and communication skills. Many of them have limited access to inclusive, quality education, cultural, recreational, or sports activities, and interaction with community members. These factors lead to deterioration in their mental health;

d) Children with disabilities who are institutionalized are at greater risk of violence, exploitation, and abuse, including sexual and psychological violence;

e) Legislation continues to provide for the institutionalization of children with disabilities as a measure of protection and alternative care, and some draft care bills continue to permit institutionalization.

13. With regard to indigenous persons with disabilities, the Committee notes that:

a) Indigenous persons with disabilities live in poverty and extreme poverty in rural areas and lack access to or have limited access to support services in their communities. Many indigenous persons with disabilities must travel long distances to reach cities, where they face linguistic, cultural, and bureaucratic barriers that prevent them from accessing community services;

b) The lack of educational options in the community for indigenous children with disabilities leads to their segregation in Indigenous Children's Homes located far from their territories.

14. With regard to women and girls with disabilities, the Committee notes that:

a) Although laws and policies have a gender-sensitive approach, their implementation does not sufficiently take into account women and girls with disabilities and does not adequately address the gender-based and disability-related violence to which they are exposed, especially those living in institutions;

b) The right to sexual and reproductive health of women with disabilities is neither respected nor guaranteed for women with disabilities living in institutions. Many of them have been victims of serious violations such as sexual abuse, rape, forced abortions, and forced sterilization. The Committee noted cases of revictimization, lack of access to legal remedies against these abuses, and impunity;

c) Many institutionalized women with disabilities remain separated from their children and are unable to exercise their right to motherhood;

d) Institutionalization is used as a protective measure against gender-based violence suffered by women with disabilities within the family.

15. With regard to migrants with disabilities, the Committee notes that:

a) Migrants with disabilities face institutionalization and administrative detention on the grounds of their disability and their mobility status;

b) Most migrants with disabilities lack individualized support that takes their disability into account. Cases of long-term institutionalization and exposure to physical, psychological, and sexual violence and abuse were documented. Confinement exposes them to increased risks of mental health deterioration;

c) Some migrants with disabilities are transferred to other institutions, such as psychiatric hospitals or rehabilitation centers, without any information being available regarding their transfer, whereabouts, or fate.

16. With regard to persons with disabilities living on the streets, the Committee notes that:

a) Institutionalization affects persons with disabilities living on the streets who may be dependent on substances, and is practiced by both authorities and non-

state actors under the guise of a protective measure. This type of institutionalization leaves them more vulnerable and exposes them to violence, exploitation, and abuse;

b) Homeless people with disabilities who have left institutions return to life on the streets in a more vulnerable state, suffering from deteriorating mental health and at risk of being reinstitutionalized. Reinstitutionalization means that the fate and whereabouts of many of them will never be known.

17. With regard to older persons with disabilities, the Committee notes that:

a) Older persons with disabilities who are institutionalized suffer from neglect, lack of contact with society, and receive medicalized treatment;

b) Physical and psychological deterioration is common among older persons with disabilities living in institutions, as is the deterioration of the degrading conditions in which they live;

c) Older adults with disabilities face a higher risk of institutionalization due to a lack of support within their family environments, insufficient income or pensions, and neglect.

c) Remaining challenges regarding the right to live and to be included in the community (Art. 19)

18. Article 19 of the Convention provides that persons with disabilities have the right to choose their place of residence, where and with whom to live; to access support services for independent living and community-based services on an equal basis with others. According to the Convention, the institutionalization of persons with disabilities, including the separation of children with disabilities from their families and their forced placement in institutions, is discriminatory as it constitutes differential treatment on the basis of disability. Institutionalization is contrary to the right of persons with disabilities to live independently and to be included in the community[5] .

19. States Parties must implement deinstitutionalization strategies for persons with disabilities, including children and adolescents with disabilities, and replace all institutional settings, including group homes, with services supporting independent living[6] and, in the case of children and adolescents, family-based living. General services must be available and accessible to all persons with disabilities, ensuring that reasonable accommodations are provided[7] .

20. The Committee notes that:

a) The institutionalization of persons with disabilities is widespread and persists over time; institutionalization continues to be accepted, and there is a lack of firm commitment to promoting independent living in the community;

b) The structural causes underlying institutionalization—such as poverty, neglect, stigmas, and prejudices against people with disabilities, including a medicalized view of caregiving responsibilities and the persistence of medical models—have not been adequately addressed, and there is a lack of studies and proposals to tackle these issues;

c) The limited understanding of individualized support and community-based services fosters institutionalization; the lack of community support prevents people with disabilities, for example, from working, earning an income, and accessing personal assistance;

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[5] Committee General Observation No. 6 (2018), paras. 30, 56, 58, and 63; Guidelines on Deinstitutionalization, including in Emergency Situations, paras. 7 and 15.

[6] Committee General Observation No. 5 (2017), paras. 42, 46, and 49.

[7] Guidelines on Deinstitutionalization, including in Emergency Situations, paras. 91 and 92.

d) Federal laws, such as the General Law for the Inclusion of Persons with Disabilities (see Article 7) and the Social Assistance Law, provide for the creation and funding of institutions, including those run by private entities, and the provision of institutionalized social services, and lack provisions recognizing the right to independent living and community-based living;

e) There is a lack of a regulatory and policy framework for deinstitutionalization in accordance with Article 19 of the Convention; there is also a need to develop a deinstitutionalization strategy and plans for all persons with disabilities, in close consultation and with the active collaboration of persons with disabilities through their representative organizations, and which includes goals, implementation timelines, and a budget;

f) People with disabilities face barriers to accessing community services on an equal basis with others, which perpetuates their isolation and confinement to home life, and leaves them with few options for community participation and a high risk of institutionalization;

g) Involuntary commitment and forced treatment continue, justified by alleged protective or therapeutic needs;

h) The implementation of the comprehensive system for the protection of the family permits, promotes, and maintains involuntary institutionalization, which is considered a protective measure;

i) Although the bimonthly allowance for people with permanent disabilities promotes their social protection, its implementation has shortcomings, such as its inadequacy relative to the cost of the monthly basic basket of goods; the inability to cover additional expenses associated with the disability; its receipt through third-party such as institutional authorities or family members; and the exclusion of people with disabilities over the age of 65;

j) There is a lack of design and implementation of a structured system of supports for independent and community-based living that includes the perspectives of people with disabilities;

k) Personal assistance is virtually unknown and underdeveloped;

l) Despite certain promising initiatives, a lack of accessibility to basic community services—such as health, education, employment, habilitation and rehabilitation, culture, and sports—prevails, which continues to segregate people with disabilities;

m) Budget allocations continue to be directed toward the operation of institutions, while there is a lack of funding for programs that support independent and community-based living for people with disabilities.

2. Harm and Impacts of Institutionalization

a) Impact on personal integrity (arts. 15 and 16)

21. In accordance with Articles 15 and 16 of the Convention, the State Party must prevent and protect persons with disabilities from any form of torture, cruel, inhuman, or degrading treatment or punishment; it must prevent any incidents of exploitation, violence, and abuse; identify victims early; put an end to these violations; provide redress to victims; prosecute and punish those responsible; and adopt measures to prevent the recurrence of such violations.

22. The Committee notes:

a) The scale, frequency, and extent of violations of the physical, mental, and moral integrity of persons with disabilities who are or have been in institutions, including:

i) The dehumanizing effect of institutionalization, through confinement and isolation;

ii) The vulnerability of institutionalized persons as a result of power imbalances that leave them at the mercy of perpetrators;

iii) Permanent and irreversible harm to physical, psychological, and moral integrity. Such harm is neither identified nor addressed, nor are the victims compensated for it;

iv) The marked deterioration of mental health among institutionalized persons with disabilities who lose their socialization, sensory, and adaptive abilities;

v) Vulnerability to suicide;

vi) Incidents of deaths among institutionalized individuals;

vii) The loss of personal identity among individuals who remain in institutions, including through the involuntary change of their first and last names;

viii) The use of physical, mechanical, and pharmacological restraints in public and private institutions, including through electroconvulsive therapy;

ix) Confinement in punishment rooms or areas;

x) Punishments, such as corporal punishment and, in some cases, the withholding of food;

xi) Gender-based violence, including sexual harassment and rape;

xii) Exposure to human trafficking;

xiii) Denial of sexual and reproductive health;

xiv) Forced contraception, forced sterilization, and forced abortion;

xv) The degrading conditions in many institutions housed in dilapidated facilities, the lack of hygiene, and overcrowding, particularly in psychiatric wings within prisons;

xvi) The suppression of privacy through constant surveillance and the use of uniforms or stereotypical clothing;

xvii) Insufficient, inadequate, and nutritionally poor food services;

xviii) Compulsory work in cleaning duties;

xix) Rigid and mandatory routines that increase depersonalization;

xx) The retraumatization of individuals who are constantly exposed to the aforementioned situations and behaviors;

b) Indifference and tolerance toward the many forms of violence and abuse affecting people with disabilities in institutions;

c) The lack of early detection and treatment of post-traumatic stress affecting people who are or have been in institutions.

b) Impacts on private and family life (Art. 23)

23. Article 23 of the Convention obligates the State Party to ensure that all persons with disabilities retain their right to found a family, marry, and decide on parenthood on an equal basis with others. Persons with disabilities must not be discriminated against in the exercise of their rights to exercise guardianship and custody of their children and must receive support to fulfill their parental responsibilities. The Convention prohibits the separation of parents and/or children with disabilities from their families on the basis of a disability. If the immediate family is unable to care for

a child or adolescent with a disability, every effort must be made to provide care within the extended family and, in the absence of such a family, within the community. Children with disabilities have the right to grow up in a family. Small institutions and group homes are not substitutes for the family. The State Party must prevent the concealment, abandonment, neglect, and segregation of children with disabilities.

24. The Committee notes:

a) Children and adolescents with disabilities living in single-parent families in situations of poverty and extreme poverty are frequently considered to be in a situation of vulnerability or neglect by authorities within the family protection system and are separated from their parents and sent to institutions. Only the Law on Alternative Care for Children and Adolescents in the Federal District establishes that poverty is not grounds for separation and that all possibilities for family cohabitation must be exhausted;

b) The lack of community support for families living in poverty and/or extreme poverty that include children or adolescents with disabilities pushes them to send these children to institutions;

c) The limited development of a foster care system allows for the institutionalization of children and adolescents considered to be at risk;

d) Children with disabilities who are institutionalized lose their ability to socialize and their ties to their families; prolonged stays in institutions and transfers to other institutions, including those in other states, exacerbate abandonment and family separation;

e) People with disabilities who are institutionalized cannot exercise their rights to marry, start a family, maintain their fertility, and exercise their parental rights on an equal footing with others;

f) Initiatives by institutional authorities for family reunification and reintegration into the community are limited and do not form part of the protection strategy, which is understood primarily as the referral of individuals to institutions; family members who wish to support persons with disabilities do not receive support from the State.

c) Impacts on mental health (Art. 25)

25. Article 25 of the Convention obligates the State Party to provide access to quality health services, including community-based mental health services, for all persons with disabilities. This access must be available, accessible, affordable, culturally appropriate, and grounded in the human rights model of disability. The Convention requires that medical treatments and interventions be based on the free and informed consent of the person with a disability concerned and must not be provided by third parties. Crisis situations must never justify institutionalization or forced medical treatments and interventions. Coercion must be eradicated from mental health care.

26. The Committee notes:

a) The prevalence of a medical approach to mental health, including the use of forced medical treatments and interventions, overmedication, the use of electroconvulsive therapy, and chemical and pharmacological restraints. Stigmas and prejudices persist among mental health system staff and officials, perpetuating models of coercion;

b) The use of therapeutic justifications to justify involuntary institutionalizations;

c) The substitution of the consent of persons with disabilities with that of third parties such as guardians, family members, and others;

d) The limited development of mental health services at the community level and the failure to take into account the experiences of persons with disabilities who are users of mental health services. Mental health services are located in remote areas, and many rural communities lack health services;

e) The meager budgets in the field of mental health are directed primarily toward psychiatric institutions. Initiatives to transition to community-based mental health care were reported; however, their approach includes psychiatric hospitalization for up to 36 days with a strong medical focus, encompassing chemical restraints, pharmacological interventions, and electroconvulsive therapy. Furthermore, projects promoting decentralization in the field of mental health do not provide quality support;

f) Medical rehabilitation of visible disabilities prevails, and efforts to develop comprehensive rehabilitation that includes all persons with disabilities and addresses aspects such as educational, occupational, social, and cultural reintegration are insufficient.

3. Institutionalization and access to justice (arts. 13, 14, and 19)

27. Under Article 13 of the Convention, the State Party must provide persons with disabilities with access to justice on an equal basis with others, including through procedural accommodations appropriate to the gender and age of persons with disabilities. In accordance with Article 13, read in conjunction with Articles 4, 16(3), and 33(2) and (3) of the Convention, the State Party must establish monitoring mechanisms to prevent discrimination, violence, exploitation, and abuse of persons with disabilities, including those who are institutionalized. In accordance with Article 13 of the Convention, read in conjunction with Article 4, all such actions must involve persons with disabilities and their representative organizations through close consultation and active collaboration. Persons who have suffered harm must be provided with redress, including compensation for the harm caused.

28. The Committee notes:

a) The lack of awareness among persons with disabilities, including those who are institutionalized, regarding the administrative and judicial remedies available to them to challenge involuntary institutionalization and forced treatment, as well as to seek redress for the harm caused. There is a prevailing lack of access to accessible, affordable, and effective legal counsel to file complaints and pursue other judicial remedies;

b) The situation of legal defenselessness in which persons with disabilities in institutions find themselves, including those institutionalized in facilities managed by private entities, as well as their lack of access to justice. It was observed that, in practice, it is impossible for institutionalized persons to access *habeas corpus* remedies to challenge the illegality or arbitrariness of their deprivation of liberty. There are no statistics on the use of such remedies and their outcomes;

c) That complaint boxes represent the only complaint mechanism available to institutionalized persons. These boxes are rarely used, lack effectiveness, do not lead to investigations, and offer no guarantees of impartiality or due process. An attitude of indifference on the part of institutional authorities toward complaints from persons with disabilities was observed;

d) The lack of diligence in seriously and impartially investigating serious incidents such as the deaths of persons with disabilities in institutions and the prevalence of impunity;

e) The difficulties faced by the National Human Rights Commission in monitoring institutions, including the sustainability of its activities, the lack of regularity, or the absence of monitoring visits to all categories of institutions. The Commission’s recommendations do not appear to be adequately addressed, and the referral of information on violations to investigative authorities is sporadic. The

Commission exercises self-censorship regarding its findings out of fear of reprisals. Disparities are observed in the monitoring carried out by state human rights commissions, and there is a limited impact on the prevention of human rights violations in institutions;

f) Frequent obstacles to monitoring work by civil society organizations, including denial of access to institutions, refusal to provide information on individuals, or the inability to approach them to conduct interviews independently and without supervision by institution staff. In some cases, civil society organizations have received warnings that they would be subject to legal action if they continued to provide community-based support services for persons with disabilities who wished to leave institutions;

g) Widespread ignorance and indifference among authorities regarding the physical, psychological, economic, and moral consequences of institutionalization. Violence in institutions is perceived as an inevitable *status quo*, which prevents measures from being taken to stop the harm inflicted on persons with disabilities in institutions;

h) The lack of effective reparations for victims of institutionalization, including compensation for damages; the lack of investigations and the failure to assign responsibility, including criminal liability; as well as the lack of accountability constitute the primary barrier preventing people with disabilities from seeking reparations. In cases where persons with disabilities have received compensation from the Executive Commission for Victim Assistance, such compensation is insufficient and does not include aspects such as support for effective inclusion in the community.

4. Attitudinal barriers, need for coordination, statistics, and budgets (arts. 4 and 19)

29. According to Article 4 of the Convention, the State Party must adopt all appropriate legislative, administrative, and other measures to give effect to the rights recognized in the Convention. Likewise, it must take into account, in all policies and programs, the protection and promotion of the human rights of all persons with disabilities.

30. The Committee notes:

a) That different authorities at the federal, state, and local levels exercise jurisdiction in various areas related to the deinstitutionalization of persons with disabilities, and therefore challenges remain in achieving effective coordination of the roles that each of them must play in deinstitutionalization. While there are certain instances of inter-institutional coordination, fragmentation prevails in efforts to implement policies;

b) That policies on education, health, employment, housing, and social security formally recognize the differentiated approach but do not mainstream disability;

c) Behaviors and attitudes rooted in medical models of disability prevail among state and non-state actors who are in contact with institutionalized persons with disabilities;

d) The fragmentation, duplication, and underreporting in the collection of statistical data on persons with disabilities, and the fact that the collection of disaggregated data remains rudimentary;

e) The lack of protection of the personal data of persons with disabilities by various institutions;

f) There are no specific budgets allocated for the deinstitutionalization of persons with disabilities.

III. Serious or systematic nature of the violations

31. In accordance with article 6 of the Optional Protocol and rule 83 of its Rules of Procedure, the Committee must assess whether the violations of rights are of a serious and/or systematic nature[8] .

32. The Committee considers violations to be "serious" if they are likely to cause substantial harm to the victims, leading to further segregation, isolation, or impoverishment. In determining the seriousness of the violations, the magnitude, prevalence, nature, and effects of the violations found must be taken into account. The Committee considers that, far from representing a possibility of protection or treatment, institutionalization exposes persons with disabilities to cruel, inhuman, or degrading treatment and even to torture, abuse, violence, and exploitation, as well as to family separation, and causes permanent and irreparable harm to persons with disabilities that prevents them from enjoying their rights to life and personal integrity, to a life free from violence, exploitation, and abuse, and to live independently and in the community. The Committee considers that institutionalization particularly discriminates against persons with intellectual and/or psychosocial disabilities, persons with disabilities living on the streets, women, children, and older persons with disabilities, as well as persons with disabilities living in poverty and extreme poverty, many of whom suffer from multiple and intersectional discrimination.

33. The term "systematic" refers to the organized nature of acts leading to repeated violations and the improbability of their random occurrence. The Committee has found the existence of a legislative framework, policies, and practices that permit and perpetuate institutionalization and that, intentionally or through their effects, negatively and disproportionately affect persons with disabilities living in institutions, constituting a systematic violation of the Convention. The Committee has also found the persistence of discriminatory conduct, behaviors, and patterns affecting persons with disabilities. Furthermore, the Committee has noted the absence of an effective system of supports for independent living, including personal assistance, which contributes to the perpetuation of the institutionalization system. The Committee notes that most of these violations of the rights of persons with disabilities have not been investigated in an independent, effective, and impartial manner; victims have not yet received redress; and perpetrators have not been punished, resulting in prevailing impunity.

34. The Committee considers that the situation regarding the rights of institutionalized children and adolescents with disabilities is particularly concerning. Institutionalization is the result of the combined and cumulative effect of laws, policies, plans, and prevailing stereotypes regarding disability and has extremely harmful effects on the children subjected to it; furthermore, it leads to their marginalization from the community and increases their vulnerability to serious violations of their right to life, safety, best interests, family life, integrity, education, human development, and well-being.

