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Convention on the Rights of Persons with Disabilities

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Committee on the Rights of Persons with Disabilities

Inquiry concerning Mexico conducted under article 6 of the Optional Protocol to the Convention

Observations of Mexico*

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* The present document is being issued without formal editing.

Introduction

1. The State of Mexico submits to the Committee on the Rights of Persons with Disabilities its observations on the findings of the inquiry conducted under article 6 of the Optional Protocol. It does so in full recognition of the central place of the rights of persons with disabilities on the national agenda and with a firm commitment to the comprehensive implementation of the Convention and the Optional Protocol.

2. The State has taken account of the factual findings of the Committee's inquiry, as well as its recommendations. There are in fact, as noted by the Committee, challenges concerning violations of the rights of persons with disabilities enshrined in the Convention, specifically rights violations related to the recognition of the legal capacity of persons with disabilities, the challenges to being included in the community and living independently and the impact of institutionalization on persons with disabilities.

3. Under Mexican law, institutionalization is neither routine public policy nor an automatic care measure but an exceptional protective measure of short duration applicable only in the face of a real, present and serious risk to a person's life or physical integrity. As such, it must be acknowledged that deinstitutionalization is a complex and highly sensitive process that requires a gradual, responsible and person-centred approach. The transition towards living independently and being included in the community must be understood not as the simple closure of institutions but as the gradual development of adequate, accessible and sustainable support systems that ensure the effective exercise of legal capacity, autonomy and dignity for persons with disabilities. The State is committed to these objectives and, by having agencies at all levels of government implement public policies, is currently taking steps to achieve them.

4. The implementation of strategies, the development and expansion of arrangements for non-institutional care and the recognition of informed consent and autonomous decision-making, as well as institutional restructuring to consolidate a person-centred model, reflect efforts to bring public policies gradually into line with the provisions of the Convention.

5. Although significant challenges remain, they should be understood not as deliberate omissions but as part of a gradual structural transformation that requires strategic planning, rigorous assessments, ongoing evaluation and continuous adjustment. Accordingly, the Government reaffirms its commitment to making steady progress towards deinstitutionalization, ensuring that each step is taken with due diligence, focusing attention on persons with disabilities, their wishes and their preferences and ensuring that no transition results in a rollback of their rights.

6. As a result not only of the provisions of Mexican law but also of measures, public policies and practices actively implemented with a view to fulfilling Convention obligations, in addition to the steps noted in the reports submitted in 2023 and 2025 (see annexes 1 and 2), the shortcomings noted in the Committee's report can hardly be considered systematic.

I. Persistence of institutionalization

7. In the past, forced and prolonged institutionalization in facilities of various types, including psychiatric hospitals, created conditions of vulnerability that could lead to violence, inappropriate treatment or rights violations. In this light, the State is of the view that there is indeed a need to further transform the service model by strengthening preventive, psychosocial and community-based strategies that promote the inclusion and autonomy of persons with disabilities.

8. A lack of support or services in the community should not be used as a pretext for institutionalization. On the contrary, that lack requires the State to expedite the creation and consolidation of satisfactory, accessible and well-coordinated community networks. In addition, institutionalization cannot be considered a form of protection for persons with

disabilities, so existing inter-agency procedures, support systems and services must be activated to review and, where appropriate, revoke commitment orders, particularly in the case of vulnerable individuals or alleged victims.

9. This process must begin with an individualized needs assessment that makes it possible to develop a life plan tailored to each person's characteristics and aspirations and with a focus on the person's inclusion in the community and ability to live independently. Following this process requires taking a comprehensive approach to issues such as employment, education, health, housing, support for living independently and participation in the community. Consequently, it is essential to strengthen cross-sectoral community-based development services by incorporating support mechanisms and safeguards for decision-making, psychosocial support that takes into account disability and gender perspectives and respect for the justice systems of Indigenous Peoples, as well as to clearly define the entity responsible for monitoring deinstitutionalization processes.

10. A case in point is the National Commission on Mental Health and Addiction, which has spearheaded a process to transform the mental healthcare model, focusing on ongoing deinstitutionalization, community-based care and respect for human rights with a gender perspective. Mechanisms for oversight, staff training and the adoption of protocols for the prevention of and response to violence, as well as for the detection and reporting of potential abuse, have been strengthened in accordance with national and international standards on the rights of persons with disabilities.

11. It has been recommended that hospitalization, where required as a result of a mental health or behavioural disorder, be an exceptional, temporary and duly justified measure, prioritizing community-based alternatives, informed consent, family and institutional support and social reintegration, with a view to eliminating forced institutionalization and preventing all forms of violence in mental health services.

12. A transition from an institutional to a community-based model, made on the basis of the overhaul of the 2022 General Health Act, is currently under way. In this context, the following are priorities:

- Specialized healthcare is no longer based on prolonged hospitalization. Hospitalization, which is of short duration, is used only as a therapeutic measure of last resort and requires the individual's informed consent, thereby eliminating the practice of involuntary commitment. Similarly, the aim of the care strategy adopted in general hospitals is to ensure that crisis care is temporary and provided in non-segregated healthcare settings, facilitating the individual's immediate return to his or her social environment. In addition, the provision of health services is being decentralized, and the focus is on primary care, which is provided by 346 units known as specialized medical units – centres for primary addiction care; these centres are community support hubs that provide outpatient care, allowing people to receive care without having to leave their home environment, not residential facilities.
- The mental health gap action programme of the World Health Organization (WHO) has been implemented on an ongoing and large-scale basis to address the shortage of specialized personnel. As a result, it is possible for non-specialist health workers throughout the healthcare system to acquire the skills needed to provide psychosocial support without having to refer individuals to segregated institutions.

13. Consequently, the State does not limit deinstitutionalization efforts to clinical settings; instead, it uses awareness-raising and training strategies in the area of mental health – such as promoting a culture of autonomy – along with advance instructions for decision-making by people with mental health disorders to incorporate social support involving cooperation by the health sector with the education sector, law enforcement and civil society organizations.

Harm and impact of institutionalization

14. The Committee notes that persons with disabilities have been subjected to torture and ill-treatment in some institutions. The mental healthcare centres administered by the National Commission on Mental Health and Addiction work in close coordination with local

commissions, and care facilities are inspected to ensure the observance of and full respect for human rights. Efforts to eliminate all cruel, inhumane or degrading treatment of substance users are, in addition, continuing to be made.

