Human Rights & Mental Health: Mexico

A report by:

Mental Disability Rights International

With photographs by:
Eugene Richards
Many Voices, Inc.

September 2000
Washington, D.C.

This report was first released in Mexico City
February 2000

Research and publication of this report primarily funded by the
Public Welfare Foundation and the John Merck Fund
Copyright 2000
by Mental Disability Rights International

Copies of this report are available for $20.00 from:

Mental Disability Rights International
1156 15th St. NW Ste. 1001
Washington, D.C. 20005
Telephone: (202)296-0800
Fax: (202)728-3053
E-mail: MDRI@mdri.org
Web page: www.mdri.org

Also available from MDRI:

Human Rights and Mental Health: Uruguay (1995) ($10.00)
Human Rights & Mental Health: Hungary (1997) ($20.00)
Children in Russia's Institutions:
  Human Rights and Opportunities for Reform (2000) ($10.00)

See also:

Eric Rosenthal, Elizabeth Bauer, Mary Hayden, Andrea Holley, Implementing the Right to
Community Integration for Children with Disabilities in Russia: A Human Rights Framework for
International Action, 4 HEALTH AND HUMAN RIGHTS (1999).

Cover photo Ocarranza psychiatric facility, Hidalgo, November 1999
All photos by Eugene Richards, Copyright 2000
Courtesy of Many Voices Inc.
Mental Disability Rights International

Mental Disability Rights International (MDRI) is an advocacy organization dedicated to the international recognition and enforcement of the rights of people with mental disabilities. MDRI documents human rights abuses, supports the development of mental disability advocacy abroad, assists advocates seeking legal and service system reforms, and promotes international oversight of the rights of people with mental disabilities in the United States and abroad. Drawing on the skills and experience of attorneys, mental health professionals, people with disabilities and their families, MDRI is forging a new alliance to challenge the discrimination and abuse of people with mental disabilities worldwide.


Authors

Eric Rosenthal, J.D. Eric Rosenthal is the founder and Executive Director of MDRI, Washington, D.C.

Robert Okin, M.D. Dr. Robert Okin is Chief of Psychiatry, San Francisco General Hospital; and Vice Chair, Department of Psychiatry and Professor of Clinical Psychiatry, University of California, San Francisco, California.

Humberto L. Martinez, M.D. Dr. Humberto L. Martinez is Executive Director of the South Bronx Mental Health Council, Inc., Bronx, New York. He is also chair of the Human Rights Committee of the World Association for Psychosocial Rehabilitation, member of the Human Rights Committee of the American Psychiatric Association and Corresponding Secretary of the Mental Health Committee of NGOs accredited by the United Nations.

Débora Benchoam, M.A., J.D. Débora Benchoam is an independent human rights consultant from Argentina.

Lynda Frost Clausel, J.D., Ph.D. Professor Frost is on leave from the University of Virginia School of Law’s Institute of Law, Psychiatry and Public Policy. She is currently a Visiting Professor at American University in Cairo.

Brittany Benowitz. Brittany Benowitz is Program Associate at MDRI.
Table of Contents

Acknowledgments ........................................................................................................... i

Summary and Recommendations ................................................................................... ii

Preface: Goals and Methods of this Report ................................................................. xiv

I. Introduction ................................................................................................................ 1
   A. Mental Disability Rights: An International Concern ........................................... 1
      1. International human rights law ................................................................. 1
      2. International trend toward community integration ................................. 5
   B. Background and Structure of Mental Health Services ........................................ 6
      1. Historical development of service system ............................................. 6
      2. Citizen activism and reform ................................................................ 7
      3. Mexico's federal mental health law ......................................................... 8
      4. Current structure of services ............................................................... 9

II. The Promise and Dangers of Reform ..................................................................... 10

III. Human Rights in Institutions .............................................................................. 13
   A. Inhuman and Degrading Conditions ................................................................ 14
      1. Daily life on the ward: pervasive inactivity ........................................... 15
      2. Unhygienic conditions of detention ....................................................... 16
      3. Lack of privacy and dignity ................................................................... 18
      4. Physical restraints ................................................................................... 19
      5. Lack of medical and dental care ............................................................. 21
      6. Lack of food, water, clothing, blankets and heat ................................. 22
      7. Reproductive rights and parenthood ..................................................... 22
   B. Lack of Appropriate Treatment, Rehabilitation and Outplacement ............... 23
      1. Lack of rehabilitation in institutions ...................................................... 24
      2. Shortage of trained staff .......................................................................... 25
      3. Improper use and control of medications .............................................. 26
      4. Failure to ensure informed consent ....................................................... 30
   C. Lack of Procedural Protections against Arbitrary Detention ............................. 31
      1. Civil commitment ..................................................................................... 32
      2. Guardianship ............................................................................................. 34
   D. Improper Segregation from Society .................................................................. 36
      1. Detention of “abandonados” .................................................................. 36
      2. Detention of people with mental retardation and other disabilities ......... 37
      3. Detention of children .............................................................................. 39
      4. Improper incentives for institutionalization .......................................... 40
   E. Assessment of reforms in Mexico City since 1996 .............................................. 41

IV. Human Rights Oversight ....................................................................................... 43
   A. Notice of Rights and Complaint Procedures ................................................ 43
   B. Independent oversight ...................................................................................... 44
   C. Citizen Participation in National Planning and Human Rights Oversight ....... 48
V. Planning and Financing Reform ................................................. 49
   A. International Obligations to Plan and Finance Reform .......... 49
      1. Immediate obligations of full enforcement ...................... 50
      2. Progressive enforcement ........................................ 51
   B. Strategies for Planning and Financing Reform ...................... 52
      1. Need for comprehensive services and planning ................. 52
      2. Need for outreach and assertive treatment in the community ..... 54
      3. Consumer and family advocacy and support ..................... 55
      4. Financing community services ................................ 56

Afterward: Events Since the Release of the MDRI Report ................. 58

Appendix A Responses by the Government of Mexico .................... 62
   1. Dr. Manuel Urbina Fuentes, Sub-secretary of Sectoral Coordination,
      Secretariat of Health .............................................. 62
   2. National Human Rights Commission (CNDH) ....................... 65

Appendix B Principles for the Protection of Persons with Mental Illness 68

Appendix C Declaration on the Rights of Mentally Retarded Persons .... 80
Acknowledgments

Mental Disability Rights International (MDRI) is indebted to many people in Mexico who generously gave their time to provide their observations and insights about the human rights concerns of people with mental disabilities in Mexico. To protect their privacy, most of the individuals MDRI interviewed are not named in this report. The people who assisted the MDRI investigators include people who use mental health services in Mexico, members of their families, mental health service providers, members of the psychiatric and nursing professions, government officials and institution staff.

MDRI’s work on this report would not have been possible without the extensive assistance of human rights advocates and service providers in Mexico. MDRI is particularly indebted to Virginia Gonzalez Torres, the founder and President of the Fundación Mexicana para la Rehabilitación del Enfermo Mental (FMREM) and the Fundación Dignidad. Ms. Gonzalez Torres provided background information about the operation of Mexican mental health services and she arranged access to psychiatric facilities in Mexico City, Guadalajara, Jalisco, and Pachuca, Hidalgo. MDRI appreciates the many staff members of FMREM and the Fundación Dignidad who provided extensive assistance to MDRI’s investigators. MDRI would also like to thank the four Citizens committees and the service users who welcomed MDRI visitors.

Many other mental health service providers and representatives of nongovernmental organizations provided MDRI with essential background about conditions in Mexican psychiatric facilities. MDRI would particularly like to thank Dr. Rosalba Bueno Osawa of the World Association for Psychosocial Rehabilitation for her assistance in Mexico and for her review of the draft of this report. Information on guardianship laws was provided by Pilar Noriega Garcia of the Servicios Legales e Información y Estudios Jurídicos. Joel Solomon of Human Rights Watch provided MDRI with helpful background on the operation of the Mexican National Human Rights Commission.

MDRI would like to acknowledge the work of Catherine O’Malley, a former MDRI staff member who organized all aspects of the 1996 visit to Mexico. MDRI experts Dr. Robert Okin, Débora Benchoam, Dr. Humberto Martinez, and Professor Lynda Frost Clausel donated their time to this project; this report would not have been possible without their contributions. This report was translated into Spanish by Greta Tovar Sieben-Tritt. The report was reviewed and edited by Jan Wilkinson, Rachel Cantor, Claudia Marquez, and Lisa Newman. A video camera was made available to MDRI by the Witness Program of the Lawyers Committee for Human Rights in New York. Thanks to Monica Bussolati of Bussolati Associates, Inc. for assistance designing the cover of the report.

Funding for the research, writing, and publication of this report was generously provided by the Public Welfare Foundation and the John Merck Fund. Core funding for MDRI has been provided by the Open Society Institute, New York.
Summary and Recommendations

This report documents the human rights conditions in Mexico’s mental health system. The report recommends steps necessary to bring the system into conformity with international human rights conventions, such as the American Convention on Human Rights, and human rights standards, such as the United Nations General Assembly’s Principles for the Protection of Persons with Mental Illness (hereinafter *MI Principles*), reproduced in full in Appendix B of this report.

The report is the product of three fact-finding investigations conducted in Mexico in July 1996, August 1998 and November 1999. During these missions, a team of attorneys and psychiatrists from MDRI visited three long-term psychiatric facilities (Ramírez Moreno, Nieto, and Sayago) serving Mexico City and the State of Mexico. The team also visited the Ocaranza institution in Pachuca, Hidalgo and the Jalisco institution in Guadalajara, Jalisco. They visited two *casas de protección social* (social protection homes), administered by Mexico City authorities for homeless people with mental disabilities. MDRI also visited Fray Bernardino, a psychiatric hospital for acute, short-term care in Mexico City. MDRI also visited programs run by nongovernmental organizations. In Mexico City, the MDRI team observed the operation of a sheltered workshop for people with developmental disabilities run by the Confederación Mexicana de Organizaciones en favor de la Persona con Discapacidad Intelectual (CONFE), and learned about an integrated, supported employment program run by this organization. MDRI also visited community-based living and rehabilitation programs for people with psychiatric disabilities (a group home, supported apartments, and a ceramics workshop) established by the FMREM. These programs are administered by the Fundación Dignidad, a sister program of FMREM.

This report identifies a number of serious human rights violations against people with mental disabilities. The report also documents that, between 1996 and 1999, there were significant improvements in some institutions (particularly Sayago and Ramírez Moreno) where physical conditions were ameliorated and limited rehabilitation programs were established. FMREM made particularly impressive headway in establishing active citizens committee in four institutions. MDRI noted a growing recognition among service providers and system administrators that people detained in long-term facilities should be returned to live in the community. By documenting both the deficiencies and recent improvements in Mexico’s mental health system, it is MDRI’s intent to assist the work of service providers and those in Mexico in and out of government who are striving for reform and improvement in the mental health system.

Where human rights abuses are identified, MDRI does not intend to cast blame on any individual. Many people working in Mexican mental health facilities have shown compassion and commitment to their work. Despite limited resources, these individuals have dedicated themselves to working for the well-being of people with mental disabilities. Under international human rights law, it is ultimately the responsibility of the Government of Mexico to protect and ensure the rights of people with mental disabilities.

The recommendations in this report draw heavily on lessons learned from the struggle against strikingly similar abuses experienced in the United States, Europe, and Latin America. MDRI hopes that this report will help Mexico build on the lessons—and avoid the mistakes—that have been made in the United States and elsewhere.
The Promise and Dangers of Recent Reforms

According to Mexican federal authorities, the entire population of Mexico’s long-term psychiatric facilities could be integrated into the community if appropriate services and support systems were created. However, Federal authorities report that the only community-based service programs in the country for people with psychiatric disabilities are run by FMREM and the Fundación Dignidad. These programs serve fewer than 100 people with psychiatric disabilities. There are more extensive nongovernmental programs serving people with developmental disabilities, but these are largely limited to people whose families can pay for services.

In discussions with the MDRI team in November 1999, a number of institution directors and staff expressed interest in learning about the creation of community programs to assist people to return to the community. The directors of some institutions, such as Jalisco in Guadalajara, said that they could and would immediately begin integrating people into the community if they had funding for such programs. The Director of Mental Health for the Federal Government told MDRI that the total number of long-term patients throughout Mexico would be reduced by one-third within one year. He also said that the new, federal Mexican mental health law, the Norma Official Mexicana, requires such community placements. Within a few years, he stated that all long-term patients would be integrated into the community, as required by Mexican law. The growing interest in community integration for people with mental disabilities is a positive development that signals great hope for the future of reform in Mexico.

While a commitment to community integration is extremely important, MDRI found an absence of planning and financing to make such programs safe and effective if they were created. International experience is consistent with the view of Mexican federal authorities that a great majority of people with mental disabilities, including those with major psychiatric disorders, can live in the community. Many people with disabilities will face serious risks to their health or safety, however, if appropriate services and support systems are not available in the community. Apart from impressive models of community integration established by Fundación Dignidad, an NGO, the Government has not begun to establish any new community-based service programs. No new funds for community services have yet been approved by the Mexican government. The amount requested by Mexican federal authorities for community integration of the entire city of Mexico is 200,000 pesos. For a city of 22 million people, this amount is minuscule (equivalent to the annual budget of community programs operated by the Fundación Dignidad to serve 62 people).

If the Government reduces the patient census without establishing new community-based service and support systems, it risks creating an even greater human rights abuse: the “dumping” of psychiatric patients into the streets. The reduction of hospital beds without first establishing adequate community-based services was a serious mistake made in many parts of the United States and other countries. Alternative models of successful community integration exist in many other parts of Latin America, Europe, and the United States. Mexico should draw on this experience.

---

1 In the Federal District and surrounding areas, there are also private half-way houses that offer open-door residential services for people diagnosed with severe mental illness. The MDRI team was not able to visit these programs, however, with proper oversight, half-way houses can be an important component of public care in the community and they should be replicated by the Mexican Government. Other nongovernmental organizations administer programs for people with mental retardation and cerebral palsy.
While international human rights law places great importance on individual liberty and the
*Ml Principles* provide a right “to be treated in the least restrictive environment” under Principle 9(1),
these same principles establish a positive “right to be treated and cared for, as far as possible, in the
community in which he or she lives,” Principle 7(1). In the absence of adequate community
programs, the premature reduction of the patient census could be dangerous or life threatening. After
detaining a person in an institution, government action that endangers a person’s health and well-
being violates the right to life and to humane treatment recognized under articles 4 and 5 of the
American Convention on Human Rights (the American Convention), and article 6 and 7 of the
International Covenant on Civil and Political Rights (ICCPR).

The full recommendations of this report are intended to balance the need for protection in
psychiatric facilities and the promotion of community integration, as required by international
human rights law and Mexican law. Because of the danger of perpetuating new human rights abuses
in the name of reform, MDRI makes two underlying policy recommendations:

**Policy Recommendations:**

**P-1** Develop immediate plans for system reform - Mexico must create a system of community-
based services that will make community integration safe and protect the health of its clients.
A national, system-wide plan should be established to determine how the new community-
based mental health system will be established and financed. If necessary, Mexico must be
prepared to increase its state and national mental health budgets for care to fully enforce the
right to community integration for people with mental disabilities.

**P-2** Prevent patient dumping - Mexican authorities should develop a careful, individualized
plan for the outplacement of each person placed in the community. Without adequate
programs for support and assistance, the Government will be responsible for endangering the
life and health of any individual placed in the community.

**Human Rights and Conditions within the Mental Health System**

**A. Inhuman and Degrading Conditions within Psychiatric Institutions**

People detained in Mexican psychiatric facilities are subject to pervasively poor and often
abusive living conditions. With few exceptions, life in Mexico’s long-term facilities (commonly
referred to as “*granjas*” or “farms”), is generally one of inactivity. People in the “*granjas*”
experience a total lack of privacy and basic control over the most minute and personal decisions of
daily life. There has been improvement in physical conditions in recent years in the six psychiatric
institutions and the two *casas de protección* MDRI visited, particularly in Mexico City where
nongovernmental advocates have been most active. Yet, in 1999, MDRI continued to document
filthy living conditions, unhygienic treatment practices, lack of appropriate medical and dental care,
improper use of physical restraints, and shortages of blankets and clothing. The MDRI team
observed elders and people with severe mental disabilities emaciated or shivering in institutions
that may have had adequate food or clothing—but did not provide the staff necessary to assist these
people. These practices are dangerous and cause great suffering. As such, they constitute “inhuman
and degrading treatment” prohibited by article 7 of the ICCPR and article 5 of the American
Convention.
Conditions in psychiatric institutions outside Mexico City were particularly poor. MDRI investigators visited two remote institutions: Ocaranza in Hidalgo and Jalisco located outside Guadalajara. At Ocaranza, people were penned into small areas of residential wards where they were left to sit, pace, or lie on the concrete floor all day. Without activities or attention, they rocked back and forth or self-stimulated in other ways. Some patients regularly urinated or defecated on the floor, in areas where others often sit or walk through with bare feet. Residents of Ocaranza were brought straight from this ward to the dining area without an opportunity to wash their hands or clean themselves. Those able to get to a bathroom did not have access to toilet paper. People on the ward were given medications with water from a common bucket, using one cup passed from one person to another.

The children’s ward at the Jalisco psychiatric facility was even worse. Children were left lying on mats on the floor, some covered with urine and feces. During both MDRI’s 1998 and 1999 visits, flies were everywhere and the smell was overwhelming. Self-abuse was common and basic medical care was lacking. Without adequate supervision, children were observed eating their own feces and physically abusing themselves without attention from staff. The institution does not have the behavior programs necessary to prevent children’s self-abusive behavior. According to staff, some children were left completely without habilitation, self-care skills training, or activities to keep them busy.

Physical restraint was also commonly misused. At Jalisco, in the absence of behavior programming for self-abusive patients, children and adults were left in physical restraints for long periods of time. One child was observed tied from head to foot to a wheelchair, where he remained most of the day. Other children were observed tied to beds or had their sleeves tied over their hands. The use of physical restraints may cause extreme discomfort and suffering, particularly when used for a long period of time. MI Principle 11 requires that physical restraints be used only to protect against “imminent harm” and can only be used for as long as they are strictly needed. The routine, long-term use of physical restraints at Jalisco constitutes “inhuman and degrading treatment” under the ICCPR and the American Convention.

In recent years, the directors of Mexico’s “granjas” have reported shortages of food, clothes, and blankets. In 1998, the director of Sayago reported a number of deaths from infectious disease (bronchitis). While the new director reported that these conditions had improved in 1999, he also reported ongoing health risks. Due to the lack of physical therapy, forty people have lost the ability to walk and are dependent on wheelchairs. The health risks of such deterioration include frequent broken bones from falling and pressure sores from hours of sitting in the same position in a wheelchair. Without an adequate number of staff to assist individuals in wheelchairs, many people were left tied to wheelchairs with bed sheets.

MDRI observed openly dangerous conditions in institutions. At the “granjas” and the casas de protección, MDRI saw many individuals who needed and did not receive immediate medical attention. In some cases, individuals did not receive necessary treatment to control the side effects of psychotropic medications. The MDRI team also observed individuals with open wounds who received no assistance or care to prevent infection.
Recommendations:

A-1  Provide adequate food, clothing and blankets in institutions - Enforcement of the most basic standards of health, safety and dignity require that institutions provide adequate food, clothing, and blankets. Where supplies are adequate, elders and people with severe mental disabilities require additional assistance from trained staff to ensure that they receive adequate nutrition and protection from the cold.

A-2  Ensure basic hygiene and safety within institutions - Immediate priority should be given to improvements in conditions necessary to ensure the safety of all people in psychiatric facilities. Funds should be provided for adequate medical care and staff to ensure basic hygiene. Dangerous conditions in buildings should be immediately fixed.

A-3  Train staff in universal precautions and provide access to continuing education - All staff should be exposed to the principles of universal precautions necessary to protect the health and safety of people in institutions. Both professional and non-professional staff should be required to enroll in regular continuing education programs. The Government should ensure that such classes are available so that international advances in treatment can be incorporated into standard mental health practice in Mexico.

A-4  Provide basic medical and dental care - There is an urgent need to adopt and enforce standards that ensure that all patients receive basic medical and dental care to protect their health and safety. No person in a psychiatric facility should be denied basic medical and dental care necessary to protect his or her health. Additional ward staff may be needed to assist with routine washing and oral hygiene, as well as to provide physical therapy.

A-5  Enforce internationally and nationally accepted treatment standards for medical and psychiatric care - Safe and effective use of medications requires documentation of the medicine's primary effects as well as side effects. As recognized by the MI Principles and Mexican federal mental health law, every patient has a right to an individualized treatment plan, which is discussed with the patient, and reviewed regularly.

Standards for the use of medications should include:

a.  a prescription policy
b.  prescription procedures
c.  a pharmacy manual
d.  specific controlled-substances information
e.  psychotropic drug regimen
f.  adequate monitoring of side effects
g.  progress reports
h.  a proper diagnosis
i.  guidelines for prescribing medications
j.  regular and periodic evaluation of patients for the presence of side effects

Treatment standards should include:
k.  internationally accepted admission and discharge practices
l.  individual evaluation and treatment planning, including a personal, social, and psychological history in charts
m. protection of basic liberties and choices regarding medical care and other personal matters in the psychiatric facility
n. dignified living conditions in psychiatric facilities, including adequate clothing
o. clinical indications for the use of psychotropic medications and physical restraints

A-6 Establish controls for use of physical restraints - As required by MI Principle 11(11), physical restraints should only be used “when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them, and their nature and extent shall be recorded in the patient’s medical record.” Physical restraints should never be used as a substitute for care that can be provided with adequate staff.

A-7 Establish a quality-assurance system - Quality assurance and utilization review must be an integral part of the service delivery system. Manuals on quality assurance, utilization review and special review may be adapted from other countries. As recommended by the National Commission of Human Rights (known by its Spanish abbreviation as the CNDH), existing manuals should be disseminated and more consistently used.

A-8 Recognize and support privacy, dignity, and individual choice - Individuals residing in psychiatric facilities should have opportunities for privacy. Living areas should permit individual choice with regard to matters of personal convenience and decoration. Safe, secure, and locked spaces should be made available for personal possessions. People should be allowed easy access to their personal belongings for daily use.

A-9 Provide activities and support for leisure time - Programs must be established to prevent inactivity and boredom for people in long-term institutions. People with mental disabilities may require support to actively engage in such programs.

B. Lack of appropriate treatment and rehabilitation

The great majority of people placed in an institution in Mexico receive inadequate treatment and rehabilitation. For most, placement in a long-term facility is an outmoded, inadequate and inappropriate form of mental health care. At some institutions, new leadership and staff have been making efforts to help people return to the community as soon as possible. New policies to promote community integration cannot be implemented until community-based services and support systems are established.

Article 12(1) of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), to which Mexico is a party, guarantees the right to “the enjoyment of the highest attainable standard of physical and mental health.” In General Comment 5, Section IV(F), the Committee on Economic, Social, and Cultural Rights has clarified that article 12(1) “implies the right to have access to, and benefit from, those medical and social services... which enable persons with disabilities to become independent, prevent further disabilities and support their social integration.” Citing Rule 3 of the United Nations Standard Rules on Equalization of Opportunities for Persons with Disabilities (hereinafter Rules on Equalization), the Committee adds that “such
persons should be provided with rehabilitation services which would enable them ‘to reach and sustain their optimum level of independence and functioning.’"

Treatment in the "granjas" is primarily aimed at providing minimal care while keeping people in the institutions. Such custodial care is generally not directed toward rehabilitation or assisting a return to the community. The majority of people remain in a facility for a year or more, often for a lifetime. Treatment practices are primarily geared toward controlling symptoms through psychotropic medications. Little or no effort is made to promote reintegration into the community. A number of important rehabilitation activities, such as ceramics workshops, have been established in recent years in facilities serving Mexico City—primarily at the initiative of nongovernmental organizations such as the FMREM. To a lesser extent, both Ocaranza and Jalisco have established rehabilitation activities. These programs have led to improvements in the quality of life of people in these facilities.

The benefits of inpatient activities are limited by the lack of psychosocial rehabilitation programs that permit community integration. The enhancement of individual autonomy strictly in the institutions is fruitless when there is no opportunity to exercise that autonomy. The exceptions to this are the community-based programs run by the Fundación Dignidad NGO in Mexico City that permit approximately 65 people with mental disabilities with limited economic resources to be reintegrated into the community. One NGO, CONFE, has established impressive community-based work programs for people with developmental disabilities. Other NGOs are reported to have established supported housing in the community for people with developmental disabilities and people with cerebral palsy. Existing community-based programs run by NGOs are not large enough to meet the needs of all people with mental disabilities in Mexico.

**Recommendations:**

**B-1 Establish psychosocial rehabilitation programs** - Psychosocial rehabilitation programs must be created to assist people in psychiatric institutions to return to the community. Community-based psychosocial rehabilitation programs should also be established to prevent unnecessary placements in institutions and to assist individuals to remain in the community once they have left the psychiatric facility.

**B-2 Expand successful Mexican models** - A number of important models exist in Mexico that can be expanded. Experts from NGOs such as CONFE, FMREM and the Fundación Dignidad can be used to train workers at other psychiatric facilities. The Fundación Dignidad should receive increased Government support to permit the replication of its supported housing programs in other locations. The Government should provide support to adapt this model to the needs of people now residing in psychiatric institutions throughout Mexico. People with severe mental disabilities will require additional supports, such as case management in the community. The supported housing model established by the Fundación Dignidad should be used as the cornerstone of a larger, comprehensive system of services needed to promote the community integration of people with mental disabilities in Mexico.