IV. Recommendations

A. Ending institutionalization (art. 14)

35. **The Committee, in accordance with its guidelines on the right to liberty and security of persons with disabilities (2014), recommends that the State Party:**

[8] The serious and systematic nature of treaty obligations has been previously defined. See CRPD/C/HUN/IR/1, paras. 107 and 108; CRPD/C/ESP/IR/1, paras. 78–80; CEDAW/C/IR/MLI/1, paras. 76 and 77; CEDAW/C/ZAF/IR/1, paras. 113 and 114; CEDAW/C/OP.8/KGZ/1, para. 86; and CRC/C/CHL/IR/1, para. 111.

a) Repeal provisions in federal and state health laws that permit the involuntary commitment of persons with disabilities to mental health institutions and medical and psychiatric treatment on the basis of therapeutic justifications, the need for involuntary protection, or the alleged dangerousness of persons with disabilities;

b) Promptly adopt regulations to implement the provisions of the General Health Act regarding community mental health;

c) Urgently adopt deinstitutionalization plans for persons with disabilities based on individualized support and ensure the deinstitutionalization of all persons with disabilities who are in public or private institutions;

d) Urgently identify all cases of persons with disabilities who have remained in institutions for prolonged periods at the state or federal level, including those who have been reinstitutionalized, and include them in deinstitutionalization plans;

e) Implement measures to prevent institutionalization at the municipal, state, and federal levels, including institutionalization related to psychiatric crises, as well as intermittent, prolonged, or indefinite institutionalization. Lack of contact with family may under no circumstances be used as a justification for institutionalization or prolonged stays in institutions;

f) Ensure that persons with disabilities involved in criminal proceedings are afforded due process and a fair trial in criminal proceedings, including procedural accommodations, and implement the recommendations of paragraph 11(b) of the Committee's opinion in the case *of Medina Vela v. Mexico*[9] .

1. Restoration of full legal capacity for all persons with disabilities (Art. 12)

36. **The Committee, recalling its General Comment No. 1 (2014), recommends that the State Party:**

a) Accelerate the process for states to bring their legislation into line with the new National Code of Civil and Family Procedure and enact legal reforms to recognize the legal capacity of all persons with disabilities, including those in institutions;

b) Urgently implement the new legislation and restore without delay the legal capacity of all persons with disabilities who are deprived of it;

(c) Identify all persons with disabilities who have *de facto* lost their legal capacity; adopt measures to restore such capacity and to support the exercise of legal capacity, including with regard to the receipt and use of the Welfare Pension for Persons with Permanent Disabilities;

d) Urgently develop a decision-making support system through close consultation and active collaboration with persons with disabilities, and ensure that the measures adopted have available resources, including financial ones, and that the support respects the autonomy, will, and preferences of persons with disabilities;

e) Ensure the exercise of legal capacity through the development of community-based services outside of institutions.

[9] CRPD/C/22/D/32/2015.

2. Groups at Higher Risk of Institutionalization

37. **The Committee recommends that the State Party include multiple and intersectional discrimination in both legislation and public policies at the federal and state levels and that it collect data disaggregated by age, sex, ethnicity, immigration status, and other categories to identify those groups at greatest risk of institutionalization.**

38. **With regard to children and adolescents with disabilities, the Committee recommends that the State party:**

a) Regularly raise awareness among authorities involved in implementing sectoral laws and policies on the protection of children's rights regarding the rights of children with disabilities, and periodically evaluate the performance of these authorities in this area;

b) Repeal laws that permit the institutionalization of children and adolescents with disabilities and take urgent measures to prevent their institutionalization, guaranteeing their right to grow up in a family and promoting support for families in the community and foster families;

c) Prohibit institutionalization as a measure of protection for children with disabilities within the federal and state System for Integral Family Development and throughout the entire social protection system;

d) Implement an urgent moratorium on the institutionalization of children and adolescents with disabilities in all institutions, whether public, private, or unregistered, and ensure deinstitutionalization through the implementation of individual independent living plans for those currently in institutions;

e) Ensure regular awareness-raising for all authorities involved in the protection of children's rights so that they can recognize violence, abuse, and exploitation of children and adolescents with disabilities at an early stage and take effective measures to prevent such violence and provide reparations to victims;

f) Implement Article 16, paragraph 3, of the Convention with regard to institutionalized children and adolescents with disabilities to allow for independent monitoring of their situation;

g) Ensure that incidents of exploitation, abuse, and violence in public and private institutions are reported and investigated in an impartial, thorough, and independent manner, with proportionate sanctions applied to the perpetrators; likewise, ensure evaluation processes aimed at removing from service any institutional staff who have been involved in rights violations and prevent such staff from having any contact with children with disabilities.

39. **With regard to indigenous persons with disabilities, the Committee recommends that the State Party:**

(a) Through close consultation and the active collaboration of indigenous persons with disabilities, implement support programs for their inclusion in their communities, respecting their culture;

b) Establish inclusive and accessible educational services for indigenous children with disabilities in their communities and end their current segregation in indigenous children's homes.

40. **With regard to women and girls with disabilities, the Committee recommends that the State Party:**

a) Incorporate disability as a cross-cutting issue in the implementation of laws and policies to prevent, identify, and punish gender-based violence; ensure ongoing training for all relevant authorities

to enable them to recognize, prevent, and address intersectional discrimination; ensure that institutionalization is never considered an alternative to protect women with disabilities from gender-based violence;

b) Provide support to women with disabilities who have been affected by gender-based and disability-based violence in institutions; ensure that such violence ceases and that those responsible are punished; remove perpetrators from their positions, whether they are public officials or private actors, and prevent them from having any contact with women and girls with disabilities; urgently develop individualized deinstitutionalization plans for women with disabilities who have experienced violence in institutions.

41. **With regard to migrants with disabilities, the Committee recommends that the State Party:**

a) Adopt urgent measures to prevent abuse against migrants with disabilities in institutions, including immigration detention centers, by providing them with individualized support, including mental health support and accessible information, regarding support networks both in the State Party and in their countries of origin;

b) Pay attention to the early detection of mental health conditions, particularly among unaccompanied migrant children, in order to ensure that they receive psychosocial support in the community and to prevent their institutionalization;

c) Train all authorities involved in migration processes in the early identification of migrants with disabilities and in the design and implementation of individualized support plans;

d) Prevent the immigration detention of persons with disabilities and adopt alternative support measures;

e) In deportation proceedings involving persons with disabilities, provide procedural accommodations and reasonable adjustments to facilitate contact between persons with disabilities and their families and ensure accessible consular assistance;

f) Prevent the reinstitutionalization of migrants with disabilities and provide accessible and available information regarding their fate and whereabouts to the families and organizations seeking them. Maintain records with up-to-date information on the identity of persons with disabilities who are in immigration detention.

42. **With regard to persons with disabilities living on the streets, the Committee recommends that the State Party:**

a) Prevent and put an end to actions by authorities and non-state actors that deprive persons with disabilities who are homeless or substance-dependent of their liberty;

b) Adopt measures to prevent the reinstitutionalization of persons with disabilities living on the streets through individualized plans with community-based supports;

c) Prevent the disappearance of persons with disabilities living on the streets, including homeless children and adolescents with disabilities, and ensure that they can return to the community settings where they previously interacted, preventing their fate and whereabouts from remaining unknown.

43. **With regard to older persons with disabilities, the Committee recommends that the State Party:**

a) Ensure the inclusion of older persons with disabilities in the community through the adoption of individualized deinstitutionalization plans, reintegration into family settings, adequate old-age and disability pensions, and access to personal assistance and adequate, accessible housing;

b) Urgently provide community-based mental health rehabilitation for older persons with disabilities who have been institutionalized, and ensure that programs providing access to bimonthly subsidies or grants are extended to older persons with disabilities over the age of 65.

3. Right to live independently and be included in the community of persons with disabilities (Art. 19)

44. **The Committee recommends that the State Party:**

a) Conduct a detailed study on the causes of institutionalization, including multidimensional poverty and taking into account intersectionality;

b) Dismantle the system of institutionalization of persons with disabilities, including involuntary placement in public and private institutions, whether or not they are registered. To this end, repeal all provisions permitting institutionalization in general and sector-specific legislation and in public policies, including those relating to social assistance facilities provided for in the General Law on the Inclusion of Persons with Disabilities and the Social Assistance Law;

c) End all practices by state and private actors that lead to institutionalization and order the closure of all unregistered private institutions;

d) Recognize and guarantee in its legislation the right of all persons with disabilities to live independently and in the community, and introduce mechanisms to ensure its enforceability;

e) Urgently design and implement policies, plans, and strategies for deinstitutionalization, in accordance with the Convention, the Committee's General Comment No. 5 (2017), and the guidelines on deinstitutionalization, including in emergency situations. As a matter of priority, the Committee recommends that the State Party:

i) Promptly enact a moratorium on the institutionalization of persons with disabilities;

ii) Establish a deinstitutionalization timeline that identifies baselines, indicators, targets, and implementation timelines;

iii) Conduct close consultations and ensure the active collaboration of persons with disabilities, including those remaining in institutions, through their representative organizations, in the design and implementation of such policies, plans, and strategies;

iv) Urgently design and implement a comprehensive mental health reform that prohibits the use of coercion, promotes community-based mental health with a rights-based approach, takes into account the experiences of persons with disabilities who use mental health services, and guarantees access to mental health care in both rural and urban areas;

v) Allocate adequate funding to provide community-based support and services, including individualized, high-quality support;

vi) End educational segregation that confines people with disabilities to institutions, identify those who have been excluded from access to inclusive, quality education, and ensure their prompt educational inclusion;

vii) Implement strategies that promote the development of employment skills for people in institutions, ensuring their access to employment in the open labor market;

viii) Develop accessible and affordable housing and ensure that people with disabilities who are in the process of deinstitutionalization or have left institutions, including homeless people, are included in these housing plans with flexible eligibility criteria and access to information in accessible formats, including easy-to-read formats;

ix) Ensure that persons with disabilities have access to all social security benefits on an equal basis with others;

x) Allocate financial resources at the federal, state, and local levels to develop and maintain systems of support for independent and community-based living, including personal assistance;

xi) Ensure that international cooperation resources are not used for the establishment or maintenance of institutions, including group homes;

xii) Prohibit and combat the detention of homeless persons with disabilities and their referral to institutions operated by both public and private entities;

xiii) Implement support plans for families with members who have disabilities and who are living in poverty and extreme poverty, in order to prevent institutionalization;

xiv) Pay attention to the situation of migrants with disabilities, including those who acquired their disability during the migration process, to prevent their institutionalization in the context of migration or deportation proceedings;

f) Based on impartial audits, urgently implement reforms to the system for managing bi-monthly pensions for persons with permanent disabilities to ensure that these pensions are indexed to the value of the basic food basket or the consumer price index, that they are delivered personally to persons with disabilities and not to the directors of institutions, their family members, or caregivers; that the amount covers the additional expenses associated with the disability; and that coverage be extended to persons with disabilities over the age of 65;

g) Ensure intersectoral and inter-institutional coordination at the federal, state, and local levels in the provision of accessible services in education, health, employment, housing, habilitation and rehabilitation, culture, and sports;

h) Ensure independent monitoring of the implementation of deinstitutionalization policies, plans, and strategies by national and state human rights commissions, the national mechanism for the prevention of torture, and civil society organizations;

i) Combat stigmatizing practices that continue to perpetuate institutionalization, including through ongoing awareness-raising efforts targeting authorities and society;

j) Urgently adopt individualized support plans for persons with disabilities subject to repeated institutionalization, ensuring that they are not left homeless and exposed to violence upon leaving an institution, but rather enabling their inclusion in the community. Furthermore, provide

reparations for the harm caused to persons with disabilities who have been subjected to transfers and reinstitutionalization, including psychosocial support, based on an independent and impartial assessment of the physical, psychological, and economic harm;

k) Investigate the whereabouts of persons with disabilities whose whereabouts are unknown, as well as whether they have been victims of the crime of disappearance.

B. Address the harm caused by institutionalization and provide reparations (arts. 15, 16, 23, and 25)

1. Identify and remedy harm

45. **The Committee recommends that the State party:**

a) Identify cases of ill-treatment, torture, inhuman or degrading treatment, violence, exploitation, and abuse against persons with disabilities who are or have been in institutions; investigate such cases thoroughly, impartially, and independently; take all appropriate measures to prevent their recurrence; expedite the adoption of individualized deinstitutionalization plans for persons with disabilities that include psychosocial support and treatment for post-traumatic stress disorder for victims, including those who are or have been in private or unregistered institutions, and prosecute individuals suspected of having committed crimes;

b) Amend the Official Mexican Standard (NOM 005-SSA2-1993) on Family Planning Services to abolish the practice of sterilizing persons with intellectual and/or psychosocial disabilities without their consent and protect the sexual and reproductive rights of all persons with disabilities;

c) Ensure that accessible, available, effective, and expeditious mechanisms for redress exist for persons with disabilities who are or have been in institutions. Broadly define possible mechanisms for redress, including individual or collective redress;

d) Consider establishing an inter-institutional reparations commission with representation from organizations of persons with disabilities and other civil society organizations, with sufficient human, technical, and financial resources; and ensure that this commission has access to all documentation regarding persons with disabilities who are or have been institutionalized. This commission should design a comprehensive reparations plan that includes protocols for the early detection of violence in institutions; the protection of victims; their reintegration into the community; and measures to prevent recurrence;

e) Ensure close consultation and active collaboration with women with disabilities through their representative organizations, as well as the participation of other civil society organizations, in the design of gender- and age-appropriate support and reparation measures for victims of violence and abuse;

f) Ensure the dismissal of institutional staff found responsible for participating in cases of torture, ill-treatment, abuse, violence, and exploitation against persons with disabilities who are or have been institutionalized, through an evaluation and/or vetting process;

g) Strengthen the monitoring mechanisms of the National Human Rights Commission and state commissions, as well as the national mechanism for the prevention of torture, and ensure the participation of persons with disabilities and their representative organizations, including

organizations of women with disabilities and other civil society organizations, in the monitoring of all institutions, including unregistered ones;

h) Adopt and implement protocols to raise awareness among staff working in institutions regarding the prevention and early identification of mistreatment, violence, abuse, or exploitation against persons with disabilities in institutions, as well as regarding their sexual and reproductive health rights. Include tools to combat stigma and prejudice regarding the sexual and reproductive health of women and girls with disabilities.

2. Ensuring private and family life (Art. 23)

46. **The Committee recommends that the State Party:**

a) Cease the institutionalization of persons with disabilities as a recourse in cases of poverty and abandonment. Authorities responsible for family protection should under no circumstances proceed with the institutionalization of persons with disabilities on the grounds that it is a protective measure;

b) Adopt legislative and policy measures at the federal and state levels that expressly prohibit the separation of persons with disabilities from their family environment on the basis of disability and in situations of poverty and extreme poverty;

c) Adopt legal, administrative, and policy measures to develop and implement community-based support systems for families with persons with disabilities, particularly families with children and adolescents, in order to avoid and prevent family separation. Include, in these measures, information in accessible formats regarding supports for independent living in the community;

(d) Adopt legislative, public policy, and administrative measures to expeditiously implement an effective foster care system to prevent institutionalization, including placement in group homes and small institutions;

e) During the deinstitutionalization process, take measures to prevent the deterioration of the socialization skills of persons with disabilities in institutions, promote the maintenance of relationships with family and the community to prevent the abandonment of persons with disabilities, and build capacities for independent living through individualized plans for independent living;

f) During the deinstitutionalization process, inform persons with disabilities of their right to marry, start a family, maintain their fertility, and exercise their parental rights on an equal basis with others, and take effective measures to guarantee these rights;

g) During the deinstitutionalization process, develop individualized plans to facilitate and promote family reunification and reintegration into society;

h) Provide financial support and resources to families with older persons with disabilities to ensure the provision of food, clothing, transportation, and housing, as well as psychosocial support.

C. Eliminate coercion in the health sector, including mental health, and develop community-based health services (art. 25)

47. **The Committee recommends that the State party:**

a) Urgently design and implement a comprehensive reform of the mental health system that explicitly prohibits the use of coercion in all its forms, including during crisis episodes, and that includes retraining of all personnel providing mental health services, the promotion of mental health in the community, and the removal of mental health personnel involved in human rights violations against persons with disabilities;

b) Prohibit the substitution of consent by third parties in any type of treatment or medical intervention involving persons with disabilities and ensure that consent is provided in all cases by the persons with disabilities concerned, by providing them with information on medical treatments in easy-to-read formats;

c) Expand the provision of quality, community-based mental health services throughout the country, respecting the dignity of persons with disabilities and taking into account their experiences as users of mental health services;

d) Increase public spending on community-based mental health care, ensuring non-coercive mental health approaches;

e) Recognize and promote peer support in the area of mental health;

f) Adopt and implement a comprehensive approach to rehabilitation that is not limited to the provision of physical rehabilitation services, is open to all persons with disabilities regardless of age or type of impairment, and includes components of educational, vocational, social, and cultural rehabilitation. In developing this approach, take into account the experiences already being implemented by civil society organizations that do not receive funding from Teletón.

D. Ensuring access to justice (Art. 13)

48. **The Committee recommends that the State Party:**

a) Adopt legislation and public policies for persons with disabilities who have been institutionalized that effectively guarantee access to justice, through, for example, the provision of procedural accommodations, access to affordable legal counsel, as well as information in accessible formats regarding these measures. Ensure regular awareness-raising among judicial authorities to combat stereotypes and prejudices against persons with disabilities;

b) Effectively guarantee access to the remedy of *habeas corpus* or other legal mechanisms to challenge the arbitrariness or illegality of the deprivation of liberty of persons with disabilities who have been institutionalized. Ensure that the families of children with disabilities who have been institutionalized have access to expedited remedies and procedures for family reunification;

c) Establish age- and gender-appropriate complaint mechanisms against abuse, exploitation, and violence against persons with disabilities in institutions that are permanently available and accessible, and ensure that persons with disabilities receive adequate information about the complaint mechanisms and how to use them. In particular, the Committee recommends that the State Party ensure that:

i) Staff working with persons with disabilities in institutions immediately report cases of rights violations;

ii) Management at institutions initiate internal investigations into complaints filed and report on the status of such investigations and the remedies adopted to the Public Prosecutor's Office;

(iii) State and federal human rights institutions and civil society organizations have access to information regarding reports of violence and abuse and may interview victims and witnesses who request it;

d) Initiate thorough and impartial investigations, including ex officio, into deaths and suspected abuses and other human rights violations committed against persons with disabilities in institutions; identify systemic failures as well as the individuals responsible; ensure the adoption of necessary remedies, including legislative measures if necessary, and that individuals suspected of having committed crimes are subject to investigation;

e) Ensure that justice system officials receive regular training on the Convention; raise awareness among the Public Prosecutor's Office to investigate allegations of human rights violations with diligence and a sense of urgency; increase the human, technical, and financial resources of the Criminal Defense Unit of the Federal Institute of Public Defenders to fulfill its functions regarding legal representation and counseling for all persons with disabilities in institutions;

f) Guarantee the participation of civil society organizations in monitoring public and private institutions, their access to facilities and documentation, and the opportunity to interview persons with disabilities without supervision;

g) During the deinstitutionalization process, ensure that staff at both public and private institutions receive on- nd ongoing training on the prevention of abuse, exploitation, and violence, as well as on how to respond appropriately to such incidents without fear of reprisal, and evaluate their performance with regard to the dignity of persons with disabilities.