15. In the units overseen by the National Commission, there are no seclusion rooms; instead, there are continuous observation areas designed exclusively for the ongoing assessment and protection of the individual's safety and that of others, thereby avoiding punitive confinement. Similarly, non-invasive strategies for crisis prevention and management are used, verbal de-escalation is favoured over all forms of physical or pharmacological restraint and respect for autonomy and human rights is made a priority.

16. Efforts are also under way to incorporate advance care planning guidelines to ensure that people's preferences are at the heart of their care, and a culture of prevention, involving awareness-raising and training for healthcare staff on human rights and person-centred care, is being fostered. In addition, there are mechanisms for monitoring and reporting human rights violations, as well as anonymous channels (such as institutional suggestion boxes) and direct channels (such as active listening) to effectively detect and respond to any suspected human rights violations.

17. In addition, the development of manuals and operational guidelines, which are among the technical resources relied on, to standardize the use of non-invasive communication strategies is particularly noteworthy. In non-coercive restraint, the focus is on learning verbal de-escalation techniques as the primary crisis management tool, thereby preventing abnormal behaviour and minimizing the use of restrictive measures, while always prioritizing the safety and dignity of the individual.

18. It should be noted, with regard to the Committee's concern about suicide, that the State has developed the National Suicide Prevention Programme, as well as the Basic Guide to Suicide Prevention, which are tools designed to strengthen guidance, raise awareness and facilitate early identification of risk in the community. In addition, the specialized telephone counselling service Lifeline is available to provide a listening ear, advice, referrals and connections for people at risk and their support networks. These initiatives are complemented by training sessions for primary healthcare providers delivered in accordance with the WHO mental health gap action programme with a view to encouraging accessible, timely and community-based care.

Impact on high-risk groups

19. The Mexican legal framework includes the General Act on the Inclusion of Persons with Disabilities, which is informed by an intersectional approach to ensuring that persons with disabilities enjoy all their rights without distinction on the basis of ethnic or national origin, gender, age or a growth disorder, social or economic status, health condition, religion, opinion, marital status, sexual orientation, pregnancy, political identity, language, immigration status or on any other ground or characteristic inherent to the human condition or that undermines their dignity. It is also stipulated that all public policies promoting the rights of persons with disabilities must involve mainstreaming, in which a framework for action and the coordination of efforts and resources cuts across vertical, horizontal and substantive dimensions.

20. The Committee notes that there are people who were admitted to institutions as children and remain institutionalized as adults. This finding should be interpreted not as evidence of deliberate State policy but as an expression of historical shortcomings in the development of community-based alternatives and weaknesses in the monitoring systems that the State is obligated to set right, in accordance with the principle of progressive development. Therefore, in accordance with the Convention and the Committee's observations on living independently and being included in the community, the State, working from a community-based perspective rather than from the perspective of hospital or psychiatric care, designs and operates facilities with a view to ensuring that persons with disabilities remain in their community and family environments.

21. These facilities also promote the transition from assisted living models to group housing offering greater personalization, participation and community engagement. The aim is to ensure that admission to these facilities is a measure of last resort, giving priority, whenever possible, to community-based support alternatives and family reunification, in line with a human rights-based and social inclusion approach.

(a) Children and adolescents

22. The finding regarding the prolonged or indefinite institutionalization of children and adolescents with disabilities, as well as the weakness of information and monitoring systems, must be analysed in the light of the Constitution, in which, in accordance with the principle of the best interests of the child, the right to identity, special protection and the effective restoration of rights is recognized.

23. Institutionalization is legally valid only to the extent that it is temporary, exceptional and focused on a permanent solution based on the right to family and community life. As such, prolonged institutionalization is an indicator of shortcomings in the processes of restitution, family reintegration or community inclusion, not a legitimate goal of State intervention.

24. The Committee's observation that the lack of comprehensive, up-to-date and interoperable records hinders the effective monitoring of alternative care arrangements and the assessment of their duration, causes and outcomes highlights the need to strengthen administrative mechanisms and inter-institutional coordination; it does not imply that the State has no duty to exercise oversight. Individualized monitoring of each child or adolescent in institutional care is essential to preventing placement in such care from being prolonged, without periodic reviews or clear goals for the restoration of rights, as a result of bureaucratic inertia. Indefinite placement in an institution, without a discharge plan or ongoing assessment, undermines the protective purpose of the placement and turns it into a form of structural exclusion.

25. The State recognizes that its responsibility is not simply to make a record of the presence of children and adolescents with disabilities in institutions but that it also extends to designing and implementing individualized plans for the restoration of their rights that include genuine alternatives: family strengthening, foster care, educational inclusion and the provision of services in their communities. The temporary nature of institutionalization is not merely an administrative matter but also an essential component of its constitutional legitimacy. In addition, the convergence of structural causes of discrimination (childhood, gender and disability) increases the vulnerability of girls with disabilities to violence, abuse and exclusion both in the family and in institutional and community settings. This convergence is not evidence of a State policy of neglect or acquiescence; it is instead a structural challenge that imposes a heightened duty of prevention, protection and restoration of rights.

26. Violence against girls with disabilities often goes unnoticed as a result of communication barriers, dependence on caregivers and difficulties in making reports. The State's response cannot therefore be neutral or limited to general preventive measures; rather, it must involve reasonable accommodation, accessible reporting systems and specialized care in which the specific needs arising from disability are taken into account. The State's duty is not fully discharged when it reacts to a fait accompli; it is, on the contrary, the State's responsibility to create safe environments that structurally limit opportunities for abuse, which is directly linked to reducing prolonged institutionalization and strengthening families and communities.

27. In this context, the need for systematic data, oversight mechanisms and tailored strategies is recognized in national public policy. Course of action 3.3.6 of the National Programme for the Protection of Children and Adolescents 2026–2030 ("Use registration and monitoring mechanisms to monitor the conditions under which shelters, refuges or any residential centres for children and adolescents with disabilities operate") contains guidance for inter-agency initiatives to monitor – by means of registration and monitoring mechanisms that make possible the identification of the duration of stays, the conditions of care and progress towards rights restoration – the conditions under which shelters, refuges, or

residential centres for children and adolescents with disabilities operate. Similarly, strategy 3.3 (“Take action to ensure the inclusion and freedom from discrimination of children and adolescents with disabilities to promote their full development”) calls for the adoption of measures to ensure that children and adolescents with disabilities are included and live free from discrimination, with a differentiated approach that addresses the heightened risks faced by girls in particular.