**C. Lack of Procedural Protections against Arbitrary Detention**

Procedural protections against arbitrary detention in psychiatric institutions, as required by international human rights law, are lacking in Mexico. MI Principle 17 establishes that any person
subject to civil commitment in a psychiatric institution has a right to a hearing and a review by a judicial or other independent and impartial body established by law. Each commitment must be periodically reviewed by an independent authority. Detention of an individual without independent review constitutes "arbitrary detention" under article 9 of the ICCPR and violates the right to liberty and security of the person under article 7 of the American Convention.

Under Mexican law, "judicial notification" is required, but the law does not require judicial or other independent review of a decision to subject an individual to involuntary psychiatric commitment. The decision to detain an individual—often for life—is left to the complete discretion of an institution's staff. While the Mexican mental health law requires "periodic review" of a person's diagnosis, this review is also left to medical authorities at the institution.

Once people are placed in an institution, the director of the facility acts as the "legal guardian" and makes all decisions on their behalf. A number of institution directors reported that they act as legal guardian without any independent review or judicial designation as such. At Ocaranza, for example, the director reported that she is legal guardian of 280 of 300 individuals. With such a large number of people appointed to the same guardian, it is difficult or impossible for the guardian to meet the individual needs of each person. The appointment of an institution director as guardian leaves no independent intermediary to look out for the interests of the patient when they may diverge from those of the institution. Legal guardians have almost complete control over the lives of these people, so the absence of such process means that many lose virtually all of their rights to independent decision making as a product of institutionalization. People detained in an institution lack any protection against abuse of guardianship by institutional staff, since the guardian and the institutional staff are one and the same. Mexican law affords no protections against such inherent conflicts of interest.

Principle 1(6) of the *MI Principles* provides every person the right to a judicial or other independent and impartial review before a guardian is appointed. The individual has a right to be represented by counsel who "shall not in the same proceedings represent the mental health facility or its personnel..." The *MI Principles* ensure that people with mental illness retain the same rights as all other citizens, including the right to make basic decisions about their lives. Thus, guardianship should not be plenary but should be limited by an independent authority after a hearing in which it is determined that a specific aspect of a person's judgment is so impaired as to present a threat to his or her health or safety.

**Recommendations:**

**C-1 Create and enforce procedural protections in all civil commitments** - Mexican law regarding civil commitment should be amended to conform to the *MI Principles*. No persons should be committed without a hearing by an independent and impartial body. Every person committed should be represented by counsel, as required by the *MI Principles*. All commitments should be periodically reviewed by an independent authority.

**C-2 Guardianships should be limited and independently reviewed** - Procedures for the establishment of guardianship should ensure that people with mental disabilities retain all their rights, as protected by international law. No guardian should be appointed without independent judicial review to ensure the guardianship is limited to those specific activities that a person is not capable of managing. The independent review should ensure that there is no conflict of interest.
between the guardian and the ward. No institution staff or director should serve as a guardian. Existing protections under Mexican laws, such as the right to a hearing, should be fully enforced in all cases.

D. Improper and arbitrary detention in psychiatric facilities

The current director of mental health for the federal government, who is responsible for oversight of Mexico’s mental health system, has observed that the entire long-term population of the “granjas” is capable of integration into the community if appropriate community services were made available. A large number of people placed in long-term facilities are officially labeled “abandonados”—people with (or without) a mental disability who may be fully capable of living in the community. The abandonados are placed in the psychiatric hospital because they have no family or no other place to go. In November 1999, the directors of two institutions estimated that 75 to 80 percent of people in their own facilities are abandonados. In 1998, the director of the National Commission of Human Rights estimated that the number is roughly 70 percent on a national level. The detention of abandonados in institutions—without any individualized determination that they meet civil commitment standards or that they are dangerous to themselves or others—is a violation of international human rights law.

In addition to abandonados, MDRI identified a number of other groups of people improperly detained in psychiatric facilities. One-third to one-half the individuals in Mexico’s “granjas” are identified as people with epilepsy or mental retardation. Such individuals do not need or benefit from psychiatric institutionalization. The vast majority of people with epilepsy could live in the community if they were provided with appropriate medications and limited assistance. Most people with mental retardation would need a full range of community-based services and support systems to permit their community integration.

Although MDRI’s investigation in Mexico focused primarily on adults in psychiatric institutions, the team found a ward of 60 children warehoused in a psychiatric facility outside Guadalajara. Under the Convention on the Rights of the Child (CRC), all children have the right to grow up in a family (with their own biological parents or with a substitute family if necessary). Under article 23(3) of the CRC, the Government of Mexico is under an obligation to provide children with mental or physical disabilities the “education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child’s achieving the fullest possible social integration and individual development. . . .” Such services would include an opportunity for integration in mainstream education, cash payments to families with children with disabilities, respite care and foster care.

Segregation from society in Mexico’s isolated “granjas” leads to a breakdown of family and social ties to the community, making long-term detention increasingly inevitable over time. As a person loses ties to the community, such detention itself may lead to a decline in social and psychological functioning. Thus, isolation in Mexican psychiatric facilities also violates the right

---

2 A portion of these individuals would also fall into the category of people considered abandonados, but MDRI encountered many such people who do have family in the community. The authorities consider a significant number of people with mental retardation or epilepsy to be inappropriate for community placement, even if they have relatives willing to keep them at home.
to the highest attainable standard of physical and mental health under article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR). Mexico’s exclusive reliance on inpatient facilities violates the Declaration of Caracas, adopted by the Pan American Health Organization. The unnecessary detention of any individual with a disability violates the right to community integration established under the Inter-American Convention on Disability adopted by the Organization of American States in May 1999.

The Mexican federal mental health law provides a right to services in the community and this law should be fully enforced. In addition, the law is not currently interpreted to apply to a whole category of facilities, the casas de protección, which are technically deemed outside the mental health systems. Casas de protección are administered by the local government in Mexico City to provide services for people who are homeless, and two facilities are set aside specifically for people with mental disabilities. Similar structures may exist in other cities of Mexico. International human rights law provides a right to community integration for people with mental disabilities no matter where they are served. To ensure the enforcement of rights provided by international law, the Mexican mental health law must be extended to include the casas de protección.

Recommendations:

D-1 Plan to end the detention of abandonados - No one in Mexico should be detained in a psychiatric facility because they have no place else to go. Inpatient detention in psychiatric institutions should be strictly limited to those individuals who meet internationally recognized standards for civil commitment on the grounds of imminent and serious dangerousness as a product of a mental illness. Careful planning will be needed to ensure a safe transition of abandonados to appropriate community-based services.

D-2 Plan to end the detention of people with mental retardation and epilepsy - People with mental retardation and epilepsy should not be subject to long-term institutionalization. It is the responsibility of the Mexican Government to undertake immediate efforts to create appropriate services and community support systems for these individuals.

D-3 Plan to end the detention of children in psychiatric facilities - As required by the CRC, Mexico must create a system of family support to prevent the unnecessary breakup of families and the placement of children with disabilities into institutions. For children who cannot remain with their parents even with support systems, as well as true orphans, Mexico should create a system of foster care. Integrated educational programs should also be created to ensure that children with mental disabilities can receive an education in the mainstream school system.

D-4 Create comprehensive community-based services - A comprehensive community-based system is needed to ensure that mental health programs provide adequate services and a safety net for all people with mental disabilities. Comprehensive community-based services should include: supported housing, supported employment, case-management, psychosocial rehabilitation, respite care, appropriate and accessible medical care, and emergency inpatient services in a community hospital. Programs should also be created to improve quality of life and provide for leisure time. Support for consumer controlled club-houses and advocacy are also an essential part of an effective community service system.
D-5 Fully enforce the new federal mental health law - Many of the reforms needed in Mexico have already been established as part of federal law. The Mexican federal mental health law requires the mental health system to provide community-based services and an opportunity for community integration of all people capable of living in the community. The law should be fully enforced.

D-6 Initiate inclusive and open national and local planning for reform - Reform of Mexico’s mental health service system will require the development of plans at the national and local levels to finance and establish an integrated network of community-based services. These plans should include a schedule to transfer people now improperly detained into community service programs as they are initiated. As established by the Rules on Equalization, every country is required to establish such plans to bring their service systems into accordance with international human rights law, including the right to community integration of all citizens. The Rules on Equalization require that people with disabilities and organizations representing them be included in all aspects of planning and program implementation. To ensure that citizen participation is open and democratic, Mexico should establish disability councils (see recommendation E-3).

D-7 Allocate adequate financing for community-based services - The Government should be prepared to expand funding for mental health services in order to finance the creation of community-based services. Programs established by the Fundación Dignidad demonstrate that it is less expensive to serve some individuals in the community than in an institution. While this is so, the system as a whole will cost more during the time of transition because the Government will have to fund institutions as it also creates new services in the community. The Government will not be able to realize the major cost savings of community integration until a fully developed community service system has been created and institutions can be closed. Even then, the overall price for mental health services may go up because many people with mental disabilities who receive no support at present are likely to seek assistance once the services are available in the community.

E. Human Rights Oversight and Citizen Participation

There have been important advances in human rights oversight within Mexico that should be supported and expanded. The Mexican federal mental health law requires the creation of citizens committees to monitor conditions in all psychiatric institutions, and MDRI has found that the citizens committees are functioning within the public psychiatric institutions of Mexico City. According to federal authorities, 90 percent of all institutions in the country now have operational committees. The citizens committees represent an important step forward and will certainly help promote future reform in Mexico. Since their creation, conditions within some of the public psychiatric facilities of Mexico City have improved. Since their visit in 1996 and return in 1998, MDRI investigators saw improved hygiene and an increase in staffing and activities in Ramírez Moreno Hospital. These improvements underscore the importance of continued development of human rights advocacy and effective oversight mechanisms. The existence of serious human rights abuses in some institutions, however, is an indication that existing mechanisms to enforce Mexican law and international human rights standards must still be improved.
Recommendations

E-1 Support and expand citizens committees - The Mexican citizens committees should be supported and expanded throughout Mexico. They should be independent from the Government and the institution in all respects. As Mexican law now requires, citizens committees should have complete, open access to psychiatric institutions. They should be able to inspect reports of abuse or neglect, review records on the use of physical restraints and seclusion, and read reports on all patient deaths and patient complaints. Mexican law also requires that citizens committees be given access to administrative information, which should include information about annual budgets and reports on expenditures of all public funds.

E-2 Support independent, nongovernmental consumer and family advocacy - The Government should financially support the development of consumer and family organizations that can advocate for improved services and rights enforcement. Consumer and family advocacy groups should be entirely independent and nongovernmental.

E-3 Create a disability council - Disability councils are public bodies made up of people with disabilities and community allies that provide a mechanism to ensure full, open and democratic participation by stakeholders in human rights oversight, mental health service policy development and program implementation. Stakeholders include consumers, family members, professionals and staff at institutions. As required by the Rules on Equalization, people with disabilities should be included in national planning for service system reform to bring about full human rights enforcement. Thus, a disability council should include a majority of primary consumers (current or former users of mental health services).

E-4 Create independent monitoring and oversight mechanisms - The Government should establish specialized mechanisms to ensure regular monitoring and oversight of human rights conditions and quality of care within psychiatric institutions and protect the rights of people with mental disabilities in the community. At minimum, each institution should be evaluated once a year by a team of independent, qualified professionals. Assessments should be based on established human rights principles (including the MI Principles in its entirety), Mexican law, and internationally accepted minimum standards for medical and psychiatric care. Results of each evaluation should be made available to professional organizations, family and consumer groups, citizens committees, and the public. People with disabilities, current users of mental health services, representatives of citizens committees, and representatives of disability councils should be included in regular human rights monitoring and evaluation.

E-5 Improve the role of the CNDH - The National Human Rights Commission (CNDH) plays an important role in bringing human rights issues in institutions to the attention of the public. This role should be preserved and expanded, whether or not a specialized human rights oversight mechanism is created. At present, the CNDH does not provide the minimum necessary human rights oversight to protect the rights of people with mental disabilities as described in E-4 because it does not review conditions within every institution on a regular basis and it does not assess the full array of rights set forth in Mexican law and the MI Principles. CNDH recommendations should also be directly enforceable in court.
Preface: Goals and Methods of this Report

This report documents the treatment of people with mental disabilities in psychiatric facilities of the public mental health system of Mexico. It recommends steps necessary to bring the system into conformity with human rights conventions and internationally recognized human rights standards, as well as Mexican law. The MDRI teams encountered many government officials, mental health professionals, direct care staff workers in institutions, and independent activists who are deeply committed to the welfare of service system users. One of the major goals of this report is to support and assist Mexican policy-makers, service providers, and activists working to bring about mental health system reform and full human rights enforcement for people with mental disabilities.

This report is also directed to the international community, which can play a much greater role providing oversight of human rights for people residing or receiving treatment within psychiatric facilities. International financial and technical support can also be of great assistance in aiding Mexican reformers. Given the severity of human rights abuses documented within this report, the concerns of people with mental disabilities should be included at the top of international human rights and development agendas for future work in Mexico.

It is not the intention of this report to single out Mexico for criticism, but rather to examine the enforcement of international human rights law that applies universally to people with mental disabilities. Human rights abuses against people with mental disabilities exist in the United States and in many other countries, and ongoing advocacy efforts are needed in every society to protect this especially vulnerable population. MDRI has conducted similar studies in other countries of Latin America and Central and Eastern Europe. MDRI has published reports on human rights conditions in the mental health systems of Uruguay and Hungary and in the orphanages of Russia.3

This report is the product of a series of fact-finding visits conducted over a period of three years. MDRI sent missions to Mexico in August 1996, late July through early August 1998, and November 1999. Each of these missions included MDRI Executive Director Eric Rosenthal and Dr. Robert Okin, Chief of Psychiatry at San Francisco General Hospital. Débora Benchamo, an independent human rights consultant, participated in the 1998 and 1999 missions. Dr. Humberto Martinez, Executive Director of the South Bronx Mental Health Clinic and member of the American Psychiatric Association’s Human Rights Committee, was a member of the 1999 team. The teams also included other experts in mental health law and social work.4 This report draws primarily from

---


4 The 1996 team also included Catherine O’Malley, JD, MDRI staff, and Sara Lee, M.S.W., Chief of Social Work at St. Elizabeth’s Hospital, Washington, D.C. The 1998 team included Professor Lynda Frost Clausel of the University of Virginia’s Institute of Law and Psychiatry. Brittany Benowitz, Program Associate at MDRI, was a member of the 1999 mission.
the August 1998 and November 1999 visits. Where conditions or treatment practices differed significantly between visits, those changes are noted.

This report focuses primarily on the human rights of people in long-term psychiatric facilities in Mexico City and its environs, as well as one institution outside Guadalajara and one in the State of Hidalgo. In addition, MDRI visited a number of other mental health facilities and a women’s prison with a section reserved for people with mental disabilities. Within the Federal District of Mexico City and the State of Mexico, the team visited four psychiatric facilities: Hospital Campestre Dr. José Sayago (“Sayago”), Hospital Campestre Adolfo M. Nieto (“Nieto”), Hospital Psiquiátrico Dr. Samuel Ramirez Moreno (Ramirez Moreno), and Fray Bernardino Alvarez (“Fray Bernardino”) in 1996, 1998, and 1999. In 1998, the team visited the Hospital Psiquiátrico Dr. Fernando Ocaranza (“Ocaranza”) in Pachuca, Hidalgo and the Hospital Psiquiátrico de Jalisco located outside the city of Guadalajara, Jalisco (“Jalisco”). During the 1999 investigation, MDRI visited the Hospital Psiquiátrico Infantil Dr. Juan N. Navarro (“Navarro”) and two Casas de Protección Social administered by the local government of Mexico City for indigent people with mental disabilities. Most of the facilities listed here have between 200 and 300 beds. The institutions MDRI investigators visited serve more than 2000 inpatients at any one time.

At most locations, MDRI teams received unrestricted access to facilities, staff, and clients. During each site visit, MDRI investigators brought a video camera to record their observations. They were met with great openness and candor, and many people gave generously of their time. Almost without exception, they expressed concern about the need to improve services and protection of rights for people with mental disabilities. This report would not have been possible without their support.

This report provides a general picture of the public services available to people with mental disabilities within the Federal District of Mexico City, a city of 22 million people. The report also gives examples of the living conditions and care provided in two locations outside of Mexico City. Mexico is a large and varied country, and MDRI recognizes that this report describes only part of a complex system of services. While conditions vary throughout Mexico, the Chief of Mental Health Services for the federal government reports that institutions MDRI visited in the Federal District of Mexico are significantly better than in the rest of the country.

The observations and conclusions reached in this report represent the position of the authors and of MDRI alone. The authors have made every effort to be as accurate as possible throughout the report and made this report available to Mexican Government authorities in advance of publication. MDRI has incorporated the corrections of these authorities and published their responses in the end of this report.

---

5 With the exception of Nieto, which MDRI did not visit in 1999.

6 MDRI was not permitted to use a videotape recorder to tape individual patients in Fray Bernardino or the Casas de Protección Social. A video camera was made available to MDRI by the Witness Program of the Lawyers Committee for Human Rights in New York. MDRI’s video tapes are kept in the video library of the Witness Program in New York and are available for review by arrangement with MDRI.
MDRI asks readers to bring factual errors and correct information to its attention. Comments, responses, and suggestions for MDRI’s future work in support of the human rights of people with mental disabilities can be directed to:

Mental Disability Rights International
1156 15th St. NW, Suite 1001
Washington, D.C. 20005
E-mail: MDRI@mdri.org

This report has been translated from English into Spanish. MDRI appreciates any corrections in the language of the Spanish translation or comments on the quality of the Spanish translation. If there are any disparities in the contents of the English and Spanish versions of the report, the English language text should be recognized as the original language used by the authors.
I. Introduction

A. Mental Disability Rights: An International Concern

1. International human rights law

The rights of people with mental disabilities have long been recognized as a matter of international human rights law. While proper enforcement has historically been lacking, core human rights law that applies to all people do—as a matter of law—provide the same rights to people with mental disabilities. The Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR)\(^8\) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR)\(^9\) provide important rights for people with mental disabilities. The American Convention on Human Rights (the American Convention) also provides a broad range of important rights relevant to people with mental disabilities—including a protection against discrimination and against inhuman and degrading treatment and protections of the liberty and security of the person.\(^10\)

Over the last few decades, the United Nations General Assembly has adopted a series of resolutions that can serve as a guide to the application of human rights law for people with mental and physical disabilities.\(^11\) In 1971, the United Nations adopted the Declaration on the Rights of

---

\(^7\) For many years, the promises of international law have not been fulfilled for people with mental disabilities. The UDHR of 1948, the foundation of international human rights law, declares that “[a]ll human beings are born free and equal in dignity and rights. They are endowed with reason and conscience...” (article 1). The UDHR protects against discrimination on the basis of sex, race, religion or “other status.” In theory, people with disabilities have always been protected against discrimination by the UDHR, but it took many years before the international community began to examine the application of this right to people with mental disabilities. At the World Conference on Human Rights in 1993, the international community reaffirmed the universality of human rights under existing international human rights conventions and declarations. At the same time, the Conference emphasized the need for increasing attention to especially vulnerable populations, including people with disabilities, “...Special attention needs to be paid to ensuring non-discrimination and equal enjoyment of all human rights and fundamental freedoms by disabled persons, including their active participation in society.” Vienna Declaration, article 1(22), reprinted in Center for the Study of the Global South, American University, EVALUATING THE VIENNA DECLARATION: ADVANCING THE HUMAN RIGHTS AGENDA 98 (1993) (conference proceedings).


\(^11\) See Eric Rosenthal and Leonard S. Rubenstein, International Human Rights Advocacy under the Principles for the Protection of Persons with Mental Illness, 16 INT’L J. L. & PSYCHIATRY 257 (1993) (describing the development of international human rights law for people with mental disabilities). For a Spanish-language overview of the rights of people with disabilities under international law, see LOS DERECHOS HUMANOS DE LAS PERSONAS CON DISCAPACIDAD (compiled and analyzed by Rodrigo Jiménez, 1996). This valuable resource, which includes a compilation of international human rights instruments relating to the rights of people with disabilities, is available from ILANUD, Apartado Postal 10071-1000, San José, Costa Rica or from the Inter-American Institute for Human Rights, Apartado 10081-1000, San José, Costa Rica. The book was published jointly by these
Mentally Retarded Persons\(^{12}\) (hereinafter, the MR Declaration--reproduced in full in Appendix C of this report) and in 1975 adopted the Declaration on the Rights of Disabled Persons.\(^{13}\) Despite the universal application of these human rights, the international community for many years neglected to hold states accountable for the enforcement of these rights with regard to people in psychiatric institutions. In 1982, the United Nations brought international attention to the concerns of people with disabilities by declaring the “Decade for Disabled Persons,” leading to the “World Programme of Action Concerning Disabled Persons.”\(^{14}\) As part of the Decade for Disabled Persons, an international team of experts began working on the development of international human rights standards that would set forth the obligations of all governments for people with psychiatric disabilities.

As the United Nations was drafting human rights standards for people with mental illness, regional bodies in Latin America, such as the Pan American Health Organization (PAHO) took the lead in calling for nations to take concrete steps to ensure the protection of human rights for people with mental disabilities.\(^{15}\) In an historic meeting convened by PAHO in November 1990, the Declaration of Caracas was adopted by legislators, mental health professionals, human rights leaders, and disability rights activists from North and South America. The Declaration of Caracas represents consensus among professionals and others in the Americas that exclusive reliance on the psychiatric hospital “isolates patients from their natural environment . . . generating greater social disability.”\(^{16}\) The Declaration concludes that such conditions “imperil the human and civil rights of patients.”\(^{17}\)

The Declaration of Caracas calls on national authorities and nongovernmental organizations (NGOs) to restructure mental health care systems to “promote alternative service models that are community-based and integrated into social and health care networks.”\(^{18}\) Mental health resources

organizations and Disabled People International, Canada.


\(^{16}\) \textit{Id. at} 83, \textit{preamble}, paragraph 2.

\(^{17}\) \textit{Id.}

\(^{18}\) \textit{Id.}, article 1.
must be used to “safeguard personal dignity and human and civil rights”\(^{19}\) and “national legislation must be redrafted if necessary. . . .”\(^{20}\) to ensure the protection of human rights.

The principles underlying the Declaration of Caracas received a major boost in 1991 when the United Nations General Assembly adopted the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (hereinafter the MI Principles), reproduced in full in Appendix B of this report.\(^{21}\) The MI Principles are the product of a decade-long effort by experts from around the world to set forth minimum human rights standards for people with mental disabilities. In the absence of a specialized convention on the rights of people with mental disabilities, the Inter-American Commission of Human Rights has held that MI Principles can serve as an authoritative guide to the interpretation of the Mental health law, as it applies to people with mental disabilities.\(^{22}\) The MI Principles are also a useful tool for international human rights documentation, because they provide a fair and consistent standard for the evaluation of human rights practices in mental health systems around the world. This report relies on the MI Principles as the primary assessment tool for evaluating Mexico’s mental health services.

The MI Principles apply broadly both to people with mental illness, whether or not they are in psychiatric facilities and to “all persons who are admitted to a mental health facility,”\(^{23}\) whether or not they are diagnosed as mentally ill. The MI Principles protect all such people against discrimination,\(^{24}\) and they detail a list of rights intended to ensure that people detained in mental health facilities are “treated with humanity and respect for the inherent dignity of the human person.”\(^{25}\)

The MI Principles have major implications for the structure of mental health systems, as they establish that “[e]very person with a mental illness shall have the right to live and work, as far as possible, in the community.”\(^{26}\) To make this possible, “[e]very patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.”\(^{27}\) When placed

\(^{19}\) Id., article 3.

\(^{20}\) Id., article 4.


\(^{23}\) MI Principles, principle 24.

\(^{24}\) Id., principle 1(4).

\(^{25}\) Id., principle 1(2).

\(^{26}\) Id., principle 3.

\(^{27}\) Id., principle 7(1).
in a mental health facility, the *MI Principles* state that a person should be “treated near his or her home . . . and shall have the right to return to the community as soon as possible.”\(^{28}\) Within the mental health facility “[t]he treatment of every patient shall be directed towards preserving and enhancing personal autonomy.”\(^{29}\)

The *MI Principles* set forth substantive criteria\(^{30}\) and due process protections\(^{31}\) against improper psychiatric commitment. Among the substantive criteria for commitment to a mental health facility, the *MI Principles* limit commitment to people diagnosed as mentally ill “in accordance with internationally accepted medical standards.”\(^ {32}\)

The *MI Principles* specify that people receiving mental health treatment have the right to protection against “harm, including unjustified medication. . . .”\(^{33}\) Treatment must be provided “based on an individually prescribed plan . . .”\(^{34}\) The *MI Principles* also ensure that “[n]o treatment shall be given to a patient without his or her informed consent . . .” except under special circumstances set forth in the *MI Principles*.\(^{35}\)

Today in the Americas, Europe, and other parts of the world, many countries have adopted laws against discrimination on the basis of mental disability. These laws help people obtain employment, housing, and access to public services. These laws have been an important part of the process of mental health reform and have greatly helped people with mental disabilities to live full lives in the community.

\(^{28}\) *Id.*, principle 7(2).