E. General obligations to implement the human rights-based approach to disability, including in inter-agency coordination, budgeting and data collection (Art. 4)

49. **The Committee recommends that the State Party:**

(a) Designate a focal point at the federal level for the deinstitutionalization of persons with disabilities to develop, in coordination with relevant entities at the state and federal levels, a comprehensive plan for deinstitutionalization in accordance with the Committee's guidelines on deinstitutionalization, including in emergency situations;

b) Redirect budgetary resources allocated to institutionalization toward the creation of accessible community-based supports and services, in accordance with the Committee's guidelines on deinstitutionalization, including in emergency situations;

c) Eradicate the medical and welfare-based approaches to disability that prevail among state and non-state actors working with persons with disabilities, including those in public and private institutions;

d) Comprehensively restructure the family protection system, including the National System for Integral Family Development and state-level systems, so as to shift the protection approach—which remains rooted in institutionalization—toward accessible community-based support and services;

e) With the aim of achieving deinstitutionalization, periodically collect statistical data on persons with disabilities in all types of institutions, public or private, disaggregated by age, gender, sex, disability, membership in Indigenous and Afro-Mexican communities, as well as by type of institution;

f) Incorporate all aspects described in the guidelines on deinstitutionalization, including in emergency situations, into deinstitutionalization policies and their implementation.

V. Dissemination and Follow-up

50. In accordance with the provisions of article 6, paragraph 4, of the Optional Protocol to the Convention, the State Party shall submit its observations to the Committee within six months of the date on which it receives the results of the inquiry and the observations and recommendations transmitted to it by the Committee.

51. Upon completion of the investigation, the Committee will make this report and the State party's observations available to the public. The Committee requests that the State party, within two years of the conclusion of the investigation, submit a report on the follow-up given to the Committee's recommendations, particularly those regarding the design of a comprehensive deinstitutionalization strategy in accordance with the guidelines on deinstitutionalization, including in emergency situations; the development of individualized supports and accessible community-based services, including mental health care and reparations, and the provision of compensation to the victims of the " ." The Committee requests that the follow-up report include information on progress made in these areas, including through the collection of disaggregated data, the establishment of baselines, indicators, concrete targets, and timelines.

CRPD/C/MEX/IR/CRP/R.1

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Committee on the Rights of Persons with Disabilities

Factual Conclusions of the Committee's Inquiry into Mexico under Article 6 of the Optional Protocol to the Convention

Committee Conference Room Paper * **

I. Introduction

1. On February 26, 2021, the Committee on the Rights of Persons with Disabilities received information indicating serious and/or systematic violations of the rights recognized in the Convention. According to this information, persons with disabilities, including children and adolescents with disabilities, are deprived of their right to live independently and in an inclusive manner within the community, and the State party fails to fulfill its obligation to protect those residing in institutions from forms of violence and abuse, as well as its obligation to implement deinstitutionalization strategies for persons with disabilities, in accordance with its obligations under the Convention.

2. Mexico ratified the Convention and acceded to the Optional Protocol on December 17, 2007. On January 2, 2012, the State party informed the Secretary-General of the withdrawal of the interpretative declaration made at the time of ratification regarding Article 12, paragraph 2, of the Convention.

II. Allegations by the source of information

3. The source reports that persons with disabilities in the State party face serious and systematic violations of their rights as a result of forced institutionalization. It notes that institutionalization affects both children and adults with disabilities, who remain in institutions for prolonged periods and, in many cases, indefinitely. According to the information provided, official statistics reported at least 118,904 institutionalized persons, of whom at least 26,000 are children who remain in places such as psychiatric hospitals, group homes, social assistance centers, villages, alternative care centers, residential care facilities for children , migrant detention centers, or rehabilitation centers. The source, however, warns of a hidden figure regarding institutionalization due to , according to which at least 140,000 children with disabilities are subject to institutionalization.

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* The information contained in this document should be read in conjunction with the official report of the Committee on the Rights of Persons with Disabilities (CRPD/C/MEX/IR/1) adopted at its 33rd session (August 11–26, 2025).

4. According to the source, institutionalization is based on intellectual and/or psychosocial disabilities, and the risk of institutionalization increases due to poverty, homelessness, abandonment, migration, membership in indigenous communities, or substance abuse[1] .

5. The source states that persons with disabilities subject to institutionalization are denied their right to legal capacity and are exposed to inhuman and degrading conditions due to unsanitary conditions, a lack of drinking water, overcrowding, as well as isolation and forms of physical and/or pharmacological restraint in institutions. Furthermore, the source indicates that institutionalization entails practices of forced sterilization and contraception that particularly affect women, sexual violence, including rape, child exploitation, forced labor, trafficking, and the disappearance of persons. In this context, the source reports that persons with disabilities have been subjected to severe trauma and death in institutions.

6. The source maintains that public health budgets, at both the federal and state levels, continue to be allocated to psychiatric hospitals in the absence of budgetary allocations to fund community-based mental health services. According to the source, the scale, nature, impact, and organized nature of forced institutionalization based on disability entail serious and systematic violations of the rights of persons with disabilities recognized in the Convention.

III. Procedure followed and cooperation with the State party

7. On December 9, 2021, the Committee invited the State party to submit observations on the information received by the Committee pursuant to article 6 of the Optional Protocol. On 10 February 2022, the State party submitted its preliminary observations to the Committee.[2] During the Committee's 26th session, the Working Group examined all the information received and concluded that there was credible information regarding serious and/or systematic violations of rights enshrined in the Convention. At its 26th session, the Committee appointed two experts to conduct an investigation and, on June 16, 2022, requested the State party's consent to conduct a visit to its territory.

8. On October 13, 2022, a virtual meeting was held between the authorities of the State Party and staff of the Committee Secretariat. The meeting provided an opportunity to address logistical and substantive issues related to the visit, its scope, and its implications. On November 16, 2022, the State party informed the Secretariat via a note verbale sent to[3] regarding the designation of focal points to coordinate preparations for a potential visit to the country. On February 14, 2023, the Committee transmitted to the State party a proposed preliminary program for the visit to the State party. On May 25, 2023, the State party transmitted to the Committee a proposed program for the visit. During the Committee's 29th session in August 2023, the Ambassador and Permanent Representative of Mexico to the UN and other international organizations in Geneva and the Director of Human Rights at the Ministry of Foreign Affairs held a meeting with the Chairperson of the Committee on the Rights of Persons with Disabilities, the experts appointed for the inquiry, and staff of the Committee's Secretariat. At that meeting, the representatives of the State party reaffirmed the State party's willingness to cooperate with the Committee in the conduct of the investigation and the possibility of carrying out the visit on a date to be determined.

9. In December 2023, the State party provided the Committee with additional information on the situation of persons with disabilities and institutionalization. On January 26, 2024, the State Party gave its consent to the Committee to conduct a visit to its territory

[1] Language of the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs of 1961.

[2] Preliminary observations submitted by Mexico pursuant to Article 6, paragraph 1, of the Optional Protocol to the Convention (CRPD/C/MEX/PO/R.1)

[3] Note verbale OGE04818

from July 8 to 19, 2024. It also consented to holding virtual meetings prior to the visit, which took place from June 25 to 28, 2024.

10. During the preparation for and conduct of the visit, the Committee received cooperation from the Office of the United Nations High Commissioner for Human Rights in Mexico, to which it extends its gratitude. The Office of the High Commissioner provided support for the Committee Delegation's ground transportation, advice and assistance regarding security requirements, and accompaniment during visits to institutions where persons with disabilities are institutionalized.

11. The Committee's delegation held virtual meetings prior to its visit and in-person meetings during its visit to the country with representatives of the Ministry of the Interior, the Ministry of Social Welfare, the Ministry of Health, the National Commission on Mental Health and Addictions, the National System for Integral Family Development, the Mexican Social Security Institute, the National Civil Protection System, the National System for the Protection of Children and Adolescents, the National Institute of Migration, the Decentralized Administrative Body for Prevention and Social Rehabilitation, the National Human Rights Commission, the National Mechanism for the Prevention of Torture, the National Council to Prevent Discrimination, the National Institute for Women, and the National Institute for Indigenous Peoples. During the *on-site* visit held from July 8 to 17, 2024, the Delegation also met with officials from the Supreme Court of Justice of the Nation, the Federal Judiciary Council, the Superior Court of Justice of Mexico City, and the Independent National Monitoring Mechanism for the Convention on the Rights of Persons with Disabilities, administered by the National Human Rights Commission. It also met with officials from United Nations agencies in Mexico.

12. The Delegation met with state authorities from Mexico City, the State of Mexico, and the State of Oaxaca. It also met with children and adolescents with disabilities and family members of persons with disabilities in urban and rural areas of Mexico City, the State of Mexico, and the State of Oaxaca, respectively.

13. Following the visit, in a note verbale dated April 17, 2025, the State party submitted additional information requested by the Committee, including statistical data on the situation of persons with disabilities in institutions.

14. The Delegation also had the opportunity to interview persons with disabilities who are still in federal and state psychiatric hospitals, in psychiatric institutions administered by private organizations, in Social Assistance Centers (CAS), and in immigration detention centers, as well as survivors of institutionalization. It also held interviews with organizations of persons with disabilities, including confederations of persons with intellectual disabilities and persons with psychosocial disabilities, human rights organizations that promote the rights of persons with disabilities, those that promote children's rights, women's organizations, and organizations of indigenous peoples. The Committee thanks civil society for its commitment to the rights of persons with disabilities and for its contributions throughout the investigation process.

15. The Committee thanks the State party for its cooperation in the preparation and conduct of the visit, including the dialogue with federal and state authorities. The Committee notes the close attention that the Ministry of Foreign Affairs paid to the activities of the Committee's delegation during its visit.

I. Information provided by the State party on legislative, judicial, and public policy measures

16. The State party provided information on legislative and jurisprudential developments, which it considers important for protecting the rights of persons with disabilities regarding the recognition of legal capacity and independent living and community-based living, namely:

Legislation:

(a) The amendment to the General Health Act of May 16, 2022, regarding mental health and addictions. This law establishes free and informed consent for any medical treatment, which may only be substituted by the family or medical staff in emergency situations; It stipulates that hospitalization is a last resort and may only be carried out voluntarily, for the strictly necessary duration, and at the general hospital closest to the user's residence; it also provides for outpatient primary care facilities and psychiatric services in hospitals and national health institutes;

(b) The recognition of the right to full legal capacity in the National Code of Civil and Family Procedures, which standardizes procedural regulations in civil and family matters across the 32 states and will enter into force on the dates determined by each state, but no later than 2027.

Judicial decisions:

(a) Direct Amparo 4/2021 of the Supreme Court of Justice of the Nation (SCJN) determining that the institution of interdiction is unconstitutional and inconsistent with international conventions;

(b) Amparo on Review 356/2020[4] and 702/2018[5] of the Supreme Court of Justice of the Nation regarding the recognition of legal capacity and its exercise with the support required for decision-making, as well as for participating in judicial proceedings and concluding legal transactions in the notarial sphere.

17. The State party also highlighted the establishment of administrative bodies in the field of mental health, as well as the development of public policy strategies and programs that benefit children and adolescents with disabilities, indigenous children, and youth and adults with disabilities, namely:

(a) The creation of the National Commission on Mental Health and Addictions (CONASAMA) on May 20, 2023, with the aim of strengthening community-based care through the coordination of intersectoral actions across the three levels of government;

(b) The National Institute of Migration's (INAMI) program of Child Protection and Care for Vulnerable Groups Officers, designed to protect the rights of children and adolescents in the context of human mobility, which provides specialized care for persons with disabilities;

(c) Rehabilitation Centers in 16 states and Mexico City, which provide comprehensive care that promotes the educational, occupational, recreational, and cultural

[4] The Court affirmed that support measures are in the exclusive interest of the person with a disability who requests them; that, if they so wish, they may participate in the trial accompanied by someone they trust; and that the court, where appropriate, must apply a gender-sensitive approach to adjudication, for example, as occurred in the case where the legal incapacitation served to legitimize the violence a woman suffered at the hands of her husband, who was appointed her guardian.

[5] The Court has also declared unconstitutional other provisions that restrict legal capacity, such as those contained in Mexico City's local notarial legislation, which authorized notaries to determine whether individuals requesting their services had the legal capacity to enter into legal acts or not. On this matter, the Court reiterated the recognition of the right to exercise legal capacity with supports and safeguards, a right that must be recognized by notaries. Furthermore, it noted that: a) The notary must accept that a person with a disability may choose and designate their supports before the notary or determine them with the assistance of the

inclusion of children and adolescents with disabilities, and where programs are implemented for children and adolescents with disabilities or at risk of developing them;

(d) The Welfare Pension for Persons with Permanent Disabilities, which aims to provide income and facilitate access to rehabilitation therapies, including for persons from indigenous peoples, Afro-Mexican communities, or those facing a high level of marginalization. Through this program, beneficiaries receive cash transfers of 3,200 pesos every two months;

(e) The "Opening Spaces" strategy, led by the Ministry of Labor and Social Welfare (STPS), aims to provide guidance to job seekers who, due to their physical or social circumstances, face greater barriers to entering the workforce, including people with disabilities. The strategy promotes an approach focused on labor inclusion, equality, and non-discrimination through job placement and the assessment of work skills across all subprograms and modalities of the Employment Support Program. It is reported that, between December 2019 and December 2025, the program benefited 80,757 people with disabilities, of whom 15,545 found formal employment;

(f) The Indigenous Education Support Program known as "Indigenous Children's Homes," which supports the continued education of indigenous children and youth enrolled in public schools, prioritizing those who lack educational options in their community. The Indigenous Children's Homes and School Cafeterias, the Indigenous Student Homes, and the Indigenous University Homes provide lodging, meals, and cultural activities to beneficiaries who require them, prioritizing indigenous persons with disabilities;

(g) The Comprehensive Social Assistance Services Program, implemented by the SNDIF at the federal level through two components: (i) the prevention, rehabilitation, and inclusion of persons with disabilities or at risk of developing a disability, and (ii) alternative care or residential foster care for children, adolescents, and older adults without parental or family care. The program also provides recreational and leisure services for low-income populations;

(h) The National Housing Program (PNV) 2021–2024, whose primary objective was "to standardize existing information and technology systems to align housing sector guidelines with the characteristics that adequate housing must meet, as well as with the priority needs of indigenous populations, female heads of household, persons with disabilities, older adults, and youth";

(i) The "Hogar a tu medida" Program, which provides people with disabilities with a free financial benefit to make adaptations to a home they intend to purchase or have already purchased through an INFONAVIT mortgage loan. The Program has been in operation since 2015 and, between January 2020 and March 2024, financed 42,123 homes that included at least one adaptation feature, benefiting people with disabilities;

(j) The ISSTE Housing Fund's "Continuous Enrollment" strategy, which allows for the continuous registration of individuals seeking mortgage loans throughout the year. The program democratizes access to financing for all eligible beneficiaries and prioritizes assistance for the most vulnerable sectors by offering better terms;

(k) The operation of Teletón Children's Rehabilitation and Inclusion Centers in 22 states, which offer specialized care services to children with neuromusculoskeletal disabilities and their families through rehabilitation. Similarly, the State party reported on the Teletón Autism Center and the Teletón Children's Oncology Hospital;

(l) The Rehabilitation and Inclusion Support Program for the Well-being of Children with Disabilities, aimed at strengthening access to rehabilitation services and contributing to the inclusion of children and adolescents with permanent disabilities. It consists of the distribution of wellness vouchers, which can be exchanged for rehabilitation sessions at accredited public or private health facilities;

(m) The National Strategy for Inclusive Education, which seeks to implement measures to strengthen inclusive education for people with disabilities. The strategy includes the development of Care Centers for Students with Disabilities that offer the educational option of certification through partial evaluations, known as Open High School;

(n) The Program to Strengthen Special Education Services, which seeks to ensure the educational retention of students with disabilities in basic education through complementary support and specific equipment;

(o) The actions undertaken by the Criminal Defense Unit of the Federal Institute of Public Defenders to request protective measures in cases of mechanical restraint of institutionalized individuals;

(p) Awareness-raising initiatives by the National Center for Gender Equity and Reproductive Health of the Mexican Ministry of Health, aimed at ensuring the adequate provision of health services to persons with disabilities, through specialized training provided to health personnel in the State Health Services;

(q) Promotional and outreach initiatives regarding the sexual and reproductive rights of children and adolescents, such as virtual participatory forums and awareness campaigns. Additionally, training has been provided to civil servants and public officials on sexuality and the prevention and care of adolescent pregnancy;

(r) The 2021–2024 National Program on Work and Employment for Persons with Disabilities, in which various agencies and entities of the Federal Public Administration participate, to ensure a non-discriminatory environment and quality of life for persons with disabilities.

II. Scope and Objective of the Report

18. The Committee has noted with concern that persons with psychosocial and/or intellectual disabilities in the State party are subject to forced institutionalization in the context of medical or psychiatric treatment and has recommended abolishing legislation that permits institutionalization based on disability.[6] Likewise, it has recommended that the State party ensure free and informed consent regarding mental health services, establish decision-making support measures to guarantee the autonomy, will, and preferences of persons with disabilities, and prevent the restriction of rights based on a legal incapacity. The Committee has also recommended an explicit prohibition on coercive measures against persons with disabilities in institutions, as well as forced sterilization, contraception, and abortion, both within and outside institutions. Furthermore, it has called on the State party to adopt measures aimed at ending institutionalization and to develop measures enabling persons with disabilities to live independently and in the community. Likewise, the Committee has requested that financial, organizational, and administrative support be provided to ensure in practice the right of children with disabilities to live with their families and to enjoy family life.[7]

19. The Working Group on Arbitrary Detention noted that persons with psychosocial disabilities are frequently subjected to detention as a result of "security measures" imposed after being declared not criminally responsible in the course of criminal investigations, and that such detentions can become indefinite. Likewise, it highlighted its concern regarding the recurring practice of involuntary institutionalization of persons with disabilities in hospitals or in public and private social welfare centers. The Working Group recommended that the State party adopt all necessary legislative, administrative, and judicial measures to prevent and remedy involuntary or disability-based institutionalizations.[8]

20. The Special Rapporteur on Torture concluded that persons with disabilities in institutions face torture and cruel, inhuman, and degrading treatment, including forced sterilization, miserable conditions, confinement, the use of cages, isolation, and the use of

[6] Committee on the Rights of Persons with Disabilities. Concluding observations on the initial report of Mexico (CRPD/C/MEX/CO/1, see para. 30.)

[7] Ibid. Concluding observations on the combined second and third periodic reports of Mexico (CRPD/C/MEX/CO/2-3). See paras. 35, 36, 42, 45, 51, 53.

[8] Working Group on Arbitrary Detention (2024). Visit to Mexico (A/HRC/57/44/Add.1). See paras. 69–74 and 88(b).

electroshocks. He also expressed concern about cases of death by suicide or starvation among persons with psychosocial disabilities in the absence of adequate psychosocial care.[9]

21. This report describes the prevalence of institutionalization on the grounds of disability in the State party and its impact on the right of persons with disabilities to their personal integrity and other rights recognized in the Convention. The Committee also analyzes the factors leading to the prevalence of institutionalization of children with disabilities and its multiple and intersectional harmful effects on them, as well as on women with disabilities, indigenous persons, older persons, and/or migrants with disabilities, persons with psychosocial and/or intellectual disabilities—including those living on the streets—in various types of institutions, such as social care centers, psychiatric institutions, group homes, and other collective settings.[10] It also addresses legislative reforms regarding legal capacity, mental health, and social protection policies that aim to strengthen the participation and inclusion of persons with disabilities in the community. Furthermore, it analyzes the stigmatization of persons with disabilities, the absence of support systems for independent living, and the lack of accessibility to community services as causes of the continued institutionalization in the State party and the violations that this entails.

22. In the dialogue between the Committee and the State party within the framework of the inquiry procedure, the Committee has noted the State's initiatives aimed at advancing legislative and public policy reforms that will enable the full implementation of the Convention.