28. The aim of these courses of action is to prevent institutionalization from becoming a permanent situation and to ensure that all measures are subject to institutional oversight, periodic review and individualized discharge plans that include realistic alternatives: family strengthening, foster care, educational inclusion, the provision of community-based services and support for living independently. As accessible services and support networks are developed in the community, structural exposure to custodial settings, where dependency and isolation can lead to abuse, decreases.

29. Consequently, it cannot be argued that the State chooses to keep children and adolescents with disabilities in institutions indefinitely or that it ignores the specific situation of girls with disabilities. The exceptional and temporary nature of residential care, as well as the need for an intersectional approach to differentiated risks, is recognized in the regulatory and institutional framework. The State’s response is not to accept indefinite placement or to ignore the risks involved but to progressively strengthen mechanisms for oversight, inclusion, accessibility and the effective restoration of rights, in accordance with the best interests of the child, the principle of non-discrimination and the constitutional mandate for enhanced protection.

(b) Older persons with disabilities

30. The National System for the Comprehensive Development of the Family and the State and Municipal Systems are the agencies responsible for the planning, operation, supervision and evaluation of senior centres, senior care homes and recreational camps. These facilities are dedicated to the care and holistic development of older persons, including those with disabilities.

31. These camps offer daytime, community-based and recreational services that promote active ageing, social integration, and participation in physical, cultural and social activities. The senior centres and the senior care homes, for their part, operate – on the basis of exceptional need, temporary placement and full protection of rights – as residential care facilities for older adults who lack satisfactory support networks.

32. A gradual shift away from traditional charity-based models towards group housing models that offer a greater degree of personalization, active participation and community engagement is, in addition, taking place at the senior centres and the senior care homes. Admission to these facilities is viewed as a measure of last resort, with priority given to community-based support alternatives and, whenever possible, family reunification.

33. Furthermore, internal guidelines have been put in place to prevent and address the violence, ill-treatment, neglect or abuse older adults with disabilities may face in senior centres, senior care homes and recreational camps. These guidelines cover early detection, documentation, referrals and follow-up with the relevant human rights protection and law enforcement agencies.

34. Punitive confinement, physical or pharmacological restraints, disciplinary fines and any form of cruel, inhuman or degrading treatment are prohibited in these facilities. Intervention based on support, reasonable accommodation, informed participation and respect for the autonomy of the older adults who use these facilities is promoted instead.

35. In addition, feedback mechanisms, user committees and satisfaction surveys are used to encourage the active participation of older adults with disabilities in shaping activities, establishing rules of conduct and making improvements at the senior centres, senior care homes and recreational camps.

36. What is more, gradual steps are being taken to make appropriate changes to infrastructure and services (physical accessibility, accessible communication, mobility aids, appropriately tailored activities) with a view to eliminating barriers and aligning recreational, cultural and care services with a model of community-based support, in accordance with international recommendations on deinstitutionalization.

37. Consequently, it cannot be argued that older persons who are in institutions in Mexico are systematically neglected, subjected to medical treatment and kept in degrading conditions. The State seeks to ensure their safety and dignity and to expand the protection of their rights under conditions of equality and non-discrimination, as well as to make them more independent.

Mental health and addiction

38. The Committee notes that, according to one source, public health funding, at both the federal and the state levels, continues to be earmarked for psychiatric hospitals, whereas no funds are set aside for community-based mental health services.

39. The Government has set funds aside for the construction and opening of public outpatient facilities for mental health and addiction treatment. Currently, and in recognition of the importance of community mental healthcare, there are 346 community mental health and addiction centres and 45 comprehensive mental health centres operating under the State Health Services and the Public Health Services for Well-being Section of the Mexican Social Security Institute, as well as 110 federally funded youth integration centres, which take preventive measures and ensure timely detection and primary-level mental health- and addiction care, while promoting psychosocial recovery in outpatient and community settings. In 2025, moreover, the Ministry of Finance and Public Credit set federal funds aside[1] for programmes addressing mental health and addiction. In all, 35% of this budgeted amount was earmarked for secondary mental healthcare and 65% for community-based care, research and training.

40. In addition, the federal authorities, in implementation of Budget Programme E025 (now E032) (mental health care and addiction prevention) and the Specific Agreement on the Transfer of Federal Budgetary Resources, make an annual allocation to the states and the Federal District to strengthen their mental health promotion and prevention efforts.

41. The states and the Federal District are helped to consolidate the community-based model by having positions filled by public servants whose salaries are paid out of the federal budget and who are responsible for prevention and care activities at the community mental health and addiction centres. Mexico City, for example, deployed the strategy “City of Emotional Health: A Fulfilling Life, a Joyful Heart” to transform the mental healthcare model, ensuring free, equitable and inclusive access. In addition, in Mexico City and the State of Mexico, leading agencies such as the Institute for Addiction Treatment and Prevention and the State of Mexico Anti-Addiction Institute transformed into the Institute for Mental Health- and Addiction Care and the State of Mexico Institute for Mental Health and Addiction, respectively, to consolidate a comprehensive, community-based model compatible with human rights and deinstitutionalization. Similarly, in the other first-level administrative divisions, state-level representatives have been brought together to develop strategies.

42. In the period 2021–2024, in addition, and in conjunction with the overhaul of the General Health Act, more than 61,000 healthcare professionals were given training on the Mental, Neurological and Substance Use Disorders Intervention Programme (WHO mental health gap action programme) with a view to expanding the capacity for mental healthcare at the primary and secondary levels.

[1] Funds amounting to 3,334,215,041 Mexican pesos set aside in accordance with the 2025 federal expenditure budget. Available at www.pef.hacienda.gob.mx/es/PEF2025/analiticos_presupuestarios.

