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.


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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 Ramirez 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.

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.
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.

While international human rights law places great importance on individual liberty and the MI 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 prescription policy
- prescription procedures
- a pharmacy manual
- specific controlled-substances information
- psychotropic drug regimen
- adequate monitoring of side effects
- progress reports
- a proper diagnosis
- guidelines for prescribing medications
- regular and periodic evaluation of patients for the presence of side effects

Treatment standards should include:

- internationally accepted admission and discharge practices
• 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.

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.
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 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.  

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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 Benchoam, 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. This report draws primarily from 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 Ramírez Moreno (Ramírez 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.

4 The 1996 team included Catherine O’Malley, JD, MDRI staff, and Sara Lee, MSW, Chief of Social Work at St. Elizabeth’s Hospital, Washington, DC. 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.

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 videotapes are kept in the video library of the Witness Program in New York and are available for review by arrangement with MDRI.
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.

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
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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.
• Introduction

• 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

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
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

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).


discrimination and against inhuman and degrading treatment and protections of the liberty and security of the person.\(^{10}\)

\(^{10}\) OAS Off. Rec. OEA/Ser.L./VII.23, doc.21, rev.6 (1979), ratified by Mexico April 3, 1982 (with reservations).
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. In 1971, the United Nations adopted the Declaration on the Rights of Mentally Retarded Persons (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. 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.” 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. In an historic meeting convened by PAHO in November 1990, the

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15 see Itzhak Levav, Helena Restrepo and Carlyl Guerra de Macedo, The Restructuring of Psychiatric Care in Latin America: A New Policy for Mental Health Services, 15 J. PUB. HEALTH & POLICY 71 (1994) (describing developments in mental health policy, and law underlying the Declaration of Caracas). The Declaration of Caracas is reproduced in English in the article at 82. A Spanish-language translation is available in Jiménez, supra note 11, at 186.
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.”\textsuperscript{16} The Declaration concludes that such conditions “imperil the human and civil rights of patients.”\textsuperscript{17}

\textsuperscript{16} Id. at 83, preamble paragraph 2.

\textsuperscript{17} Id.
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.” Mental health resources must be used to “safeguard personal dignity and human and civil rights” and “national legislation must be redrafted if necessary...” 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. 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 illness, the MI Principles provide a framework for protecting the rights of individuals with mental disabilities.

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18 Id., article 1.
19 Id., article 3.
20 Id., article 4.
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.”\(^{25}\)

\(^{22}\) *Case of Victor Rosario Congo*, Report 29/99, Case 11.427, Ecuador, adopted by the Commission in Sess. 1424, OEA ser. L/7.102, doc. 36 (1999). The Inter-American Commission cited Rosenthal and Rubenstein, supra note 11, for the proposition that the *MI Principles* can be used as a guide to the interpretation of human rights covenants. *Case of Victor Rosario Congo* at 8, n.7.

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

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

\(^{25}\) *Id., principle 1(2).*
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 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.”\(^{32}\)

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

\(^{27}\) *Id.*, principle 7(1).

\(^{28}\) *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.
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.

2. **International trend toward community integration**

33/d, principle 8.

34/d, principle 9(2).

35/d, principle 11(1).
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

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36 WHO, Public Health in Europe: Mental Health Services in Europe 10 Years on 75 (1985).

37 Id., at 71.

mental health system, such as cutbacks in social programs in the 1980s.\textsuperscript{39} 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.\textsuperscript{40}

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

\textsuperscript{40}DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT TO THE SURGEON GENERAL 287 (1999).
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 Curundú, 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.

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42 Id. at 44.

43 Id. at 51


45 Hospitals Psiquiatricos: Resunideros de la Siniason, Editorial Tres, in 3(March 16, 1992) and personal communication with Virginia González Torres, President of the Fundación Mexicana para la Rehabilitación del Enfermo Mental, IAP.
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”).

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. 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. 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 the psychiatric hospital. 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. 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. 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.

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46 Id.