IV. Legal Framework[11]

A. Right to equality and prohibition of discrimination

23. The Convention has constitutional status and is directly applicable in the State party.[12] The Political Constitution of the United Mexican States (Art. 1)[13] and several state constitutions[14] recognize the right to equality and non-discrimination for persons with disabilities.

[9] A/HRC/34/54/Add.4 "Follow-up report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment on his mission to Mexico" 2017. See paras. 90, 98–103.

[10] The Committee recognizes that group settings constitute institutions. See Guidelines on Deinstitutionalization, including in Emergency Situations (2022), para. 15.

[11] National Legal System

[12] Combined second and third periodic reports that Mexico was required to submit in 2018 pursuant to Article 35 of the Convention. CRPD/C/MEX/2/3, see para. 11 "The provisions of the Convention apply on the premise that the content of international human rights treaties is equivalent to the Political Constitution of the United Mexican States (CPEUM) in accordance with the reform of June 10, 2011."

[13] Political Constitution of the United Mexican States, Article 1: "Any discrimination based on ethnic or national origin, gender, age, disability, social status, health conditions, religion, opinions, sexual orientation, marital status, or any other ground that violates human dignity and is intended to nullify or impair the rights and freedoms of persons is prohibited."

[14] With the exception of the constitutions of Chiapas, Durango, Tabasco, Tamaulipas, and Veracruz, local constitutions recognize disability as a protected category against discrimination. See: Mexico's responses to the list of issues regarding its combined second and third periodic reports (CRPD/C/MEX/RQ/2-3, para. 15).

24. On the one hand, both the General Law for the Inclusion of Persons with Disabilities[15] and the Federal Law to Prevent and Eliminate Discrimination[16] contain provisions that prohibit discrimination against persons with disabilities and mandate the adoption of measures to promote equality, including affirmative action. Additionally, the Federal Law to Prevent and Eliminate Discrimination[17] recognizes multiple and intersectional discrimination (Article 1) and acknowledges that discrimination has occurred and may occur in "detention centers or in institutions providing care for people with mental or psychosocial disabilities."[18]

B. Right to personal integrity and protection against violence and abuse

25. Federal law provides constitutional protection for the right to personal integrity, which may not be suspended or restricted in situations of grave danger or conflict (Art. 29);[19] ; and federal and state laws contain provisions to protect persons with disabilities from violence, including gender-based violence.

26. For its part, the General Law to Prevent, Investigate, and Punish Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment absolutely prohibits torture and cruel, inhuman, or degrading treatment or punishment and establishes the National Prevention Mechanism.[20] It defines institutionalization as a form of deprivation of liberty[21] and recognizes disability as a factor of vulnerability to torture and ill-treatment (Art. 6, Section III)[22] . It also provides that a public official commits the crime of torture if they perform medical or scientific procedures on a person without their consent or without the consent of the person legally authorized to grant it (Art. 24, Section III) and stipulates that penalties for the crime of torture are increased by up to half when the victim is a person with a disability (Art. 27).

27. Furthermore, the General Law on Women's Access to a Life Free of Violence recognizes disability as a factor of vulnerability to violence against women. This law provides that the issuance of protection orders and the adoption of measures to prevent, address, punish, and eradicate violence against women must take into account the situation of

[15] Published on May 30, 2011. General Law for the Inclusion of Persons with Disabilities. (Article 2) "Discrimination on the grounds of disability. This shall be understood to mean any distinction, exclusion, or restriction on the basis of disability that has the purpose or effect of hindering, impairing, or nullifying the recognition, enjoyment, or exercise, on an equal footing, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil, or other spheres. It includes all forms of discrimination, including the denial of reasonable accommodations;"
All 32 states have a law for the protection of the rights of persons with disabilities (see CRPD/C/MEX/2-3, para. 13).

[16] Published on June 11, 2003. Federal Law to Prevent and Eliminate Discrimination. Articles 1, 2, and 9.

[17] Published on June 11, 2003. Federal Law to Prevent and Eliminate Discrimination. Articles 1, 2, and 9.

[18] See Article 9 (XXIX) of the Federal Law to Prevent and Eliminate Discrimination.

[19] See the Political Constitution of the United Mexican States (Art. 29)

[20] Decree published in the Official Gazette of the Federation on April 28, 2022. **VII. Absolute prohibition:** Torture and cruel, inhuman, or degrading treatment or punishment are strictly, completely, unconditionally, and imperatively prohibited. **Article 72** establishes the National Prevention Mechanism. Article 81 grants it the authority to prepare reports regarding "detention centers and private detention centers and institutions of public interest."

[21] **XVIII. Deprivation of liberty**: Any act in which a person is deprived of their freedom of movement resulting in any form of detention, arrest, apprehension, internment, custody, imprisonment, or confinement of a person, by order or act of a judicial or administrative authority or other competent authority, or with the express or tacit consent of any of these."

[22] **III. Differentiated and Specialized Approach**: In applying the Law, authorities must take into account the existence of population groups with particular characteristics or who are in a more vulnerable situation due to their ethnic or national origin, language, religion, age, gender, sexual preference or orientation, gender identity, disability, social, economic, historical, and cultural status, as well as other distinguishing circumstances that require specialized attention;

disability. It also establishes that authorities at women's justice centers must make reasonable procedural accommodations to ensure that women and girls with disabilities can exercise their rights.[23]

28. For its part, the General Law on the Rights of Children and Adolescents (amended May 27, 2024)[24] recognizes their rights to a life free from violence and to personal integrity (Chapter Eight, Articles 46–49) and their right not to be discriminated against on the basis of disability (Art. 39)[25] . It also requires authorities to implement special measures to prevent, punish, and provide redress for the various forms of violence against children and adolescents with disabilities (Art. 47).

C. Recognition of Legal Capacity

29. Through the new National Code of Civil and Family Procedures published in 2023[26] , the Federation repealed the procedures for the deprivation of legal capacity[27] and incorporated the concept of "extraordinary support" for decision-making by persons with disabilities, when their will and preferences cannot be ascertained by any means. To achieve the restoration of legal capacity, however, it is necessary for the authorities of the states to harmonize their civil and family legislation with the National Code.

30. The Mexico City Judiciary determined that the "state of interdiction" violates the legal capacity and the right to equality and non-discrimination of persons with disabilities and was the first court to request a declaration of the validity and application of the new National Code of Civil and Family Procedures. In 2024, Mexico City amended its legislation[28] recognizing the legal capacity of all persons and their right to request support in decision-making. Standard supports include the appointment of a person to provide accessible information, act as a facilitator of the expression of will, or help explain the consequences of certain decisions.

D. Legislation on mental health and health treatments

31. The amendments to the General Health Law ([29]) regarding mental health and addictions include provisions whereby the State party recognizes free and informed consent as a condition for conducting a diagnosis and/or health treatment, as well as

[23] Published in the Official Gazette of the Federation on February 1, 2007. General Law on Women's Access to a Life Free of Violence. See Articles 5, 32, 33, 35, 44, 47, 52, 59 Bis.

[24] Latest amendment published in the Official Gazette of the Federation on May 27, 2024

[25] Article 39. Children and adolescents have the right not to be subject to any discrimination or to any limitation or restriction of their rights, on the basis of their ethnic, national, or social origin, language, age, gender, sexual orientation, marital status, religion, opinion, economic status, circumstances of birth, disability, or health condition, or any other condition attributable to themselves or to their mother, father, guardian, or person having them in their care and custody, or to other members of their family. Likewise, the authorities are obligated to implement special measures to prevent, address, and eradicate multiple discrimination faced by children and adolescents who are socially excluded, living on the streets, of African descent, subjected to the worst forms of child labor, or in any other situation of marginalization.

[26] Decree Enacting the National Code of Civil and Family Procedures, published in the Official Gazette of the Federation (DOF) on June 7, 2020. (wo17190.doc).

[27] Transitory Articles **"Article Nineteen.** All provisions establishing interdiction procedures, the effect of which is to restrict the legal capacity of persons over 18 years of age, are hereby repealed, in accordance with the provisions of the Transitory Provisions of this Decree."

[28] Mexico City Congress. Reform of the Code of Civil and Family Procedures, August 22, 2024. See Article 445. Congress promotes national standardization of civil and family procedures. Microsoft Word - codigo_procedimientos_civiles.docx;

[29] See: Decree amending, adding, and repealing various provisions of the General Health Law regarding Mental Health and Addictions. Published in the Official Gazette of the Federation on May 16, 2022. DOF - Official Gazette of the Federation.
Decree amending and adding various provisions to the General Health Law regarding mental health. Published in the Official Gazette of the Federation on January 15, 2013. DOF - Official Gazette of the Federation.

the possibility of accepting or rejecting the latter. Likewise, they establish the duty to provide reasonable accommodations for decision-making regarding medical treatments and the duty to provide reasonable support and accommodations for children and adolescents so that their opinions are taken into account in decisions related to their health. The legislation provides, however, that health care providers may administer treatment without informed consent in circumstances of imminent risk to life or irreversible harm to a person's physical integrity (Art. 51 Bis 2). In such cases, the healthcare provider must document the situation in the medical record and submit a justified report to the Ethics Committees and the competent judicial authority.

32. The legislative reforms of 2022 stipulate that, to eliminate the institutional psychiatric model, no new hospitals specializing exclusively in psychiatry shall be built; and existing psychiatric hospitals must, progressively, be converted into outpatient centers or general hospitals within the integrated health services network (Art. 74). In this context, hospitalization is considered a "last therapeutic resort," subject to the person's consent (Art. 75). Current provisions presume the capacity for discernment in all individuals and regulate the possibility of expressing advance directives regarding health treatments (Art. 75 Ter).

33. Both the 2013 amendment to the General Health Law and the 2022 amendment included provisions regarding the development of community-based mental health services[30] . The implementation of these provisions, however, remains pending. In this regard, the Committee was informed that mental health services in primary-care outpatient units have been strengthened, as has the training of health personnel to enhance capacities for community-based mental health care.

34. At the federal level, the National Commission on Mental Health and Addictions is the governing body for mental health and addictions and is responsible for integrating a community-based model for mental health and addictions, with a focus on comprehensive primary health care, respect for human rights, interculturality, and a gender perspective.[31] Within the framework of its mandate, the Commission is carrying out the process of updating and harmonizing legislation, including NOM-025-SSA2-2014 and the Regulations of the General Health Law regarding the Provision of Medical Care Services, in order to ensure individuals' legal capacity and respect for their human rights. The legislation also provides for the participati , of external human rights observers and the implementation of a monitoring mechanism and the development of programs that promote, protect, and guarantee human rights in any health facility (Art. 73 VII).

E. Non-Criminal Responsibility in Criminal Proceedings

35. The Federal Criminal Code[32] establishes non-imputability on the basis of an impediment, meaning that persons with disabilities cannot be held criminally responsible for a crime. A declaration of non-criminal responsibility, however, allows judicial authorities to adopt measures involving deprivation of liberty by ordering psychiatric hospitalization (Art. 24, para. 3) for a term that must not exceed the maximum term of imprisonment corresponding to the offense for which hospitalization is ordered (Art. 69). For its part, the National Code of Criminal

[30] See texts of the 2022 Reform: **Article 72 Bis** Mental health care shall be provided with a community-based, recovery-oriented approach and with strict respect for the human rights of the users of these services, in accordance with the principles of interculturality, interdisciplinarity, comprehensiveness, intersectorality, gender perspective, and social participation. **Article 73.—**Services and programs related to mental health and addictions must prioritize community-based, comprehensive, interdisciplinary, intercultural, intersectoral, gender-sensitive, and participatory care for individuals starting at the primary care level and in general hospitals.

[31] It began operations on May 29, 2023. See "Additional Information from the Mexican State regarding the confidential investigation procedure against Mexico pursuant to Article 6, paragraph 2, of the Optional Protocol to the Convention on the Rights of Persons with Disabilities." Government of Mexico, December 2023.

[32] Microsoft Word - FEDERAL CRIMINAL CODE.doc

Procedure[33] and its amendments of December 16, 2024, provide for reasonable accommodations in the context of proceedings involving persons who are deemed not criminally responsible. Such accommodations must be implemented from the time of the initial hearing, in relation to the collection of samples, and in proceedings leading to the imposition of precautionary measures[34] .

F. Right to Family and Support for Children with Disabilities

36. The State Party's Constitution protects the organization and development of the family, the best interests of children, and the full guarantee of their rights, as well as the State's duty to provide "facilities to individuals so that they may contribute to the fulfillment of children's rights" (Art. 4). Likewise, pursuant to the General Law on the Rights of Children and Adolescents (Art. 11)[35] , they have the right to live in a family (Arts. 13 and 22). In this context, it is the duty of federal, state, and municipal authorities to establish "family strengthening policies to prevent the separation of children and adolescents from their family environment (…)".

37. According to the 2015 Law on Alternative Care for Children and Adolescents in the Federal District, now Mexico City,[36] the State must implement programs to prevent the separation of children and adolescents at risk of losing their family care. It also establishes that poverty is not a justifiable cause for separation and that, before deciding to separate a child or adolescent from their family, there must be certainty that all possibilities for continuing to live with their family of origin have been exhausted (Art. 3). Some states recognize in their respective laws on the rights of children and adolescents the right of children and adolescents to live with their families. However, they lack measures to prioritize family unity and prevent family separation on the grounds of disability.

38. The legislative initiative[37] , which seeks to create a National Care System, defines its target population as "dependent populations" who, according to , "require care" from the national system, and includes people who "require care" due to disability and "lack the autonomy to perform activities of daily living." This legislative proposal, however, permits forms of institutionalization known as "residential care" based on age and disability,[38] assumes a lack of autonomy among people with disabilities, and lacks provisions regarding support for independent living.

[33] Published in the Official Gazette of the Federation on March 5, 2014, and amended on December 16, 2024, Articles 414 through 419 regarding the procedure for persons not criminally liable.

[34] See Articles 414 to 419. Articles 414 to 419 [Procedure for Persons Not Criminally Responsible] ‹ National Code of Criminal Procedure (CNPP) | Justia Mexico

[35] General Law on the Rights of Children and Adolescents

[36] Published in the Official Gazette of the Federal District on March 10, 2015. See: Microsoft Word - ley_cuidados_alternativos.docx

[37] Senate of the Republic. LXVI Legislature: Bill proposing a decree enacting the General Law on the National Care System. https://www.congresocdmx.gob.mx/media/documentos/1d08b2cc3950f86b43af611400523aac12953d67.pdf

[38] Ibid., "Article 14. Care services are those that provide attention, assistance, and care for people in situations of dependency and are classified into the following types, among others:
(…)
II. Institutional care: child care centers or extended school hours for children, early childhood care centers, day centers for people with mild or moderate dependency;
III. Residential care: These are care services with a biopsychosocial, social-health, and socio-educational focus provided in long-term care centers where individuals stay overnight. They shall be provided in residential centers authorized for this purpose, according to age and degree of lack of autonomy (…)."

G. Social protection system and support for independent living

39. The social protection framework includes constitutional provisions recognizing financial support for people with disabilities (Art. 4) subject to age conditions (children under 18 and adults up to age 64) and the permanent nature of a disability.[39] This support is called the "welfare pension for persons with permanent disabilities"[40], which is equivalent to approximately 150 USD as of the end of 2024[41] and is paid every two months.

40. The State party reported that, as of April 2025, 24 states had entered into an agreement with the Federal Government and were implementing the Welfare Pensions. It also noted a total of 1,339,105 pension beneficiaries, of whom 450,498 are women and 569,674 are men. In terms of age, 318,933 are children.

41. Furthermore, the social security system[42] in the State Party establishes a mandatory benefits scheme linked to employment relationships and includes disability benefits (Art. 11) that may be provided in cash or in kind (Art. 57).

42. Additionally, the General Law for the Inclusion of Persons with Disabilities recognizes the right of persons with disabilities to decent housing (Article 18), which includes the development of architectural construction projects that take into account their accessibility needs and access to loans or subsidies for the purchase, debt repayment, and construction, remodeling, or adaptation of housing. The scope of application of this legislation regarding persons subject to institutionalization lacks regulation.

V. Statistical Information

43. The State Party provided statistical information on the official registry of persons with disabilities in institutional settings, including data on their distribution across states, their age, sex, indigenous status, and migration and refugee status, namely:

(a) In 2024, 777 persons with psychosocial disabilities were reported to be admitted to public-sector psychiatric hospitals under the Ministry of Health in 16 states nationwide. The average age of the 777 admitted individuals was 52.68 years. The majority were men; 360 were women and 417 were men. The length of stay ranged from a minimum of 3 years to a maximum of 38 years.

(b) In 2024, there were 488 children and adolescents with disabilities registered in Social Assistance Centers across 17 states**,** distributed across the following age ranges: 59 in the 0–5 age group; 184 in the 6–12 age group; 141 between 13 and 15 years old; and finally, 104 between 16 and 17 years old.

(c) In 2024, a report was filed regarding a three-year-old girl with an intellectual disability, specifically diagnosed with Down syndrome, who was in pre-adoptive foster care;

(d) In 2024, 26 children and adolescents were reported to the Social Assistance Centers of the National System for Integral Family Development (SNDIF), located in 16 states and Mexico City. The average length of stay in residential care for children and adolescents with disabilities in these centers is 8 years.

(e) During the second half of 2024, five private Social Assistance Centers were identified where children and adolescents with disabilities reside. These centers are located in Chihuahua (1), Nuevo León (1), Sonora (1), and San Luis Potosí (2). Additionally, 12 civil

[39] CPEUM: The State shall guarantee the provision of financial support to persons with permanent disabilities under the terms established by law. Priority for receiving this benefit shall be given to minors under the age of eighteen, indigenous persons and Afro-Mexicans up to the age of sixty-four, and persons living in poverty.

[40] Welfare Pension for People with Permanent Disabilities | Ministry of Welfare | Government | gob.mx

[41] 3,100 Mexican pesos. See Pension for the Well-being of People with Permanent Disabilities | Ministry of Welfare | Government | gob.mx

[42] Defined in the Mobile Social Security Law - Social Security Law

society organizations that place people with disabilities in residential care were identified. These are located in the following states: (6) in Mexico City; (2) in the State of Mexico; (1) in Veracruz; (2) in Querétaro; (1) in Morelos;

(f) Thirteen children with disabilities were reported at the psychiatric institution "Clínica Campestre Citlaltépetl, S. A. de C. V.," including one girl between the ages of 6 and 11, three female adolescents, and nine male adolescents between the ages of 12 and 17;

(g) Registration of persons with disabilities in immigration stations and immigration centers:

During the period from January 1 to December 31, 2024:

(i) Eight adults, five men and three women, at the Acayucan immigration station; seven people at the Mexico City immigration station, four women and three men; one man at the Tuxtla Gutiérrez immigration station; one man at the Nuevo León immigration station; three women at the Reynosa immigration station.

From January 1 to February 28, 2025:

(ii) One man at the Zacatecas immigration station; 4 adults (one woman and 3 men) at the Chetumal station; one man at the Acayucan immigration station; two men at the Mexico City station; one man at the Tuxtla Gutiérrez station; 3 people (one woman and two men) at the Villahermosa station.

44. The State party also provided information on the registration of children and adolescents with disabilities reunited with their families after a period of institutionalization and adults who returned to the community, explaining:

(a) Between 2022 and 2024, 12 children and adolescents were returned to their families from SNDIF Social Assistance Centers;

(b) Between 2022 and 2024, 7 adults aged 18 were reintegrated into the community by the CAS, comprising 5 women and 2 men;

(c) Between January 2022 and December 2024, the state reported 1,644 discharges from the Dr. Juan N. Navarro Children's Psychiatric Hospital, of which 1,113 were women and 531 were men between the ages of 7 and 51.