\(^{29}\) *Id.*, principle 9(4).

\(^{30}\) To be involuntarily admitted to a mental health facility, a person must be diagnosed as mentally ill and “because of that mental illness” there must be a “serious likelihood of immediate or imminent harm to that person or to other persons” *Id.*, principle 16(1)(a). In cases in which “mental illness is severe and . . . judgment is impaired” commitment may be justified to prevent “serious deterioration” or to provide “appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.” Principle 16(1) (b). Under that principle, “[e]very patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.” Principle 9(1).

\(^{31}\) Individuals subject to involuntary commitment have a right to independent review by a “judicial or other independent and impartial body. . . .” *Id.*, principle 17(1). The decision of the review body may be appealed to a “higher court.” Principle 17(7). The individual subject to commitment has a right to counsel, to request and present an independent mental health report, to cross-examine witnesses, and to present oral, written, or other evidence. Principle 18.

\(^{32}\) *Id.*, principle 4.

\(^{33}\) *Id.*, principle 8.

\(^{34}\) *Id.*, principle 9(2).

\(^{35}\) *Id.*, principle 11(1).
2. International trend toward community integration

Advances in the legal recognition of disability rights are one part of a larger, interconnected set of social, economic and political developments that are leading to great improvements in the lives of people with mental disabilities. As part of this reform, there has been a broad international trend toward community integration in much of the world. Within Europe, the World Health Organization (WHO) has found “a remarkable degree of common ground” regarding the importance of shifting away from reliance on large psychiatric institutions and promoting community-based services that permit the maximum possible integration into the community. In a retrospective study of 30 countries from 1972 to 1982, the WHO characterized the changes in mental health services:

During the last 30 years, psychiatric practice has undergone profound changes, and in consequence so too has the organization of services for the care and treatment of the mentally ill. New Mental Health programmes, policies and legislation have been developed in many countries, and continue to be developed in others. Institutional psychiatry has given way to community psychiatry with, first, an emphasis on extramural facilities such as outpatient clinics, day hospitals, after care hostels, mental health centers, units in general hospitals, emergency crisis intervention centers and their like.

Despite tremendous gains in the acceptance of community mental health, the transformation of mental health services has not been trouble-free in Europe or the United States. In the United States, many people began to associate the growing problem of homelessness with the failure to create adequate community-based services. While community mental health services have never received the amount of support they have needed, studies have shown that the problem of homelessness in the United States was not caused by deinstitutionalization but by factors beyond the mental health system, such as cutbacks in social programs in the 1980s. Despite difficulties in the transition to community care and financing appropriate community services, the role of inpatient hospitalization in the United States has largely shifted from a reliance on custodial care to short-term, acute treatment to resolve crises that cannot be treated in the community.

There has also been a move toward the development of community mental health programs in Latin America. PAHO has documented the establishment of community-based mental health programs in Buenos Aires, Argentina; Puerto Alegre, Brazil; Cali, Columbia, and Curundu,

---

36WHO, Public Health in Europe, MENTAL HEALTH SERVICES IN EUROPE: 10 YEARS ON 75 (1985).

37Id., at 71.


39Most of the people who are homeless need community support, but these individuals would not be appropriate for placement in a psychiatric institution. Id. at 104.

Panama. These programs have been particularly important because they have demonstrated how existing outpatient programs can be used as the basis for the development of more comprehensive community-based services. General hospitals have also been increasingly used to provide services once available only at long-term facilities. In Costa Rica, for example, the number of psychiatric units in general hospitals grew from one to seventeen between 1965 and 1986. This change in Costa Rica has led to an increased emphasis on short hospital stays and social reintegration of people with mental illness. As consensus grows in Latin America, recognizing that community integration is both a need and a right, human rights organizations have increasingly called for the protection of rights under the MI Principles.

B. Background and Structure of Mental Health Services

1. Historical development of service system

The institutionalization of people suffering from mental illness in Mexico dates back to the 1500s with the creation of Hospital San Hipolito, the first specialized mental hospital on the continent. In 1910, La Castañeda asylum was established, housing people with mental illness, people with mental retardation, and a broad range of others marginalized from society. Approximately 1,000 people were transferred to La Castañeda from all parts of Mexico. By the first half of the 1960s, La Castañeda asylum held 3,500 inpatients. Conditions were reported to be extremely poor, including inadequate food, lack of treatment, and crowded living areas. During reforms undertaken in the 1965-70 period, La Castañeda asylum was closed. As part of a national plan called Operación Castañeda, eleven new psychiatric institutions were created, including six institutions known commonly as “granjas” (literally, “farms”). “Granjas” are long-term facilities located in the outskirts of the city. During this period, the following “granjas” were established: Sayago, Ramírez Moreno, Nieto, Ocaranza, and La Salud, Tlazolteotl. The Sayago, Ramírez Moreno, and Nieto “granjas” are described in this report.

At about this time, the Fray Bernardino psychiatric hospital was established within the heart of Mexico City. Fray Bernardino was intended as an academic research and treatment center with programs to train mental health workers. The new institutions were established by the Department of Mental Health (Dirección de Salud Mental) under the Secretariat of Health (then called the Secretaría de Salubridad y Asistencia or “SSA”).


42Id. at 44.

43Id. at 51

44See, e.g. ILANUD, Programa Mujer, Justicia y Genero, in Derechos Humanos de las Personas con Enfermedad Mental en el Sistema de Salud de Costa Rica (1998).

45Hospitales Psiquiátricos: Resumideros de la Sinrazón, Editorial Tres” in 3(107) MIRA, (Mexico, D.F., March 16, 1992) and personal communication with Virginia Gonzalez Torres, President of the Fundación Mexicana para la Rehabilitación del Enfermo Mental, I.A.P.
2. Citizen activism and reform

There are a number of important NGOs in Mexico made up of people with mental retardation and cerebral palsy and their family members. The most active Mexican NGO working to improve care within psychiatric institutions is the Fundación Mexicana para la Rehabilitación del Enfermo Mental (FMREM). FMREM has participated in international and Mexican forums defending the human rights of people with mental illness who have limited economic resources. This organization maintains a position against the model in public psychiatric hospitals and supports a model of psychosocial rehabilitation. FMREM initiated the creation of citizens committees in public psychiatric hospitals in Sayago, Ramírez Moreno, Nieto and Ocaranza. Both the Fundación Dignidad and FMREM were created with the objective of establishing programs in the community. The Fundación Dignidad is the only organization in Mexico that administers such programs. These free residencies for people with psychiatric disabilities provide housing and programs for 62 people.

The founder and president of FMREM, Virginia Gonzalez Torres, has long been an outspoken advocate for the improvement of conditions within Mexico’s psychiatric facilities. Gonzalez Torres has been recognized for her work by the World Association for Psychosocial Rehabilitation, which has appointed her to the board of their Human Rights Committee. In the early 1990s, a series of exposés by FMREM and other mental disability rights activists brought the subject of mistreatment and abuse in Mexico City’s psychiatric facilities to the press on a number of occasions.46 In response to public outcry, numerous improvements were made in the “granjas”. Under continued pressure from FMREM, the Government drafted a new federal mental health law. FMREM was active in drafting and commenting on the law. The new federal mental health law was adopted by the federal legislature in 1994 and entered into force in the Federal District of Mexico City in 1995.47 In other parts of the country, portions of the law were phased in between 1996 and 1998. While there are major gaps in the law’s implementation (described below), the law is legally binding throughout the country.

One of the most important contributions of FMREM was the establishment of citizens committees to protect the rights of people in psychiatric facilities and to provide them with an opportunity to participate in the development of policies and programs at their institutions. The first citizens committee was created by FMREM by negotiating agreements directly with the director of Ramírez Moreno and the Secretary of Health. In many cases, FMREM struggled on its own for months to obtain this recognition. The Mexican mental health law now recognizes the citizens committees and requires them at all psychiatric hospitals. The FMREM has created a number of independent organizations that serve as recognized citizens committees at various institutions, including Ramírez Moreno, Sayago, Nieto, and Ocaranza.

A number of important changes took place following an incident in October 1997, when Gonzalez Torres was physically attacked at the Sayago institution. She visited the institution to seek

---

46 Id.

entry for herself and members of an officially recognized citizens committee to investigate allegations that staff members had raped residents of the facility. González Torres and members of the Committee had been denied access to Sayago for three weeks. One day, after members of the Committee were refused entry, González Torres was permitted to enter the facility alone. Once inside, she reports that she was punched and kicked by institution staff, and she hit her head as they forcibly pushed her out of the institution. She was taken to a general hospital in Mexico City, where it was found that she suffered bruises and a cerebral concussion.

The attack on González Torres received an enormous amount of attention in the Mexican press. The director of Sayago was fired, and shortly after, there was a sweep of top leadership in Mexico City institutions. The directors of Ramírez Moreno and Nieto were replaced, as were key authorities responsible for mental health in Mexico City Government. Within two months, González Torres and members of the Human Rights Committees at Sayago, Nieto, Ramírez Moreno and, later, Ocana were permitted regular access to the facilities.

3. Mexico’s federal mental health law

Mexico’s federal mental health law was adopted before the attack on González Torres, but it has been implemented in an atmosphere much affected by the change in top leadership as a result of that incident.

The mental health law was patterned after the *MI Principles*. Large portions of the *MI Principles* were incorporated verbatim into the mental health law, though a number of additional wording was added, and a few significant sections of the *MI Principles* were omitted. Despite this, Section 11 of the mental health law declares that the legislation is intended to harmonize Mexican federal law with the *MI Principles*. The mental health law provides broad guidelines to public psychiatric institutions regarding the rights, care and rehabilitation of people with mental disabilities.

The mental health law establishes that it is the responsibility of the Government to provide community-based services for people with mental disabilities. Under Section 7.1.3, hospitals have the duty to promote the creation of community-based programs in order to facilitate the reintegration of people with mental illnesses in the community. To achieve a successful transition to the community, hospitals must provide comprehensive (“integral”) rehabilitation programs. Section 3.5 of the mental health law identifies comprehensive rehabilitation as a group of activities aimed at the maximization of the development of the individual to overcome or diminish the disadvantages acquired as a result of their mental illness. Under the law, rehabilitation programs must educate service system users to care for themselves in their daily lives so that they can participate in community activities and engage in a full social and cultural life in the community.  

---

48 Norma, section 11.
49 *Id.*, section 7 (describing integrated rehabilitation programs, “Actividades de Rehabilitación Integral”).
50 *Id.*, section 7.1.3.1 (community-based services should be provided, including services in mental health community centers, day centers, half-way houses, and other outpatient programs).
51 *Id.*, section 3.5, (describing integrated rehabilitation programs, or “Rehabilitación Integral”).
Section 4.2.2 of the mental health law delegates responsibility for assessing individual needs to each psychiatric institution or hospital. Mental health services must provide service users with humane, dignified and hygienic treatment and facilities and must guarantee respect for their civil and human rights.\textsuperscript{52}

The mental health law called for the creation of “citizens committees” to monitor conditions in the “granjas” and other psychiatric institutions.\textsuperscript{53} The mental health law also established the Division of Mental Health (Coordinación de Salud Mental), under the authority of the Secretariat of Health, to establish mental health policy. The Division of Mental Health also serves as a monitoring agency which can make confidential recommendations to institutions for the reform of treatment practices needed to bring service systems into compliance with the mental health law.

The citizens committees have total access to review the institution’s treatment programs, including the service user’s physical and psychiatric records, as well as the administrative records of the hospital. A representative of the citizens committee takes part in the ethics and oversight Committee, which must be established within each institution. Information available to the Committee from observations or direct communication on users’ clinical records must be confidential.\textsuperscript{54} Since the establishment of the mental health law, at least six psychiatric hospitals and “granjas” in Mexico City have established citizens committees.\textsuperscript{55}

The major limitation of the federal mental health law is that it does not contain provisions requiring independent review of civil commitment. This aspect of Mexican law is examined in more detail below in Section III. C.

4. Current structure of services

Mexico is divided into 31 states and territories, each of which administers its own health care programs, including mental health programs. All state programs are regulated by the Federal Government. The Secretary of Health oversees the national health system and directs policies regarding preventative treatment and social services for different types of mental health institutions. Within Mexico, there are 32 public psychiatric institutions, ten private psychiatric hospitals, and four social security psychiatric hospitals.\textsuperscript{56} In addition, Mexico City authorities provide services to indigent and homeless individuals through the Casas de Protección Social and administers two such institutions especially for people with mental disabilities.

\textsuperscript{52}Id., Section 4.2.2. (General provisions “Disposiciones Generales”); Section 8 (Human rights and respect for the dignity of the patient “Derechos Humanos y de Respeto a la Dignidad de los Usuarios”).


\textsuperscript{54}Id., Section 12.2 Appendix B at 77.

\textsuperscript{55} According to FMREM, there are citizens committees at Sayago, Ocaranza, Fray Bernardino, Nieto, Jalisco and Ramirez Moreno hospitals.

\textsuperscript{56} The public and the social security institutions are funded through private, individual and charitable donations as well as by governmental and social security funds. The Social Security system is an insurance system for workers by which the medical services are paid with funds from the government, the employer and the employee.
The Mexican Secretariat of Health (formerly the “SSA”) is responsible for national policies in all areas of health, while the General Directorate of Health Services Regulation (Dirección General de Regulación de los Servicios de Salud) supervises the implementation of policies and regulations at the national level affecting health institutions, including mental health.\footnote{This division was created as part of the 1982-1987 administrative reforms intended to decentralize responsibility for health care and transfer authority to the states.} Within the Federal District of Mexico City, the Subsecretariat for Mental Health (Subsecretaría de Coordinación Sectorial de Salud Mental) regulates public psychiatric services and mental health institutions.

The Social Security system covers half the people in Mexico—people of moderate economic resources who have been employed and have contributed to the social security system. The indigent population and individuals not covered by social security are covered by public mental health services provided by federal and state governments.

Most, but not all, states in Mexico have one public psychiatric hospital. There are approximately 5,500 long-term inpatient beds in the Mexico’s public mental health care system (including services in the Mexico City Federal District and any other programs under federal authority in Mexico; it does not include state mental health services and long-term beds in locally funded institutions, such as casas de protección).\footnote{Data provided by the Coordinación de Salud Mental, Recursos de Atención Psiquiátrica Hospitales SSA (1997).} A study conducted by the Subsecretariat of Mental Health for the Federal District of Mexico City, the National Program for Mental Health of 1998-2000 (hereinafter Programa 2000), estimates that one out of six Mexicans suffers from a mental illness and will be in need of specialized treatment at some time in their life.\footnote{Programa Nacional de Salud Mental 1998-2000 at 8. The report states that “the findings are in accordance with those conducted in other countries, where there is an indication that one of every six persons will suffer from a significant problem related to their mental health that will require the attention of specialized psychiatric treatment for its solution” (translation by MDRI).} As a matter of policy, the great majority of mental health care is supposed to be provided in the community or in general hospitals.\footnote{Coordinación de Salud Mental: Programa Nacional de Salud Mental 1998-2000, at 24-27.} According to the Programa 2000, psychiatric hospitals are to be used only for “a pathology or behavioral disorder which represents a danger to the user and/or the community” or for individuals in need of “a highly technical specialized treatment.”\footnote{Id. at 29-30.}

II. The Promise and Dangers of Reform

There is great promise for human rights enforcement and mental health system reform in Mexico, despite the serious human rights abuses MDRI documented in Mexico’s psychiatric institutions (see Section III). Community-based alternatives to institutions are lacking, and as a result, large numbers of people are improperly detained in institutions and segregated from society. Under these circumstances, it is significant and promising that the new federal Mexican mental health law creates a right to services in the community for people with mental disabilities. The team of Mental Disability Rights International (MDRI) interviewed many service providers and institution
directors interested in developing new programs to support the return to the community of people now living in institutions. Many of these professionals have been inspired by the new Mexican law and others express awareness of a worldwide trend toward community integration. At the Jalisco institution in Guadalajara, for example, the director reported a new initiative to find funding to create the first group home in the community for people now residing in the institution. There were, unfortunately, no federal or state funds available for such new experiments in community-based care.

The chief of mental health services (Coordinación de Salud Mental) at Mexico’s federal Secretariat of Health, told MDRI investigators that immediate efforts were needed to bring about the community integration required by the federal mental health law. He reported that plans were underway to implement the right to treatment in the community which was established under the new law. Over several years, all long-term patients are to be fully reintegrated into the community. The chief of the Coordinación de Salud Mental reported that there was a plan to reduce the inpatient census at institutions throughout the country by one-third within one year. The plan’s first step toward community integration is to transform the “granjas” into “night hospitals” and integrate people into the community during the day.

The promise of the American Convention is consistent with the requirements of international human rights law and the right to community integration recognized under the MI Principles. The MI Principles require governments to ensure that appropriate services and support systems are available to permit people with mental disabilities to live safely in the community. Under the MI Principles, it is ultimately the responsibility of the state to ensure that the rights of people with mental disabilities are protected through adequate support systems both in the community and institutions.

The current approach taken by Mexican authorities to enforcing the Mexican mental health law and the right to community integration raises grave concerns about the safety and care of people returned to the community. Federal authorities reported in November 1999 that there were no government-sponsored community-programs anywhere in the country, and currently no new programs were being established. While there is a national plan to reform the mental health system that calls for the allocation of funding, the Government of Mexico has not set aside the funds to create community-based service and support systems. The federal authorities responsible for mental health have requested new funds, but the amount they have requested, 200,000 pesos (approximately $20,000 dollars), is extremely small. For Mexico City, a city of 22 million people, the federal

The MI Principles provide both a “negative” right which protects against improper detention in a psychiatric facility for individuals capable of living outside an institution and a “positive” right to treatment in the community. The negative right is expressed in principle 9 which states that, “[e]very patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.” The positive right to treatment in the community is expressed as part of principle 7(1), that “[e]very patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.” The right to treatment in the community extends to all people in the community, whether or not they have been institutionalized by the government. Thus, “[a]ll persons have the right to the best available mental health care, which shall be part of the health and social care system.” principle 1(1). The CNDH has called on the Government to fulfill its positive obligation to allocate funds necessary to create community services, as mandated by the MI Principles. See Comisión Nacional de Derechos Humanos, Recomendación 70/95 Caso de Hospital Psiquiátrico de Ocaranza, 1995. The Government of Mexico has not yet fulfilled this obligation.
authorities have requested an amount equivalent to the annual budget of community programs operated by the Fundación Dignidad which serves 62 people.

It is possible that the lack of planning for the transition of individuals to the community is a set-up for failure, without any real intention to carry through with a program of reform. Some institution directors interviewed in November 1999 had never heard of the proposed reform. Within the “granjas” serving Mexico City, however, there had already been an effort to reduce the census of long-term patients. At other “granjas” MDRI visited, the census had recently been reduced. For example, Ramírez Moreno has reduced its long-term patient population by almost 200 people in just over a year. While the director states that all these people were released to the care of their families or to state hospitals, there has been no effort to provide follow-up to these individuals and no new programs in the community have been created for their care. According to the director of Ramírez Moreno, individuals released from that institution may be living on the streets.

Asked why his office requested such limited funds to promote community integration, the chief of the Federal Coordinación de Salud Mental stated that community-based services are expected to be less expensive than treatment in the institution. Given the absence of any studies in Mexico to ascertain the cost of community-based care, the lack of allocated funds and the failure to initiate programs, a rapid decline in the institutional population would be nothing short of reckless. The evidence is clear from experience around the world that it will cost something to integrate people with mental disabilities and it will require careful planning to do so. In country after country, people with mental disabilities have been left homeless and neglected even when countries have planned for some form of treatment in the community.

While evidence from other countries suggests that it may be cheaper for many people with mental disabilities to be integrated into the community—particularly children, people with mental retardation, and people without severe psychiatric disabilities—it is entirely possible that the system as a whole will cost more (international experience financing reform is described further in Section V below). Where community services have been shown to be less expensive than institutional care on a system-wide basis, they have been funded by a transfer of funds from hospital to community-based programs. Until some institutions can be closed, the cost will be increased as two parallel systems are funded at once. The proposed Mexican approach to creating “night hospitals” will retain the most expensive functions of institutions while not producing significant savings in the short term.

The reform of Mexico’s mental health system must be viewed as a human rights prerogative—and not as a cost-saving measure. The current outmoded and abusive system of institutional care very likely fails to serve a large number of people with mental disabilities who prefer to struggle alone in the community with the support of family and friends. They may do this rather than seek treatment in the only place now available—the institutions. In the long term, if more community services are established and the quality of the mental health care system as a whole improves, many people with mental disabilities who currently receive no services could begin seeking additional

---

63 Fundación Dignidad has shown that on an individual level, community care can be less expensive than institutional care. The Fundación Dignidad currently serves 62 people in the community, and it reports that the average cost of care is significantly less than the cost of care in Ramírez Moreno. This experience is encouraging and suggests that with careful planning, current resources could be used more effectively. However, these findings may not hold true for a much larger group of patients who might require more intensive assistance and support to live in the community.
assistance. While the per capita cost of serving these individuals may be lower than current programs, the improvement of Mexico’s mental health system may well create additional costs as it serves more people.

Careful planning for the support and protection of people with mental disabilities in the community is essential for the protection of their rights. This is particularly true in a country like Mexico that does not have a history of community-based services and support systems. In 1998, Mexican authorities reported to MDRI that it would be an enormous task to begin establishing community programs. They also conveyed that it is the Government’s stated objective to create community-based alternatives for psychiatric institutions, but that such services are not in place. To make the creation of these services possible at a national level—even for a small number of patients—federal authorities reported in 1998 that mental health professionals need training to provide such services. For the most part, the majority of service providers have never been exposed to models of community-based psychosocial rehabilitation or support systems for people either with mental illness or developmental disabilities.

Section V describes experiences and lessons from other countries that could be used as guidance in creating a safe and effective reform program.64

III. Human Rights in Institutions

The following is a description of the major human rights issues MDRI identified regarding conditions within Mexico’s psychiatric institutions, “granjas”, and casas de protección. MDRI investigators found considerable variation within the different institutions, as well as some commonalities. By far the worst conditions the MDRI team observed were in the Ocaranza psychiatric institution in Pachuca, Hidalgo and the Jalisco psychiatric facility in Guadalajara, Jalisco, where children and adults were detained in conditions of squalor. The three major “granjas” on the outskirts of Mexico City—Ramirez Moreno, Nieto, and Sayago—were considerably cleaner and conditions of living were more dignified. However, all the long-term institutions (the five “granjas” and the two casas de protección) suffered from the same basic inadequacies: they segregated people from society for long periods of time, often for life, and they were poor environments for rehabilitation. The pervasive quality of life in these institutions was one of isolation and inactivity. Cut off from society, people lose social skills and community contacts that might give them any hope of returning to normal life.

As a facility that provides primarily short-term acute care, the Fray Bernardino Alvarez Psychiatric Hospital was considerably less of a concern than the other seven institutions described in this report.65 Despite this, the general lack of protection of patients’ rights in Mexico, the lack of human rights oversight and advocacy programs, and the lack of respect for individual choice creates

---

64 Additional Spanish-language resources on psychosocial rehabilitation are available from the PAHO and are cited on its website at www.paho.org. In addition, the following resource is available in Spanish from Dr. Humberto Martinez, “Principios de Rehabilitación Bio Psicosocial Fuente: Programa de Acreditación de los Estados Unidos por la Comisión Conjunta Sobre el Cuidado de Salud Mental como aparece en el Boletín de la Asociación Mundial de Rehabilitación Psicosocial,” translated by Humberto L. Martinez, M.D. (for more information contact MDRI).

65 General statements about Mexico’s long-term facilities or “granjas” used in this report are not intended to apply to Fray Bernardino Alvarez.
risks for all people with mental disabilities in Mexico’s mental health system, including short-term facilities like Fray Bernardino.

As described below, MDRI found that the system of “granjas” and the casas de protección in Mexico City, Hidalgo, and Guadalajara violated many fundamental rights of people who live within the institutions. These rights include the right to be free from arbitrary detention,\(^{66}\) protections against arbitrary deprivation of personal liberty and security,\(^{67}\) and the right “to be treated in the least restrictive environment . . . appropriate to the patient’s needs.” The lack of appropriate medical and psychiatric care and unhygienic conditions in some facilities created life-threatening dangers and great suffering.\(^{68}\) These conditions constitute “inhuman and degrading” treatment in violation of international human rights law.

A. Inhuman and Degrading Conditions

Poor physical conditions and lack of appropriate medical treatment and habilitation within Mexican “granjas” and casas de protección cause great suffering and present a very real threat to the health and safety of people residing within psychiatric institutions. At their most extreme, poor physical conditions violate the right to protection from inhuman and degrading treatment and the right to the protection of life.\(^{69}\) The MI Principles require that “[a]ll persons with mental illness . . . shall be treated with humanity and respect for the inherent dignity of the human person.”\(^{70}\) Thus, “living conditions in mental health facilities should be as close as possible to those of the normal life of persons . . .”\(^{71}\) The National Human Rights Commission (Comisión Nacional de Derechos Humanos, hereinafter CNDH) has reported on unhygienic conditions in hospitals throughout Mexico. According to the CNDH, these poor conditions violate the right to the protection of health and protections against undignified treatment.

Over a long period of time, the degrading condition of living in institutions will have a major psychological impact on most individuals, leading to lethargy or depression, loss of self-esteem, and a tendency not to maintain the basic living or self-care skills that a person may have upon entry to the facility. Degrading conditions undermine any efforts to promote psychosocial rehabilitation or individual autonomy, or efforts to promote reintegration into the community, as required by the MI

---

\(^{66}\)ICCPR, article 13.