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 entry for herself and members of an officially recognized citizens committee to investigate allegations that staff members had raped residents of the facility. Gonzalez 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, Gonzalez 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 Gonzalez 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, Gonzalez Torres and members of the Human Rights Committees at Sayago, Nieto, Ramírez Moreno and, later, Ocaranza 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 Gonzalez 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

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48 Nor na, section 11.

49 Id., section 7 (describing integrated rehabilitation programs, “Actividades de Rehabilitación Integral”).
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.

\[50\] /d, 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).

\[51\] /d, 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.  

The mental health law called for the creation of “citizens committees” to monitor conditions in the “granjas” and other psychiatric institutions. 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. Since the establishment of the mental health law, at least six psychiatric hospitals and “granjas” in Mexico City have established citizens committees.

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. In addition, Mexico City authorities provide services to

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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 Usuari os”).


54 Id., Section 12.2 Appendix B at 77.

55 According to RWMEM there are citizens committees at Sayago, Ocaxan, Fray Barnardi no, Neto, Jalisco and Ramírez Moreno hospitals.

56 The public and the social security institutions are funded through private, individual and
indigent and homeless individuals through the Casas de Protección Social and administers two such institutions especially for people with mental disabilities.
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.\(^57\) 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).\(^58\) 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

\(^57\)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.

\(^58\) Data provided by the Coordinación de Salud Mental, Recursos de Atención Psiquiátrica Hospitalares SSA (1997).
mental illness and will be in need of specialized treatment at some time in their life. As a matter of policy, the great majority of mental health care is supposed to be provided in the community or in general hospitals. 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.”

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.

59 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).


61 Id. at 29-30.
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

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\[62\] 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
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 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 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.

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63Fundación 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.
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—Ramírez 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

64Additional 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 Martínez, “Principios de Rehabilitación Psicosocial,” 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. Martínez, MD (for more information contact MDRI).
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. 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 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, protections against arbitrary deprivation of personal liberty and security, 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. 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. 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.” Thus, “living conditions in mental health facilities should be as close as possible to those of the normal life

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65 General statements about Mexico’s long-term facilities or “granjas” used in this report are not intended to apply to Fray Bernardino Alvarez.

66 CCR, article 13.

67 American Convention, article 7.

68 The Government of Mexico is responsible for dangerous and life-threatening treatment practices in public psychiatric institutions. Article 6 of the CCR and Article 4 of the American Convention prohibit state action that would create life-threatening dangers.

69 CCR 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).
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.

71/Id., principle 13(2).
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 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.

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21 Id., principle 13(2)(d) (living conditions should include “[f]acilities, and encouragement to use such facilities, for a patient’s engagement in active occupation . . . and vocational rehabilitation measures to promote reintegration in the community”); principle 9(4) (“[t]he treatment of every patient shall be directed towards preserving and enhancing personal autonomy”).

71 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”).
In Jalisco, there were limited activities for a small number of people. Jalisco had an 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.

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.

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*Individuals in the hospital can participate in these programs and earn a total of 70 pesos, or ten US 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.*
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

75 Norma, Section 8.4.

76 Id. Section 8.6

77 Comisión Nacional de Derechos Humanos, Reconducción 2/97, Caso de Hospital Psiquiátrico de Jalisco, 1997.
The 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 women is considerably cleaner than Ocaranza, MDRI observed a similar practice of providing water for taking medications to a large number of people from a single cup.

Ocaranza’s former director reported to MDRI that Ocaranza’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 Ocaranza, 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 CNDH also reported finding fecal matter and flies at Jalisco. CNDH supra note 77.
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.

The Sayago, Nieto and Ramírez 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

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

\(^{80}\) *Id.*, p. 13(2).
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 bedsore prevention can be dangerous and life-threatening.

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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.

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“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.
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 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.”


85 MI Principles, principle 11(11).
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.”\(^{86}\)

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 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.

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

88 People who can only eat soft foods will often substitute carbohydrates for meat and vegetables.