VI. Factual Conclusions

A. Prevalence of involuntary institutionalization based on a disability

1. Institutionalization is far more common than community-based support

45. The Committee notes with deep concern that institutionalization on the basis of disability prevails over systems of support for independent and community-based living. The causes of this phenomenon are manifold and lie in legislation, public policies, historical practices, and deeply entrenched negative stereotypes against persons with disabilities prevalent in the State party, which have legitimized social ableism by depriving persons with disabilities of their participation in the community.

46. The charitable and medical approaches to people with disabilities, deeply rooted in society, have promoted and enabled the segregation of people with disabilities through a system of institutions formally designed to provide "care" and "rehabilitation." Mexico was the first country in Latin America to establish a psychiatric hospital. People with disabilities have been viewed as objects of medical treatment and charity, with the assumption that they lack rights. In the absence of broad recognition by the State of the rights of people with disabilities and its obligations to respect, protect, and fulfill those rights, it is the families of people with disabilities who, in many cases, assume the role of supporting their family members with disabilities. This support, however, remains limited to the domestic sphere, posing serious risks to the exercise of personal autonomy and self-determination, as well as risks of gender-based and disability-based violence, and the risk of ending up homeless and/or institutionalized should family support fail.

47. The Committee notes with concern that legislation on disability and in the social security sphere continues to permit institutionalization. On the one hand, the General Law on Persons with Disabilities grants federal authorities[43] the power to establish institutions for persons with disabilities known as "temporary or permanent care centers" intended for persons in situations of neglect.[44] This law also states that the Ministry of Social Development should "promote the opening of specialized facilities for the care, protection, and shelter of people with disabilities living in poverty, abandonment, or marginalization" (Art. 21).

48. Furthermore, the Social Assistance Act[45] provides for care in specialized facilities for children, adolescents, and older adults in a state of abandonment or neglect and "people with disabilities without resources" (Art. 12). Similarly, it provides for the development of social assistance centers[46] that constitute a system of group housing intended for people considered to be in a situation of vulnerability or with specific care needs, including people with disabilities.[47] These centers include facilities such as group homes for children and adolescents; group homes for older adults; shelters; rehabilitation centers; psychiatric hospitals; centers or residences for people with "mental disorders or mental disabilities"; hospitals or residences for people with incurable or terminal illnesses; and refuges.

49. The Committee is concerned that the institutional care system continues to be prioritized in public spending, including the renovation of existing psychiatric hospital infrastructure, and takes precedence over public spending on community-based support. On the one hand, financial resources are allocated to medical services such as short-term hospitalization and/or outpatient care. However, such services remain inaccessible to many people with disabilities who must travel for several hours to access them. On the other hand,

[43] The Ministry of Health and the Ministry of Social Development, respectively.
[44] See Art. 7
[45] SOCIAL ASSISTANCE LAW
[46] INEGI "Characteristics of Social Assistance Facilities. Methodological and Conceptual Summary."
[47] Ibid., INEGI "The data also provide insights for identifying population groups with specific care needs, because, due to their physical, mental, legal, economic, or social conditions, they require specialized services for their protection and full integration into society, as is the case with children and adolescents at risk, migrants, displaced persons or those in vulnerable situations, older adults, people with disabilities or special needs, victims of crime, the homeless, and people with alcohol or drug dependencies."

authorities from the State Systems for Integral Family Development (DIF) continue to pay funds to institutions, such as rehabilitation centers, for the accommodation of individuals referred there. According to research conducted by social organizations, between 2015 and 2022, state governments in nine states reportedly signed agreements totaling more than 31 million Mexican pesos.

50. The Committee notes with deep concern the lack of investment and/or prioritization in public budgets to develop supports for independent living and community-based mental health services. Only 5 percent of the federal health budget is allocated to mental health. Some sources indicate that 80 percent of the budget goes to psychiatric hospitals. The 2025 federal expenditure budget for Branch 12 "Health" indicates that 65 percent of the budget is allocated to prevention, research, and training in mental health. Community mental health remains absent, and health personnel working in institutions such as psychiatric hospitals acknowledged the lack of community psychiatric services in their settings.

51. The Committee is also concerned that psychiatric hospitals and social welfare institutions only exceptionally allow persons with disabilities to leave these facilities. These institutions, however, lack the human, technical, and/or financial resources to develop community-based support for persons with disabilities and systematically implement deinstitutionalization in their favor. The General Law on the Rights of Children and Adolescents provides for periodic reviews of the special protection measures that led to admission to social welfare centers. The practical application of these measures could not be established.

2. Limited impact of the federal reform on civil and family proceedings and continued use of the legal concept of legal incapacitation

52. The Committee notes that legislative measures regarding civil, family, and mental health proceedings recognize the human rights, independent living, and social participation of all persons.[48] It is concerned, however, that reforms such as those to the National Code of Civil and Family Procedure remain unenforceable, as their implementation depends on pending legislative reforms at the state level. As of the date of this report, 31 states have yet to enact legislative changes to affirm the recognition of legal capacity and establish decision-making support systems.

53. The limited progress in reforming state civil and family procedure laws has meant that persons with disabilities continue to be subject to the loss of their legal capacity on the basis of a disability and lack support in decision-making. The Committee noted that, in the absence of legal capacity, persons with disabilities lack the freedom to decide their place of residence and remain systematically exposed to forced institutionalization.

54. The Committee is concerned that in psychiatric hospitals and in residential and social care facilities, admission and institutionalization procedures continue to be carried out without taking into account the legal capacity and consent of the persons concerned.

3. Persistence of forced institutionalization in law and practice

55. A purely medical approach toward persons with intellectual and/or psychosocial disabilities predominates in state health laws. According to information received, only the state of Baja California has introduced rules regarding informed consent prior to admission.[49] Furthermore, eighteen state laws permit involuntary treatment in various types of institutions, including those not specialized in health care, such as halfway houses or sheltered psychiatric rehabilitation workshops.[50] Under these laws,

[48] General Health Law, 2022 amendment (Art. 72 Bis)

[49] Public Health Law for the State of Baja California, Art. 33.

[50] See: State Health Law of the State of Chihuahua (Art. 68); State Health Law of Coahuila de Zaragoza (Articles 66–70); State Health Law of the State of Oaxaca (Articles 66–70); State Health Law of Tamaulipas (Article 73); Yucatán (Articles 72–76); Mental Health Law of the State of Jalisco 2013; Mental Health Law of the State of Sonora 2013: permits release from

individuals subject to forced institutionalization may eventually have "representatives who look after their interests." Other laws still explicitly permit isolation and physical restraints[51] and/or provide for the loss of legal capacity resulting from forced hospitalization.[52]

56. Federal and state psychiatric hospitals continue to admit persons with disabilities for involuntary commitment without the consent of the person concerned and/or based on a request from a third party, generally a family member or guardian. The Committee is concerned that such third-party requests allow for the misinterpretation of the person's will and preferences in a manner that enables the substitution of consent and the carrying out of involuntary commitments. At the federally administered psychiatric hospital—Samuel Ramírez Moreno—"Type 1 consent" implies that the person concerned expresses their willingness to be admitted; however, "Type 2 consent" entails the absence of consent from the person subject to admission, but with a request from a third party, generally a family member. At that hospital, between 60 and 70 percent of admissions are reportedly carried out forcibly or under "Type 2 consent." At the Juan N. Navarro Psychiatric Hospital, forced admissions of children may occur not only with the authorization of their parents or guardians but also through decisions by the DIF authority, which, acting as guardian, sends them to institutions. The Committee also received information regarding the occurrence of involuntary admissions to private institutions, such as shelters, group homes, and so-called social assistance centers. There, people with disabilities are sent as a result of decisions by the DIF at the request of third parties—family members or neighbors.[53]

57. In the institutions visited, the Committee found that most placements are involuntary and lack due process. There are cases of people who, seeking support during a crisis, were admitted to these institutions, where they subsequently lost all ability to make decisions for themselves, were overmedicated, and subjected to unnecessary treatments, with no justification whatsoever for their institutionalization. Information was received indicating that, in private institutions, people with disabilities lose the right to leave on their own accord, as discharges are subject to the decision of family members and, in their absence, to the institution's board of directors and medical staff, who retain the authority to deny residents "permission" to leave.[54]

4. Deprivation of liberty on the basis of disability in the absence of criminal liability and conditions of persons with disabilities deprived of liberty in the context of criminal investigations

58. The Committee is concerned that intellectual and/or psychosocial disabilities continue to be the main cause of rulings of non-criminal responsibility, often followed by deprivation of liberty. The Committee received information indicating that, between February 2022 and February 2025, six persons with disabilities were declared not criminally responsible in the context of a criminal investigation[55] , and the

detention facilities only with the authorization of medical personnel, even though it recognizes legal capacity as a right; Mental Health Law of the State of Michoacán de Ocampo 2014; Mental Health Law of the State of Sinaloa 2017; Mental Health Law of the State of Querétaro 2017; Mental Health Law of the State of Yucatán 2018: authorizes isolation and physical restraints when they are the only available means to prevent immediate or imminent harm to oneself or to third parties.

[51] Mental Health Law of the State of Campeche 2018: Authorizes isolation and physical restraints when they are the only available means to prevent immediate or imminent harm to oneself or to third parties; Chihuahua State Mental Health Law 2018: Authorizes isolation and physical restraints when they are the only available means to prevent immediate or imminent harm to oneself or to third parties.

[52] Mental Health Law for the State of Nuevo León 2018: States that individuals receiving mental health services lose their legal capacity and decision-making authority when they are admitted against their will.

[53] Testimony

[54] Testimony

[55] Information submitted by the State party. NV OGE01446 of April 17, 2025.

investigations leading to the declaration of non-criminal responsibility involved criminal conduct such as carrying a firearm, embezzlement, drug possession and abuse, the illegal theft of hydrocarbons, and/or human trafficking. Furthermore, according to statistics from the National Penitentiary System, as of June 2023, 664 people had been declared not criminally responsible and 6,431 were registered in correctional facilities as individuals with psychosocial and/or intellectual disabilities[56] . One such correctional facility is the Federal Center for Psychosocial Rehabilitation (CEFEREPSI), whose function is to provide psychiatric treatment to persons deemed not criminally responsible with psychosocial and/or intellectual disabilities.

59. The Committee also received information indicating that, between February 2022 and February 2025, 110 people with disabilities were deprived of their liberty in Federal Criminal Justice Centers in 20 states and Mexico City, pursuant to decisions on pretrial detention or the enforcement of prison sentences[57] . Additional information on deprivation of liberty indicates that as of 2022, 12,507 people with disabilities were incarcerated in various types of correctional facilities[58] and as of June 2021, there were 2,329 people with disabilities, of whom 7% were women and 93% were men, who were held in the so-called "annexes" of correctional facilities[59] .

60. The Committee received information indicating that persons with disabilities face isolation and permanent confinement within prisons, overcrowding, widespread pharmacological treatment, and the inability to access any basic services available to the prison population, including mental health services. Similarly, the Committee received information regarding cases documented by the authorities in the Federal Social Rehabilitation Centers (CEFERESO), in which people with psychosocial disabilities have faced suicide risks due to the lack of mental health care and activities that contribute to maintaining their emotional stability and social reintegration[60] .

5. Institutionalization occurs indefinitely and/or for prolonged periods

61. The Committee notes with grave concern situations of indefinite and/or prolonged institutionalization. Indefinite institutionalization occurs in several states,[61] in residential institutions for children and/or adults, regardless of whether they are public or private. Recurrently, indefinite institutionalization occurs due to the lack of community support and concrete measures to release individuals who have been institutionalized and facilitate their transition to independent living. The Committee is deeply concerned about the lack of social programs that enable persons with disabilities to maintain community ties, assistance for community inclusion, or budgets allocated for the deinstitutionalization of persons with disabilities.

62. The Committee encountered persons with disabilities who had been institutionalized in psychiatric hospitals for 36 years. Institutionalized persons, regardless of the length of their stay in psychiatric institutions, are subjected to sedatives and psychotropic medication. However, the criteria for admission and the care provided are insufficient to address the underlying causes of mental health crises. Similarly, the Committee observed cases of young adolescents who remained completely sedated during the initial periods of institutionalization.[62]

[56] Monthly National Prison Statistical Information Bulletin 2023.
[57] Information submitted by the State party. NV OGE01446 of April 17, 2025.
[58] 2023 National Census of the Federal and State Prison Systems.
[59] Data collected through information requests submitted to prison authorities.
[60] CNDH Issues Recommendation to the OADPRS for Failing to Provide Comprehensive Psychological Care to Five Women Deprived of Liberty at CEFERESO 16 in Morelos | National Human Rights Commission - Mexico
[61] Testimony
[62] Testimonies

63. The Committee also received information indicating that the lengths of stay in psychiatric hospitals range from one month,[63] three months,[64] one year,[65] two years,[66] seven years,[67] (specifying that these are individuals deemed not criminally responsible and whose commitment was ordered by a court), 8.5 years,[68] 11 years,[69] 13 years,[70] 14 years,[71] 23 years,[72] 25 years,[73] 40 years,[74] 41 years, specifying that these were individuals institutionalized under the authority of judges or due to social neglect[75] up to 51 years.[76] Equally concerning is the information indicating that several psychiatric institutions lack maximum periods of stay or hospitalization, and these periods depend on the conditions of the institutionalized individuals.[77]

64. Children with disabilities are also at risk of prolonged and/or indefinite institutionalization both during childhood and/or once they reach adulthood. The Committee was informed of several cases where adults with disabilities remain institutionalized in facilities they entered as children or adolescents.[78] The Committee also noted with concern the case of older women who have been subject to institutionalization since childhood. They were initially institutionalized at the now-defunct "La Castañeda" psychiatric hospital, and after 50 years, they remain confined in psychiatric centers under the care of federal and/or state authorities. The Committee met with some of them[79] . The Committee also learned of cases of older women with disabilities in psychiatric hospitals who remain institutionalized even despite psychiatric evaluations suggesting their deinstitutionalization.[80]

65. The Committee received information regarding children's shelters run by religious communities where children have been separated from their parents due to the parents' disability (usually their mothers). The lack of support for families of children with disabilities often leads to their separation. The actual or perceived disability of single mothers or mothers who are survivors of gender-based violence carries greater risks for the institutionalization of their sons and daughters. Once children reach the age of 6, they are transferred to other institutions. Children with disabilities, however, are at greater risk of remaining institutionalized beyond the age of six. Although these are institutions for children, they may house adult women with disabilities who arrived there as girls and remain there into adulthood.[81]

6. Underlying, multidimensional causes that drive and perpetuate institutionalization

66. The Committee noted with concern several cases of institutionalization resulting from the lack of support for independent living in the community. In this context, people with disabilities are often forced to rely on family members and/or friends for support or, alternatively, face institutionalization. Some women, who have

[63] Tampico Psychiatric Hospital
[64] León Psychiatric Hospital.
[65] Villa Ocaranza Psychiatric Hospital. (State of Hidalgo)
[66] State of San Luis Potosí
[67] Dr. Miguel Vallebueno Mental Health Hospital. State of Durango.
[68] Sinaloa Psychiatric Hospital.
[69] Dr. José Torres Orozco Psychiatric Hospital (State of Michoacán).
[70] Specialized Mental Health Hospital, Zacatecas.
[71] Baja California Sur Psychiatric Hospital.
[72] State of Chihuahua. Chihuahua and Baja California Health Institute (Baja California State Institute of Psychiatry).
[73] State of Guadalajara. Comprehensive mental health care center for long-term and short-term stays.
[74] State of Puebla (Long-term Inpatient Care)
[75] Yucatán Psychiatric Hospital
[76] Dr. Gustavo Leon Mojica Garcia Psychiatric Hospital (Aguascalientes)
[77] Ramón de la Fuente Muñiz National Institute of Psychiatry (Mexico City), State of Aguascalientes, State of Chihuahua, State of Oaxaca, State of Michoacán, Baja California Sur Psychiatric Hospital.
[78] Testimonials
[79] Testimonials
[80] Testimonial
[81] Testimonial

been institutionalized for years, told the Committee that their placement was due to factors such as abandonment since childhood because of a disability, the lack of psychosocial support to help families understand and accept the disability, and barriers to accessing community services.

67. The lack of community support and protection against violence against people with disabilities within the family is another factor that has allowed institutionalization to persist. Given the insufficient availability of foster families or direct support for children with disabilities, in cases of domestic violence, they are institutionalized, losing their chances for inclusion in the community. Gender- and age-based violence affecting older adults and women, girls, and adolescents with disabilities is one of the main causes of institutionalization, given that psychosocial support services are difficult to access or nonexistent.

68. Similarly, the perception that people with psychosocial and/or intellectual disabilities are dangerous is used to justify forced institutionalization. The Committee interviewed individuals admitted to psychiatric hospitals who were admitted following incidents of domestic violence, based on perceptions of disability and dangerousness. Such situations could be resolved through psychosocial support and conflict resolution mechanisms within the community.

69. Institutionalization persists as a social practice because it remains associated with compassion, charity, and the rehabilitation of people with disabilities—concepts that carry altruistic connotations. Furthermore, the lack of community-based mental health services contributes to the continuation of institutionalization, which affects people with disabilities.

70. The causes of institutionalization cut across all social spheres. However, they primarily affect those living in rural areas, rural residents, and those in low-income socioeconomic strata.

7. Situation in private, unregulated, and/or unmonitored institutions

71. The Committee noted with concern that institutionalization is spreading through a variety of private institutions, many of which operate irregularly, without registration or State oversight. This is the case with institutions operating in residential garages or as addiction rehabilitation centers, where people with disabilities and addictions face recurrent involuntary confinement.[82] According to information provided to the Committee, there are reportedly around 4,000 such institutions, where children, adults, and elderly people with disabilities are institutionalized without their consent and exposed to severe overcrowding and cruel, inhuman, and degrading treatment. Additionally, such institutions may cease operations and be dismantled without providing information on the situation and fate of the people they housed.[83]

72. The Committee underscores its concern regarding information received concerning private and unregulated institutions in states such as Baja California, the State of Mexico, and Guerrero.[84] According to available data, some institutions operate in homes characterized by squalor, overcrowding, and unsanitary conditions, where adults and children with disabilities share a single living space.[85] Other institutions operating as rehabilitation centers lack the training to provide such rehabilitation and also fail to meet minimum hygiene and sanitation standards, and where rooms have locks and external barriers.[86]

73. Equally concerning is the available information regarding incidents of inhuman and degrading treatment, including physical, chemical, and mechanical restraints, and violence—including sexual violence—in specialized centers for the treatment of

[82] Testimonial
[83] Testimonial
[84] Testimonial
[85] Pequeño Mundo Especial Institution in Baja California;
[86] Fortalécete en Cristo Rehabilitation Center.

addiction in states such as Aguascalientes, Colima, Coahuila, Hidalgo, Jalisco, Morelos, Nayarit, Oaxaca, Querétaro, and Tlaxcala.[87]

74. Given the proliferation of institutions and forced institutionalization, the Committee is concerned that initiatives by nonprofit organizations to provide temporary shelters for persons with disabilities who have been subjected to sexual violence in institutions are being discouraged. The Committee received deeply concerning information indicating that state authorities threatened members of social organizations with potential criminal investigations if persons with disabilities left or "escaped" from the institutions where they had been placed to go to the temporary shelter.[88] Such practices undermine survivors of violence and institutionalization's access to mechanisms for redress and reparation, as well as civil society's role in promoting and protecting the human rights of persons with disabilities.