Hospitalization of children and adolescents with psychosocial disabilities or mental healthcare needs

43. The issue of institutionalizing children and adolescents with psychosocial disabilities or mental healthcare needs must be analysed within the framework of the Constitution, in which the right to health, development and personal liberty, as well as the principle of the best interests of the child, is recognized and taking into account the State's international obligations under the Convention on the Rights of Persons with Disabilities. Admission to psychiatric hospitals or secure units is not a standard response to mental health issues but an exceptional measure that can be justified only when there is a real and immediate risk to the life or safety of the individual or others and provided that it has been established that there are no less restrictive alternatives available in the community.

44. The mental health of children and adolescents with disabilities must be based not on an approach involving control or confinement but on a comprehensive, community-based and rights-centred model of care. A psychosocial disability does not deprive a person of his or her status as a holder of rights or authorize the State to automatically override the will of a minor or separate a minor from his or her family and social environment. In accordance with the right of persons with disabilities to live and thrive in the community, the State is under an obligation to develop outpatient care services, psychosocial and family support services and early intervention mechanisms that prevent crises from leading to prolonged or repeated hospitalization.

45. In this context, the need to promote mental health from the earliest stages of life is recognized in national public policy. Under course of action 1.1.8 ("Promote the full potential for development and well-being of children in early childhood by encouraging positive parenting and the mental health of both children and their caregivers") of the National Programme for the Protection of Children and Adolescents 2026–2030, guidance is provided for State action to prevent psychosocial harm with the help of early intervention, support for families and the promotion of healthy caregiving environments, thereby reducing the likelihood that situations of stress, neglect or lack of support will lead to crises requiring institutionalization. This preventive and community-based approach is consistent with the State's obligation to promote the comprehensive development of children and adolescents with disabilities and to ensure that the support they need is provided in their family and community settings.

46. There is no legal basis for institutionalization without an individualized assessment, without taking the individual's wishes into account to the extent possible and without periodic review. Any mental health intervention must be based on an individualized clinical assessment performed by specialized personnel and grounded in objective medical criteria. Legitimate State action requires that any mental health intervention be based on objective clinical criteria, accompanied by procedural safeguards and intended to restore the right to live in the community. The safeguards include periodic reviews of the necessity of institutionalization, the involvement of family members or caregivers and the development of discharge plans that facilitate gradual reintegration into the community. Psychiatric hospitalization without discharge plans, family support or effective community-based alternatives undermines its therapeutic purpose and turns it into a form of exclusion from society.

47. Consequently, it cannot be argued that the State has adopted a policy for the systematic institutionalization of children and adolescents with disabilities as a means of control or segregation. Community-based and preventive mental healthcare are prioritized in the legal and institutional framework, and hospitalization is a last resort used only in emergencies. Public policy is designed to progressively strengthen accessible, community-based mental health services that are family- and community-centred; the State's response is not to make institutionalization the norm but to strengthen, by degrees, accessible, community-based mental health services centred on families and communities, in accordance with the best interests of the child, the principle of non-discrimination and the right of persons with disabilities to live and participate in the community on an equal basis with others.

II. Situation of children and adolescents

48. The Committee notes that the State has not taken measures to identify and combat multiple and intersectional discrimination against children with disabilities, who face a greater risk of being institutionalized and separated from their families. It also notes that the temporary and prolonged institutionalization of children with disabilities affects their cognitive, social and emotional development, exposing them to situations of risk.

49. The existence of prolonged hospitalization is a reflection not of a State policy of hospitalization but of structural shortcomings, a legacy of charity-based models, that the authorities have acknowledged and are obligated to address. From the perspective of the principle of progressive improvement, the State's obligation is to demonstrate that it has taken deliberate, specific measures to steadily reduce recourse to residential care as a primary response. The transition from a model focused on institutionalization to a model based on social inclusion is a structural process that requires regulatory changes, institutional strengthening and the expansion of community services, including family support services and alternative care arrangements in family settings, developments that are already under way.

50. In Mexico, these shortcomings are evident chiefly in the existing infrastructure, in outdated administrative practices and in the historically insufficient coverage of specialized community services for children with disabilities. In current public policy, however, these shortcomings are explicitly acknowledged, and institutional transformation intended to gradually replace the charity-based model with a protection system based on social inclusion, family strengthening and community support has begun. Current national public policy thus reinforces the view that institutionalization is not and cannot be the State's structural response to disability or poverty. Course of action 3.3.6 of the National Programme for the Protection of Children and Adolescents 2026–2030 ("Use registration and oversight mechanisms to monitor the conditions under which shelters, refuges or any residential centres for children and adolescents with disabilities operate") establishes a specific obligation for institutional oversight and strict regulation of residential care. This course of action strengthens the mechanisms for the oversight and registration of these facilities with a view to identifying human rights violations and ensuring that these facilities are used on an exceptional and temporary basis alone.

51. Likewise, social assistance programmes, rehabilitation services, the National Strategy for Inclusive Education and the initiatives of the National System for the Comprehensive Development of the Family are not isolated responses; that is, they are components of a State strategy designed to transform the structural conditions that have historically led to the separation of children and adolescents with disabilities from their families. Its purpose is not to legitimize institutionalization but to progressively reduce dependence on it by strengthening community services, promoting educational inclusion, supporting families and expanding specialized care mechanisms without severing family and social ties.

52. Similarly, the National Programme for Equality and Non-Discrimination, informed by an equality and non-discrimination perspective, prioritizes countering and eliminating discriminatory practices that affect members of groups historically subjected to discrimination, including children and adolescents with disabilities. This approach involves the adoption of measures to level the playing field, promote inclusion and take affirmative action to ensure genuine equality of opportunity and effective access to services in conditions of dignity and respect.

53. Specific means of identifying and eliminating structural barriers in this context include providing reasonable accommodation to make tailored services available to persons with disabilities, receiving complaints of potential acts of discrimination and organizing training and awareness-raising for public servants. These initiatives not only strengthen rights protection but also indirectly help prevent exclusion or dependence on institutions, phenomena that can lead to the prolonged institutionalization of children and adolescents with disabilities.

54. The National Programme for Equality and Non-Discrimination thus complements public policies for rights restoration and inclusion, ensuring that services are accessible,

respectful and tailored to each person's specific needs, in accordance with the principle of non-discrimination and the State's commitments to ensuring equality of opportunity and decent treatment.