\(^{67}\)American Convention, article 7.

\(^{69}\)The Government of Mexico is responsible for dangerous and life-threatening treatment practices in public psychiatric institutions. Article 6 of the ICCPR and article 4 of the American Convention prohibit state action that would create life-threatening dangers.

\(^{68}\)ICCPR, articles 7 (“[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”) and 6 (“[e]very human being has the inherent right to life”); American Convention, article 4(life) and article 5 (inhuman or degrading treatment).

\(^{70}\)MI Principles, principle 1(2).

\(^{71}\)Id., principle 13(2).
Principles. Poor conditions violate the right to the “highest attainable standard of physical and mental health” even under the limitations of existing economic resources in the Mexican health care system as a whole.

1. Daily life on the ward: pervasive inactivity

Pervasive inactivity was the most common characteristic MDRI teams observed at all “granjas” and casas de protección in Mexico. The great majority of people in every institution MDRI visited were observed doing nothing—laying in bed, sitting on a bench or on the floor, or—for those able to go outside—laying on the grass or dirt. There were no books, newspapers, or writing materials in most areas. At Ocaranza, men and women were divided into two wards of approximately 70 people, and they spent all day in these wards. Some patients were permitted into a barren courtyard outside the ward for part of the day. Most patients were literally penned into a small part of the residential ward (an area of approximately 10 by 20 meters), separated by benches from their beds so they would not wander back to their bed and sleep all day. A few were apparently allowed outside of this perimeter and did spend their day in bed, also doing nothing. A large television on a shelf beyond the reach of patients was left on all day at high volume, making any conversation or other form of activity—such as reading—impossible. There was no reading material or any other form of distraction on the ward. MDRI observers sat in these wards three or four hours at a time, and observed no activities. People sat motionless on chairs or benches or curled up on the barren floor. In the absence of any other stimulation, some individuals pace in the small encircled area, while others rocked back and forth, masturbated, or self-stimulated in other ways.

According to staff at Ocaranza, there were virtually no activities for most patients. The MDRI team in 1999 observed arts and crafts activities attended by a small number of higher-functioning residents. While these activities were open to all, the program had insufficient staff and materials to realize this goal, especially for people with more severe disabilities who would have needed more individual attention. At the time of the 1999 visit, an independent citizens committee was initiating a program to pay those who participated in activities for their work.

In Jalisco, there were limited activities for a small number of people. Jalisco had a arts-and-crafts workshop and a work program in which people were given responsibilities, such as cleaning. The Casas de Protección had a similar lack of activities.

---

\(^{72}\)Id., principle 13(2)(d) (living conditions should include “[t]he treatment of every patient shall be directed towards preserving and enhancing personal autonomy”).

\(^{73}\)ICCPR, article 12(1); American Convention, article 26 (“full realization of the rights implicit in the economic, social, scientific and cultural standards set forth in the Charter of the Organization of American states as amended by the Protocol of Buenos Aires”).

\(^{74}\)Individuals in the hospital can participate in these programs and earn a total of 70 pesos, or ten U.S. dollars, for working four hours a day, five days a week. Of the hospital’s 352 residents, only 70 selected by the hospital are allowed to participate. The MDRI team observed facilities for the arts and crafts workshops, but these programs were not in session during the visit. According to the director of the program, individuals must be in “remission” in order to qualify. The programs are sponsored by a local, nongovernmental civic association.
During visits to Nieto, Sayago and Ramírez Moreno in 1996, the MDRI team members observed a pervasive lack of activities similar to what they observed in Jalisco and Ocaranza. During the return visits in 1998 and 1999, they observed significant improvements at the three institutions that serve people from the Federal District. They were initiated, in large part, by the FMREM, which introduced a ceramics program operating three to five days a week for three hours at a time. At Sayago, the 150 people working in the ceramics workshop were paid for their time. Both Sayago and Ramírez Moreno hospitals provide buses for workshop participants to travel to the city to spend money earned in the workshop.

The MDRI team observed ceramics workshops at Sayago and Ramírez Moreno and were impressed by the extremely high level of enthusiasm of participants who appeared to greatly appreciate having an activity. Participants also appreciated having an opportunity to make a small amount of money. Many patients repeatedly requested that the time of the workshops be expanded. The workshops are funded by the FMREM with matching funds from the hospitals. Both workshops were full. In addition to the ceramics workshop, the citizens committee at Sayago was operating an embroidery workshop. Approximately 80 residents of Sayago were reported to participate in meetings and activities of the citizens committee. The citizens committees at both Sayago and Ramírez Moreno were operating stores on the hospitals’ grounds that sold toilet paper, cigarettes and snack food at cost. In addition, at Ramírez Moreno, the citizens committee installed lockers in the wards where participants could keep their purchases. With money earned in the program, the majority of the men had bought padlocks for their lockers. These lockers were among the very few personal spaces seen by the MDRI team in any psychiatric facility in Mexico.

While the workshops and activities of the citizens committees filled up only a small portion of the few days in which they were available, even this very limited program appears to have had an enormous impact on the population of the “granjas”. Unlike the withdrawn population of Jalisco and Ocaranza, many residents of Sayago and Ramírez Moreno proudly presented the product of their work to the visiting MDRI team and spoke of what they would do with their earnings from the program. The team also observed much more interaction of residents among themselves and with staff. This situation was in sharp contrast with the situation MDRI observed at these “granjas” on previous trips.

In addition to ceramics workshops, the citizens committees of both Sayago and Ramírez Moreno were conducting “citizens assemblies” to discuss issues regarding the hospital with the men and women of the institutions. In these assemblies, service users and the citizens committees discussed issues such as restrictions on smoking and the hours of the workshops. The citizens committees then tried to negotiate these issues with the institutions’ staff.

2. **Unhygienic conditions of detention**

At Ocaranza and Jalisco, MDRI observed a near total disregard for the health and safety of residents: grossly unhygienic conditions were permitted to persist without the intervention of staff. The lack of guarantees for basic health, safety, and dignity violates international human rights law and the Mexican mental health law. The Mexican mental health law requires a
“safe, hygienic, and human atmosphere that guarantees adequate conditions of food, room, professional medical attention and safe space.” The Mexican legislation also provides people in psychiatric facilities with the right to receive clothing and footwear or to have the ability to use their own if they wish. Clothing was inadequate in all the “granjas”, and many people had no shoes. The CNDH’s findings regarding the condition of psychiatric facilities were in accordance with those of MDRI. The commission reported lack of clothing, ventilation, illumination, beds, living space, food and maintenance services.

At Jalisco, MDRI observed children living in extremely unhygienic conditions. In one room, 12 to 15 children remained permanently on the floor on rubber mats or on concrete. Many urinated or defecated and were permitted to remain in soiled clothing during the entire MDRI visit. MDRI observed children unable to care for themselves with flies on their faces and crawling into their mouths. The smell of urine and feces was terrible in much of the institution. Some staff wore surgical masks, apparently to protect themselves from smell or infection. No such safety measures were available for the children forced to live in these conditions. In a yard area where children were playing, piles of feces were permitted to remain without being cleaned up. MDRI observed one child eating feces and dirt without receiving any attention from staff. When MDRI team members returned to this institution in 1999, they were told that the most of the children with disabilities were no longer permitted outside because of the lack of staff to provide supervision.

At Ocaranza, men and women spent their day sitting or pacing on the ward, often urinating or defecating on the floor. Other patients walked through or sat in urine and feces until staff brought cleaning supplies. At any given time, urine and feces could remain on the floor for 20 to 30 minutes before staff would hose down or mop the floor. According to staff, patients capable of requesting would be permitted to go to the lavatory. MDRI observed no efforts to encourage, assist, or train individuals to leave the room to go to the bathroom.

At meal times, there was no effort to encourage or assist patients to clean themselves before going to the dining halls and there was little opportunity to do so. MDRI observed that many patients waited until the residential ward was unlocked at meal times to go to the bathroom. Where no toilet paper was available, MDRI observed a number of residents use the toilet facilities, wiping themselves with their hands, and going straight to the dining area to eat. Many people, particularly those with mental retardation, were then permitted to eat with their hands.

Staff at Ocaranza were distributing medications twice a day with a common pail of water with one or two cups for a ward of 40 people. This manner of sharing a cup for such a large group of individuals disregards any consideration for hygiene and the prevention of communicable diseases. This situation is particularly serious as many patients take their medications after sitting or walking through their own or other peoples’ urine or feces. While the casa de protección for

---

75 Norma, Section 8.4.
76 Id. Section 8.6
78 The CNDH also reported finding fecal matter and flies at Jalisco. CNDH, supra note 77.
women is considerably cleaner than Ocapanza, MDRI observed a similar practice of providing water for taking medications to a large number of people from a single cup.

Ocapanza’s former director reported to MDRI that Ocapanza’s budget was only sufficient to cover food and medications. He said they face daily scarcity of such items as soap, clothing, toilet paper and cups. At Ocapanza, authorities reported in 1998 that there was not enough staff to keep the residents’ clothes clean.

Many people in the *granjas* and *casas de protección* lacked shoes or other appropriate clothing. Even when considerable funds are invested in new clothing or pajamas, often this clothing is the wrong size or inappropriate for wear in public. Pants were often held up by rope or string. Authorities at Sayago and Ramírez Moreno reported a constant shortage of shoes and other clothing. At Fray Bernardino hospital, generally the cleanest facility MDRI visited, clothing was apparently not washed regularly during the 1998 visit. There was no running water in parts of the hospital and patients complained about the lack of opportunity to get clean clothes. The odor of inadequate washing was strong among a few of the residents MDRI interviewed.

3. Lack of privacy and dignity

The *MI Principles* require that “[e]very patient in a mental health facility shall . . . have the right to full respect for his or her . . . privacy.”\(^{79}\) In addition, “[t]he environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of a similar age. . . .”\(^{80}\)

At every institution visited by the MDRI team, living areas were impersonal, lacking in privacy and almost completely bare of decorations or personal possessions. In living areas, most people had no private space except their bed. At some institutions, there was a night table next to the bed. Some individuals had cups or a toothbrushes, while occasionally some had photographs, a stuffed animal, or reading material. Most lacked any personal belongings in their living area.

In most institutions, beds were grouped together in large rooms with only low dividers separating them. Rooms containing 30 to 40 beds were common. At Fray Bernardino, there were rooms with 24 beds, divided by low walls into four sections of six beds each. MDRI observed a number of beds with thin plastic mattresses and no sheets.

A number of people residing at the “*granjas*” told MDRI investigators that there was literally no place they could ever go to be alone. While the lack of privacy or personalized surroundings is common in a hospital setting, it becomes a much more serious problem for people who spend weeks, months, or a lifetime in an institution. For most people who reside in Mexican institutions, their bed is the only place they can call their own.

\(^{79}\) *MI Principles*, principle 13(1).

\(^{80}\) *Id.*, principle 13(2).
The Sayago, Nieto and Ramirez Moreno “granjas”, located on green campuses in the countryside, have the potential to be beautiful settings, but they were barren of the basic conveniences that might make them dignified living areas. While there were a few benches, some areas had no chairs. Most people sat or lay on the grass or sprawled on open concrete floors.

Most institutions had a television area often with too few chairs. At many institutions, such as Ocaranza, people who did not want to watch television could not sit in an area without a television blaring. In practice, most people seemed to ignore the television.

While conditions at Fray Bernardino were generally better than at the “granjas,” MDRI investigators observed degrading conditions at this facility during their 1998 visit. They observed unhygienic conditions in bathrooms lacking running water, toilet paper or toilet seats. One major complaint of institution residents was the lack of potable water. In some wards, people slept on thin plastic mattresses placed on a metal bedframe without sheets. Extremely loud music was permitted in some living areas, and patients complained that they could not go anywhere for quiet. In much of the institution, there was little or no effort to decorate or personalize the sterile hospital environment for individuals who must remain there weeks or months. Many patients were not provided any place where they can keep personal possessions for daily use.

4. Physical restraints

At Sayago and Jalisco, MDRI investigators observed the extensive misuse of physical restraints. During the 1998 and 1999 visits to Sayago, they observed 10 to 15 people in a ward of 30 left tied to wheelchairs. Staff on this ward explained that restraints were used due to lack of personnel to supervise residents. In addition, ward staff informed MDRI investigators that personnel were lacking to provide people with adequate physical exercise or to prevent swelling or bedsores. The permanent detention of people in physical restraints is not only inhuman and degrading, it can also lead to increased disability as muscles atrophy. The lack of staff attention to bed sore prevention can be dangerous and life-threatening.

Throughout the unit for children with severe neurological problems at Jalisco, MDRI investigators observed children tied to bed frames and to a wire mesh fence. They observed children wearing sweat shirts with the sleeves tied over their fists to prevent the use of their hands. In 1998, they also observed an adolescent boy tied to a wheelchair with strips of cloth. Both arms and legs were fully secured to the wheelchair; strips of cloth across his chest prevented him from moving forward or backwards. The MDRI team was told by staff that this boy remained permanently in

81 Bedsores pose a serious danger to the health of anyone confined to bed or a wheelchair. People in physical restraints are at particular risk of bedsores. Lillian Sholtis Brunner & Doris Smith Suddarth, The Lippincott Manual of Nursing Practice 66 (1982). Unless the bedridden person shifts body position to reduce pressure, “the local pressure continues and skin ulcers develop” Joseph Agris and Melvin Spira, Pressure Ulcers: Prevention and Treatment, in CLINICAL SYMPOSIA ANNUAL 2, 6 (1979). To avoid bedsores, staff would have to check each person regularly to ensure that they do not remain in the same position for more than two hours, and they would have to make sure that bedridden individuals maintain an adequate diet and are kept clean. Id. at 6-7.

82 “Pressure ulcers in early stages involve only superficial tissues; if not recognized and treated early, however, the damage may extend through fat and muscle, even onto the underlying bone. In extreme cases, bacterial infection of the ulcer may be life threatening.” Id.
restraints because he was self-abusive. Behind the boy, the team observed a pole coming out of the wall about 12 feet off the ground, with a rope hanging from it. At the end of the rope, there was a hand-made halter made of cloth. Investigators were told that the boy in the wheelchair would be suspended periodically from this rope to permit him to change position.

Research indicates that self-abuse can often be prevented with the use of non-restrictive measures, such as behavior modification. Along with psychotropic medications, behavioral modification is widely considered the treatment of choice for self-abusive behavior. Staff at Jalisco explained that people who were self-abusive could be restrained indefinitely and that no treatment or behavior modification programs were used. While they agreed that certain individuals could be assisted by staff with constant attention, they also indicated that they lacked sufficient staff to supervise potentially self-abusive individuals.

The MI Principles prohibit the use of physical restraints on a permanent basis or as a substitute for appropriate treatment or staff supervision. Physical restraints may be employed “only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.” To ensure that the use of physical restraints is properly monitored and evaluated, “[a]ll instances of physical restraint . . . shall be recorded in the patient’s medical record.”

A shortage of staff is a poor reason to use physical restraints, because restraints can be dangerous unless individuals are closely monitored. The safe use of physical restraints will require more rather than less individualized attention. The MI Principles require that “[a] patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff.”

At Fray Bernardino in 1998, MDRI conducted a limited check of one woman’s patient record and found inadequate documentation and lack of proper controls for the use of physical restraints. MDRI investigators interviewed a 22 year old woman (Teresa RM) with bruises on her arms and wrists, who reported that she had been held in physical restraints for 12 hours shortly after her admission three days earlier. She also alleged that staff had held a pillow over her face until she stopped screaming when she was first admitted. When they examined Ms. RM’s medical records, they found that it contained an authorization for physical restraints “as necessary.” Unlike other medical records at Fray Bernardino, which are typed and detailed, this record provided no medical indication or guidance as to when restraints could be used. This was apparently left to the discretion of ward staff. While staff agreed that Ms. RM had been restrained, there was no documentation in her chart as to when the use of restraints had started or stopped. Fray Bernardino medical staff reported that hospital policy requires that the start and end times of physical restraints be marked in


81 HAROLD I. KAPLAN & BENJAMIN J. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/VI 2364 (sixth ed. 1995).

82 MI Principles, principle 11(11).

83 Id.
each patient’s record on each occasion restraints are used. A physician who tried to help MDRI investigators reported that the record "should be here but it is not." However, he indicated that authorization to ward staff to administer physical restraints at their own discretion is common in the institution. The lack of documentation for each use of physical restraints, the authorization of such restraints by non-medical staff, and the use of restraints in any condition other than what is necessary to prevent imminent harm, violate the MI Principles.

An interview with Teresa RM suggested that instead of providing appropriate personal attention to this woman's situation, staff misused physical restraints. Ms. RM was admitted after her baby died and she had become, according to her own account, "hysterical." She said that since her admission three days earlier, no member of the institution staff had spoke to her to hear her story. Ms. RM said she was still "very sad" but had calmed down on her own since her institutionalization. She said individualized attention would have helped her calm down earlier.

Authorities at Ocaranza reported that five or six of 300 people in the institutions require the regular use of restraints by means of wrapping their arms and legs wrapped in bed sheets. Restraints could only be used at Ocaranza when ordered by a physician, and each use of physical restraints must be marked in the patient’s medical record. According to authorities at Ocaranza, some women were regularly placed in physical restraints just before their menstrual period.

5. Lack of medical and dental care

The MDRI team observed a failure to provide basic medical and dental care in the “granjas” and casas de protección. Particularly at Ocaranza and Jalisco, the team observed instances when the most simple medical care necessary to prevent infections was not provided. At Ocaranza, the team observed an individual who had cut his foot on a drain in the floor of the men’s ward. His foot was covered with blood but the two nurses on staff who were providing patients with medications made no efforts to assist him. As the team watched, the man walked through puddles of urine on the floor. When asked about this wound, ward staff said it was caused by the grate on the floor but they made no effort to treat the wound or fix the grate. On the women’s ward, MDRI found a woman with an infected and untreated wound on her arm. The nurse told MDRI visitors that this woman had been bitten by another patient. The nurse was obviously aware of the wound, but she did nothing to treat the infection.

Despite the brevity of the visits, MDRI witnessed a number of cases in which people lacked medical care for serious conditions. At Jalisco in 1999, for example, the MDRI team observed a boy tied to a wheelchair with his feet elevated on a chair in front of him. His feet were swollen, discolored and dry. They were covered with untreated cuts and flies. The MDRI psychiatrist could not find a pulse anywhere on either of the child’s feet. When the hospital director was asked about the boy’s condition, he responded that the intern was responsible for the physical state of the patients. The unit psychiatrist reported that the boy was receiving physical therapy but was unable to find an appointment for the boy on the therapist’s schedule. He responded that if the boy was not on the schedule, then he had not been receiving physical therapy. Extensive physical therapy is necessary for people confined to wheelchairs in order to prevent muscle and bone atrophy, to maintain circulation and to fight infection.
Many residents of the “granjas” and casas de protección were lacking teeth and apparently received inadequate dental care. At Ocaranza, staff reported that there was not enough personnel to help everyone clean or brush their teeth. In a 1995 report, the CNDH found the dental care at Ocaranza to be negligent. At Jalisco, the great majority of children appeared to have missing or decaying permanent teeth. Staff at Jalisco reported that only six of 60 children were capable of brushing their own teeth. They said that staff do their best to assist children to brush their teeth after every meal, but they admitted that this was difficult with limited staff. This lack of oral hygiene for the children of Jalisco may lead to increased health risks over time. Decay and loss of teeth can create discomfort (in addition to toothaches, loss of teeth may lead to decreased saliva production, muscle spasms, and chronic headaches) and serious health risks. People who lose their teeth and lack replacements must eventually limit themselves to soft foods, which may lead to malnutrition and a general decline in health.

6. Lack of food, water, clothing, blankets and heat

The CNDH found dangerous deficiencies in both food and clothing in numerous institutions. The Director at Sayago reported a lack of adequate food, clothing and blankets in 1998 to protect the lives of residents. He attributed a number of deaths to the lack of heat, and explained that “we do not have enough money to buy electric” heat in an emergency. The director also said that current levels of funding did not permit “optimal” levels of nutrition. This is an area in which he said that great improvements had been made over previous years, but more improvements were needed.

At a number of institutions there were problems with running water. During the 1998 visit to Fray Bernardino hospital, MDRI found that some wards lacked running water. At Ocaranza, authorities reported that they went for five months in 1997 without running water. According to the director, the institution’s water pump broke. The institution received special funds from the local government to buy a new pump. Despite the fact that funds were available to purchase another pump, the director reported that it took five months to find an adequate pump. During this time, he reported that water had to be brought to the institution at great expense by truck.

During the 1999 visit, the MDRI team observed ten to twelve elderly women in Ocaranza whose appearance suggested severe malnutrition. While the food at Ocaranza had improved since earlier visits, the skeletal appearance of these women suggested either inappropriate diet or lack of staff to provide adequate nutrition.

7. Reproductive rights and parenthood

At one institution, Ocaranza, MDRI received reports from staff that women had been sterilized without their knowledge or consent. The MDRI team was not able to corroborate this with evidence from physical examinations at Ocaranza. In this institution, where more than 100 women

---

87Carolyn Jarvis, Physical Examination and Health Assessment 405 (1992).

88People who can only eat soft foods will often substitute carbohydrates for meat and vegetables. Id.
share a common yard with a slightly larger number of men, staff reported that almost all the women had been sterilized. Further investigation is needed.

The right to informed consent under the *MI Principles* applies to any medical procedure, including sterilization. The *Rules on Equalization* specifically state that “[p]ersons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships, and experience parenthood. Taking into account that persons with disabilities may experience difficulties in getting married and setting up a family, States should encourage the availability of appropriate counseling. Persons with disabilities must have the same access as others to family-planning methods, as well as to information in accessible form on the sexual functioning of their bodies.”

MDRI interviewed women who reported that they had been denied parental rights as a result of being placed under guardianship. In one case, a woman reported that her husband had been designated as her guardian. In addition to placing her in the institution against her will, he denied her all access to her children. Women with mental retardation and *abandonados* are particularly vulnerable to having their reproductive rights or decisions about family denied. These women are commonly declared mentally incompetent and placed under guardianship (a process that lacks appropriate procedural protections for both men and women; see Section III. C.). Special protections must be established for women under guardianship to ensure that highly personal decisions about parenthood, reproductive rights, and sexuality are respected.

**B. Lack of Appropriate Treatment, Rehabilitation and Outplacement**

MDRI found a pervasive lack of treatment, rehabilitation, and continuum of care in the community for residents of Mexico’s *granjas*. Placement in institutions without rehabilitation and efforts to return an individual to the community often leads to unnecessary isolation and contributes to a long-term decline in mental health and well-being. The detention of individuals without such programs violates the right to health, as guaranteed in article 12 of the ICESCR. In General Comment 5, Section IV(F), the Committee on Economic, Social, and Cultural Rights has clarified that article 12(1) “implies the right to have access to, and benefit from, those medical and social services...which enable persons with disabilities to become independent, prevent further disabilities and support their social integration.” Citing Rule 3 of the *Rules on Equalization*, the Committee adds that “such persons should be provided with rehabilitation services which would enable them ‘to reach and sustain their optimum level of independence and functioning.’

The *MI Principles* require that “the treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.” Mexican law requires that “rehabilitation activities will be developed according to the particular needs of the user, with the interdisciplinary participation

---

89 Standards Rules on the Equalization of Opportunity for Persons with Disabilities rule 9(2) (hereinafter StRE).

90 Article 15 of the Convention on the Elimination of All Forms of Discrimination Against Women mandates that countries “shall accord women, in civil matters, a legal capacity equal to that of men and the same opportunities to exercise that capacity.”

91 *MI Principles*, principle 11.
of the health worker, the family and the general community in cognitive, affective, and psychomotor spheres which will comprise the design, promotion, execution, pursuit, and evaluation of programs that promote the user's incorporation in productive life...”

1. Lack of rehabilitation in institutions

Treatment for the vast majority of residents in Mexico’s granjas and casas de protección consists of psycho-pharmacology and little else. Between 1998 and 1999, some rehabilitation programs were developed within the granjas of Mexico City, but there was still no meaningful psychosocial rehabilitation taking place at Ocaranza, Jalisco and the casas de protección. In the absence of such rehabilitation, people spending years in inactivity will tend to lose the life skills they had on entry to the facility. Without social work programs to assist people to maintain ties to family, work opportunities, or other community ties, people grow increasingly isolated over time.

The lack of treatment and rehabilitation programs can lead to a degeneration of physical and mental health conditions, as well. At Jalisco, the Director reported in 1998 that 70 percent of the children at the institution could be toilet trained but adequate staff were not available. As a result, children were living in filthy and unhygienic conditions, many wearing diapers well into their adolescent years. The overpowering smell and inappropriate clothing of these children made it more difficult for them to receive visitors or to spend time outside of the facility. While staffing improved at Jalisco between 1998 and 1999, authorities report that most children are still not toilet trained.

Since MDRI’s visit in 1996, Mexico City’s granjas (particularly Sayago and Ramirez Moreno) introduced occupational therapy programs (e.g. sewing classes, ceramics workshops, simple ball games) that kept some individuals active and engaged. Many of these programs are run by FMREM through the citizens committees within the institutions. The programs appeared to reduce the depression and listlessness associated with inactivity and constituted a major improvement in quality of life that MDRI observed. These programs should be supplemented with vocational and living skills programs that would prepare current institution residents to care for themselves in the community.