8. Involuntary transfers and reinstitutionalization of people with disabilities

75. Once institutionalized, people with disabilities are subject to involuntary transfers between institutions within the same city, between states, or from state institutions to those under federal authority. Such transfers generally occur without the consent of the individuals with disabilities and without informing family members or community contacts. Transfers also involve children and adolescents with disabilities who are sent from private in t institutions in states such as Nuevo León or Quintana Roo to private psychiatric clinics in other states such as Veracruz[89] . Transfers are used as a substitute for an individualized deinstitutionalization plan for people with disabilities, the provision of support for independent living, and their inclusion in the community. Transfers of children and adolescents also occur pursuant to decisions by the Federal and State Offices of the Attorney General for the Protection of the Rights of Children and Adolescents, in compliance with restitution plans.

76. The Committee is concerned about reinstitutionalization as a systematic pattern that deprives persons with disabilities of the opportunity to leave institutions and choose housing options within the community. The Committee was informed of several cases of women with psychosocial and/or intellectual disabilities who had been subjected to arbitrary and successive transfers from defunct institutions such as Casa Esperanza to Social Assistance and Integration Centers in Mexico City.[90]

77. The Committee received testimony from a woman with a disability who recounted that she had been institutionalized in seven facilities, including those administered by religious communities in different states, from infancy through adulthood. In her testimony, she noted that she remained in forced institutionalization where she was exposed to various forms of abuse and was only released following legal actions on her behalf initiated by civil society organizations.[91] The Committee was also informed of the case of a woman who grew up in the state of Aguascalientes and was sent to a psychiatric institution in another state, where she was a victim of physical and sexual violence, and from there was transferred to another institution in Mexico City. She received neither psychosocial support nor reparations for the sexual assaults she suffered; instead, she was successively transferred to institutions where she faced further assaults and new traumas.[92]

78. Likewise, the Committee received information regarding several persons with disabilities who were arbitrarily transferred from the Granja la Salud psychiatric

[87] Cases documented by the National Mechanism for the Prevention of Torture of the National Human Rights Commission in 2022. See: Addictions | National Human Rights Commission - Mexico

[88] Testimony

[89] Information from the National Transparency Platform (PNT): cardPNT1750799639542 (2024); PNT card 1750799639542 (2023); PNT card 1750809618575 (2017); PNT card 1750809995780 (2027).

[90] Testimony.

[91] Testimony

[92] Testimony

institution to private facilities, thereby increasing the barriers to learning about their current situation or the possibility of their return to the community.

79. Arbitrary transfers between institutions can occur within the context of a continuous period of institutionalization or one interrupted by temporary discharges. The Committee heard from people with psychosocial disabilities living on the streets who had been forcibly institutionalized on multiple occasions and in different institutions for periods of less than one year. Due to the lack of support for independent living in the community, people with disabilities who had been released were left exposed to homelessness. Homelessness has exposed people with disabilities to various forms of violence, secondary trauma, and revictimization, as well as increased mental health needs and reinstitutionalization. Civil society provided information to the Committee confirming the serious difficulties faced by persons with psychosocial and/or intellectual disabilities in reintegrating into society after being institutionalized for the first time, given the back-and-forth between institutional settings and the community.[93]

80. The Committee also received information regarding cases in which transfer between institutions has led to the disappearance of persons with disabilities, as individuals who were institutionalized without their consent were subsequently transferred to unknown destinations.

81. The Committee is concerned by the testimonies of women and men with disabilities interviewed in institutions, who stated that they were there as a result of readmissions. This information was corroborated in the admission records of both private and public institutions. The reasons why people have been reinstitutionalized are manifold, including the lack of alternatives to institutionalization, loss of contact with family or the community of origin, and unresolved intra-family crises and conflicts that lead to the reinstitutionalization of family members with actual or perceived disabilities.

B. Groups at highest risk of institutionalization

1. Institutionalization of children and adolescents with disabilities

82. The lack of support for independent living and community inclusion is a major cause of institutionalization affecting children and adolescents with disabilities. The Committee noted with great concern that children and adolescents with disabilities—especially those living in poverty and extreme poverty—are frequently at risk of institutionalization in Mexico. This is a consequence of the lack of support for family and community-based living, exacerbated by barriers and a lack of support for accessing inclusive and quality education.

83. The Committee received information indicating that, as of March 2024, in 44 social welfare centers with a care model designed for children and adolescents with disabilities, there were 541 institutionalized girls and female adolescents and 573 institutionalized boys and male adolescents. The highest number of children aged 0 to 15 in institutional care is found in Nuevo León, Yucatán, Puebla, Sinaloa, Jalisco, Querétaro, Mexico City, the State of Mexico, Chihuahua, Baja California, Morelos, Michoacán, Durango, and Chiapas.[94] It is estimated, however, that at least 140,000 children and adolescents, including children with disabilities, are institutionalized in places such as psychiatric hospitals, special boarding schools, unregulated private institutions, and rehabilitation centers.

84. Institutionalization is permitted under legislation that continues to authorize the use of residential care measures for children with disabilities—that is, the deprivation of liberty based on disability. Indeed, the General Law on the Rights of Children and

[93] See Documenta “For Necessary Reasons?” p. 183.

[94] PowerPoint presentation by the Ministry of Health and the National System for Integral Family Development. Data as of March 2024.

Adolescents[95] contains provisions that promote the right to substantive equality, family life, and community inclusion alongside those that permit the use of residential care in social welfare centers.[96] Such residential care primarily affects children and adolescents in situations of marginalization due to factors such as disability, poverty, or immigration status.[97] The legislation states that residential care is of a subsidiary nature and should be for the shortest possible time. In practice, however, institutionalization takes precedence over the search for alternatives that would allow children and adolescents with disabilities to remain in their family units and prevent separation based on disability.

85. Institutionalization due to disability and poverty frequently occurs in the context of decisions made by authorities within the Comprehensive Family Development System. The Committee received information regarding practices that result in the "referral" or transfer of children with disabilities to various institutions, including social welfare centers. It also noted gaps in the implementation of measures that would allow children and adolescents with disabilities to remain in their family of origin, extended family, or foster family, or to be placed in a foster family by the Comprehensive Family Development System. Programs promoting foster families are, in fact, scarce; they are not developed in all states or are only developed to a limited extent. The Committee notes with concern that special protection measures other than residential care for children and adolescents with disabilities are implemented only to a limited extent.[98] Additionally, the legislation lacks provisions on reasonable and procedural accommodations for children and adolescents with disabilities in proceedings to decide on the imposition of a special measure, including residential care. The Committee was also informed of the lack of certified families for foster care as an alternative care mechanism to ensure the best interests of the child.

86. DIF system officials still perceive institutionalization as the primary option available to address the needs of children in precarious situations, particularly when it comes to children and adolescents with disabilities or exhibiting negative or at-risk behavior. This is a consequence of the limited support available to enable families to care for their children. The Committee noted with deep concern that some authorities consider an effective "intervention" to be any action by the DIF that results in a decision for residential care.[99] The general perception that there are no alternatives to institutionalization perpetuates the system's reliance on institutionalization and prevents action in favor of the inclusion of children and adolescents with disabilities in the community.

87. The lack of support to enable families to keep their children at home primarily affects families living in poverty. In particular, the economic dimension of institutionalization reveals the stigmatization of families with members with disabilities—whether parents or children—who face situations of poverty. For children and adolescents with disabilities who are members of families lacking economic resources, the prospect of institutionalization remains ever-present, and with it, abandonment and permanent segregation from the social environment. The Committee was informed of situations in various group homes in states such as Guanajuato, Morelos, Puebla, and Querétaro, where more than 60 percent of placements result from situations of poverty.

88. The Committee received several testimonies from people with disabilities who had survived institutionalization; they had been separated from their families—typically single-parent households—and grew up in closed institutions, where, over time, they lost contact with their families. Similarly, single mothers in situations of economic hardship lost their children as a result of "protective measures" implemented by the DIF authorities, consisting of the separation of their sons and daughters and

[95] Amended May 27, 2024. See Arts. 53 and 55
[96] Ibid. Art. 4 II; V; Art. 26
[97] Ibid., arts. 107 and 108.
[98] Ibid., Art. 10.
[99] Testimony

their placement in state care centers, followed by transfer to residential facilities in other states.[100]

89. The Committee is deeply concerned that single mothers with disabilities and those with children with disabilities face greater challenges in retaining and maintaining custody of their children within the framework of DIF procedures. The Committee learned of cases involving mothers with psychosocial disabilities who have sought to escape abuse and who were subjected to institutionalization and unjustifiably separated from their children. The Committee is concerned that in such cases, women with disabilities were deemed "unable to care for their children" due to the stigma and stereotypes that prevail regarding disability

90. Under residential care, children and adolescents with disabilities are overexposed to violence, mistreatment, and abuse, contrary to the protective aims of the legislation. Institutional care also exposes children with disabilities to adoption processes with a maximum duration of [6] months.[101] In many cases, children and adolescents with disabilities are institutionalized, separated from their families, and declared abandoned or neglected, making them eligible for adoption—a process that often results in permanent separation from their biological families due to their disability.

91. The Committee was made aware of several cases of children and adolescents with disabilities who were institutionalized, whose parents were promised an improvement in their children's lives and that the stay in the residential system would be temporary. However, once inside the institution, the children's stays were extended indefinitely, citing a lack of identification documents, despite the fact that the mothers had provided birth certificates. As a result, it is common to find incomplete files that prevent efforts to return the children to their families of origin or extended family from being followed up.

92. In interviews with children and adolescents with disabilities and their families, the Committee noted with concern the lack of support for children and adolescents with disabilities in the community. In the State of Mexico, parents and relatives of children and adults with disabilities have established social organizations that manage support programs for their family members with disabilities, including support for personal care, the development of work skills, support for access to mainstream education, income-generating activities, and information in Easy-to-Read format.[102] These initiatives, however, lack support from the state or federal government.

93. The Committee is also concerned about the information provided regarding children and adolescents with disabilities in the state of Baja California who remain in institutions during the day, particularly during their parents' work hours, due to the lack of support in community settings.[103]

94. The lack of quality mental health care in the community—which would allow children and adolescents to remain with their families—is also a major cause of the institutionalization of adolescents with disabilities. The Committee learned of cases of adolescents who were admitted to psychiatric hospitals following suicide attempts. Adolescents lacked support for managing their mental health in their communities, and therefore, it was decided to admit them to hospitals. Various sources confirmed to the Committee the absence of foster families, foster families with support, and/or foster families with therapeutic resources for children and adolescents.

95. The Committee notes with concern that programs for the development of children with disabilities and their access to health care, education, and sexual and reproductive health are limited and lack coverage in all states. In fact, children and adolescents with disabilities are at a disadvantage in accessing education compared to their peers

[100] Testimony
[101] During the visit, it was announced that the term would be reduced to 3 months.
[102] Testimony
[103] Testimony

without disabilities. Additionally, the institutionalization of children and adolescents with disabilities also leads to their withdrawal from school.

2. Indigenous children with disabilities and children with disabilities living in rural areas

96. The lack of community-based support systems similarly affects indigenous children with disabilities and those living in municipalities and/or rural areas of municipalities with indigenous populations. In interviews with indigenous children and their families, it was observed that they have difficulty accessing support for community living beyond what their parents can provide. Furthermore, they lack access to regular education, and habilitation and rehabilitation are provided only on a limited basis through the volunteer work of civil society organizations that lack support from state governments.

97. The Committee interviewed children with intellectual and/or psychosocial disabilities, as well as hearing impairments, who described that community gathering spaces, playgrounds, and sports facilities are located in the center of the municipality, which is difficult to access. The Committee is concerned about the lack of activities that allow children with disabilities to interact and develop community ties on an equal footing with other children.[104]

3. Institutionalization of women with disabilities

98. The lack of psychosocial support in the community for women with disabilities who are victims of violence is one of the main causes of the institutionalization of women with disabilities. According to available data, at least 72 percent of women with disabilities in Mexico City had experienced gender-based violence, and less than 12 percent had sought and received psychosocial support from public agencies for protection against gender-based violence.[105] In these cases, institutionalization has been presented as the only option for accessing psychosocial care services. This is despite the fact that places of confinement pose an additional risk of violence. The Committee received information regarding private-type shelters, where 90 percent of the women reportedly faced gender-based violence, primarily sexual violence, including the exploitation of women through prostitution.[106]

99. Stereotypes and discrimination against women with disabilities, particularly as they intersect with gender, age, socioeconomic status, immigration status, refugee status, or asylum-seeker status, sexual orientation, and membership in indigenous and Afro-descendant communities, expose women with disabilities to a higher risk of institutionalization. Institutionalization is also used as a response to the lack of quality mental health care in the community and as a consequence of the inadequacy of community-based services. This particularly affects women with intellectual and/or psychosocial disabilities, who are more at risk of losing their autonomy through the deprivation of rights and subsequent institutionalization. Persistent gaps in access to primary, secondary, and tertiary education[107] and exclusion in the areas of health, sexual and reproductive health, mental health, work, and cultural life increase their marginalization and lead to institutionalization.

100. The Committee noted with deep concern gender-based violence, abuse, and revictimization, as well as the lack of protection for women with disabilities who are institutionalized. The information provided to the Committee reveals recurring cases of violence, such as forced sterilization, forced abortions, and pressure to be separated

[104] Testimonials

[105] 2020 survey. Interdisciplinary Center for Childhood and Parenthood Rights (CIDIP) cited in the report by Mexicanas con Discapacidad and Women Enabled International. “Submission to the CRPD Committee,26thsession, for the Review of Mexico. February 14, 2022”

[106] Testimonials

[107] INEGI, *Disability in Mexico, 2014 data* 54 (2017), https://www.inegi.org.mx/contenidos/productos/prod_serv/contenidos/espanol/bvinegi/productos/nueva_estruc/702825094409.pdf.

from their children. Likewise, information was received regarding abuses within the context of mental health services, such as the lack of safe spaces that ensure confidentiality and the inability of women with disabilities to access temporary shelters. The Committee learned of cases involving women with psychosocial and/or intellectual disabilities in public social assistance centers in Mexico City who faced physical, sexual, and psychological violence.

101. Women and girls with disabilities in institutions face isolation in environments that resemble those of detention centers. Similarly, institutionalization entails separation from their communities and/or family environments. The testimonies received by the Committee revealed situations of helplessness and despair among many women who insisted on their desire to leave the institutions and reunite with their families.

4. Institutionalization of people with psychosocial and/or intellectual disabilities living on the streets

102. People with disabilities living on the streets are at risk of experiencing violence based on gender and disability. Living on the streets also exposes these individuals to a higher risk of being institutionalized. People with psychosocial and/or intellectual disabilities are more likely to be placed in social welfare centers if they face homelessness, abuse, and/or abandonment. Once in institutions, they face greater obstacles to regaining their freedom and living in the community. The Committee received information on cases of women with psychosocial disabilities living on the streets who were subjected to institutionalization and arbitrary transfers between institutions due to the lack of community-based measures and support to address mental health crises.[108]

103. Institutionalization frequently affects people with psychosocial and/or intellectual disabilities living on the streets, including those who use psychoactive substances. Available information indicates that police authorities detain people living on the streets and take them to rehabilitation centers. Such detentions are reportedly used as a mechanism to remove these individuals from public spaces, as a form of social cleansing intended to keep public areas suitable for tourism. These institutionalizations lack judicial orders or administrative procedures to regulate the conditions for admission and continued stay of individuals in these institutions.[109]

104. Similarly, people with disabilities who are homeless and/or abandoned are referred to the National System for Integral Family Development, which in turn refers them to institutions known as care centers. The Committee received several testimonies from people with psychosocial disabilities in Mexico City who were subjected to involuntary institutionalization while living on the streets and subsequently to arbitrary transfers between institutions. In their testimonies, they reported that the institutions were closed and they were prohibited from leaving. Those who were able to leave the institutions did so with the support of civil society organizations that provided them with support for community living.[110]

105. The Committee received with great concern information regarding rehabilitation centers operating in the state of Baja California in an irregular manner and without registration[111] , and implementing the so-called practice of “The Spiritual Patrol.” The purpose of these centers is the rehabilitation of homeless individuals and those dependent on psychoactive substances. According to the information received, members of the so-called Patrol drive through the streets in vehicles looking for homeless people who appear to be using psychoactive substances; they detain them and transfer them to one of the rehabilitation centers for periods lasting at least six

[108] See Documenta in “Por Razón Necesaria?”
[109] Testimony
[110] Testimonials
[111] Testimony

months until they are considered "rehabilitated." The Committee was also informed of physical violence and even the death of people admitted to these centers.

106. Information was also received regarding people with intellectual and/or psychosocial disabilities living on the streets in the municipality of Acapulco, state of Guerrero, who have been detained by the police and sent to rehabilitation centers. In these facilities, individuals face unsanitary, degrading conditions, and overcrowding.[112]

107. People who have been living on the streets and are institutionalized find themselves in a state of extreme vulnerability and defenselessness in the face of the risks of violence. Given that people with disabilities living on the streets have generally lost ties to social support networks, once in institutions they have difficulty accessing support to return to the community. Additionally, if they have faced gender-based and/or disability-based violence, they lack the information needed to seek protection and access to justice for the violations of which they have been victims.

5. Institutionalization of migrants, asylum seekers, and refugees with disabilities

108. The context of migration in Mexico specifically affects people with disabilities, including those who have acquired a disability during the migration journey.[113] According to estimates, there were at least 240,000 migrants detained in Mexico as of June 2023, and at least 126,000 migrant children had been sent to centers administered by the National System for Integral Family Development.[114] According to information provided to the Committee, at least 20 percent of unaccompanied migrant children and adolescents involuntarily returned from third countries would remain in institutions for several months and/or years if their families of origin could not be identified.

109. Migrants with disabilities face institutionalization and administrative detention on the grounds of their disability and their migration status. The Committee received information regarding dozens of persons with disabilities who are held in migration and/or rehabilitation centers located in border areas, in states such as Baja California, where they may remain detained for several months. Many of these institutions are privately run and operate without a license and in the absence of official oversight. In these institutions, children, adolescents, and adults with disabilities, migrants, and people with substance use disorders are held together without distinction; they lack access to supports for community living and are exposed to violence, including sexual violence and abuse.

110. The Committee received information regarding cases of adult male migrants with disabilities who are survivors of institutionalization in addiction rehabilitation centers and who were victims of rape and sexual abuse.[115] Similarly, it was informed of practices of isolation and physical restraints, including being tied to beds for several consecutive days as a result of punishments and/or disciplinary measures imposed on individuals deemed to have engaged in misbehavior in such rehabilitation centers. People with disabilities in such rehabilitation centers are also subjected to isolation in "detoxification" rooms for several consecutive days, under completely unsanitary conditions. There is information regarding cases of individuals with psychosocial disabilities who, after being deported from the United States, were sent to rehabilitation centers and, once there, were subjected to isolation for the purpose of "detoxification."

[112] Testimony

[113] In 2023, 43.94 million people entered Mexico legally, while 782,176 entered illegally and were subject to administrative immigration proceedings. 113,660 children and adolescents were in an irregular situation in 2023. Of this figure, 72% were children up to 11 years old and 28% were children between 12 and 17 years old. Ministry of the Interior. Migration Policy, Registration, and Identity Unit.

[114] Group on Arbitrary Detention. 2024 Visit Report.