55. Consequently, it cannot be argued that the State has, in respect of children and adolescents with disabilities, adopted a policy of discriminatory institutionalization. What there is a legal framework under which the removal of such children and adolescents from their homes for reasons of personal status is prohibited, a public policy in which the exceptional nature of residential care is acknowledged and a national strategy that seeks to address, with the help of oversight, regulation and the strengthening of family- and community-based alternatives, the root causes of institutionalization.

56. In addition, national public policy includes measures intended to strengthen family- and community-based care alternatives, as well as to expand support services that enable children and adolescents with disabilities to remain in their family environment under conditions that ensure their protection and development. In this respect, the State's response is not to make institutionalization the norm but to limit it strictly by legal means and to progressively reduce recourse to it, while strengthening community-based services and family support, in accordance with the best interests of the child, the principle of non-discrimination and the right of children and adolescents with disabilities to live and develop in the community on an equal basis with others.

Right to a family life

57. The observation that children and adolescents with disabilities are separated from their families owing to factors such as disability, poverty or neglect must be analysed within the constitutional and legal framework within which the State intervenes and in the light of the international human rights standards applicable to children and adolescents with disabilities. The right to live with one's family is a guiding principle of the comprehensive protection system and does not permit interpretations that would facilitate automatic or generalized separation on the basis of personal or socioeconomic status. Disability and poverty are not, in and of themselves, legally valid grounds for the dissolution of a family relationship; on the contrary, these conditions trigger enhanced obligations on the part of the State to provide the social, community and protective support that enables children and adolescents to remain in their family and community environments.

58. Family separation is constitutionally permissible only when there is a real, present and verifiable risk to the life, physical well-being or development of the child or adolescent, and provided that it has been established that there are no viable family- or community-based alternatives. An individualized, evidence-based assessment, which is subject to oversight by the competent authorities, must take place before this determination is made. Alternative care is the exception, not the rule, and must be preceded by family strengthening measures, social assistance, psychosocial support and the provision of specialized services. Whenever possible, priority should also be given to care in family or community settings in which the emotional and social bonds of the child or adolescent are preserved.

59. Separation that is not intended to protect the rights of a child or adolescent or that is grounded in stereotypes about disability or poverty has no legal basis and is a departure from the model of comprehensive protection. From this perspective, family separation on the grounds of disability or socioeconomic status is not legitimized in the Mexican system of law; on the contrary, the system establishes State obligations intended to prevent such separation by means of timely support, specialized services and family-strengthening mechanisms.

60. In respect of children and adolescents with disabilities, the State's duty is heightened, as two coinciding factors of enhanced constitutional protection are involved. Family separation based on the perception that the family is incapable of raising a child or providing care – and without an objective assessment of available support systems – is another manifestation of the charity-based model that the Mexican legal system has been progressively moving away from by adopting an approach grounded in human rights and social inclusion. Under the current standard, the State is required to explore, promote and ensure the availability of family support networks, extended families, foster families and

community services before resorting to residential care, thereby preventing disability from being used as an implicit criterion for separation. Consequently, care arrangements must be made on the strength of individualized assessments that take into account family capabilities and available support, not on assumptions about disability.

61. The aim of national public policy is to replace the practice of separation with a practice involving preservation and recovery of the family environment. Social assistance, rehabilitation, educational inclusion and healthcare programmes are designed specifically to help eliminate the historic causes of the breakdown of the nuclear family. These are not mechanisms that exist alongside the protection system but tools designed to prevent social vulnerability from resulting in the loss of the right to family life. Legitimate State intervention involves not the removal of a child from his or her family but the components of a public strategy that, with the provision of social, educational and community support, is designed to prevent family separation.

62. In this context, national public policy reinforces the view that family separation cannot be the State's structural response to disability or poverty. Institutional action taken to see to it that all alternative care measures are designed as temporary protective measures rather than as permanent solutions is informed by strategy 2.5 of the National Programme for the Protection of Children and Adolescents 2026–2030 ("Ensure access to safe, protective and appropriate forms of alternative care that take into account the best interests of children and adolescents in order to guarantee their full exercise of the right to live in a family"). Under this strategy, priority must be given to preserving and restoring family ties, strengthening families of origin, including extended and expanded families, and developing foster-care arrangements, so that residential care is used only as a last resort and for the shortest possible time, particularly for children and adolescents with disabilities.

63. The existence of prolonged or permanent separation is a manifestation not of a deliberate policy of separating families but of structural shortcomings in the past development of family and community alternatives, which are recognized as priorities. In accordance with the principle of progressive improvement, the State is taking measures to steadily reduce recourse to residential care and expand family-based care options by strengthening family networks, foster families and community support services, particularly for children and adolescents with disabilities.

64. In this context, State intervention is legally designed to ensure that any separation is exceptional, temporary and subject to periodic review, as well as to promote family reintegration once there are no longer reasons for the family to be separated. These measures must be based on individualized assessments and intervention plans that prioritize the reintegration of the family when reintegration is in the best interests of the child. Separation is a temporary measure intended to restore rights in high-risk situations, not an end in itself; it becomes unlawful when it is prolonged and involves no clear reintegration goals or strategies for supporting families.

65. Consequently, it cannot be argued that there is a public policy designed to systematically separate children and adolescents with disabilities from their families on account of their condition or their poverty. Family and community life are prioritized under the legal and institutional framework, and separation, a last resort, is used only in the event of serious rights violations. The focus of current public policy is on preventing separation by strengthening families, expanding community support services and promoting alternative care arrangements in family settings. The State's response is not to make separating families the norm but to progressively strengthen support mechanisms that can prevent and reverse family breakdown, in accordance with the best interests of the child and the principle of non-discrimination.

Violence, abuse and ill-treatment in institutional settings

66. The finding regarding the exposure of children and adolescents with disabilities to violence, abuse and ill-treatment in institutions must be analysed in the light of the Constitution, under which their right to integrity of the person and a life free from violence is guaranteed, as well as the State's international obligations to protect children and

adolescents with disabilities from all forms of violence. Institutionalization, even as an exceptional protective measure, is accompanied by oversight, safeguards and control mechanisms as a result of the inherent risks of secure care settings and the possible relationships of dependency between caregivers and children and adolescents.