While rehabilitation programs within institutions are important, most people with mental disabilities will never experience enhanced autonomy or opportunity for community integration without the establishment of programs that permit them to exercise a higher level of functioning. To take the next step, people need vocational training and supported work programs that would assist them to gain access to work outside the institution. Social work services are needed to assist participants to establish family and other ties to the community. Rehabilitation programs are also needed to support the development of other life skills needed for community integration. Once these programs are established, case managers would be needed to assist individuals to take advantage of services available in the community.

Staff at Fray Bernardino reported that they have diverse rehabilitation programs which were limited by the lack of follow-up services in the community, such as case management, that would support the utilization of skills learned in rehabilitation. In 1999, authorities at Fray Bernardino

---

92Norma, sections 7 and 7.1.1.5.
reported that they had only one professional staff person available to provide support outside the hospital to individuals who were discharged.

2. Shortage of trained staff

MDRI investigators were impressed by the commitment and dedication of most staff to the well-being of individuals receiving services in the mental health system. In every institution MDRI visited, however, there are insufficient numbers of trained staff to meet the needs of the people receiving services. In the last year, there has been an effort in the granjas of Mexico City and Jalisco to increase the number of staff. Despite this, there is a lack of trained specialists in every institution. In some areas, institution staffing levels were so low that it would be impossible to provide anything more than the most basic custodial care.

The majority of recommendations issued by the CNDH on psychiatric hospitals mention shortages of staff. In addition, the CNDH found a lack of training and inappropriate promotion of untrained staff.\(^93\) The MDRI team also found that the lack of trained staff to provide treatment such as physical therapy led to increased health concerns and thus to an escalating need for staff. In short, stricter requirements and better training could greatly increase the efficiency of existing staff. Interviews with both the current Director of Coordinación de Salud Mental and the President of the FMREM revealed concern about the training of mental health professionals in Mexico. The FMREM conducted human rights and social rehabilitation trainings for nurses, administrators and doctors for three weeks in Sayago. This was supported by the Secretariat of Health and the Union of Health Workers.

Unless there are major new investments in staff, it will be impossible to develop the individualized treatment and rehabilitation programs required by international human rights law. Current staffing practices also violate the Mexican federal mental health law, which establishes that a sufficient number of qualified staff to provide psychiatric services must be made available. This includes a requirement that each institution be equipped with personnel for emergency care as well as psychosocial rehabilitation.\(^94\) The most basic minimum standards of care, let alone those required by Mexico’s ambitious federal mental health law, cannot be met at current staffing levels.

The Director of the Sayago granja reported that the lack of staff to supervise patients is an urgent problem. Without sufficient staff, he said unsupervised patients may endanger themselves while wandering around the grounds of the facility. Many of the direct-care staff at Sayago and Ocaraanza reported being overwhelmed by the task of caring for a large population of service users in such conditions. At Sayago, one young woman working on the ward in 1998 described how the lack of staff was dispiriting for both patients and staff. Due to the lack of personnel, she said, staff can observe patients decline in functioning over time and staff feel overwhelmed and defeated by their inability to help.

---

\(^{93}\) Comisión Nacional de Derechos Humanos, Recomendación 187/93 Caso de Hospital Psiquiátrico de Ramírez Moreno, 1993.

\(^{94}\) Norma, Sections 4.2.2, 4.2.4. and 4.2.6.
At Sayago, MDRI observed individuals with bandages on their legs, the result--the team was told--of a failure to have enough physical movement. Staff reported that there was such a shortage of personnel that they cannot provide adequate physical therapy to everyone who needed it. The situation was particularly serious for elders and people with physical disabilities, who needed assistance getting in and out of chairs. As a result, people unable to walk were often forced to drag themselves across the floor. In other cases, people were tied to wheelchairs. In a ward of 30 people, MDRI investigators observed almost half of these individuals left tied to wheelchairs. The investigators were told that staff were insufficient to move patients regularly enough to prevent individuals from getting pressure sores.

The Director of Sayago informed the MDRI team that of a population of 380 women, 80 were permanently dependent on wheelchairs. He reported that if these women had received proper physical rehabilitation and staff attention, half would not be in wheelchairs. An average of 8 to 10 women have fractures each year due to bone atrophy from being confined to a wheelchair without sufficient physical therapy. The director of Sayago reported that he would need three times the number of present staff to provide the women with appropriate care. He had requested but had not received funding from the Government for more staff and equipment.

At Ocaranza, staff reported that there were insufficient personnel to assist patients to go to the bathroom. As a result, many urinate or defecate on the floor of the residential and living areas. In 1998, the MDRI team entered the men’s unit at Ocaranza at the end of the night shift and found one nurse and one guard on a unit with 110 people. Staff at Ramirez Moreno explained that if more personnel were hired, the majority of the patients could learn how to take care of themselves for most daily life activities.

The Director of the Dirección General de Salud Mental reported that in Mexico there are only approximately 3,000 psychologists and fewer psychiatrists because of a lack of economic incentives to enter the profession. Due to low salaries, the Director reported that individuals available to work in public mental health are scarce. Those who do work in the public mental health system often take one or more other paying jobs. Personnel at Ocaranza reported that psychiatrists earned 8,000 pesos, or $800 US, a month and nurses earned half that amount.

3. Improper use and control of medications

The use of psychotropic medications was the most common form of treatment at all psychiatric facilities and granjas MDRI visited, and authorities reported that nearly every resident at the facility was receiving psychotropic medications. Consistent with MDRI findings, the CNDH

---

95 According to staff, there were only two staff ("stretcher bearers") dedicated to this kind of assistance for a population of 296, many of whom are old and physically disabled.

96 Interview with Director of Dirección General de Salud Mental. (July 27, 1998).
found insufficient monitoring of side effects, the use of out-dated medications\textsuperscript{97} and the inconsistent use of medications due to insufficient supplies.\textsuperscript{98}

MDRI’s limited review of patient records suggests a lack of control over the use of powerful and potentially dangerous medications. MDRI conducted only a limited review of patient records at the Sayago, Ocaranza, Ramírez Moreno and Jalisco facilities and thus generalization is difficult with regard to these institutions or the Mexican psychiatric system as a whole. However, interviews with psychiatrists at these facilities indicate that the findings were most likely representative. At Sayago, staff reported that there were not enough psychiatrists to review records regularly, and there was no system for reviewing medication practices. Except at the Fray Bernardino psychiatric institution, the records MDRI reviewed lacked necessary social, psychological, and medical information to administer psychotropic medications as part of an effective individualized treatment program. Even more serious, the lack of medical information or documentation about side effects would make it impossible for psychotropic medications to be used safely at these facilities.

Without adequate controls, the use of psychotropic medications in “granjas” presents a threat to individuals’ basic right to life, as guaranteed by the ICCPR\textsuperscript{99} and the American Convention, as well as the right to the highest attainable standard of physical and mental health, as guaranteed by the ICESCR.\textsuperscript{100} According to the \textit{MI Principles} “every patient shall be protected from harm, including unjustified medication.”\textsuperscript{101} The \textit{MI Principles} require that “a determination of mental illness be in accordance with internationally accepted standards [so as] to provide appropriate care to the [individual’s] need.”\textsuperscript{102} The Mexican mental health law provides users of mental health services with the right “to receive truthful, concrete, respectful information and in a language understandable to him and to his legal representative, about his medical diagnosis, his rights and the treatment that will be applied.”\textsuperscript{103} All medications must be prescribed by a legally authorized specialist and must be registered in the service users’ clinical record. Service users may request a “clinical review of his case.”\textsuperscript{104}

One necessary component of adequate treatment is a complete treatment record. Psychotropic medications have troublesome side effects, which can be dangerous or life-threatening if not properly monitored. Positive effects of medications must also be monitored in order to determine whether they warrant the inherent risks. The \textit{MI Principles} require such records, including

\textsuperscript{97} CNDH, \textit{Recomendación 187/93, Ramírez Moreno}, 1993.


\textsuperscript{99} ICCPR, article 6.

\textsuperscript{100} ICESCR, article 12(1).

\textsuperscript{101} \textit{MI Principles}, principle 8 (2).

\textsuperscript{102} \textit{Id.}, principle 4(1), 8(1).

\textsuperscript{103} \textit{Norma}, article 8.8

\textsuperscript{104} \textit{Id.} Sections 8.11, 8.15, 8.8 and see 8.7
documentation of all treatment \(^{105}\) and a full treatment plan. \(^{106}\) Records must also indicate whether treatment is voluntary or involuntary. \(^{107}\)

None of the records reviewed included a full, individualized treatment plan. Nor did they indicate negative or positive effects of medications. Standard medical practice includes taking social and medical history into account as well as monitoring for adverse side effects of psychotropic medications. \(^{108}\) Such practice was not apparent in any of the records MDRI reviewed in Mexican institutions.

Treatment records MDRI reviewed at the “{granjas}” were sparse and lacking in adequate narrative. \(^{109}\) For the most part, they recorded the date, time, and dosage of medications prescribed, without explanations for levels of medication or changes in these levels. The records often did not specify a complete diagnosis, nor do they provide more than a very limited social or medical history of the patient. \(^{110}\) No individualized treatment plans or progress notes (including essential information about responses to medications) were observed in any of the public psychiatric institutions. The records showed no evidence of physical examination and generally little or no evidence that medical information was integrated into the psychiatric assessment. \(^{111}\) The Director of Ramirez Moreno reported that in 1999 the hospital achieved, for the first time, its goal of giving three physical examinations a year to each patient. Psychiatrists at Ocaranza reported that they have not yet been able to reach their goal of giving each patient biannual examinations. In 1998, MDRI reviewed some medical records at Sayago and found that no notations had been made for at least three months. \(^{112}\) A member of the professional staff at Sayago explained in 1998 that “users do not

\(^{106}\) Id. Principle 9(2).

\(^{107}\) Id. Principle 11(10).


\(^{109}\) An exception to the lack of data in records was found at Fray Bernardino.

\(^{110}\) In general, diagnoses are no more specific than “psychotic” or “schizophrenic.” Often, the one additional detail in the record is whether the patient is viewed as “acute” or “chronic.” The directors at various institutions visited by MDRI in 1998 reported that they are making efforts to complete records because they had found incomplete users’ records and uncontrolled medical treatment as they entered the institutions in 1997. Since the arrival of such directors, new efforts are being made to provide users with improved hygiene, respectful treatment and review of users’ clinical records.

\(^{111}\) Records reviewed showed insufficient information about side effects regarding particular bodily organs, such as bone marrow (through complete blood counts), thyroid, liver, and kidney (though laboratory profiles). Records also lacked documented physical assessments, such as the AIMS (Abnormal Involuntary Movement Scale) to assess for tardive dyskinesia, an often irreversible and potentially debilitating involuntary movement disorder.

\(^{112}\) With the permission of a psychiatrist, MDRI was able to review records at the women’s ward number 6, August 1998.
need regular review of records because they do not have serious psychological problems." Despite this, many of these individuals received powerful and potentially dangerous neuroleptic medications.

Without adequate records, psychiatrists cannot consistently evaluate the effects of any treatment. Without proper record keeping, oversight, or control, the use of psychotropic medications in the psychiatric facilities MDRI visited is potentially harmful and may be life-threatening. In certain cases, the misuse of psychotropic medications can slow or inhibit a patient’s capacity to return to the community. They can also cause great suffering, permanent debilitation from tardive dyskinesia, and even death from neuroleptic malignant syndrome.

Psychiatrists at a number of institutions in Mexico report that they are unable to use basic medications, such as lithium and carbamazepine, because they lack funds for the reagents needed to monitor blood serum levels (the use of these medications can be toxic if blood levels rise too high). Lithium is a well-accepted treatment for individuals with manic-depression and the lack of access to lithium can expose these individuals to unnecessary suffering and danger. In their report, the CNDH ordered that Ocaranza obtain the necessary equipment and reagents to monitor blood toxin levels.

At Sayago, Ocaranza, Jalisco and Nieto, MDRI observed individuals showing apparent signs of advanced tardive dyskinesia--rhythmic movements of the lips and tongue, teeth grinding, shifting back and forth on the feet, and twisted movements of hands--that could easily have been identified as part of routine monitoring of psychotropic medications. At each of these facilities, many people appeared highly sedated, suggesting that high dosages of psychotropic medications were common. The lack of appropriate documentation of the use of medication leaves open the possibility that psychotropic medications are routinely misused through unnecessarily high dosages or through polypharmacy, the dangerous and unnecessary combination of medications. Under these

---


115 Neuroleptic malignant syndrome, heat stroke, asphyxia and cardiovascular effects are the most common causes of psychotropic drug-induced deaths. The following are a small sampling of articles on each of these topics: A. Shalev, H. Hermesh & H. Munitz, Mortality from neuroleptic malignant syndrome, 51 J. CLINICAL PSYCHIATRY 18-25 (1989); W.G. Clark and J.M. Lipton, Drug-related heat stroke, 26 PHARMACOLOGY AND THERAPEUTICS 345-388 (1984); Richard P. Brown and James H. Kocsis, Sudden death and antipsychotic drugs, 35 HOSPITAL AND COMMUNITY PSYCHIATRY 486-491 (1984); O.P. Mehtonen, K. Aranko, L. Malkone and H. Vapahtalo, A survey of sudden death associated with the use of antipsychotic and antidepressant drugs: 49 cases in Finland, 84 ACTA PSYCHIATRICA SCANDINAVICA 58-64 (1991).

116 Kaplan & Sadock, supra note 84, at 2024.

circumstances, a broader investigation into these potential patterns of abuse is warranted. A thorough medical review of every record is needed for everyone residing in Mexico’s “granjas.”

At Ramírez Moreno in 1998, psychiatrists reported that shortages of medications are common at the end of each month. Budgets for purchasing medications were reported to be adequate, but supplies were sporadic. While appropriate medications are not available, patients may be forced to temporarily switch to other medications.

4. Failure to ensure informed consent

The right to informed consent is routinely ignored in Mexican psychiatric facilities. Under the MI Principles, every person subject to treatment within a psychiatric facility must be provided with information about his or her diagnosis; the purpose, method, likely duration and expected benefits of the proposed treatment; alternative modes of treatment available, and possible pain, discomfort, risks, and side effects of treatment. Every person in an institution also has a right to “an individually prescribed plan” which he or she must be able to discuss with a qualified member of the professional staff. He or she has the right to refuse or stop treatment and cannot be invited or induced to waive this right. Even if a person is subject to involuntary treatment, the right to refuse treatment must be respected except when an independent authority reviews the case, finds that a person lacks capacity to consent, and determines that the “proposed plan of treatment is in the best interest of the patient’s health needs.”

The Mexican law does not address informed consent; it simply gives people the right to receive information about the treatments they are given. The voluntary admission form for Fray Bernardino gives permission for staff to apply necessary treatment after receiving the individual’s consent, but staff there informed the MDRI team that the signature on the voluntary admission form is taken to be authorization for all subsequent treatment. Doctors may explain treatment to patients, but most physicians and psychiatrists MDRI interviewed believe they are under no obligation to do so.

In practice, psychiatric personnel most commonly fail to see a need for informed consent. At one of the casas de protección, the chief psychiatrist expressed what is viewed as the consensus among professionals: “silence is consent.” There is no recognition that people may be afraid or unable to speak about their concerns or voice an objection to a particular course of treatment. Rarely are special efforts made to inform individuals about potential dangers or choices. The general attitude expressed to the MDRI team is that the doctors know what is best for patients, so there is no need to ask patients to make decisions.

118 MI Principles, principle 11(2).
119 Id., principle 9(2).
120 Id., principles 9(4) and (5).
121 Id., principle 9(6).
122 Norma, Section 8.8.
There is also a common perception in Mexico that family members can consent to treatment on behalf of their relatives. Thus, if a family member consents to treatment, that treatment is considered voluntary—whether or not the person receiving treatment was ever asked. This practice is a clear violation of international human rights law, which provides rights to individuals and not to family members or groups at large.\(^{123}\) Principle 11 of the *MI Principles*, which protects the right to informed consent, does not permit this right to be exercised by any adult other than the person who is to receive treatment. There are provisions for consent by a “personal representative”\(^{124}\) but such a representative can only be appointed “after a fair hearing by an independent and impartial tribunal” established by law for that purpose.\(^{125}\) In practice, Mexican institutions routinely defer to family members, physicians, psychiatrists, or non-professional staff to make decisions that effectively override the right to informed consent.

There can be an important role for families to play in assisting in the process of informed consent, but this is no substitute for the individual right to make a decision about treatment. The *MI Principles* require that “[e]very patient shall have the right to treatment suited to his or her cultural background,”\(^{126}\) but there is nothing in the *MI Principles* or international law that permits human rights to be denied because of cultural differences. Perceptions about the role of individuals in relation to their families vary widely among different cultures, and effective approaches to medical care and informed consent must be sensitive to this.\(^{127}\) Among Mexican-Americans, for example, there is a widespread reliance on family members to help individuals make medical decisions.\(^{128}\) A culturally appropriate approach to informed consent for some people in Mexico might be facilitated by ongoing contact between a psychiatrist and members of the family of the person receiving treatment. Families can help people explain their choices to medical personnel, and families can facilitate the delivery of information about treatment options to a person who may choose to obtain mental health care.

C. **Lack of Procedural Protections against Arbitrary Detention**

One of the major gaps in the new federal mental health law of Mexico is the lack of protection regarding civil commitment and guardianship. When the Mexican mental health law was drafted, the CNDH criticized the draft for its failure to meet the requirements of the *MI Principles*,

\(^{123}\) Under the *MI Principles*, every person with a mental illness has the same rights as any other citizen. *MI Principles*, principle 1(5).

\(^{124}\) Id., principle 9(6).

\(^{125}\) Id., principle 1(6). Mexican law and practice for the appointment of guardianship is discussed below in section C.

\(^{126}\) *MI Principles*, principle 7(3).


\(^{128}\) Id. at 824.
and it warned that the failure to provide these protections would create “serious risks to the human rights of consumers.”

In practice, the failure to provide appropriate protections in Mexican law results in the violation of the rights of every person voluntarily or involuntarily detained within Mexico’s institutions. Most people are never informed of their rights under international law. In the absence of any less restrictive alternative to inpatient treatment, individuals are given no real choice about detention in the facility. MDRI interviewed people at every institution who desperately wished to return to their homes. Many are theoretically “voluntary” patients. Whatever their technical, legal designation, the detention of these people constitutes a massive deprivation of their civil liberties.

1. Civil commitment

The Mexican mental health law provides a number of important substantive provisions regarding civil commitment, although they are relatively loose and would permit some people to be committed who would not meet the requirements of the MI Principles. The greater flaw in the Mexican mental health law is the lack of procedural protections required by international law.

a. Substantive standards

The Mexican mental health law requires involuntary commitment to be limited to those who require “urgent care” or “pose a grave or immediate danger to themselves or others” as a result of a “severe mental disturbance.” Like the Mexican mental health law, the MI Principles require that a person must present “a serious likelihood of immediate or imminent harm” as a product of mental illness in order to be subject to involuntary commitment. However, the MI Principles have stricter requirements with regard to the commitment of a person for what the Mexican law calls “urgent care.” The MI Principles permit commitment for urgent care “in the case of a person whose mental illness is severe and whose judgment is impaired . . .” only if “the failure to admit or retain a person is likely to lead to serious deterioration in his or her condition and will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility. . . . Even under these circumstances, a person may not be committed if they would be capable of living in a less restrictive environment “appropriate to the patient’s health needs and the need to protect the physical safety of others.” Thus, the MI Principles, unlike Mexican law, make clear that a person is improperly committed to a psychiatric facility if he or she is capable of living safely in the community.

---


130 Norma 4.4.2

131 MI Principle, principle 16(1)

132 Id.

133 Id., principle 9(1).
The Mexican law permits people to be committed as a product of a “severe mental disturbance.” This term is not defined in Mexican law, but it appears to permit people to be committed who have a broad range of mental disabilities that might not be internationally recognized as a “mental illness.” The *MI Principles* require that civil commitment be limited to people with a “mental illness” as defined by “internationally accepted medical standards.”

There are many categories of “mental disturbance” that may not constitute a mental illness, and the detention of people based on these categories would violate international law. The largest such group is people with mental retardation, who make up a large percentage of people served by Mexico’s mental health system. Under international law, these people may be detained in an institution only if they met the standards set for commitment set forth in the “Declaration on the Rights of Mentally Retarded Persons” (the “MR Declaration”). The MR Declaration creates an even higher standard for commitment. Under the MR Declaration “[w]herever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life.” The MR Declaration, commitment to an institution is permissible only when it “becomes necessary.”

The MR Declaration is not as modern and detailed as the MI Principles, so the term “necessary” is not well defined. International experience has shown, however, that people with the most severe forms of mental retardation and other developmental disabilities can be successfully integrated into the community. Thus, it is not necessary for the vast majority of people with mental retardation to be institutionalized.

**b. Procedural protections**

The *MI Principles* establish strict procedural protections for determining whether a person meets the substantive criteria for civil commitment described above. Under the *MI Principles*, people involuntarily committed have a right to a hearing by an independent and impartial review body. The individual has a right to counsel at the hearing, free of charge if he or she is an indigent patient. If the individual is dissatisfied with the outcome of the hearing, he or she has the right to appeal the decision to a higher court. The individual may also request and produce an independent medical health report or other evidence at the hearing and have access to his or her own medical records. Mexican law does not provide any of these rights to people subject to civil commitment.

Under Mexican law, involuntary commitment requires only the written approval of a psychiatrist and a responsible family member or legal guardian (as described below, Mexican

---

134 Id., principle 4(1).


136 *Id.*

137 *Id.*, principle 16(2).

138 *Id.*, principle 18(1).

139 *Id.*, principle 17(7).

140 *Id.*, principle 18(3) and (4).
procedures for appointing guardians also lack procedural protections). In the case of an “extreme emergency,” an individual can be committed upon the approval of the doctor in charge of the admissions unit of a hospital. The Mexican law does not require judicial oversight of the civil commitment process. There is no mechanism requiring any independent review of the initial commitment.

The Mexican law requires the hospital to inform the Ministerio Publico (an investigating judge) of the admission and “development” of the case, but it does not require the Ministerio Publico to review or approve the commitment. Psychiatrists informed the MDRI team that the notification of the Ministerio Publico is done to help locate individuals under suspicion of criminal behavior. At one institution, MDRI investigators were shown a form used to notify the Ministerio Publico of the diagnosis, reason for commitment, and date of admission. According to the psychiatrists, progress reports are rarely if ever filed.

Mexican law requires periodic clinical review of each case by medical authorities at the institution. This review is not conducted by an independent authority, and it does not require any determination that a person continue to meet the substantive standards for civil commitment. Under the Mf Principles, an independent review body must review each case “at reasonable intervals” set forth in the law.

As described above, doctors at Fray Bernardino and the “granjas” reported that the majority of patients are there voluntarily. Where the doctors recognized any process at all, the patients were usually committed by family members. When family members consented to institutionalization, people were routinely treated as “voluntary patients,” whether or not they agreed to the commitment. This common practice violates the basic terms of the Mexican mental health law. This law permits voluntary commitment to an institution, but it requires that such commitment be “at the user’s request.” The law does not permit family members to agree to voluntary treatment on behalf of someone else. A number of “voluntary” patients reported to the MDRI team that they never requested admission and were committed against their will by husbands or other family members. The only exception the team of investigators observed was at Fray Bernardino, which required the signature of the person being committed.

2. Guardianship

People in Mexican institutions are commonly treated as “mentally incompetent” and placed under guardianship. This strips them of their right to make decisions about their life. A number of institution directors reported that they act as legal guardian without any independent judicial review or judicial designation as such. At the “granjas” and casas de protección, the director of the

---

141 Norma, section 4.4.2.
142 Id., section 4.4.2.
143 Norma, section 6.4.3.1.
144 Id., principle 17(3).
145 Norma, section 4.4.1.
institution acts as the guardian of a great majority of the people. In the absence of family members to consent to treatment on behalf of the patients, people labeled *abandonados* are regularly placed under guardianship without process. At Ocarañza, for example, the director reported that she is legal guardian of 280 of the institution's 300 residents—that is, almost every *abandonado* in the institution.

As guardian, the institution director can make any decision on behalf of a person (known legally as a "ward"). Thus, as guardian the director can consent to all forms of treatment in the institution and to the decision that the ward will spend a lifetime in the institution. Guardianship thus provides a way to deprive a person of their right to informed consent and their right to protection in the civil commitment process, because any decision made by the guardians is theoretically a "voluntary" decision of the ward.

The appointment of a guardian without legal process violates international law. The *MI Principles* ensure that people with mental illness retain the same rights as all citizens, including the right to make basic decisions about their lives. Thus, any decision to appoint a guardian should "be made only after a fair hearing by an independent and impartial tribunal." Recognizing the potential for a conflict of interest between a ward and the institution providing him or her with residential care and psychiatric services, the *MI Principles* ensure the individual has "a right to be represented by counsel who shall not in the same proceedings represent the mental health facility or its personnel." No such protections exist at Mexican institutions. Indeed, the fact that the decision to place a person under guardianship is made by the institution itself presents grave dangers to anyone who may disagree with an institution on any matter. The fact that institution directors serve as guardians for so many people at once belies any attempt on their part to represent or respect the choices or decisions of their wards. With 280 individuals under one person's guardianship, individualized attention would be impossible even if it were intended.