[115] Testimony

111. The Committee also learned of cases involving migrants with disabilities who have been detained as part of immigration proceedings and sent to psychiatric hospitals, where they remain for several months. According to official information, people with disabilities have been referred, for example, to nursing homes and psychiatric hospitals. In migrant centers, people are locked up; the dormitories can only be opened from the outside, and there are surveillance cameras that allow for monitoring of every corner of the area where people spend the night.[116]

6. Institutionalization of Older Adults with Disabilities

112. According to the latest population census, half of people with disabilities are over 60 years of age. The Committee observed many older women and men with disabilities in the institutions visited. Older adults are subject to institutionalization due to their age, disability, and the lack of support for independent living in the community.

113. Older adults with disabilities may spend their days bedridden, without access to stimuli to live independently or to personal assistance. The Committee noted with concern the cases of older women who have lost contact with their families after being institutionalized.

114. The Committee expresses concern regarding the lack of statistical systems that account for the proportion of older persons with disabilities in institutions, as well as regarding mechanisms to raise awareness of their situation and develop age-appropriate supports for community living.

C. Insufficient support systems for independent living in the community

1. Absence and lack of understanding regarding support systems for independent living

115. The welfare-oriented approach toward people with disabilities persists in legislation and public policies, which are dominated by concepts such as “assistance,” “well-being,” and “care.” In this context, the concept of support and measures to support independent living lack legal and practical development. Psychiatric treatment and rehabilitation continue to be the State’s primary response to persons with disabilities, particularly when it comes to persons with intellectual and/or psychosocial disabilities.

116. The Committee received information regarding persons with disabilities who lack support at home and/or in the community when they need it and whose only option is to turn to general health services provided in public hospitals. Several testimonies from persons with disabilities in institutions show that residents are there as a last resort due to the lack of community support that would allow them, for example, to work, earn an income, and access personal assistance.[117]

117. Cases were identified in which, through the initiative and willingness of institutional authorities, people with disabilities were supported to live in the community, obtain employment, and access adequate housing. These cases demonstrate that an institutional approach to deinstitutionalization is possible.

2. Institutionalization prevents people with disabilities from accessing supports for independent living and pensions

118. In institutions, the lack of individualized support is widespread. Additionally, there are limitations on the availability of staff who can provide individualized support, including through personal assistance. The absence of permanent programs for integration, mobility, and job training, as well as habilitation and rehabilitation, is

[116] Testimony
[117] Testimonies

concerning. People with disabilities remain in institutions without a life plan, without opportunities to learn, develop, or enhance their abilities. Occasional domestic tasks, such as laundry or cooking, are the only activities to which women have access in some social welfare centers.

119. People with disabilities also face legal and practical barriers to receiving direct financial support for independent living. The law allows public funds to be allocated to institutions rather than making direct payments to people with disabilities. In this context, there have been cases of organizations of people with intellectual and/or psychosocial disabilities that have formed as civil society organizations to advocate for people with disabilities' access to individualized budgets for independent living, yet these resources are not provided to them due to their disability. This legal barrier prevents people with disabilities from leaving institutions and returning to community life with the financial support they require.

120. Likewise, information was received regarding cases of people with disabilities residing in private group homes who, despite having been granted access to a disability pension, had the funds withheld by the institution.[118] The Committee observed cases in which people with disabilities stated they were aware of the existence of pensions, but in practice did not have access to cash or bank accounts in their own names.

121. Despite the allocation of resources, institutionalized individuals rely on donations for something as basic as clothing, which reveals a serious neglect of their essential needs. In some places, they are dressed uniformly. For example, in a completely sterile area, all residents were wearing white pajamas.

D. Structural barriers that prevent access to community services

122. People with disabilities face barriers to accessing community services on an equal footing with others. Barriers to accessibility in the physical environment, attitudinal barriers, and barriers to accessing information for participation in education, health, employment, sports, and cultural life in the community are prevalent. Such barriers lead to the isolation of children and adults with disabilities, who often remain confined to home life, with few options for community participation and at risk of institutionalization.

123. In rural areas, community services are generally scarce or difficult to access, and institutions located in rural areas are isolated and lack basic services for the people with disabilities who live there.

124. The Committee noted that the inclusion of persons with disabilities has been incorporated into the objectives of public policies and the language of various authorities interviewed. This objective, however, contrasts with a limited understanding of the nature and type of individualized community support services for persons with disabilities. It is concerning that programs still lack measures to facilitate the inclusion of people with disabilities who are in institutions and those who have been subject to institutionalization. Furthermore, the few existing community services, being limited in the services they offer, end up referring people with disabilities to institutions.

1. Educational gap and emphasis on special and segregated education increase the risk of institutionalization

125. The Committee received information regarding the educational gap that continues to affect children, adolescents, and adults with disabilities. According to available data, at least 80 percent of persons with disabilities aged 15 and older do not attend school; only 45 percent have completed primary school, 23 percent have no

[118] Testimonies

schooling, and only 7 percent have completed higher education.[119] According to the ENADIS survey, while 96% of children aged 6 to 14 are enrolled in school, only 80% of children with disabilities have access to education.[120]

126. The State party maintains special education services that are not in line with the Convention and hinder progress toward consolidating quality inclusive education for persons with disabilities. In the State of Mexico[121] , the Committee received testimony from a couple of grandparents, older adults, who are caring for their two grandchildren on the autism spectrum, 5-year-old twins. The grandparents explained that the children were moved from the city of Cancún due to a lack of age-appropriate support. Although their grandparents work hard to provide for their grandchildren, the children lack access to quality mainstream education that would allow them to develop skills and participate in the community.

127. The lack of individualized support to enable access to and retention of children with disabilities in mainstream schools poses a constant risk of institutionalization for children with disabilities. The Committee is alarmed by the stigma that persists against children with disabilities in education and in the practice of psychiatry. The Committee learned of the case of a 10-year-old boy with an intellectual and/or psychosocial disability in Mexico City who attended a special school. Given the lack of support for the child, his family, and the teacher at the school, the child was referred to an addiction treatment facility, where he was subjected to physical violence; he was discharged from there and subsequently reinstitutionalized.[122]

128. The Committee also noted with great concern the inability of institutionalized girls and young women to access education. The institutions visited by the Committee lacked inclusive education plans and programs for persons with disabilities. These institutions had not entered into agreements with schools and universities that would allow children and adults with disabilities to pursue any educational program.

129. The Committee received with great concern information indicating that in some institutions where girls with disabilities and girls who have been institutionalized as a result of sexual violence or suicide attempts are housed together, girls with disabilities remain confined to their dormitories, without access to educational activities, while the other girls are enrolled in school and attend classes regularly.[123]

2. Barriers to Accessing Mental Health Care and Community-Based Habilitation and Rehabilitation

130. The Committee noted with concern that quality mental health care and habilitation and rehabilitation services remain very limited and, in some cases, nonexistent. This situation significantly impacts persons with disabilities living in rural areas and/or marginalized parts of cities and municipalities. The Committee interviewed persons with disabilities living in rural areas of Oaxaca, for whom mental health care and rehabilitation programs are difficult to access and located far from their homes.[124] It also received information regarding rehabilitation programs in states, which are age-restricted to children up to 6 years old due to the stigma against persons with disabilities and their learning capacity beyond that age.[125]

131. Furthermore, the Committee is concerned that access to alternatives to psychiatric care in mental health crisis situations is limited. It is also concerned about the lack of support for initiatives by organizations of persons with disabilities in the

[119] See the report by the Mexico Coalition for the Rights of Persons with Disabilities (2022) submitted to the Committee on the Rights of Persons with Disabilities. tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCRPD%2FCSS%2FMEX%2F47920&Lang=en

[120] ENADIS. 2018 Newsletters

[121] Testimonials

[122] Testimony

[123] Testimonials

[124] Testimonials

[125] Testimonials

area of mental health, which could offer alternatives to institutionalization. Some mental health services are provided through 343 community centers for mental health and addictions (CECOSAMAs). In these institutions, psychiatric services are limited, and individuals are transferred to federal psychiatric hospitals far from their home communities within the state[126] or referred to telemedicine services.

132. The institutions visited face deficits in habilitation and rehabilitation services for people with disabilities. Only some of the institutions provided rehabilitation activities; however, these were conducted in group settings and with limited human resources to implement individualized processes and plans tailored to rehabilitation requirements. In some of the psychiatric hospitals, the rehabilitation areas were under renovation or closed, and people with disabilities reported having no knowledge of or involvement in habilitation and rehabilitation activities since their admission to the institution.[127]

133. Available information indicates that, in other institutions, people with disabilities lack access to rehabilitation consisting of speech therapy or physical rehabilitation, and the only form of support offered to them consists of services for personal hygiene or feeding.[128]

3. Limited access to employment

134. According to available information, people with disabilities work primarily in the informal sector of the economy.[129] Additionally, programs designed to promote the labor inclusion of people with disabilities had limited coverage for people with disabilities who were institutionalized.[130]

135. The Committee heard of cases involving people with disabilities who live in the community but lack opportunities to access the labor market or generate income. In the State of Mexico, cases were reported of young adults with disabilities who face serious obstacles to participating in the workforce and pursuing their careers. A 40-year-old woman with a disability interviewed by the Committee recounted that opportunities to practice her profession as a lawyer became nonexistent after her diagnosis of multiple sclerosis, as she lacks support for mobility, health, rehabilitation, and accessible technologies that would allow her to work and interact in the community. Likewise, the Committee heard testimony from a deaf musician and a deaf-blind teacher who, with the necessary support, would have opportunities to live in the community; however, their lives are spent at home.

4. Lack of access to accessible and affordable housing for persons with disabilities

136. The Committee is concerned that access to housing for persons with disabilities is limited and that women with disabilities and those living in precarious socioeconomic conditions face structural barriers to accessing accessible housing in the community. Likewise, it is concerned that persons with intellectual and/or psychosocial disabilities under guardianship or conservatorship face obstacles in accessing housing, given their inability to enter into contractual relationships that would allow them to buy, sell, or rent real estate.

137. The Committee also underscores its concern regarding the absence of measures in legislation and policies to ensure access to housing for persons with disabilities who

[126] Testimonial

[127] Testimonials

[128] Testimonials

[129] Report by the Mexico Coalition for the Rights of Persons with Disabilities (2022). https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCRPD%2FCSS%2FMEX%2F47920&Lang=en.

[130] For example, the National Program on Work and Employment for Persons with Disabilities 2021–2024.

are in institutions or who have been in them. Housing policies and programs, while in some cases targeting people with disabilities—such as the Social Housing Program, the "Hogar a tu medida" program, or Mexico City's "Vivienda en conjunto" program—are disconnected from deinstitutionalization plans for people with disabilities. Furthermore, information on housing access for people with disabilities who have been institutionalized is scarce and is not disaggregated by factors such as sex or age[131].

138. People with disabilities who have left institutions after prolonged stays face greater obstacles to reintegration, particularly regarding access to decent housing. Furthermore, housing program requirements—such as proof of a formal employment contract or specific individual and combined income thresholds—constitute a barrier for people with disabilities who were institutionalized, particularly for extended periods. This is because they remain subject to systems that restrict their rights, lack accessible information, or lack the minimum financial resources to apply and be considered eligible candidates for housing subsidies.

E. Disability-based violence and cruel, inhuman, and/or degrading treatment in the context of institutionalization

1. Disability- and gender-based violence

139. The Committee received with deep concern the testimonies and information regarding various forms of violence affecting children and adults with disabilities in institutional settings, some of which have been reported by the media.[132] The violence often began with forced institutionalization and continued throughout the period of institutionalization in various types of institutions, such as social assistance and integration centers, social rehabilitation centers, psychiatric hospitals, or institutions administered by private organizations.

140. Between January 2018 and May 2024, the National Human Rights Commission received 2,896 complaints, of which 245 involved persons with disabilities in psychiatric hospitals, 543 in shelters, and 28 in group homes.[133] These complaints primarily concerned the physical and psychological well-being of persons with psychosocial and/or intellectual disabilities. The Committee notes with concern the underreporting of cases of violence, both at the federal and state levels.

141. According to the information provided to the Committee, persons with disabilities face disability- and gender-based violence, including physical violence, psychological violence, and abuse; bullying; and sexual violence, including rape, harassment, sexual abuse, and sexual exploitation, which affects both children from an early age and adults. Some sources have also documented the withholding of health information, precarious living conditions, and unsanitary conditions as common forms of violence in places of detention.[134] In some institutions, the Committee found forms of exploitation associated with forced labor in cleaning tasks and the care of other detainees in the institution, which staff often justified as a form of "collaboration" that residents "enjoyed."

142. The Committee received with deep concern information regarding violence and ill-treatment in several private institutions. In particular, it received information about children with intellectual disabilities who were victims of beatings, kicks, and corporal punishment, and about children who must fight to obtain food in institutions such as homes for migrant children.[135]

[131] The State Party reported that, between January 2020 and March 2024, 42,123 homes (5% of the total) were financed that had at least one accessibility feature at the time of appraisal or mortgage application, benefiting people with disabilities. Information provided in April 2025.
[132] Testimonials
[133] Testimony
[134] Testimony
[135] Testimony

143. At the now-defunct "Casa Esperanza para Deficientes Mentales" (House of Hope for the Mentally Disabled), which was located in Mexico City, forms of violence documented by civil society indicate that both children and adults were restrained in cage-beds and subjected to sexual abuse, rape, and forced sterilization. In several institutions operating in the states of Guanajuato, Michoacán, and Querétaro under the administration of the entity "Ciudad de los Niños, Salamanca A.C.," the National Human Rights Commission documented serious human rights violations against 536 people with disabilities. In its ruling, the Commission concluded that there were situations of neglect of children and adults with disabilities, inhuman and degrading conditions, torture, physical violence—including beatings with sticks and burns inflicted as a form of corporal punishment—psychological violence, and sexual violence, including widespread incidents of rape and sexual abuse, as well as indications of human trafficking. Likewise, violations of the right to identity, health, education, the free development of personality, dignified treatment, and the best interests of the child were documented.[136]

144. Furthermore, the Committee received information regarding the case of the now-defunct institution "La Gran Familia," where serious violations against children and adults were also documented as a result of abandonment, sexual abuse, human trafficking, forced abortions, corporal punishment, the corruption of minors, and medical negligence. In that case, the National Human Rights Commission concluded that various authorities had failed in their duty to protect, noting that the violations occurring at that facility had been reported for several years without any action being taken to remedy the harm caused.[137]

2. Sexual violence and forced sterilization

145. Institutionalization places people with disabilities in unequal power dynamics that are exploited to perpetrate and perpetuate violence against them. Sexual violence in institutions, as well as forced sterilizations and/or the use of contraceptive methods, are forms of violence based on gender and disability that particularly affect women with disabilities in institutions.

146. The Committee received information on many cases of sexual violence, including harassment and rape against women, girls, men, and boys with disabilities in institutions. Despite the underreporting of cases of sexual violence, more cases are known of women who have faced sexual violence. Sexual violence occurs in different types of institutions, and some people with disabilities have faced sexual violence in the various institutions where they were institutionalized. Transfers of individuals from one institution to another perpetuated sexual violence and prevented access to remedies for the harm caused.

147. The reports of widespread abuse—including sexual abuse, harassment, and rape of children and adolescents in institutions—are deeply concerning, as these individuals were exposed to sexual violence and abuse from a very young age. Such cases remain unpunished.[138] In some instances, child victims of sexual abuse were transferred to other institutions where they were once again subjected to sexual violence, including rape. Children exposed to these forms of violence lack access to psychosocial support and measures to protect their physical and psychological well-being. On the contrary, some girls who were victims of rape and became pregnant were subjected to arbitrary transfers during their pregnancy and then sent back to the institutions but without their babies.

148. Federal legislation classifies forced sterilization as a crime. However, health regulations prescribe sterilization in cases involving persons with intellectual and/or psychosocial disabilities.[139] In fact, authorities at the Ministry of Health have confirmed that sterilizations may be performed based on the consent of guardians. The

[136] National Human Rights Commission. Recommendation 32VG/2020. In: RecVG_032_.pdf
[137] National Human Rights Commission, Recommendation 14VG/2018. RecVG_014.pdf
[138] Testimony
[139] Official Mexican Standard for Family Planning Services. DOF - Official Gazette of the Federation

Committee noted, however, that the stigma against persons with disabilities regarding the exercise of their sexuality has encouraged forced sterilization as a means of preventing the exercise of parental rights and the right to start a family.

149. Furthermore, forced sterilizations have been imposed as a method to cover up sexual violence in institutions, particularly the rape of women and adolescents with disabilities, thereby preventing pregnancies resulting from rape.[140] Often, women with disabilities have been sterilized during their institutionalization without their consent and/or without subsequent information about the procedure they underwent. In fact, many women with disabilities were subjected to contraception, including the insertion of intrauterine devices. In her testimony before the Committee, a woman with a psychosocial disability described how she only learned of the forced treatment during a gynecological checkup after her release from an institution. She stated that she suffers from trauma and depression as a result of her permanent infertility caused by that forced treatment.

3. Use of physical and chemical restraint

150. The Committee received with great concern the testimonies and information regarding coercive practices involving the use of physical and/or pharmacological restraints against persons with disabilities. Coercion is used both in hospital emergency departments for short periods and during prolonged hospitalizations. Restraint is a common practice in the institutions visited and forms part of psychiatric care protocols in both federal and state-run psychiatric hospitals as well as in private psychiatric institutions.[141] Restraints are implemented by both nursing staff and security personnel within the institutions. The Committee notes with extreme concern that in some cases it is the authorities of the family protection system themselves who order the use of physical and pharmacological restraints in relation to children who are transferred to institutions[142] .

151. People with disabilities find themselves in a completely defenseless situation and at constant risk of disability-based violence. The Committee noted with concern the items used for mechanical restraint practices, including bandages, belts, and/or tape to immobilize adults and children with disabilities in their assigned beds and/or chairs in psychiatric hospitals and/or group homes. It also received information regarding persons with disabilities who are restrained by their upper limbs through the use of straitjackets, bound from head to toe with bandages, and some who are tied with bandages to wheelchairs and permanently isolated in rooms.

152. The Committee received with extreme concern information regarding children with disabilities who have been restrained to beds, cells, and radiators, as well as cases of autistic children and children with cerebral palsy who were subjected to physical restraint for prolonged periods in private institutional settings.[143]

153. During its visit, the Committee frequently observed adolescents, young people, and adults with disabilities under the effects of overmedication with sedatives. Many of the residents were completely sedated or confined to their beds.

154. The Committee also noted that some psychiatric institutions still have rooms dedicated to electroconvulsive therapy. Staff at institutions where electroconvulsive therapy is practiced justify its use by stating that people with disabilities “would not suffer because they would be under the influence of sedatives.” The Committee also received information from persons with disabilities in private psychiatric hospitals in Mexico City who were subjected to forced institutionalization for periods of two weeks during which they were subjected to electroconvulsive therapy. These therapies

[140] Testimony
[141] Testimony
[142] Testimonial
[143] Testimonial

caused damage to their eyes, loss of taste, diminished sense of smell, and effects on the cardiac and nervous systems.[144]

4. Practices of Individual and Collective Isolation

155. The Committee received testimonies regarding the use of isolation rooms within institutions, including psychiatric hospitals.[145] Additionally, the Committee received information about psychiatric hospitals that maintain specific rooms designated as "observation rooms" and used in connection with individuals with infectious diseases who require constant support and monitoring due to their level of medication.[146] Cases were also reported regarding the use of isolation rooms for children with disabilities. The isolation of children in these rooms ranged from three to several consecutive days. Furthermore, in some institutions, beds with bars are used for girls and boys with disabilities on a permanent basis.[147]

156. The Committee noted with great concern that adult women with disabilities and older women in psychiatric hospitals were confined to areas outside the wards and dormitories, where people are outdoors, surrounded by fences and locked gates. Women with disabilities may spend hours in such places, without access to bathrooms, food, or the opportunity to engage in physical or intellectual activities, habilitation or rehabilitation, or simply for recreation.[148]

157. The Committee also observed adolescent girls in psychiatric institutions under the influence of sedatives. Adolescent girls frequently lack access to education and are out of school as a result of their institutionalization. The adolescent wards are isolated, enclosed areas containing dormitories that are also barred and subject to surveillance. When the delegation entered the adolescent girls' ward at one of the institutions visited, some of the girls were outside the dormitory, yet in a space lacking furniture that would allow them to engage in activities other than wandering and sleeping. During the visit to the adolescent girls' wing, it was observed that the entire area was under the surveillance of medical and nursing staff of both genders.[149] The Committee received testimonies from adolescent girls who spend their days in communal dormitories; they are almost always assigned to remain in specific areas within the institution and lack the autonomy to enter or leave. The young women interviewed confirmed that there are no educational or recreational activities and that their routine consists of waking up, eating, taking medication, and returning to the dormitory. A 15-year-old adolescent stated*, "We can only sleep," "We can't paint or draw," "We can't go out," "It's very boring*."