67. Violence in institutional settings is neither tolerated under the law nor inherent to alternative care. Any form of ill-treatment gives rise to administrative, civil and criminal liability. The obligation to prevent, investigate and sanction any form of violence against children and adolescents, including violence that may occur in institutional care settings, is established in Mexican law. The existence of documented cases is indicative not of a policy of leniency but of operational failures or instances of individual misconduct that are not only prevented but also investigated and sanctioned, thereby strengthening oversight and accountability mechanisms.

68. The State recognizes that the risk faced by children and adolescents with disabilities is exacerbated by their dependence, communication barriers and difficulties in reporting abuse. As a result, a greater duty of structural prevention is imposed: creating safe environments, having trained members of staff and establishing accessible procedures for the early detection of abuse. In addition, complaints and protection mechanisms must be accessible and tailored to the communication and comprehension needs of children and adolescents with disabilities. Combating violence is not limited to imposing penalties; it also requires a transformation of the care model to avoid cycles of control and isolation.

69. The aim of national public policy is to have active prevention and comprehensive protection take the place of passive acceptance of violence. Social assistance programmes, oversight mechanisms for alternative care facilities, staff training initiatives and protocols for responding to risky situations are designed to reduce the likelihood of abuse in institutional settings. They operate not as isolates but as parts of an oversight and regulatory system designed to prevent abuse, promptly identify situations of risk and ensure that the rights of children and adolescents are effectively protected.

70. In this context, the eradication of all forms of violence against children and adolescents, including those occurring in alternative and institutional care settings, is a high-priority objective under the National Programme for the Protection of Children and Adolescents 2026–2030. The steps taken by the authorities to strengthen mechanisms to prevent, detect and respond to violence in all settings where children and adolescents are present, as well as to establish systems for the oversight and registration of residential facilities, are guided by the Programme. The aim is to ensure that residential care is a temporary protective setting subject to strict human rights standards, ongoing institutional oversight and accountability mechanisms, not a place where the child or adolescent is at risk.

71. Instances of violence can therefore not be used to claim that the system is structurally ineffective or that acts of violence are systematically committed by the State; rather, the existence of such instances helps build the State’s capacity to respond. The duty of the State, which acts in accordance with the principle of progressive improvement, is to steadily reduce the incidence of abuse, improve complaints mechanisms and strengthen institutional oversight. Furthermore, protection from violence is linked to the gradual reduction of institutionalization and the strengthening of family- and community-based alternatives, which reduce structural exposure to secure settings and promote care models centred on community life.

72. Consequently, another claim that cannot be made is that the State tolerates or legitimizes violence against children and adolescents with disabilities in institutions. All abuse of or violence against children and adolescents is strictly prohibited by law, and the specific risks posed by institutional settings are taken into account in public policy, which guides the steps taken by the authorities to prevent, detect and sanction such abuse and violence. The State’s response is not to make violence the norm but to strengthen, by degrees, the mechanisms for oversight, protection and the restoration of rights, in accordance with the best interests of the child, the principle of non-discrimination and the right of children and adolescents with disabilities to live and develop in safe family and community settings.

Community support for family life

73. The observation that there is no (or not enough) community support to enable children and adolescents with disabilities to remain with their families must be analysed within the framework of the Constitution, in which the right to family life and the State's duty to ensure the material conditions necessary for the exercise of that right are recognized. The lack of services in the community is an indicator of public policy shortcomings that the State, as it has acknowledged, must correct, not a legitimate reason to separate families. Remaining in a family environment depends not only on the family but also on the existence of support networks that make it possible to meet the specific needs arising from disability.

74. Under the current legal framework, the State is obligated to gradually replace institutional care with a system of community-based support that makes institutionalization unnecessary. This includes health services, rehabilitation, inclusive education, psychosocial care and financial assistance, as well as family counselling and support programmes. The absence of any of these components does not automatically lead to institutionalization; rather, it requires the State to intervene to strengthen the family and the community, the primary settings for protection.

75. The State acknowledges that the lack of support for children and adolescents with disabilities has an indirect discriminatory effect by making disability a cause of exclusion from housing. The State has a duty not simply to provide care in specialized facilities but also to make services an integral part of daily life, thereby preventing family ties from being severed and social isolation.

76. That the lack of community support has historically been a cause of segregation and institutionalization is recognized in national public policy. In this regard, strategy 3.3 of the National Programme for the Protection of Children and Adolescents 2026–2030 in particular ("Take action to ensure the inclusion and freedom from discrimination of children and adolescents with disabilities to promote their full development") guides inter-agency initiatives to strengthen community-based health, rehabilitation, inclusive education and psychosocial support services, including those at the community level, so that families are given real support for the provision of care. Consequently, the State should focus on coordinating services in the community, not on placing the child in an institution.

77. Shortcomings in coverage or quality are not a policy of neglect; they instead reflect regional inequalities and historical disparities that must be addressed in accordance with the principle of progressive improvement, gradually expanding the availability and accessibility of support, especially in rural and Indigenous communities. In short, strengthening community support systems is essential to achieving a sustained reduction in institutionalization. Without any real alternatives in the community, separation will continue to be the de facto response to disability or poverty. For this reason, building a robust system of community support is essential to guaranteeing the right to family life and preventing having to fall back on institutionalization.

78. Consequently, it cannot be argued that the State has chosen institutionalization as a substitute for community support. Family-based care is prioritized in the legal and institutional framework under which the Government works to develop alternatives in the community. The State's response is not to give up attempting to provide services but to gradually expand them to ensure that disability does not lead to family separation, in accordance with the best interests of the child and the principle of non-discrimination.

Inclusive education

79. The observation on the limited access to education of children and adolescents with disabilities, particularly those in institutional settings, must be analysed within the framework of the Constitution, in which education is recognized as a human right and an indispensable means for holistic development and social inclusion. The lack of effective access to mainstream education should be viewed not as an inevitable consequence of disability but as the result of structural barriers that the State is obligated to eliminate.

80. The aim of national education policy is to replace segregated education with inclusive education systems by removing physical, pedagogical and communication barriers in schools. The State must not simply provide special education services here and there but also integrate children and adolescents with disabilities into the regular education system with the necessary support. This approach involves making appropriate changes to facilities, providing teacher training and supplying specialized resources with a view to ensuring that disability does not lead to a lack of schooling or social exclusion.