The Mexican mental health law makes no reference to the issue of guardianship. Technically, Mexican state laws do govern guardianship. Most of these laws are similar to the provisions of the Mexico City Federal District. Under this law, guardians may be appointed for minors or for people who are deemed "personally incapable" under the law and are obliged to protect the interests of their wards.

The guardianship law provides some important procedural protections, though it stops short of providing all the protections required by the *MI Principles*. There is a right to a hearing before a judge. The judicial authority can assign the nearest capable relative (or, in their absence, a court appointed "friend") to serve as temporary guardian for the purpose of the proceedings. There is no provision for independent legal counsel, and there is no requirement that the advocate explicitly represent the expressed interest of the individual.

---

146 *MI Principles*, principle 1(6).

147 See e.g., Code of Civil Procedure for the Federal District, Capítulo II, which addresses the "Nomming of Guardians and Caretakers and Judgement of these Positions" (translation by MDRI).

148 *id.*, section 450.
In practice, attorneys in Mexico report that this law is generally used only when an adult with mental disabilities has property or other wealth that family members wish to control. There is nothing in this law that would restrict it to such cases. In practice, people in psychiatric institutions or casas de protección generally do not benefit from this law’s protections. Enforcement of Mexican guardianship law for all people with mental disabilities would represent a great step forward in the protection of rights in Mexican psychiatric facilities.

D. Improper Segregation from Society

The majority of people subject to long-term placement in Mexico’s psychiatric institutions are improperly, unnecessarily, and arbitrarily detained. This section focuses on the improper segregation of people from society in closed psychiatric facilities. International law recognizes a right to community integration that is distinct from the rights that pertain to the civil commitment process. As established in the MI Principles, every person receiving mental health services “shall have the right to be treated in the least restrictive environment . . . appropriate to the patient’s health needs . . .”

The official Mexican policy of limiting psychiatric placement to individuals who are dangerous to themselves or others, or in need of specialized treatment unobtainable outside the institutions, is consistent with the MI Principles. In practice, however, this policy bears little or no relation to the actual population of Mexico’s “granjas”. The great majority of those detained are not dangerous and would be capable of living in the community with appropriate services and support systems. In most cases, such services could be provided more effectively in the community than in psychiatric facilities.

1. Detention of “abandonados”

A large number of people placed in long-term facilities are officially labeled “abandonados” — people placed in psychiatric hospitals because they have no family and no place to go. In theory, abandonados have some form of mental disability. Whether or not this is so, abandonados live in the institution—usually for life—because they do not have a family willing to keep them at home, and the government has no other program that can care for them. Government authorities, administrators, and medical staff at the psychiatric institutions visited by MDRI estimated that between 33 and 80 percent of the individuals subject to long-term placement in institutions are abandonados. According to most directors interviewed, the great majority of these individuals would be capable of living in the community if they had families willing and able to take them, or if the government

---


150 MI Principles, principle 9(1).

151 Government reports from 1996 made available to MDRI officially identify 36 percent of the inpatient population in Mexico as abandonados. Ms. Rocati, former President of the CNDH, reported to MDRI that approximately 70 percent of the institutional population in Mexico are abandonados. At Sayago and Jalisco, authorities reported that 75 to 80 percent of their patients are abandonados.
provided appropriate services in the community. According to the Chief of Mental Health Services for the Federal Government, all of the people now detained in the “granjas” nationwide would be capable of living outside the hospital if appropriate services were available in the community. In 1998, the predecessor of this official shared a similar opinion. According to him, “80 percent could be returned to the community, and of these 100 percent could have been rehabilitated but they have been institutionalized for so long without services that they could not go out now.”

In other countries, outplacement efforts have proven successful for the great majority of people subject to long-term placement. With proper support and rehabilitation, even those who have spent decades in an institution can learn to live in the community with great improvement in quality of life. After years of living within the closed walls of an institution, most abandonados would require assistance re-establishing ties to the community, even if they no longer have symptoms of mental illness. The Mexican official’s perception that life skills diminish over time for individuals in long-term placement is consistent with research findings. While psychiatric morbidity will generally decline over time, long-term placement does create dependency on institutional services, even for those who could once care for themselves. Long-term detention of abandonados contributes to “iatrogenic disabilities,” a decline in health and social functioning caused by treatment (in this case, detention in an institution). Despite this, individuals have been institutionalized for a long time can still benefit from community integration programs.

2. Detention of people with mental retardation and other disabilities

A large proportion of people placed in Mexico’s long-term psychiatric facilities do not have a “mental illness” but are admitted or detained because of some other disability. Mental retardation is reported to be the primary cause of long-term institutionalization in the “granjas,” and many of the staff MDRI interviewed improperly referred to this condition as a “mental illness.”

The Mi Principles prohibit the psychiatric commitment of individuals not suffering from mental illness, and a psychiatric diagnosis must be made “in accordance with internationally

---

152 Officials and institution directors varied in their estimates. According to the Director of Sayago, 100 percent of the population of his institution could benefit from community integration. At any one time, however, he said he believed, 20 percent of the current population would require short-term, acute inpatient care.


154 Harding, supra note 153, at 667.


156 WHO REVIEW OF EFFECTIVENESS, supra note 155, at 19.

157 Mi Principles, principle 16.
accepted medical standards."¹⁵⁸ People with mental retardation do not require psychiatric care or commitment to a psychiatric institution. Under the MR Declaration the United Nations has stated that "[w]henever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life."¹⁵⁹ Placement in an institution should only take place when "necessary."¹⁶⁰ In the last 30 years, many countries have made great strides in developing effective support services that permit most people with mental retardation in many countries to be integrated into the community.¹⁶¹

Placement in a Mexican psychiatric institution can be particularly dangerous for people with mental retardation because these institutions lack the professional staff trained to serve them. Most long-term facilities visited by MDRI have few if any education, habilitation, or behavior programs geared to the needs of people with mental retardation--either to help them reintegrate into the community or to provide them with basic living skills necessary for day-to-day survival. There was a widespread misperception on the part of direct-care staff that people with mental retardation could not acquire self-care skills. In the "granjas" and the casas de protección, there is little or no effort to distinguish between patients with mental illness and mental retardation.¹⁶²

As a result of the lack of staff assistance or training in self-care, people with mental retardation are permitted to languish in the worst conditions in the institution. In Jalisco and Ocaranza, the MDRI team observed people with mental retardation living in filth, wearing ragged clothing, often covered in their own feces. Most people with mental retardation spend their days without any activities, often laying on the filthy floors of the ward, the pavement or the grass outside.

Many others are unnecessarily subjected to long-term institutionalization. People with substance abuse problems, alcoholism, or alcohol-related dementia could be more appropriately and more cost-effectively treated in the community.¹⁶³ The detention of people because of epilepsy

---

¹⁵⁸ Id., principle 4(1). The Mexican mental health law also recognizes that the WHO’s International Classification of Mental Illness should be used. However, the Mexican mental health law does not provide any protections against the commitment of people with mental retardation to a psychiatric facility.


¹⁶⁰ Id.

¹⁶¹ A recent study in the U.S. state of Minnesota found that with appropriate community supports such as behavioral management plans and follow-up consultation, even people with mental retardation who display aggressive or severely destructive behavior could live successfully in the community. Josefin S., Coluna and Norma A. Wiesler, Preventing Restrictive Placements through Community Services, AMER. J. MENTAL RETARDATION 100(2), 201 (1995). In Greece, a 1993 European Union-funded pilot project successfully moved residents of an extremely isolated institution into a community-integrated group home in Athens. Tsantis, supra note 153, at 14.

¹⁶² In 1999, MDRI investigators observed improvements in Ramírez Moreno hospital. Some specialized programs had been established to serve the population with mental retardation.

¹⁶³ Long-term psychiatric institutionalization is not an accepted treatment for people with a history of substance abuse. The WHO’s Review of Effectiveness cites studies showing that “hospital services are of little value to the patient and are probably not cost-effective; virtually all treatment modalities are possible in an outpatient or day care setting...” Lorenzo Burti & Vasily Yestreblov, Procedures Used in Rehabilitation, in WHO, REVIEW OF EFFECTIVENESS, supra note 155, at 298. People with alcohol-related dementia can also be served in the community.
(reported to be 12 percent of inpatient populations) indicates a high level of unnecessary institutional placements. At Sayago, staff reported that, due to the lack of treatment in the community, people with epilepsy must remain in the institution for life. Epileptic seizures can usually be controlled with anti-convulsant medications, permitting the majority of people with epilepsy to be fully integrated into the community.\textsuperscript{164}

The placement of people with mental retardation, epilepsy, alcoholism and substance abuse problems within psychiatric facilities is inappropriate, unnecessary and depletes the resources of the mental health system as a whole. Funds are inadequate to provide appropriate mental health treatment and psychosocial rehabilitation for people diagnosed with major mental illness and in need of chronic or acute care. By draining institutional resources from those who most need care, the improper and unnecessary detention of individuals not in need of hospitalization contributes to the inappropriate and inadequate treatment of all.

3. Detention of children

The MDRI study focused on institutions for adults with mental disabilities, so the authors are not in a position to determine the extent to which children are detained in Mexican institutions. At the Jalisco psychiatric institution in Guadalajara, however, MDRI investigators observed 58 children detained in a long-term psychiatric facility. Staff for physical therapy, educational programs and what is called “psychological” rehabilitation is limited\textsuperscript{165} and there are no specialists on staff for speech therapy or behavioral habilitation.

The lack of behavioral habilitation experts is particularly serious because of the widespread problem of self-abuse. Such children were either ignored (one child was observed banging his face against the floor for 15 minutes without receiving any attention or assistance) or are held permanently in physical restraints. Staff on the ward reported that they lack training in how to respond to self-abusive children. The chief of the ward, a child psychiatrist, reported that there are no programs, other than physical restraints, to respond to the needs of children with self-abusive behavior. In the absence of appropriate habilitation programs, children in Jalisco are allowed to languish on beds, on the floor, or on foam pads for hours without attention. Many of these children were observed literally covered in their own feces.

There are no outplacement services to ensure that children are returned to the community or to a substitute or foster family. During MDRI’s 1999 visit, the hospital director reported that Jalisco was attempting to establish a group home for the children with mild mental retardation. The Government was unwilling to provide funding for the home so the director was looking for resources from NGOs. He said he had not yet succeeded in finding funding for the home.

\textsuperscript{164}Kaplan & Sadock, supra note 84, at 205.

\textsuperscript{165}MDRI investigators found significant improvements in staff in 1999. The administration of the institution should be credited for its creative use of students and interns from nearby schools.
International human rights law creates greater protections for children than for other people with disabilities because the placement of any child in an institution can be dangerous.\textsuperscript{166} Children raised in congregate facilities experience potentially irreversible psychological deficits as well as developmental delays. This is true even when facilities are well funded, well maintained and well staffed.\textsuperscript{167} Children who are raised in congregate setting are subject to higher rates of infectious morbidity and malnutrition than their counterparts who are raised in home-like environments.\textsuperscript{168} Without appropriate education, habilitation, and other programs designed for children, the psychological and developmental risks associated with placing children within institutions are greatly increased.\textsuperscript{169}

The Convention on the Rights of the Child (CRC) recognizes that every child should grow up with a family (their biological family or a foster family) rather than in an institutional setting.\textsuperscript{170} To make it possible for children with disabilities to be placed in the community, article 23 of the CRC requires that service systems be:

designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child’s receiving the fullest possible social integration and individual development.\textsuperscript{171}

Mexico has failed to fulfill its legal obligation to children with disabilities at Jalisco.

4. Improper incentives for institutionalization

The lack of community-based services and support systems force many people to seek treatment in psychiatric facilities. In addition to \textit{abandonados} who lack family or other community supports, there are people with family and community support who are forced to seek treatment in institutions because certain treatments are provided only in an inpatient context. As a rule, psychotropic medications are free only for inpatients and not on an outpatient basis. People with access to health care through the social security system can receive medications outside the hospital.


\textsuperscript{167}Studies from Romanian orphanages demonstrate that, when social stimulation is limited, developmental deficits can be profound. Even in well-staffed institutions, deficits in cognitive development and verbal skills will be significant. Deborah A. Frank, Perri E. Klass, Felton Earls, & Leon Eisenberg, Infants and Young Children in Orphanages: One View from Pediatrics and Child Psychiatry, 95 PEDIATRICS 569, 572 (1996); Sandra Kaler & B.J. Freeman, Analysis of Environmental Deprivation: Cognitive and Social Development in Romanian Orphans, 35 J. CHILD PSYCHOLOGY AND PSYCHIATRY 769 (1994).

\textsuperscript{168}Frank, et al., supra note 167, at 570.

\textsuperscript{169}Id.

\textsuperscript{170}CRC, \textit{preamble}; see Rosenthal, et al., supra note 166, at 85.

\textsuperscript{171}Id., article 23(3).
but approximately 40 percent of the population must rely on the public mental health system. People with disabilities are more likely to rely on the public system because they are less likely to work and hence receive social security benefits. People with limited incomes who rely on the public health system may enter a psychiatric hospital solely to receive medications.

On a case-by-case basis, hospital psychiatrists can authorize the provision of free psychotropic medications. However, staff report that approval for free medications as an outpatient is difficult to obtain. The Sayago outpatient department reportedly received more than 9,900 visits in 1998, most of which were brief consultations for individuals on psychotropic medications. According to staff at Sayago, only 20 to 30 people are approved to receive free medications. At Ramirez Moreno, the Director stated that outpatients receive only prescriptions and no medications. As he described it, “(hospital staff) have to choose between medications and beans.”

For many, the cost of maintaining psychotropic medications is prohibitively high. Individuals in need of medications who might otherwise be able to live in the community are thus forced to check into an institution to receive medications. Individuals who are not admitted or who are discharged without follow-up services will receive nothing in the community.

E. Assessment of reforms in Mexico City since 1996

MDRI investigators found major improvements in Mexico City’s mental health system since their first investigation in 1996. The greatest changes appeared to have taken place between the 1996 and 1998 MDRI visits, but additional improvements also took place in 1999. Between 1996 and 1999, there was a great deal of attention in the Mexican press to poor conditions within psychiatric hospitals. The well-publicized incident involving the attack on activist Virginia Gonzalez Torres, was apparently an important turning point. As a result of public outrage, new directors were appointed to the Coordinación de Servicios de Salud and to Ramirez Moreno, Nieto, and Sayago. During MDRI’s 1998 visit, the new federal mental health authorities and directors of the “granjas” serving Mexico City promised major improvements in the mental health system. These authorities reported that their efforts would be greatly aided by two very important developments: the new federal Mexican mental health law and the citizens committees officially required by that law.

MDRI investigators observed particularly significant improvements within Sayago and Ramirez Moreno “granjas.” During its 1996 visit, the investigators observed people naked or in ragged clothing, soiled or covered in urine and feces. In 1999, for the most part, they found clothing cleaner and in better condition. While most individuals lacked shoes in 1996 visit, many had shoes by 1998. As described above, FMREM has contributed enormously to the improvement of the institutions through the creation of ceramics classes and other rehabilitation activities. In addition, both institutions provided opportunities for daily work at areas designated for such activities. In addition, there are an increased number of field trips to the community. A citizens committee operates at each institution and arranges for a weekly assembly where residents are able to express their concerns.

The changes at Ramirez Moreno hospital are striking. In a newly constructed ward, MDRI investigators observed extremely disturbing conditions in 1996. The inhuman and degrading conditions within this building provided an object lesson in the abuse that can be perpetrated despite large financial investments in new physical facilities. In 1996, people with mental retardation and
Mental illness were mixed together on the same ward and everyone in this ward was left in a state of almost total neglect. In a central courtyard, MDRI observed people naked or in ragged clothing. The smell of urine and feces was overpowering. People on the ward were detained without activities, and were left to pace, rock, self-stimulate, or lay for hours on the pavement.

In 1996, a psychiatrist on the ward reported that chaos reigned within the ward as doctors were unable to enforce orders for appropriate treatment or monitoring of medication among nurses or other direct-care staff. According to the psychiatrist, staff sold psychotropic medications on the black market, and supplies would run out by the middle of every month. As a result, he said that all patients would be abruptly denied medication until supplies came in the next month. Asked why doctors could not ensure proper treatment, the psychiatrist reported that nurses or other staff would resign en masse if they tried to establish order. Indeed, he pointed out that his telephone service had recently been cut by staff who had protested his efforts to provide basic protections for his patients. The psychiatrist stated that, in his opinion, people with mental retardation and mental illness would be significantly better off if they were at least placed in separate wards so that a modicum of individualized, appropriate treatment and activities could be established. When asked why he did not do this on his own initiative, the psychiatrist said that this was the “tradition” of Mexican psychiatry. He said that many young psychiatrists would like to bring about change, but they could not exercise initiative in face of the authorities who controlled the system.

When the MDRI team returned to Ramírez Moreno in 1998, they found that this young psychiatrist had become the director of the institution. In his position as director, he had made many of the changes he had wanted to make two years earlier. Physical conditions were cleaner, and clothing was improved. Telephones were in order. People with diagnoses of mental illness were separated from people with mental retardation, and activities were established to keep people busy during the day. Staff no longer reported shortages of neuroleptic medications, though inadequate laboratory supplies made it impossible to use other essential medications, such as lithium. During its 1999 visit, MDRI found that conditions had continued to improve as rehabilitation programs have expanded to serve more people.

Improvements at Ramírez Moreno demonstrate the enormous possibility for reform through individual leadership by the director of a psychiatric institution, along with sympathetic city authorities. Funds have not been significantly increased at this institution, yet living conditions at Ramírez Moreno have greatly improved—including the basic dignity afforded to those residing at the institution. Despite these important gains, the underlying difficulties at Ramírez Moreno remain the same as at the other long-term facilities MDRI visited. The lack of funding for supportive services and medications in the community continues to create unnecessary incentives for people to be placed in institutions when they are capable of living in the community.
IV. Human Rights Oversight

People detained in psychiatric or other facilities are uniquely vulnerable to human rights abuses, in part because they are totally reliant on these institutions for basic needs, medical care, and permission to have any form of contact with the outside world. People with mental disabilities may not have the wherewithal to speak out for their own rights, and when they do, they are usually seen to lack credibility because of their psychiatric label. Thus, as documented in this report, the worst forms of inhuman and degrading treatment take place in closed facilities. Cut off from public view, abuses can continue for years unexposed. Specialized human rights oversight and enforcement mechanisms are needed to ensure that the rights of all people in psychiatric facilities are protected.

A. Notice of Rights and Complaint Procedures

The *MI Principles* create layers of safeguards to ensure the protection of the rights of institutionalized people. Thus, there is not only a requirement that individuals be notified of their rights, but this must also be “in a form and a language which the patient understands... which information shall include an explanation of those rights and how to exercise them.”[^172] Where domestic law does not provide the full protections of the *MI Principles*, patients must be informed about *both* domestic and international legal protections.[^173] If a person has a personal representative, guardian, or friend “best able to represent” his or her interests, that person needs to be informed of the patient’s rights.[^174] A person may choose someone to represent his or her interest with institutional authorities.[^175] Even if a person is deemed incapable of making an informed decision about his or her care, “every effort shall nevertheless be made to inform the patient” about his or her care and the available choices.[^176]

In a number of Mexican institutions, MDRI observed a list of rights posted on the wall. Often, these rights were not posted near living areas, so some people could not see this information all or part of the time. Within most residential wards, there was no information about how to make a complaint or telephone numbers that people could call to make a complaint. Even when numbers were posted, people did not have easy access to telephones. In Fray Bernardino, for example, authorities reported that patients could make calls from the nurses’ station on the ward. Patients MDRI interviewed at the institution reported, however, that they were often denied access to this telephone.

MDRI encountered no formal programs designed by institutions to educate people in institutions about their rights. The creation of citizens committees under the Mexican law, however, provides an important avenue for educating patients about their rights and providing them with an opportunity to make complaints. Under the law, the committees are to ensure respect for patients’

[^172]: *MI Principles*, principle 12(1).

[^173]: Id.

[^174]: Id., principle 12(2).

[^175]: Id., principle 12(3).

[^176]: Id., principle 11(9).
rights and to protest violations of those rights. According to Mexican federal authorities, 90 percent of psychiatric hospitals have citizens committees. Some committees are functioning very effectively. MDRI teams observed committee meetings at Ramirez Moreno and Sayago and MDRI investigators were impressed by how patients were able to freely offer their ideas for improving the institutions. The success of these committees has apparently not been uniform throughout the country, however.

Independent activists have alleged that many committees are controlled formally or informally by institutions. Some citizens committees work closely with institutional directors and do not see their role as advocates for the patients’ rights. The head of the Jalisco Citizens Committee boasted about the Committee’s success in raising money to pave the institution’s driveway. The next goal of the Committee is to raise money for an MRI, an extremely expensive piece of medical equipment. While these may be valuable projects, the director of the Citizens Committee did not report on any activities to address the serious human rights issues MDRI observed at Jalisco.

Apart from anecdotal stories of this kind, MDRI is not in a position to evaluate the independence of the citizens committees throughout Mexico. In the absence of citizen advocacy outside the institution, however, it is clear that it is difficult for citizens committees to operate independently. MDRI investigators have seen that in Mexico City, where independent activists are available to support the citizens committees, this collaboration has greatly aided in the operation of the committees.

In addition to citizens committees, there are a number of other mechanisms that have the potential to protect patient rights. All hospitals are required to have ethics and oversight committees. At Fray Bernardino, the Ethics and Oversight Committee reviews the patients’ situations to see if personnel are mistreating patients and to ensure that staff do periodic treatment reviews. If the Committee receives a complaint, it can review charts, do investigations, call witnesses, and make a formal complaint.

B. Independent oversight

In addition to rights protection mechanisms within institutions, international law requires independent human rights oversight mechanisms. The *Principles* require that:

States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient. (Principle 22)

The body primarily responsible for independent human rights oversight in Mexico is the CNDH. The CNDH is responsible for human rights at the federal level, and there are similar governmental human rights commissions in each state of Mexico. The CNDH documents human rights violations over many sectors of society. The third division of the CNDH investigates

---

177 *Norma*, Appendix B.
complaints of deprivation of liberty, including those that may occur in jails, prisons, and psychiatric hospitals.

The CNDH has surveyed 30 psychiatric institutions and centers that offer mental health care in Mexico and published 15 reports of these investigations. As a fact-finding body, the CNDH has made a positive and important contribution to bringing rights abuses in psychiatric facilities to public attention. While the CNDH has not done a systemic report on human rights within the psychiatric institutions of Mexico (and many institutions have never been investigated by the CNDH), its inspections provide the public with valuable information about treatment and human rights enforcement within certain institutions. These reports corroborate many of MDRI’s findings. Of the hospitals visited by MDRI, the commission has written reports on Jalisco (report 2/97), Ramirez Moreno (report 187/93) and Ocaranza (report 70/95). The commission finds numerous violations of the Mexican Constitution, the federal mental health law and the MI Principles. These violations include the right to the protection of health, dignified treatment, sufficient medical care and rehabilitation. Furthermore, the CNDH found that Mexico has failed to provide the resources necessary for treatment and rehabilitation, as required by MI Principle 14(1).178

While the National Human Rights Commission (CNDH) conducts valuable investigations, its operations are limited. The most basic limitation is that the CNDH responds to complaints on an ad hoc basis179 and does not provide oversight for human rights within every psychiatric facility. When people in the community are subjected to abuse, they may be expected to lodge formal complaints, but people in psychiatric facilities may not have access to the resources necessary to approach the CNDH. Also, the right to oversight in the MI Principles applies to every person in every facility. Mexico must establish a mechanism that ensures regular and systematic oversight throughout the mental health system. That function could be assumed by the CNDH if it were to ensure that each institution’s record was reviewed on a regular basis and if it assessed a full array of domestic and internationally recognized rights. Alternatively, a more specialized oversight agency could be established. Given the important role the CNDH plays in bringing human rights issues to national attention, MDRI strongly encourages the CNDH to expand its work evaluating rights protections for people in psychiatric facilities.

The second major limitation of the CNDH is its lack of enforcement powers. The CNDH exposes human rights issues to the public, but its recommendations, in the words of the Executive Secretary for Foreign Relations, rely solely on “moral authority” for their enforcement. According to the Executive Secretary for Foreign Relations, the CNDH has proposed changes that would allow for greater enforcement powers, but these have not yet been established by law. Commenting on a draft of this MDRI report, the CNDH informed MDRI that in the future it will seek to play a greater role in mediating complaints between aggrieved individuals and relevant government authorities. If this occurs, the CNDH will release reports as a “last resort,” only after attempts at mediation fail.180 If mediation efforts do not lead to effective remedies, however, the CNDH could not act

178 CNDH, RECOMENDACION 70/95, 1995.

179 According to CNDH authorities, most investigations are initiated in response to a filed complaint. Two of the three inspections conducted by the CNDH at institutions MDRI also visited were initiated by complaints by FMREM.

180 Memo to MDRI, Feb. 7, 2000 from Ulises Canchola to MDRI, CNDH, Oficio No. SE/DG/278/00,
further. Local and state governments would have the responsibility of taking legal action against perpetrators of abuses.

Within the current legal framework, the effectiveness of the CNDH has often been undermined by its own failure to report violations of all rights protected under Mexican or international law. In addition, the CNDH has often couched recommendations in an open-ended manner that permit a psychiatric facility to report that CNDH recommendations have been fulfilled when serious human rights issues persist.