158. Other forms of isolation arise from communication barriers within the institutions. This is the case, for example, of a deaf woman residing in an institution for women with and without disabilities in the municipality of Acapulco, Guerrero state, who remains isolated because she cannot use sign language to interact with the staff in charge of the institution.

5. Deaths of Children and Adults with Disabilities During Institutionalization

159. The Committee received with deep concern information regarding the deaths of children and adults with disabilities in private institutions, including rehabilitation clinics and group homes in states such as Baja California, Guerrero, Hidalgo, Puebla, and Mexico City.[150] Some of the deaths were reported within a short span of 4 months.[151]

[144] Testimonial
[145] Testimonial
[146] Testimonial
[147] Testimonial
[148] Testimonial
[149] Testimonial
[150] Testimonial
[151] Testimonial

160. According to the information received, some deaths of individuals in institutions occurred as a result of the use of psychotropic medications and physical health complications such as hypertension and/or heart problems. In particular, the use of psychotropic substances administered to people with disabilities, combined with bronchial aspiration, is reported to have led to their deaths. The Committee also received concerning information regarding the deaths of children and adults with disabilities while under physical restraint[152] and deaths caused by the misuse of psychiatric medications.[153]

161. The Committee received with grave concern information regarding suicide attempts and suicides in institutional settings. Suicide attempts endanger the well-being of both adolescents and adults.

162. The Committee also noted with concern that investigations into the causes of death of institutionalized persons are rarely conducted, and that general statistics on institutionalization lack records of reported deaths.[154]

F. Absence of gender-responsive measures and lack of recognition of the exercise of sexual and reproductive rights

1. Denial of sexuality

163. The Committee also noted with concern the denial of the sexuality of people in institutions, which results in the absence of sex education programs. This failure to recognize the diversity of needs and experiences reflects a lack of an intersectional approach in the policies and practices implemented. Psychiatric hospitals and clinics often maintain separate areas and dormitories for women and men. This practice, however, has been ineffective in preventing sexual abuse, including rape and harmful sexual practices against children, men, and women with disabilities.

2. Lack of access to sexual and reproductive health

164. The Committee noted a general lack of age-appropriate sexual and reproductive health programs and care for people in institutions. People in institutions lack information about their right to sexual and reproductive health, including the right to preserve their fertility.

G. Conditions in institutions

1. Disciplinary Regime

165. The Committee observed the prevalence of a system of closed institutions with a strict disciplinary regime. Generally, hallways and dormitories are locked from the outside and are opened only by nursing or security staff who manage the institutions.

166. Daily disciplinary routines and surveillance cameras are enforced. Furthermore, institutional staff, including security personnel, continuously monitor movement in the hallways.

2. Violations of Privacy

167. People with disabilities face restrictions on communication with the outside world once they have been institutionalized. The Committee noted a total lack of privacy in the institutions and the presence of surveillance cameras in all areas (courtyards, dormitories, hallways). Similarly, it observed that bathrooms and showers had no doors and, instead, were open areas, exposing residents' privacy. In some institutions,

[152] Testimonial
[153] Testimonial

administrators justified the design of open bathroom areas on security grounds. The Committee also observed communal dormitories under constant camera surveillance.

3. Degrading conditions

168. Unhygienic conditions in institutions pose a constant risk to the health of people with disabilities. During the Committee's visits, staff working in the institutions often went out of their way to present clean facilities. However, the pungent smell of bleach and, in some cases, traces of soap bubbles indicated that the institutions had been cleaned prior to the delegation's visit. At one of the institutions, this was confirmed by a woman with an intellectual disability who approached the director of the institution, acknowledging his efforts to clean the facility, which, in her words, was very different from the foul odor she usually noticed there. The Committee observed precarious conditions, dilapidated and abandoned facilities, with no repairs, foul odors, and in some institutions, non-functioning sewage systems. Frequently, people with disabilities in institutions spent their days doing nothing, sitting or curled up on the floor. In several institutions, the water supply is irregular or scarce, the food is inadequate, and the precariousness of the sleeping areas was noted; these generally consist of concrete beds covered only by mats, infested with insects, in cold, damp spaces with unpleasant odors.

169. Clothing conditions were often inadequate; some people wandered around in uniforms, others in pajamas, without being able to engage in any kind of activity. In very few centers was it evident that there were activities outside the facility. In some institutions, the activities observed appeared to have been organized specifically for the delegation's visit. The Committee noted with concern that in most cases, people with disabilities lack access to education, culture, or other community activities.

170. In several institutions, there is insufficient medical, social work, and cleaning staff.[155] Given the isolation experienced by people in these institutions and the lack of connection to community services, they frequently lack specialized medical care, such as that required for people living with HIV/AIDS.

171. The Committee is concerned that degrading conditions are recurring in private institutions such as group homes. One such institution in the State of Mexico[156] housed around 100 people in a 180-square-meter garage where residents lived surrounded by trash and human excrement, which generated foul odors and attracted cockroaches. Residents slept on the floor due to the lack of beds and limited space. Furthermore, the toilets did not work and there were no showers. Additionally, residents reported insufficient food and the fact that they received meals only once a day.

H. Harmful Consequences of Institutionalization

1. Harm to personal integrity

172. The Committee found that institutionalization causes harm to the physical and mental integrity of those affected and severe trauma from which they can hardly recover. The Committee received testimony from a male survivor of institutionalization who stated that he had been subjected to repeated rape by different perpetrators, physical restraints, and periods of isolation lasting up to two months at the institution where he was institutionalized during his childhood. In his testimony, he described suffering from depression, anxiety, drug addiction, and suicide attempts as a result of the violence and abuse he endured during his time in institutional care.

173. Institutionalization causes irreversible psychological harm, stress, behavioral issues, and delays and/or permanent damage to the cognitive and development of children with and without disabilities. In adults, institutionalization impairs oral language skills, cognitive function, mobility, gait, and social and psychological well-being. People with disabilities experience a decline in their physical health, as

[155] Testimonials
[156] Testimonial

comorbidities frequently arise that go untreated during institutionalization. Mental health deterioration occurs as a result of feelings of discouragement, depression, and boredom caused by isolation, the absence of visitors, and the neglect faced by people in institutions.

2. Loss of autonomy and alienation

174. People with disabilities in institutions are deprived of their decision-making capacity, leaving them at the mercy of administrators who often do not consider their individual needs and wishes. This deprivation of autonomy, coupled with poor living conditions such as poor hygiene, inadequate nutrition, and a lack of meaningful activities, contributes to a situation of alienation and physical and mental deterioration that places them in a state of extreme vulnerability.

175. When people are admitted during crisis situations, they are stripped of their rights, foremost among them the right to give consent to institutionalization. Furthermore, they lack information about pharmacological or medical treatments and the opportunity to give consent to them. In interviews conducted, it was found that institutionalized individuals have lost control over the type and quantity of medications they take, as these are administered by the institutions' medical staff in the exercise of their authority to use pharmacological restraint. People with disabilities also lose their personal care skills and become dependent on nursing staff or other individuals who reside or work in these institutions. Some individuals often lose track of where they are after being subjected to transfers and reinstitutionalization.

176. The Committee observed that, in the institutions visited, routines are monotonous and repetitive, completely discouraging and boring, without taking into account the will and preferences of the individuals. These routines consist solely of getting up, having breakfast, lunch, and dinner, and sleeping, in addition to wandering around the facility during the day. The dining areas are generally insufficient to accommodate the residents, and access to food is almost always limited. For example, cases were observed of some persons with disabilities who, as a result of sedatives, reduced mobility, or other causes, are unable to reach the dining hall and may go days without eating.

3. Neglect

177. Prolonged institutionalization primarily results in the isolation and segregation of people with disabilities from their family, community, and social circles. The Committee observed instances of neglect of people with disabilities in institutions, manifested both in the lack of adequate care and support and in emotional disengagement.

178. People with disabilities are frequently forgotten once institutionalized and progressively lose their family and emotional ties. Families who decided to send their family members with disabilities to institutions, believing it was the only viable option for their relative given the lack of community support, often abandon them. In some cases, people with disabilities in institutions receive financial support, known as a "bimonthly stipend," through their families, who, however, have lost interest in the life of their relative with a disability or in their return to community life.

179. The Committee observed that over time, many people with disabilities in institutions have become "invisible," receiving no visits for years and sometimes for decades, with no contact with the outside world and no hope of inclusion in the community. The reality for them is indefinite confinement, where their rights are ignored and their lives have been reduced to mere repetitive routines, wandering without purpose or dignity.

180. Psychiatric hospitals or social care centers are often located in remote areas, which contributes to the further isolation of the people residing there. Institutionalization has the effect of hiding and even denying the existence of people with disabilities from society.

4. Loss of Identity

181. The changing of names and the suppression of the identity of institutionalized individuals appears to be a recurring practice. The Committee received testimony from a man with a psychosocial disability who resided at the now-defunct institution "La Gran Familia Casa Mamá Rosa," who explained how his last names were changed upon admission to that institution. This change proved irreversible since no records were kept of his name, his relatives, or other social relationships in the community. In the case of women with psychosocial disabilities subjected to consecutive institutionalizations after being abandoned in childhood at the now-defunct La Castañeda Psychiatric Hospital, the Committee observed that their names were changed, thereby severing all ties to their previous relationships with the community as a result of institutionalization.

182. The Committee also received information regarding institutions where children with disabilities were registered under the surname of the institutions' founders and/or administrators. This is the situation for 90 women with disabilities in a psychiatric institution in the State of Mexico, many of whom bear the surname of the first director of the institution where they are institutionalized.[157] This is also the case for more than 130 girls and boys with disabilities residing at Ciudad de los Niños in Salamanca, Guanajuato State, who bear the surname of the institution's founder.[158]

I. Inadequate independent monitoring of institutions and remedial mechanisms for persons with disabilities

1. Absence and/or limitations in independent monitoring

183. Human rights institutions in the states have monitoring powers. The National Human Rights Commission, through the Independent National Monitoring Mechanism, has conducted visits to psychiatric hospitals and shelters. However, the Committee received information indicating a lack of oversight of private institutions by state authorities, including by state human rights institutions, even though their internal regulations permitted them to conduct such visits[159] . Information was also received indicating that state oversight of private detention centers generally occurs reactively in response to situations of violence and abuse reported by civil society organizations and/or the media.

184. Civil society organizations may, in principle, conduct visits to institutions. However, in practice, such visits are subject to authorization that must be granted by the State or Federal Ministry of Social Welfare or Health. Organizations lack the authority to conduct unannounced visits and lack legal recourse to challenge the denial of a visit or entry into institutions for monitoring purposes. Some civil society organizations have been restricted and/or prohibited from entering and monitoring private institutions and psychiatric hospitals in states such as the State of Puebla, the State of Mexico, and Mexico City.

185. The Committee received information indicating that, on repeated occasions, state authorities—such as those within the comprehensive family development system—have denied civil society access, citing potential privacy violations.[160] Similarly, organizations that promote the rights of persons with disabilities have faced restrictions on access and the ability to conduct interviews with persons with disabilities who have been victims of violence in institutions and subjected to transfers.

[157] Testimonial
[158] Testimonial
[159] Testimonial
[160] Testimonial

2. Obstacles to using complaint boxes

186. Health legislation stipulates that institutions must have mechanisms for monitoring and receiving complaints.[161] Additionally, the Committee was informed about complaint boxes that would allow people in institutions to report cases of mistreatment and/or situations violating their rights, which were supposed to be recorded. The Committee, however, observed that such complaint boxes were either nonexistent and/or out of reach for individuals subject to institutionalization. Only in one of the institutions visited was the complaint box operational and visible. However, it was located in the outpatient psychiatry area, which limited its use by those in permanent institutionalization.

3. Lack of Access to Justice

187. The right to access to justice is virtually nonexistent for persons with disabilities in institutions or after they have left them, and there are no efficient and accessible mechanisms for reporting crimes or human rights violations within institutions.

188. The Committee observed that, with the exception of some efforts by the Public Defender's Office and certain civil society organizations, people with disabilities in institutions lack regular and systematic legal counsel. The absence of information and legal counsel leaves people defenseless. This was evident in institutions that detain migrants as a result of so-called "rescue operations."

189. In cases where people with disabilities living in institutions manage to obtain legal assistance that allows them to file a complaint, they face attitudinal barriers that invalidate their testimony on the grounds of an intellectual and/or psychosocial disability. The Committee received information indicating that "it is common for the testimony of persons with disabilities to be dismissed due to their mental condition, with claims that they 'cannot' give testimony because they 'are unwell' or 'do not understand'."[162] Information was also received regarding several cases in which procedural accommodations are lacking to facilitate communication and understanding for persons with disabilities during judicial proceedings; conversely, psychiatric diagnoses are used to demonstrate an intellectual and/or psychosocial impairment in potential victims, which results in the restriction of their participation in judicial proceedings.

4. Limitations in investigations and the establishment of accountability for rights violations

190. The Committee was informed of decisions by the Public Prosecutor's Office to open investigative files regarding violations of the rights of persons with disabilities in institutions, as well as some criminal investigations opened against institutional staff for allegations of sexual offenses against children and adults with disabilities in institutions.[163] However, the Committee also received information showing that in high-profile cases of human rights violations in several states, investigations by the Public Prosecutor's Office were shelved, progressed slowly, and rarely resulted in accountability for crimes committed in institutions.[164]

5. Lack of reparations and guarantees of non-repetition

191. The Committee noted that the system for requesting and accessing reparations, including compensation for damages during institutionalization, is limited. Persons with disabilities informed the Committee that the procedures for requesting reparations are complex and that, on some occasions, reparations that should be granted by the Victims' Commission have been suspended due to a lack of budget.

[161] Health Regulation NOM-025
[162] Testimonial
[163] Testimony
[164] Rulings of the National Human Rights Commission from 2018 and 2020

J. Lack of a Deinstitutionalization Strategy for Persons with Disabilities

1. Lack of budget for deinstitutionalization and for the development of community-based support

192. The Committee is concerned by information indicating that the public budget at the federal and state levels continues to be directed toward the maintenance of institutions and/or their transformation within the federal government's health services framework.[165] The Committee received information indicating that in emergency situations resulting from natural disasters, state authorities make efforts to rebuild and expand institutions that have operated for more than 50 years in order to restore their capacity and expand it for the institutionalization of children with and without disabilities.[166]

193. The Committee also notes the lag in public policies and sectoral plans to develop support systems for independent living in the community. Federal and state planning lacks plans aimed at designing support services, and current discussions on care systems exclude the possibility of establishing support for independent living in the community.

2. Lack of measures to facilitate the transition from institutions to community living

194. The Committee notes that institutions lack plans aimed at redirecting services toward the community, including the necessary budgets for doing so.

195. The Committee received information regarding the development of transition programs to community living known as "halfway houses." This initiative, however, was implemented on a limited scale, and there are no updated records available to account for the number of persons with disabilities benefiting from them or the impact of this strategy on community integration.

3. Lack of mechanisms for close consultation and involvement of persons with disabilities and their organizations in the development of deinstitutionalization plans

196. The Committee noted with concern the absence of close consultation and active collaboration with persons with disabilities through their representative organizations regarding deinstitutionalization for persons with disabilities. Although some states have established consultation forums on topics such as health or indigenous peoples' issues, consultations to redefine the objectives of the social assistance system, create a community support system, and dismantle institutionalization are limited or nonexistent.

K. Attitudinal barriers and lack of preparedness and coordination among authorities

197. The Committee notes with concern that several authorities and officials interviewed continue to endorse the institutionalization of persons with disabilities, based on therapeutic criteria or a purported need for protection. In this context, ableist ideas and medical models persist among a significant proportion of staff who come into contact with persons with disabilities in care systems, particularly mental health systems. These stigmatizing attitudes are even more pronounced toward persons with intellectual and/or psychosocial disabilities.

198. It is also a cause for concern that understanding of the implications of the Convention and the human rights of persons with disabilities remains limited, and that not all authorities are familiar with the principles and standards of the Convention. In

[165] Testimony.
[166] Testimony

general, there is a significant lack of awareness regarding the harm caused by institutionalization to which persons who are or have been institutionalized are exposed, including post-traumatic stress. Denialist attitudes were also observed regarding the harmful impact that institutionalization has on persons with disabilities. In this regard, the Committee is concerned that some authorities within the comprehensive family development system continue to refer children with disabilities to institutions, including unregulated private institutions where there are serious risks to their safety and well-being.

199. The Committee notes that there are multiple authorities exercising jurisdiction at the federal, state, and local levels regarding issues related to persons with disabilities. This dispersion, which the Committee understands to be a consequence of a decentralized framework for the exercise of the authorities' functions, has, as the Committee observed, led to fragmentation and siloed work among the different authorities. In some cases, attempts to coordinate efforts were observed. However, significant challenges remain in achieving efficient coordination among all the authorities involved. Furthermore, it is noted that there is a system of focal points on disability issues that, in some situations, is intended to function, but this system fails to exercise effective leadership that brings together and enables better inter-institutional coordination.

200. The Committee is also concerned that there are no coordinated efforts to prevent the institutionalization of persons with disabilities. Furthermore, the fragmentation of the authorities' efforts limits the monitoring and oversight of public policies implemented on a sectoral basis by the various entities and authorities. The lack of coordinated efforts is also evident in the limited availability of support services for persons with disabilities in the community and in an insufficient information strategy regarding community integration programs for persons with disabilities.

201. The Committee noted that, while there are public policies targeting children, older adults, women, migrants, or Indigenous and Afro-Mexican peoples, these policies do not adequately account for the intersectional dimension of disability with other identities held by persons with disabilities, resulting in a deficient differentiated approach regarding the diversity of persons with disabilities. Likewise, it is observed that sectoral responsibilities in areas such as education, health, employment, or social security are not sufficiently coordinated to address the issues of people with disabilities. It is also observed that there are no intersectoral initiatives promoting deinstitutionalization. Some of the authorities interviewed indicated an interest in moving toward deinstitutionalization for people with disabilities, but lacked the support, guidelines, or tools to initiate deinstitutionalization processes.

202. The Committee is equally concerned that authorities show little interest in following up on complaints of inhuman and degrading treatment committed in institutions, including attitudes of denial and surprise when asked about incidents of inhuman or degrading treatment. These behaviors and attitudes result in a lack of oversight that allows human rights violations committed in these institutions to go uninvestigated, unpunished, and unremedied[167] .

[167] Written response from the State party submitted via note verbale dated April 17, 2025.