81. In this context, course of action 3.3.4 (“Combat educational disparities by giving priority to children and adolescents with any type of disability in the educational sphere”), for the implementation of which the offices comprising the Interministerial Commission of the National System for the Comprehensive Protection of Children and Adolescents are responsible, was specifically established under strategy 3.3 (“Take action to ensure the inclusion and freedom from discrimination of children and adolescents with disabilities to promote their full development”) of the National Programme for the Protection of Children and Adolescents 2026–2030. This course of action gives concrete form to the State’s obligation to make school environments accessible, inclusive and functional for students with disabilities, including those in alternative care settings.

82. Any gaps in the coverage or quality of inclusive education should be interpreted not as a deliberate State policy of exclusion but as a reflection of regional disparities and structural challenges that the authorities themselves acknowledge and are obligated to address. The State, observing the principle of progressive improvement, must demonstrate that it is taking steps to steadily expand access to education, reduce dropout rates and provide reasonable support so that, in accordance with the best interests of the child and the principle of non-discrimination, disability does not constitute an obstacle to the exercise of the right to education.

Indigenous children and adolescents

83. The observation on the situation of Indigenous children and adolescents, and of that of children and adolescents with disabilities living in rural areas, must be analysed in the framework of the Constitution, in which the right to substantive equality, non-discrimination and respect for cultural diversity is recognized. The State recognizes that belonging to an Indigenous community or living in a rural area does not increase the risk of being institutionalized or of being denied access to basic services. On the contrary, these conditions impose on the State a heightened duty to adopt targeted measures that ensure effective access to rights, taking into account the geographic, linguistic, cultural and socioeconomic barriers faced by these population groups.

84. The increased vulnerability of these children and adolescents to family separation or institutionalization is the result not of a State policy designed to achieve that outcome but of long-standing regional disparities in the accessibility of health services, rehabilitation, education and psychosocial support. The lack (or insufficient availability) of such services in rural and Indigenous communities leads to structural exclusion that the State, by adopting targeted public policies, is obligated to address. The appropriate response, then, is not to place the child in an institution far from his or her cultural and family environment but to bring services closer to the child’s community and build local capacity for support and care.

85. Accordingly, the need for a differentiated approach is recognized in national public policy. Strategy 3.4 (“Take action to ensure the inclusion and freedom from discrimination of Indigenous children and adolescents and Mexican children and adolescents of African descent for their full development”) of the National Programme for the Protection of Children and Adolescents 2026–2030 contains guidance for inter-agency efforts to eliminate the structural barriers, including those related to disability, faced by Indigenous children and adolescents and children and adolescents of African descent. The adoption of a local, intercultural and linguistically appropriate approach to promoting the integration of health, rehabilitation, inclusive education and social protection services, as well as community participation in care and rights restoration processes, is promoted in this strategy.

86. Respect for the right to family and community life takes on an additional dimension in the case of Indigenous children and adolescents, whose comprehensive development is closely linked to their cultural identity, language and Indigenous forms of social organization. Institutionalization outside their home community not only affects their right to family life but also their right to cultural identity. The aim of public policy is therefore to prevent separation and, when separation is strictly necessary for reasons of immediate protection, to ensure that the measures are implemented temporarily, close to the child's environment and with an intercultural perspective.

87. Consequently, it cannot be said that there is a State policy directed towards the disproportionate institutionalization of Indigenous or rural children and adolescents with disabilities. Laws and institutions are designed to recognize their specific vulnerability and guide government action to eliminate the territorial, cultural and social barriers that hinder the exercise of their rights. The State's response is not to replace the family and community setting but to gradually strengthen accessible, culturally relevant and locally available services in accordance with the best interests of the child and the principle of non-discrimination.

88. In response to the information provided by the Committee on the lack of support systems for community living that affects children with disabilities belonging to Indigenous Peoples, the State reports that the overall objective of the Indigenous Education Support Programme is to improve access, retention, educational completion and academic attainment for Indigenous and Afro-Mexican children and young people enrolled in public and community schools of all types and educational levels.

89. In this context, the criteria for the construction and adaptation of Centres for Indigenous Children explicitly incorporate the principle of accessibility in order to ensure that persons with disabilities can access the physical environment, services and facilities on an equal basis with others. Obstacle-free circulation routes within buildings and their integration with open spaces and external access routes are guaranteed, so that persons with disabilities can move freely and safely to any part of the facility.

90. In addition, School Centres for Indigenous Children provide meals, lodging and extracurricular activities to the beneficiary population, giving priority to those who come from communities and localities that lack education services. The aim of this affirmative action measure is to reduce school dropout rates and preserve and strengthen the country's cultural and linguistic diversity.

III. Transition to a deinstitutionalization model

91. The State has been working to transition from a hospital-based model to a community-based model. In accordance with article 25 of the Convention, which states that health services for persons with disabilities must be provided as close as possible to their own communities, Mexico amended the General Health Act to incorporate a community-based, preventive and comprehensive approach to mental healthcare with a view to reducing dependence on institutional settings and strengthening care in the community.

92. The National Development Plan 2025–2030 sets out a cross-sectoral road map to ensure the effective exercise of social rights through a universal and human rights-based approach, steering public policy towards the progressive replacement of traditional welfare models and the strengthening of accessible community services. Under the Health Sector Programme 2025–2030, preventive and follow-up home visits will be incorporated into healthcare, with health professionals providing comprehensive diagnoses and direct care in the community. This will reduce the need to transfer patients to hospitals and promote care models that are closer, preventive and centred on the community.

93. Steps are also being taken to strengthen community-based programmes through a model of community networks or coalitions, with the aim of training groups of community members who decide to participate formally, voluntarily and in a disinterested manner, for the benefit of their own social, physical and community environment. This model promotes

social participation and shared responsibility in preventing and dealing with issues related to mental health and social well-being, through a structured process and methodology by which communities interact with surrounding sectors.

94. The hospital and community network is also being strengthened with the aim of delivering services to users in their homes. Actions taken include the provision of support by specialist professionals who receive in-service training in mental healthcare, favouring early intervention, community follow-up and direct support for families and caregivers.

95. The Comprehensive Strategy for Social Assistance, Nutrition and Community Development 2025 prioritizes highly vulnerable children and adolescents who require mental healthcare. This strategy builds capacity for the implementation of the National Alternative Care Model, which focuses on the family reunification and integration, foster care and/or adoption of children and adolescents with the aim of ensuring that they grow and develop in safe and protective family environments.