The CNDH findings and recommendations regarding Ocaranza demonstrate this weakness. The CNDH conducted an investigation in 1995 and found a wide range of abuses at the institution. In 1997, the CNDH found that Ocaranza had “totally fulfilled” its recommendations. In 1998 and 1999, however, MDRI observed inhuman and degrading treatment in the institution. The CNDH has taken no action to rectify these conditions.

The CNDH recommended, for example, that Ocaranza improve its food service. MDRI investigators found in 1999 that the institution hired a new dietician. This is a positive indication about the effectiveness of a specific CNDH recommendation. Unfortunately, basic hygiene still has not been improved, rendering any meal a health risk. MDRI investigators observed as residents went straight from filthy areas covered in urine and feces to the bathroom (where there is no toilet paper or towels) to the dining area without any assistance in washing their hands.

At Ocaranza, the CNDH also recommended improvements so that “… health services [can] be administered in the minimally acceptable conditions.” In addition, the CNDH recommended that “… sufficient space and necessary equipment be given to the hospital, in order to achieve the rehabilitation of the patients.” The MDRI team found serious deficiencies in medical care, equipment, and rehabilitation. The inhuman and degrading living conditions MDRI investigators observed in Ocaranza’s barren wards and have described in this report, could not be considered “minimally acceptable.”

It is difficult to imagine what standard the CNDH used to find that its recommendations had been “entirely fulfilled” at an institution violating so many provisions of the Mexican mental health law, the MI Principles, and the American Convention. The case of Ocaranza is all the more striking because two representatives of the CNDH accompanied MDRI on its visit to the institution in 1998 and observed much of what is documented in this report. In 1999, the CNDH had yet to take action against Ocaranza.

CNDH investigations in other facilities offer valuable, in-depth critiques of medical treatment, but fail to address the full range of human rights issues protected by the Mexican law or the MI Principles. While the CNDH pointed out the failings of the Mexican mental health law with regard to civil commitment, it did not document the widespread problem of arbitrary detention.
within the institutions investigated by MDRI. None of the CNDH reports on facilities visited by MDRI mentioned the inappropriate placement of persons with mental retardation or epilepsy in psychiatric facilities. Nor did the CNDH reports address the detention of persons who could receive treatment in the community.

According to the Executive Secretary of Foreign Relations, the CNDH is working on a study of mental health care in Mexico that will emphasize the need for rehabilitation and treatment in the community as recommended by the WHO. In the event of such a publication, future hospital inspections should document the number of people unnecessarily detained in institutions in violation of their right to community integration and to the highest attainable standard of mental and physical health. A study of this kind would document the national extent of this human rights problem on a national level and provide a basis for future planning to begin enforcement of the Mexican law requiring community integration.
C. Citizen Participation in National Planning and Human Rights Oversight

The Rules on Equalization recognize that national planning will be necessary to bring about the reform of service systems necessary to promote human rights and community integration of people with disabilities. The concerns of people with disabilities should be “included in all relevant policy-making and national planning”\textsuperscript{184} and “[t]he needs and concerns of people with disabilities should be incorporated into general development plans and not be treated separately.”\textsuperscript{185} International law recognizes the right of people with disabilities and the organizations that represent them to participate in program planning and implementation\textsuperscript{186} and in developing legislation to reform laws necessary to protect human rights.\textsuperscript{187} In addition, “States must ensure that organizations of persons with disabilities are involved in...ongoing evaluation of that legislation.”\textsuperscript{188} To this end, the Rules on Equalization provide that “ States are responsible for the establishment and strengthening of national coordinating committees, or similar bodies, to serve as a national focal point on disability matters.”\textsuperscript{189}

The Mexican Government has created a National Commission on Issues Concerning the Elderly and Disabled. Its objective is to promote policies and legislation to bring about equality and community integration of elders and people with disabilities. The Commission has also sought to “promote the incorporation of leaders with disabilities into the structure of the Directive Committee and Political Advisory of the [PRI] Party.”\textsuperscript{190} In addition to raising political awareness, the Commission supported a network of organizations that seeks to create work training programs, pension plans, accessible public accommodations, clubs and workshops for elders and people with disabilities.

The Commission has the potential to be an important resource for people with mental disabilities. At present, however, it does not actively include participation by people with mental disabilities or collaborate with organizations made up of such individuals. To fulfill the mandate of the Rules on Equalization, the government should provide grants to support the training and development of independent NGOs made up of people with psychiatric and other mental disabilities. It should support the work of nongovernmental advocacy groups working at the legal and local

\textsuperscript{184}Standard Rules on Equalization for Opportunities for Persons with Disabilities (hereinafter StRe), rule 14(1).

\textsuperscript{185}Id., rule 14(3).

\textsuperscript{186}“States should involve organizations of persons with disabilities in all decision-making relating to plans and programmes concerning persons with disabilities or affecting their economic and social status.” Id., rule 14(2).

\textsuperscript{187}Id., rule 15(1).

\textsuperscript{188}Id.

\textsuperscript{189}Id. Rule 17.

\textsuperscript{190}Pamphlet given to MDRI by Lic. Humberto Cruz, PRI Consejo Político Nacional, Comisión Nacional de Asuntos de la Tercera Edad y Discapacitados.
levels. Once these groups are established, they should be actively involved in program planning and implementation, as well as human rights oversight. 191

V. Planning and Financing Reform

Reintegration of people with mental disabilities into society will require the creation of a comprehensive system of community-based mental health care. Creating such a system requires planning, financing and a continued commitment to implementation over a number of years.

Enforcement of the fundamental human rights of people with mental disabilities creates costs that must be assumed by society. By establishing these as internationally recognized human rights, the international community has made clear that these concerns are an imperative in all countries—not merely a luxury affordable in wealthy parts of the world. 192 Thus, human rights enforcement for people with mental disabilities is never solely a matter of having adequate resources available. Enforcement of disability rights requires the commitment—and the political will—to make the best use of available resources so that people with mental disabilities have the opportunity to live as part of society like all other citizens.

Section A below identifies Mexico’s responsibilities under international law to take immediate action in order to remedy the human rights violations identified in this report. Section B describes some of the planning and financing issues that should be considered and provides suggestions for this process based upon the experience of mental health service reform in other countries.

A. International Obligations to Plan and Finance Reform

The MI Principles call on States to “implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.” 193 The Rules on Equalization provide non-binding guidelines for national reform efforts to ensure appropriate public participation, including participation by people with disabilities and organizations representing them.

International human rights conventions, to which Mexico is a State Party, create immediate obligations to remedy human rights abuses. These obligations are of two kinds: (1) immediate

---

191 The Rules on Equalization state that “States should recognize the right of the organizations of persons with disabilities to represent persons with disabilities at national, regional, and local levels.” Id., rule 18.

192 The World Conference on Human Rights in Vienna in 1993 reaffirmed the universality of human rights, equally applicable in all parts of the world. Vienna Declaration, supra note 7. This understanding of human rights has been increasingly accepted by the psychiatric community to apply to the provision of mental health treatment. Norman Sartorius, former Director of WHO’s Division of Mental Health, has written that “[t]oday, availability of appropriate care for all forms of mental disorders is seen as a human right that must be respected even if resources for health care are scarce. And this is not all; the fact that services should be made available to all who need them implies that they can no longer be provided exclusively, nor even mainly, through the psychiatric institutions.” WHO REVIEW OF EFFECTIVENESS, supra note 155, at xvii.

193 MI Principles, principle 23(1).
obligations of full enforcement under the International Covenant on Civil and Political Rights (ICCPR) and the American Convention and (2) obligations of progressive implementation under the International Convention on Economic, Social and Cultural Rights (ICESCR). As described below, enforcement of the rights of people with mental disabilities cannot be neatly divided between these two categories. Full enforcement of the rights will require both immediate action on the part of the Government of Mexico and a commitment to bring about the long-term outcomes mandated by international human rights law.

1. Immediate obligations of full enforcement

   The ICCPR creates a legal obligation of State Parties to “respect” and “ensure” the full enforcement of their protections.194 State Parties agree to take “legislative or other measures as may be necessary to give effect to the rights recognized in the present Covenant.”195 The ICCPR makes no exception to the duty of full enforcement of rights that may require the investment of resources. Mexico must take action to bring about full enforcement of protections against discrimination, inhuman or degrading treatment, and arbitrary detention.

   Enforcement of the ICCPR may require Mexico to finance immediate reforms. The major violations of the ICCPR documented in this report must be so remedied. For example, long-term, unsupervised placement of people in restraints is a clear case of inhuman and degrading treatment. Failure to provide adequate hygiene to these and other individuals is dangerous and life-threatening. Ending these abuses requires Mexico to outlaw such practices and provide the funding and staff necessary to ensure that these practices are avoided in the future.

   Protections against arbitrary detention may also require the expenditure of resources. An amendment to the Mexican mental health law to protect against arbitrary civil commitment in the “granjas” and casas de protección is necessary, but it would not be sufficient. Human rights conventions require that these protections be “ensured.” In order to do this, State Parties must allocate sufficient funding for court administration and patient representation to make these rights enforceable in practice.

   As described in this report, many people are detained in institutions because of the lack of community-based alternatives. Policies and resources to promote community-based treatment and community integration would help avoid improper and unnecessary psychiatric detention. Obviously, such programs cannot be fully implemented immediately. But policies to develop services and promote community integration can be immediately adopted. The commitment to ensure full enforcement of the ICCPR mandates the immediate adoption of policies and the provision of necessary resources to promote community integration and support.

   Like the ICCPR, the American Convention mandates respect for human rights and creates immediate obligations to remedy abuses. As a State Party to the American Convention,

---

194 ICCPR, article 2(1).
195 Id., article 2(2).
Mexico undertakes “to ensure to all persons” in its jurisdiction “the free and full exercise of those rights and freedoms” recognized in the Convention. In recognition of the interrelated nature of human rights, the American Convention also includes a provision for “progressive development” of rights of an “economic and technical” nature. Under article 62 of the American Convention, Mexico has recognized that decisions of the Inter-American Court of Human Rights interpreting the American Convention constitute binding law in Mexico.

2. Progressive enforcement

As a State Party to the ICESCR, Mexico guarantees its citizens the “highest attainable standard of physical and mental health.” Recognizing the need to develop programs to enforce rights of this kind, the ICESCR creates a duty of “progressive enforcement.” Under the ICESCR, each State Party “undertakes to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights” established in the Covenant. Even though outcomes may only be achieved over time, “the obligation ‘to take steps’ is an immediate one.” The steps taken should be “deliberate, concrete, and targeted” to the full enforcement of rights. This process may include “the drawing up of a detailed plan of action for the progressive enforcement of the right.”

The ICESCR’s requirement that a State take steps “to the maximum of its available resources” does not specify which of its national resources can be considered “available” for reform. At a minimum, State Parties to the ICESCR must use resources currently available in mental health budgets to enforce policies that will uphold the rights established in the ICESCR. Even where resources are limited, the obligation to “devise strategies and programmes” for the promotion of rights established in the ICESCR “are not in any way eliminated as a result of resource constraints.”

The ICESCR has major implications for the allocation of resources in Mexico’s mental health system. As described in this report, the long-term placement of people in the “granjas” and

19 American Convention, article 1.

17 American Convention, article 26.

18 ICESCR, article 4(1).

19 Id., article 2(1).


21 Id.

22 Id.

23 As the United Nations’ Manual on Reporting explains, “[t]he phrase ‘its available resources’ refers to both the resources of the State Party itself and to those which are available to it from the international community ‘through international assistance and cooperation.’” Id. At 46.

24 Id. at 45.
casas de protección because of a lack of community-based alternatives creates unnecessary dependency on institutions, undermines the ability of people with mental disabilities to retain and rebuild ties with the community, and ultimately detracts from their physical and mental health. To the extent that community-based service and support systems would better serve the needs and protect the rights of people with mental disabilities, Mexico is under obligation to provide available resources toward such goals.

B. Strategies for Planning and Financing Reform

International human rights law obliges nations to remedy human rights abuses, but it does not specify exactly how a country should plan, finance, or conduct mental health system reform. The MI Principles were constructed to permit every country to adapt human rights principles to local circumstances, respecting local culture and building on country-specific strengths. Since the first community-based systems were developed, an enormous amount has been learned in the United States, Europe, and other countries about how to finance, implement, and reform community-based services. Building on such experiences, there is now a broad consensus about principles and practices that should guide mental health system planning and the community integration of people with mental disabilities. By adapting models from abroad, Mexico can save scarce financial resources and many years of trial and error.

Many different approaches to planning and financing mental health system reform have proven successful, and MDRI does not endorse any one, particular approach. This section is intended to describe some of the lessons from international experience.

1. Need for comprehensive services and planning

A safe and effective transition from institutions to community-based treatment requires the creation of comprehensive, community-based service and support systems. Any complete community-based mental health service should include: community inpatient and outpatient treatment and case-management teams, supported housing, supported employment, 24 hour crisis services, respite care, consumer-controlled social clubs, as well as, consumer, family, and legal oversight and advocacy. A system of income supplements (disability pensions) for individuals

205 “Every patient shall have the right to treatment suited to his or her cultural background.” MI Principles, principle 7(3).

206 See, e.g., WHO REVIEW OF EFFECTIVENESS, supra note 155, at 278; LOREN MOSHER & LORENZO BURTI, COMMUNITY MENTAL HEALTH: A PRACTICAL GUIDE (1989) (summarizing lessons from the experience with mental health system reform in the United States and Italy); ROBERT DESJARLAIS, LEON EISENBERG, BYRON GOOD, AND ARTHUR KLEINMAN, WORLD MENTAL HEALTH 38 (1995).

207 Id. at 269.

208 WHO REVIEW OF EFFECTIVENESS, supra note 155, at 321.

209 See, id. at 304-321 (describing international experiences with the implementation of such programs). See also Mosher and Burti, supra note 206, at 99-224 (a guide to the development of community-based services drawing from experiences in the United States and Italy); Leonard I. Stein, Ronald J. Diamond and Robert M. Factor, A system approach to the care of persons with schizophrenia, in 4 HANDBOOK OF SCHIZOPHRENIA: PSYCHOSOCIAL
unable to support themselves is also essential.\textsuperscript{210} Such programs should be integrated into primary health care systems and adapted to work in conjunction with community structures.\textsuperscript{211}

In the worst cases, deinstitutionalization without effective community-based services has led to “patient dumping,” homelessness, and the abandonment of people with mental disabilities.\textsuperscript{212} More commonly, the failure to provide adequate community-based services leads to disconnected services that permit individuals to “fall through the cracks” of existing programs.\textsuperscript{213} Without adequate support in the community, people discharged from hospitals may quickly decompensate and return to inpatient treatment (the “revolving door” syndrome).\textsuperscript{214} Well-planned, integrated, comprehensive service systems, however, can avoid or reduce these dangers.\textsuperscript{215} In some areas where comprehensive community-based programs have been developed, long-term inpatient institutions have been safely eliminated.\textsuperscript{216}

Given the need for comprehensive community-based services, piecemeal efforts to reform service systems are often doomed to failure.\textsuperscript{217} Improvements in inpatient programs will be of limited value if there is an incomplete system of community-based programs to which people may go once they are released.\textsuperscript{218} Most countries cannot afford comprehensive community-based services if they are also supporting an extensive network of large, expensive, inpatient facilities. Mental health systems will require additional funding during this transition. Over time, countries can reduce

TREATMENT OF SCHIZOPHRENIA 218(1990) (describing the need for a comprehensive “systems approach” to community mental health services).

\textsuperscript{210} Id. at 214. In the United States, the development of income supplements in the 1960s played an important role in the development of alternatives to inpatient treatment for many people. Lafond & Durham, supra note 38, at 88.

\textsuperscript{211} Desjarlais, Eisenberg, Good and Kleinman supra note 206, at 269.

\textsuperscript{212} In some areas of the United States, poorly planned deinstitutionalization resulted in what has been called “psychiatric ghettos” in inner cities where people lived in poverty and neglect. Some people discharged from institutions ended up in the streets, others in jails, and still others were “transinstitutionalized” in nursing care homes. Lafond and Durham, supra note 38, at 100. While poorly planned deinstitutionalization did result in many abuses in the United States, these policies were also improperly blamed for the broader failings of economic and social policies. The problem of homelessness, for example, goes beyond failings of the mental health system to cuts in other social programs and a lack of low-cost housing. The great majority of people who are homeless are not homeless because of deinstitutionalization and would not be candidates for inpatient treatment under even the broadest commitment standards. Id. at 105.

\textsuperscript{213} Id. at 109.

\textsuperscript{214} Stein, Diamond, & Factor, supra note 209, at 213.

\textsuperscript{215} Id.

\textsuperscript{216} Robert Okin, Testing the Limits of Deinstitutionalization, 46 PSYCHIATRIC SERVICES 569 (1995) (describing the transition to a completely community-based mental health system in western Massachusetts).

\textsuperscript{217} Stein, Diamond, & Factor, supra note 209, at 213.

\textsuperscript{218} WHO REVIEW OF EFFECTIVENESS, supra note 155, at 304.
rates of institutionalization as they develop better and more comprehensive community care systems.  

2. Need for outreach and assertive treatment in the community

One of the most important advances in the development of community-based services is the recognition that services must provide active outreach to people with mental disabilities. Programs that rely almost exclusively on weekly or monthly appointments to dispense medications have major limitations in providing support for people with severe mental disabilities in the community. The core of an effective community-based mental health program is the case manager (or case-management team), responsible for coordinating the services provided by all government agencies. Experience with community mental health programs also demonstrates that service systems must be designed to provide ongoing, long-term support.

Assertive community mental health care programs that actively seek-out and follow up with individuals living in the community have been demonstrated more effective than traditional aftercare programs in helping people remain in the community. As part of a comprehensive community-

---

219 As a general rule, “the need to use hospital-based services varies inversely with the comprehensiveness of community-based services.” Id. at 241.

220 Leonard I. Stein and Mary Ann Test, Alternative to Mental Hospital Treatment: A Conceptual Model, Treatment Program, and Clinical Evaluation, 37 ARCH GEN PSYCHIATRY 392 (1980) In Dane Country, Wisconsin, researchers found a greatly reduced need to hospitalize patients served in an assertive community treatment program compared with patients in a conventional aftercare program. As described by the authors, “[c]hronically disabled patients are frequently passive, interpersonally anxious, and are prone to develop severe psychiatric symptomatology. Such characteristics often lead these patients to fail to keep appointments and ‘drop out’ of treatment, particularly when they are becoming more symptomatic. Hence, the program must be assertive, involve patients in their treatment, and be prepared to ‘go to’ the patient to prevent dropout. It must also actively ensure continuity of care among treatment agencies rather than assume that a patient will successfully negotiate the often difficult pathways from one agency to another on his own.” Id.

221 “The case manager, whether this is an individual clinician or an entire core service team, assumes responsibility for all aspects of the care that the patient may require in order to live satisfactorily in the community. We have found the more stable patients with schizophrenia can be well served by an individual clinician functioning as the case manager, more difficult patients with more pressing needs and more frequent crises require an entire team to share case management responsibilities. These responsibilities include either providing all the services needed, or arranging for missing services to be provided by another agency. In all cases, the case manager remains responsible for making sure that needed services are provided. This broadly based care includes psychiatric treatment, rehabilitation, housing, finances, etc.” Case management alone, however, is of limited value without the existence of comprehensive community-based services. Id. at 216.

222 When assertive community-based programs are terminated, rates of recidivism return to those in traditional aftercare programs. Thus, psychiatrists have observed that “until we are able to prevent or cure chronic psychiatric disease we should change our treatment strategy from preparing patients for community life to maintaining patients in community life.” Stein & Test, supra note 220, at 392.

223 The following critique of the “discontinuity” of aftercare programs in the United States may contain useful lessons for Mexico:

Despite these . . . programs, large numbers of persons with schizophrenia continue to experience frequent relapses and have a poor quality of life even when in remission. One can ask whether this problem is due simply to a lack of sufficient resources to provide greater numbers of these
based mental health system, intensive case management has been shown in the United States to reduce overall rates of hospitalization.\textsuperscript{224}

Despite their benefits, some assertive community-based programs in the United States have been criticized for bringing coercive care into the community (critiques of assertive community treatment programs by consumers can be found on the world wide web at www.madnation.org and in linked websites). The creation of consumer-controlled programs, described below, provides one way to protect against such abuses. A related danger is the adoption of legal regimes that permit involuntary treatment in the community. It is very important to create safeguards against abuse in the community - whether or not the law permits coercive community treatment.

3. Consumer and family advocacy and support

Consumers (also known as psychiatric survivors or users of mental health services\textsuperscript{225}) and family members can play an important role in the development and operation of community mental health services. In the United States, Western Europe, and Latin America, consumers and families have established advocacy organizations that have played an important role in promoting their rights and interests. Consumers and family members have worked closely as part of the same organizations or coalitions, and at times each group has felt the necessity to have independent advocacy organizations. Organizations of psychiatric survivors and family members of people with mental disabilities have become powerful political forces in the United States in matters relating to mental health policies.\textsuperscript{226}

specific interventions and programs. We believe that lack of resources may contribute to the problem; however, we also believe there are some major problems with how these programs are organized: they are uncoordinated, they are non-collaborative, and they often compete with one another. Together, they comprise a 'non-system' of mental health care where a few patients get more than they need, many patients get less than they need, and some get nothing at all. Patients may get lost in this non-system, and no one feels obliged to look for them . . . Patients are moved from the community into the hospital and from the hospital back into the community in such a way that the hospital, the community, the patient, and the family all feel mistreated. A major problem with this non-system is that it is episode-oriented rather than oriented to providing continuous care. This non-system fails the patient and undermines the potential effectiveness of the professionals working in it.

Stein, Diamond, & Factor, supra note 209, at 213.


\textsuperscript{225} As used here, the term "consumer" refers to a person who uses or once used mental health services. Some people prefer to be called users, ex-patients, or psychiatric survivors.

\textsuperscript{226} Consumer (or psychiatric survivor) organizations have been politically important in the United States, even though they have never had the political influence that their representation in the population as a whole would indicate. Organizations of family members, such as the National Alliance for the Mentally Ill (NAMI), on the other hand have been very powerful. Organizations of family members and psychiatric consumers have often taken different positions in the political arena and it can be important to distinguish between these two types of advocates. See discussion in Lafond & Durham, supra note 38, at 112.
Consumer-controlled organizations have been established to provide self-help, advocacy, mental health services, and social support in the community. Consumer-controlled drop-in centers provide a place for mental health system users to gather for meals, social events, mutual support, and peer counseling. Consumers have also established telephone hotlines, resource libraries, and other information networks. Programs of this kind provide invaluable assistance to people with mental disabilities helping them remain in the community and avoid unnecessary hospitalization. These programs are also very low in cost. A number of consumer-controlled projects have been established in Mexico, and they deserve recognition and support.

Consumers can also take an active part in the operation of psychosocial rehabilitation programs in the community. These programs are usually work focused, providing job skills and supporting people with mental disabilities to obtain and keep real jobs in the community. Mental health professionals and consumers work collaboratively in these programs which are designed to foster consumer independence and to promote a supportive community.

4. Financing community services

Effective planning for community integration will permit the mental health system to use available resources more widely and efficiently. Phasing down the "granjas" and casas de protección must not, however, be viewed as a way to save on overall cost of mental health care. Indeed, a significant new investment of resources will be necessary in order to create a comprehensive community-based service system. A portion of this new investment will be temporary, because the current level of institutional care needs to be improved during the period when new community services are beginning to be developed. Some of the increase in cost, however, will be permanent. In part, the increase will be due to the fact that community-based mental health programs provide more and better services to people who have not been receiving appropriate (or any) services. The per capita cost of care in the community is likely to be lower than in the institution, but the overall cost of mental health care may go up.

Reform of Mexico's system of health care financing will be critical to the development of a new community-based service system. The new financing system must also end current incentives for unnecessary inpatient treatment. While the financing system is being reformed, start-up grants should be provided to local authorities so they can create the infrastructure and initial funding for community services. The new financing system should then be restructured to maintain and promote the development of these services. Once community-based services are created, the need for long-

---

227 See JUDI CHAMBERLIN, ON OUR OWN (1980).

228 Judi Chamberlin described a number of different models of consumer-controlled or operated services, stressing the need to distinguish between consumer-controlled and consumer-operated services. Id. See also Ed Van Hoon, Changes? What Changes? The Views of the European Patients' Movement 38 INT'L J. SOCIAL PSYCHIATRY 30 (1992) (describing the view of consumer activists who work within the structure of the mental health system despite reservations about the system).

229 Mosher & Burti, supra note 206, at 152 (describing the Fountain House model, "an intentional community designed to create a restorative environment within which individuals who have been socially and vocationally disabled by mental illness can be helped to achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.")
term institutional care will diminish. Some resources saved as a result of a declining institutional census should be used to improve conditions within these facilities. The balance of the savings should be reallocated to further the development of the community-based system of services. In this way, the quality of care in institutions can be improved and the full spectrum of community services can be simultaneously enhanced.
Afterward: Events Since the Release of the MDRI Report

MDRI released Human Rights & Mental Health: Mexico in Mexico City on February 17, 2000 at a press conference in Mexico City. In addition to extensive coverage within Mexico,230 the report brought unprecedented international attention to the human rights concerns of people with mental disabilities.231 The MDRI press conference in Mexico City was co-sponsored by FMREM. The report’s findings were publicly supported by Virginia González Torres of FMREM, as well as representatives of other Mexican NGOs advocating for people with psychiatric and developmental disabilities. As a result of this publicity and the concerns raised by Mexican activists, the government of Mexico has made historic new commitments - and important first steps - to develop programs that would protect the rights of people with mental disabilities and promote their community integration.

On March 2, 2000, the Inter-American Commission on Human Rights held hearings on the findings of the report, the first time the Commission held an inquiry into a pattern of human rights abuses in a mental health system as a whole. Report co-authors Eric Rosenthal and Dr. Robert Okin testified before the Inter-American Commission, and members of the Commission reviewed MDRI videotapes of conditions in Mexican institutions. MDRI urged the Commission to conduct a further inquiry, including site visits to Mexican psychiatric facilities as part of the Commission’s future

230MDRI provided an advance copy of the report to the Mexican government and activists in Mexico, and articles in the Mexican press anticipated the actual release of the report. The following is a partial list of articles about the MDRI report in the Mexican Press: Maria Scherer Ibarra, En México, el peor trato del mundo a los enfermos mentales: Misericordia abandonó a los enfermos inhumanos en los hospitales psiquiátricos, PROCESO, January, 2000, at 10 (cover story); Maria Scherer Ibarra, La accion incorpuesta de Gonzalez Fernandez al psiquiátrico Ocaranza, PROCESO, February 6 (1214), 2000; Monica Livier Gómez, Condiciones inhumanas en Psiquiátrico, SOMOS人類, 5(52), February 18, 2000; Reuters, Los Hospitales psiquiátricos de Mexico, de los peores del mundo: Robert Okin, NOVEDADES, February 18, 2000 at A16; En México se violan los derechos humanos de enfermos mentales, LA JORNADA, February 18, 2000 at 16.

work in Mexico. As a result of this hearing, the Commission raised concerns about Mexico’s treatment of people with mental disabilities in its annual report on Mexico’s human rights record.\textsuperscript{232}

The Mexican Government has taken quick action to respond to the abuses documented in the MDRI report. In February 2000, Secretary of Health Jose Antonio González Fernández made 8 million pesos available (just over $800,000 US dollars) to improve conditions in Mexico City’s institutions and to provide 50,000 pesos (just over $5,000) for each of 400 people living in Mexico City institutions to participate in community-based workshops.\textsuperscript{233} After a personal visit to Ocaranza, González promised an additional 12 million pesos (just over $1.2 million dollars) to improve conditions there.\textsuperscript{234}

Interviewed on the US television network ABC News 20/20, Secretary González stated that he knew of problems in the mental health system of Mexico. After he viewed video tapes of conditions within Guadalajara and Ocaranza, he said on camera that he was “ashamed” of what he saw. González Fernandez publicly promised major changes at Ocaranza by May 2000.

Within a week of the public release of MDRI’s report, officials at the Secretariat of Health met with Dr. Okin and González Torres and requested their help in bringing about immediate reforms at Ocaranza. Dr. Okin agreed to assist the Mexican government as an independent consultant with the understanding that reforms in Ocaranza would be the first step in a government policy to bring about changes throughout the Mexican mental health system.\textsuperscript{235} Under-Secretary of Health Manuel Urbina agreed to this, stating that he would make his best efforts to promote a system of community-based services to permit the safe community integration of people with mental disabilities.

Over the course of the next month, Dr. Okin prepared the outlines of a plan for the Mexican government for emergency reforms at Ocaranza to end the inhuman and degrading treatment and dangerous conditions at Ocaranza. The Mexican government agreed to pay all travel expenses for an inter-disciplinary team of experts from San Francisco to make recommendations for the future of Ocaranza and its patients. Dr. Okin brought a team of five mental health experts to Ocaranza.


\textsuperscript{235}Dr. Okin’s work for the Mexican government is entirely voluntary and unpaid in order to leave no doubt about his professional independence and judgement. His work as a consultant to the government is also independent from his work for MDRI. MDRI has pledged to continue monitoring human rights conditions in Mexico and to assess promised reform efforts and must, therefore, remain fully independent of government authorities or NGOs providing services to people with mental disabilities.
in May 2000 and worked out of the facility with the staff and administrators for the better part of a week.\(^{236}\)

The major finding of Okin’s team was that the conditions in Ocarañza were so poor, degrading, unhygienic and dangerous that it would be practically and economically impossible to make fundamental improvements. The team recommended:

1. Ocarañza should be leveled and replaced by new services so that no person would have to remain in the institution; 100 patients Ocarañza would be placed in group homes and other community programs in Pachuca, and 96 patients would be placed in transitional housing in small, newly built homes on land adjacent to Ocarañza until they could be placed in community settings;

2. A cohort of people with severe physical disabilities now living at Ocarañza would be transferred to two of the institutions in Mexico City where they would be provided with physical therapy and other treatment and assistance with their disabilities;

3. An acute unit would be created in the general hospital in Pachuca for people needing acute, short-term psychiatric hospitalization;

4. A structure for a comprehensive community-based mental health program would be created with strong links to the general health care system.

The Secretary of Health of the Federal Government and the Secretary of Health for the State of Hidalgo agreed to the basic elements of Dr. Okin’s plan. They agreed both to finance this plan and to make their support public.

Dr. Okin and Sharon Wicher returned to Ocarañza in June 2000 to examine the progress of reform and to plan for the creation of the acute care unit. As of that time, two group homes with workshops had been created in Pachuca to serve 37 people. Okin reported that these homes were clean, safe, and provided a human environment in an integrated community setting for the individuals who were about to be placed there. Near the Ocarañza institution, Dr. Okin observed extensive building of transitional homes.

Since Dr. Okin’s visit in June, he received word from Virginia González Torres that the Secretary of Health of Mexico had committed an additional 5 million pesos to the reform plan. Dr. Okin was unable to ascertain whether the additional sum would be sufficient to resolve the concerns he had raised or to complete the reform plan. As of late June 2000, 37 residents of Ocarañza were at the point of being transferred out to group homes in Pachuca, but the remainder of the people at Ocarañza continue to live in the institution in extremely abusive conditions.

**MDRI assessment of current reforms and future opportunities**

The July 2000 elections in Mexico brought the first major change in political parties in more than 70 years. The transfer of power creates an opportunity for officials not associated with past mental health policies to create a fresh start in mental health and human rights policy. MDRI

\(^{236}\)In addition to Dr. Okin, the team included: Phyllis Harding, RN, a hospital administrator and emergency room nurse; Sharon Wicher, RN, a nursing administrator; Taliia Puzzianti, Pharm.D, a psychopharmacologist; and Miriam Martinez, Ph.D., a psychologist and expert in children’s services.
strongly encourages the new government to learn from past mistakes - both in the Mexico and other countries (including the United States) - and to make plans for an entirely new community-based system of mental health care, as recommended in this report. The recommendations in this report provide a basic outline to assist the new government to bring Mexico's mental health policies into conformity with international human rights law.

MDRI encourages the new government of Mexico to support and build on the Ocaranza reforms initiated this year. A model community-based program in Pachuca could serve as a pilot for national, system-wide reforms. This project can be used to train and enhance the skills of professionals in the development of community-based services. With proper documentation, this pilot project can provide Mexico with data that can be used to budget for the creation of community-based services throughout Mexico.

Much more needs to be done, however, in Ocaranza and elsewhere. A full network of community-based mental health programs must be created in Pachuca. The new program must provide appropriate supportive services to people living in the community, as well as advocacy and oversight to ensure rights enforcement in the community. Community-based acute care and emergency service programs must also be established. Failure to create these services will result in individuals being left behind in the isolated setting of the Ocaranza facility. The eight new homes on the grounds of Ocaranza represent an important step from the inhuman and degrading conditions in which people presently live at Ocaranza, but the new homes do not constitute community integration and should not be used beyond a short-term transitional period.

Ultimately, the 17 million pesos dedicated to reform Ocaranza are almost certainly not enough to safely and effectively integrate the population into the community. Supplemental funds may be needed to ensure that the transitional programs on the grounds of Ocaranza are adequate. As more people are transferred to the community, plans should be made to hire the trained professional staff to provide appropriate services to people in the Pachuca community.

While the Ocaranza pilot project will provide important data for a national program, the government of Mexico should not await its final results before planning national reform. Serious, abusive conditions still exist at other facilities. Even at the better institutions in Mexico City, thousands of individuals continue to languish without appropriate opportunities for psychosocial rehabilitation and community integration. The 8 million pesos dedicated to reform in Mexico City institutions is just a beginning, and the new government of Mexico must create a detailed plan to create and finance an entirely new system of community-based services.

Despite the modest size of reform efforts, the shift in policy focus by the Mexican government away from its institutions and toward the creation of community-based programs provides great hope for future reform in Mexico. The new government of Mexico must now fulfill the commitments established by its predecessors and take up the challenge to implement sustainable reforms. MDRI will continue to monitor Mexico's reform efforts and conditions in institutions throughout Mexico.
Appendix A  Responses by the Government of Mexico

1. Dr. Manuel Urbina Fuentes, Sub-secretary of Sectoral Coordination, Secretariat of Health, received by MDRI February 16, 2000.

Note: the following comments were received by MDRI the evening before our report was released to the public in Mexico City. Subsequent to the release of the report, Dr. Urbina made a number of new promises to promote reform in Mexico. Dr. Urbina’s new promises are described above in the Afterword of this report.

GENERAL CONSIDERATIONS

We consider the title of the report “Human Rights and Mental Health in Mexico” to be imprecise. In truth, the facts and documents, which are the basis of inferences, are restricted to seven establishments of all that exist in the country; resulting in an incomplete representation of public, private and social mental health services in Mexico.

The organization of the units for mental health care is based on the integration of varied services distributed throughout the country, integrated in models and centers of community mental health, psychiatric services of general hospitals and other specialties, as well as specialized institutions; altogether, the system consists of more than 300 establishments. Based on this, we consider that the report should be called “Human Rights and Mental Health in Mexico: The case of five hospitals and two casas de protección.”

Likewise, the methodology of the report creates a significant bias, due to the time period during which the observation occurred and, more so, to the fact that the standards used in the study are not explained or made evident.

Another issue that limits the report is the fact that there is evidence of abuse in only two of the five hospitals visited.

One of the most common inconsistencies found in the report is the recurring use of wording, in a reiterative manner, that makes generalizations of particular situations and, often, uses testimonial facts, the majority of which are not objective.

COMMENTARY ON THE REPORT

During the present administration, mental health problems have been a public health priority. These problems represent a very vulnerable aspect of the human condition, present situations demonstrate that we can utilize different means to benefit or improve the conditions of this lamentable population.

The report that was sent to us raises doubts and considerable concern Regarding a partial panorama of a section of the services and does not say anything about how the treatment of mental health problems in Mexico has evolved, in the last few years.
Important goals have been accomplished; nonetheless, we recognize that there are numerous and varied challenges. We continue to resolve the problems in the practical daily life of service users in the field of training, teaching and in the availability of resources.

We should mention that one of the greatest achievements of this administration is that work programs have been organized under a new conception of mental health; this has led to beginning steps and will be continued with double the effort. This situation is not mentioned in the report in a way that sufficiently portrays the current situation in many centers of care.

In this sense, the Mental Health and Reform Program of the Health Sector 1995-2000, establishes that: “this ongoing program calls for preventative actions based on unified criteria and contents, as well as of mental health treatment in the primary and secondary levels of care. The treatment of mental illness should be based on a model of progressive steps to promote quality and efficiency. Models for mental health should be established in health centers and general hospitals located with regard to the prevalence of mental disorders. In each state, a basic net of services for mental health care will be organized to fortify prevention, treatment and rehabilitation, and to promote mental health research in public and private institutions as well as in higher education.”

Achievements have been congruent with this compromise. The following includes some of the main results to date:

**Resources**
- Between 1995 and 1999, three hospitals were built: in Sinaloa, Tabasco and Coahuila, by which the infrastructure in this field grew by 214 beds and 433 human resources. This was the result of an investment of 83 million pesos.
- In the last five years, the number of psychiatric and mental health consultations increased 86%, from 423 to 781.
- In this period, 827 new employees were hired; of which, 37.8% (296) are nurses, 34% (283) are paramedics and 25% (206) are medical specialists.

**Budget assigned to units that offer Mental Health services in the Federal District**
- The budget grew in real terms 73.7%, (1999 with respect to 1995).
- In 1995 it was 20.4 pesos (mdp) and in 1999 it was 74.0 mdp. For 2000, 88.2 mdp were assigned and authorized.

**The Psychiatric Hospitals and the completion of the NOM-025-SSA2-1994**
- Citizens committees were integrated in 27 hospitals.
- In all the units the service users were informed about their human rights.
- Rehabilitation programs operated in 27 of 28 psychiatric hospitals.
- According to an evaluation of the degree of completion of the Norma, 9 of 28 hospitals qualified with a high grade of completion and 16 with a medium grade.

**Psychosocial Rehabilitation in Specialized Public Units**
- Between 1995 to 1999, the number of units that offered psychosocial rehabilitation services in hospitals increased from 7 to 24--that is, a growth of almost 3.5 times.

---

237 Included since 1998 in the Coordination of Mental Health.
The number of units with a Partial Hospital Program or Day Center grew six times from 2 to 12.
Beginning in July, a new unit opened that operates under a new model of integrated, ambulatory mental health care that increases the capacity of the Health Sector’s response.

**Discharges**
- The number of hospital discharges in 1994 was 10,042 and in 1999 it was almost 18,700; this increase of 85.5% is important if we consider that the majority of these discharges were due to improvement.
- In 1999, almost 92% of those hospitalized showed improvement thanks to the great social rehabilitation programs, individual and group therapy the more rational use of medications.

**Psychotherapeutic consultations and sessions**
- The number of consultations grew by 86.4% between 1994 and 1999 and psycho-therapeutic sessions increased more than 51%.

**FINAL CONSIDERATIONS**

Given the importance of this problem, we do not accept a partial vision of what we have done and, in some cases, the subjective affirmations of the transition that is taking place in mental health care in Mexico at this time.

Today, a Mexican model of mental health care should be analyzed and seen as a process of transition toward a renovated model in transition.

For this reason, we ask that the report be profoundly revised with a critical, objective and scientific eye, to arrive at a definitive version that shows before the eyes of millions of people in our country, and in other countries, the problems that we have, but also what we have accomplished and the plans that are in development to achieve better results.
2. National Human Rights Commission (CNDH), received by MDRI February 7, 2000

The recent visit of the Executive Secretary of this Commission to Washington, D.C., to meet with representatives of various nongovernmental organizations including MDRI, was very productive. The President of the National Human Rights Commission (CNDH), has taken due note of the results of the meeting, especially with regard to the situation of psychiatric centers in Mexico.

Regarding this last point, I will make reference to the document “Human Rights and Mental Health: Mexico”, MDRI’s report on this matter. As the Executive Secretary expressed in Washington, the CNDH has read with interest the report, and is conscious of the grave problems and insufficiencies that trouble the mental health system in our country. The current administration of the Commission seeks to prevent problems. Therefore, we double the forces for attending to the worrisome situation of the human rights of the disabled, particularly of the mentally ill.

For several years, the CNDH has made visits to supervise psychiatric hospitals. Nonetheless, the resources of the Commission have been overwhelmed by the magnitude of this problem. At this time, the Commission is gathering the necessary support to more effectively complete its mission.

The National Human Rights Commission considers the mentally ill to be highly vulnerable to their caretakers and, furthermore, due to the nature of the sufferings, it is very difficult for the affronted to bring complaints to this National Organization.

Neither can they hope that their family members will present complaints because in the psychiatric hospitals, known as “granjas”, the majority of the people with mental illness do not have a family member who is responsible for them.

For this reason, the Third General Visitor conducts supervisory visits of psychiatric hospitals and psychiatric areas of prisons throughout the country.

During the first visits conducted in the psychiatric hospitals “Samuel Ramírez Moreno,” “Fernando Ocaranza” and “Hospital Psiquiátrico de Jalisco,” we found diverse violations of human rights, similar to those mentioned in the report “Human Rights and Mental Health: Mexico,” for this reason we issued Recomendaciones 187/93, 10/97, 70/95 and 2/97.

We have not, till this time, completed a supervision of the psychiatric hospital “Fray Bernardino Alvarez”, though we have conducted visits of around 30 hospitals that were not mentioned by the nongovernmental organization Mental Disability Rights International, these are: in Aguascalientes, the Neuropsychiatric Center; in Baja California, the Institute of Mental Health and the Psiquiátrico Municipal; in Baja California South, the “Juan Maria Salvatierra”; in Coahuila, the “Parras de la Fuente” and the “Centro Estatal de Salud Mental”; in Chiapas, the shelter for Persons with mental illness “San Agustín”; in Colima, the Psychiatric Annex of the General Hospital of Ixtlahuacán; in Chihuahua, the “Civil Libertad” and the “Chihuahua”; in the state of Mexico, the “Granja de Salud Tlazoltéotl”; in the Federal District, the hospitals “San Fernando”, “Morelos” and the Unit Number 10 of the Mexican Institute of Social Security, as well as the “Instituto Nacional de Neurologia y Neurocirugia”; in Durango, the “Dr. Miguel Vallecuelo”; in Guanajuato, the hospital of León; in Michoacán, the “Dr. José Torres”; in Nuevo León the hospital “Monterrey” and the University Hospital; in Sonora the “Cruz del Norte” and the “Dr. Carlos Nava Muñoz”; in Oaxaca, the “Cruz
Also, in these last establishments, when human rights violations were found, the respective files were opened.

Regarding this matter, the National Human Rights Commission has emitted the following Recommendations: 187/93, regarding the case of the committed patients in the Rural Psychiatric Hospital “Dr. Samuel Ramirez Moreno”; 21/94, regarding the case of the Municipal Psychiatric Hospital of Tijuana; 10/95, regarding the case of the late Mr. Miguel Angel Rivas Bernal, patients of the Rural Psychiatric Hospital “Dr. Samuel Ramirez Moreno”; 56/95, regarding the case of the Psychiatric Hospital “La Salud Tlazolteotl”; 70/95, regarding the case of the Rural Psychiatric Hospital “Dr. Fernando Ocananza”; 116/95, regarding the case of the Rural Psychiatric Hospital of “Parras de las Fuentes”; 133/95, regarding the case of the involuntary commitment of Mr. Alejandro Jacobo Arreguín; 2/97, case of the Psychiatric Hospital of Jalisco; 33/99, regarding the Shelter for People with mental illness “San Agustín”; and 37/99, regarding the case of the Psychiatric Annex of the General Hospital of Ixtlahuacán.

Of these Recommendations, eight were totally completed, two were partially completed and one was not accepted by the corresponding authorities.

In regards to the recommendations considered totally complete that were referred to above, it is important to note that in several cases, human rights violations have occurred after the respective Agreement was completed. This Commission has responsibilities in all of Mexico and has limited personnel and material resources, therefore we are obliged to give priority to the hospitals that have not received a Recommendation, as well as the psychiatric centers in prisons where we observe a greater number of human rights violations against people with mental illnesses.

In addition, the primary responsibility for supervising their establishments lies with the corresponding Health Sector.

Though the Recommendations of the National Commission only have “moral” force, sanitary authorities, especially the Coordinación de Salud Mental, have always shown a good disposition for completing them, within the confines of the resources promised by the State. Nonetheless, since this is a second generation right to be accomplished in a progressive manner, the result is always insufficient, both to provide personnel prepared to attend to the people with mental illness, as well as those with physical disabilities; similarly the economic resources do not cover the costs of medicines, food and clothing, among other things. In addition, there are enormous differences in the financial resources of the States and the Mexican Republic, not only in the health sector, but also within mental health.

The visiting committees of the National Human Rights Commission have proven that the Coordinación de Salud Mental conducts periodic supervision of the psychiatric hospitals throughout the country, to verify compliance with the federal mental health law NOM-025-SSA2-1994, For the Provision of Comprehensive Health Services in Psychiatric Units; likewise, they complete reports on deficiencies that should be corrected and verify the correction of previous problems.
The visiting committees have also recorded the efforts of some psychiatric hospital directors to rehabilitate the patients and reintegrate them into the community, but in many occasions family members are the most likely to oppose the release of the sick, for in fact there is no community infrastructure to support families.

With regard to informed consent, the visiting committee of this Commission observed that psychiatrists are resistant to accept the autonomy of the mentally ill; Such an attitude is inadequate, but it might be explained in the traditional medical model that still prevails in Mexico and has to be modified quickly.

In regards to the non-existence of community programs for people with mental illness, certainly it remains to be done; specialists in psychiatry from this National Organization consider that people with mental illness, especially the children, under no circumstance should be confined in establishments, whether it be a psychiatric hospital or shelter, the authorities must reintegrate these people into society; in order to do this, a consciousness must be created to accept and protect this most vulnerable population, which includes those suffering from psychiatric illnesses.

This National Organization considers the issues addressed in the report Human Rights and Mental Health: Mexico, which was prepared by the nongovernmental organization Mental Disability Rights International, to be of great importance; however, it is important to recognize that the National Human Rights Commission has completed, to the best of its abilities, its obligation to defend the human rights of people with mental illness; nonethe-less the effort is always insufficient, especially with regards to the financial materials of the State and the creation of a consciousness of these rights.

Also, we should mention that with the change in the administration in the National Commission, and the autonomous character that it now has, it will lead, in the near future, to more attention and care for the inherent issues of people with mental illnesses.
Appendix B  Principles for the Protection of Persons with Mental Illness

Adopted by United Nations General Assembly resolution 46/119 of 17 December 1991

Application

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

Definitions

In these Principles:

"Counsel" means a legal or other qualified representative;

"Independent authority" means a competent and independent authority prescribed by domestic law;

"Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

"Mental health facility" means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

"Mental health practitioner" means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

"Patient" means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

"Personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

"The review body" means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

General limitation clause

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.
Principle I

Fundamental freedoms and basic rights

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.

3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.

4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.

5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interest.
Principle 2
Protection of minors

Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

Principle 3
Life in the community

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

Principle 4
Determination of mental illness

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.

2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.

3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.

4. A background of past treatment or hospitalization as a patient shall not of itself justify any present or future determination of mental illness.

5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

Principle 5
Medical examination

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.

Principle 6
Confidentiality

The right of confidentiality of information concerning all persons to whom these Principles apply shall be respected.
Principle 7
Role of community and culture

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.

2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.

3. Every patient shall have the right to treatment suited to his or her cultural background.

Principle 8
Standards of care

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs and is entitled to care and treatment in accordance with the same standards as other ill persons.

2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients staff or others or other acts causing mental distress or physical discomfort.

Principle 9
Treatment

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Principle 10
Medication

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy.
2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient's records.

\[ \text{Principle II} \]
\[ \text{Consent to treatment} \]

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.

2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

(a) The diagnostic assessment;

(b) The purpose, method, likely duration and expected benefit of the proposed treatment;

(c) Alternative modes of treatment, including those less intrusive; and

(d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek, to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

(a) The patient is, at the relevant time, held as an involuntary patient;

(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15
below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.
16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

**Principle 12**

**Notice of rights**

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.

2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

**Principle 13**

**Rights and conditions in mental health facilities**

1. Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:

   (a) Recognition everywhere as a person before the law;

   (b) Privacy;

   (c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;

   (d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

   (a) Facilities for recreational and leisure activities;

   (b) Facilities for education;

   (c) Facilities to purchase or receive items for daily living, recreation and communication;
(d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.

4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

**Principle 14**

**Resolution for mental health facilities**

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:

   (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;

   (b) Diagnostic and therapeutic equipment for the patient;

   (c) Appropriate professional care; and

   (d) Adequate, regular and comprehensive treatment, including supplies of medication.

2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.

**Principle 15**

**Admission principles**

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.

3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient as set forth in Principle 16 apply, and he or she shall be informed of that right.
Principle 16
Involuntary admission

1. A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with Principle 4, that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgment is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

Principle 17
Review body

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.

2. The review body's initial review, as required by paragraph 2 of Principle 16, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.
4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.

5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph I of Principle 16 are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.

6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.

7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

Principle 18
Procedural safeguards

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.

4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is with held from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and shall be subject to judicial review.

5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.

6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.
7. Any decision whether the hearing or any part of it shall be in public or in private and may be publicly reported shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

**Principle 19**

*Access to information*

1. A patient (which term in this Principle includes a former patient) shall be entitled to have access to the information concerning the patient and his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

2. Any written comments by the patient or the patient's personal representative or counsel shall, on request be inserted in the patient's file.

**Principle 20**

*Criminal offenders*

1. This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

2. All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.

3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.

4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11.
Principle 21
Complaints

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

Principle 22
Monitoring and remedies

States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

Principle 23
Implementation

1. States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.

2. States shall make these Principles widely known by appropriate and active means.

Principle 24
Scope of principles relating to mental health facilities

These Principles apply to all persons who are admitted to a mental health facility.

Principle 25
Saving of existing rights

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that these Principles do not recognize such rights or that they recognize them to a lesser extent.
Appendix C  Declaration on the Rights of Mentally Retarded Persons

Proclaimed by United Nations General Assembly resolution 2856 (XXVI) of 20 December 1971

The General Assembly,

Mindful of the pledge of the States Members of the United Nations under the Charter to take joint and separate action in co-operation with the Organization to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

Emphasizing that the Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the Rights of Mentally Retarded Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.

2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.

4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should
receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.

6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.

7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.
Casa de Protección, 1999