96. With regard to the Committee's observation on the involuntary institutionalization of persons with disabilities and its recommendation to reform national legislation, it should be noted that, following the overhaul of the General Health Act, the State is taking practical measures to transition towards community-based alternatives to institutionalization. These measures form part of a transformation of the mental healthcare and social protection system that is designed to gradually reduce institutionalization and strengthen community- and family-based alternatives for care and support.

National Alternative Care Model

97. The State has adopted the National Alternative Care Model as a guiding instrument that places the right to family and community life at its core. The Model prioritizes the prevention of unnecessary separation and provides that residential care should always be exceptional, subsidiary and temporary. It also recognizes the adverse effects that prolonged stays in social welfare centres can have on children's overall development and the State's obligation to strengthen family- and community-based care alternatives, while promoting the shared responsibility of the State, families and society to prioritize family environments and ensure that all decisions are guided by the best interests and effective participation of children and that the measures taken are temporary.

98. Alternative care is not limited to residential placement but encompasses a set of modalities aimed at preserving family life and the continuity of emotional bonds to the greatest extent possible. The Committee's observation regarding the shortcomings of alternative care arrangements, particularly the foster family system, must be analysed in the context of a constitutional framework that recognizes the right of children and adolescents to live in a family and to receive special protection when they are deprived of parental care. The lack of these alternatives cannot justify institutionalization as the primary response; on the contrary, it highlights the need to strengthen family-based protection mechanisms.

99. Children and adolescents with disabilities fall into two categories of persons that enjoy strengthened constitutional protection: children and persons with disabilities. This imposes an obligation on the State to adopt differentiated measures to prevent disability from resulting in housing exclusion. Institutionalization based on disability or poverty does not respond to the best interests of the individual but reflects the lack of sufficient family and community support. For this reason, the State response is not limited to operating alternative care facilities but is geared towards strengthening families through rehabilitation services, inclusive education, healthcare, psychosocial support and social inclusion mechanisms that allow children to remain in the family and community setting.

100. The limited development of foster-care programmes disproportionately affects children and adolescents with disabilities, who face greater barriers to being placed with substitute or support families due to social prejudice, a lack of technical support and limited training for caregivers. These barriers highlight the need to strengthen public policies to raise public awareness, train foster families and develop specialized support services that facilitate the inclusion of children and adolescents with disabilities in family settings. This situation is

not the result of a State policy of exclusion, but rather of structural lags in the development of specialized family care systems. The State's duty is not to keep children and adolescents with disabilities in institutions but to create conditions so that foster families have sufficient material, psychosocial and technical support to provide care with dignity.

101. For this reason, the State is focused on building a diversified system of family-based options – extended families, foster care and adoption – so that the specific needs of children and adolescents with disabilities can be met without resorting to prolonged placements in institutions.

102. In this context, strategy 2.5 of the National Programme for the Comprehensive Protection of Children and Adolescents 2026–2030 ("Ensure access to safe, protective and appropriate forms of alternative care that take into account the best interests of children and adolescents in order to guarantee their full exercise of the right to live in a family") guides inter-institutional action in strengthening alternative care schemes in family settings and reducing the use of residential care. This strategy involves promoting and strengthening foster families, building institutional capacity to support and supervise them and ensuring that all forms of alternative care are designed to be temporary and are geared towards restoring the right to family life, particularly in the case of children and adolescents with disabilities.

103. The existence of a limited number of foster families or family-based care arrangements should be interpreted not as neglect on the part of the State but as a reflection of an ongoing process of gradually building an alternative care system in family settings. In keeping with the principle of progressive realization, the State is required to demonstrate that it is taking steps to gradually expand these arrangements, reduce reliance on residential care and strengthen support for those who provide family care.

104. The placement of children and adolescents in an institution should always be done with the consent of parents or guardians and, insofar as possible, with the consent of children themselves. Verbal communication and psychoeducation strategies are pursued with a view to providing high-quality, person-centred care. In addition, priority is given to alternative measures such as referral and counter-referral, ongoing review of placement and telephone follow-up to ensure the early return children and adolescents to their communities.

105. In the light of the foregoing, it cannot be argued that the State has opted for institutionalization as a permanent substitute for family care. The legal framework prioritizes family life, and public policy steers government action towards expanding and strengthening alternative care arrangements within the family environment. The State has responded not by resigning itself to institutionalization but by progressively strengthening foster-care systems that allow children and adolescents with disabilities to effectively exercise their right to family life in accordance with the best interests of the child and the principle of non-discrimination.

106. For example, the government of Mexico City runs support programmes for caregivers, focusing mainly on women, with beneficiaries receiving financial assistance every two months, training, workshops and guidance on matters related to caregiving and self-care. These measures contribute to ensuring the right to care for dependent persons and to reducing income and time poverty, preventing a lack of family support from leading to institutionalization.

IV. Autonomy and independent living

107. In accordance with the principles set forth in the Convention (art. 19) and the observations made by the Committee, the State is taking steps to strengthen autonomy and independence in all areas of public life and to ensure that community-based care replaces the institutionalization of persons with disabilities.

108. At the constitutional level, the welfare allowance programme for persons with permanent disabilities is designed to broaden opportunities for such persons, although beneficiaries can use the allowance however they choose. In this way, the State is creating the conditions necessary for persons with disabilities to live independently. The aim of the

programme is to increase their income through an intersectional approach that helps to ensure the effective realization of the rights of children, adolescents, young people, Indigenous persons and Afro-Mexicans living with disabilities.

109. This financial support enables beneficiaries to manage their daily activities and reduces their dependence on their families, giving them greater control over their lives, considering that independent living for persons with disabilities is not just about the absence of physical restrictions but also about addressing the socioeconomic barriers and marginalization that often affect this population group. This support may also prevent dependence on social welfare institutions, as it is consistent with a social and community-based approach and avoids recourse to solutions involving institutionalization, particularly as a result of poverty.

110. In the area of social security, the Mexican Social Security Institute designs and implements health programmes focused on prevention and the promotion of self-care, linked to medical benefits. In that context, and with a view to implementing the Committee's recommendations, "social healthcare" programmes focused on community-based mental health and social support networks within social security centres will be strengthened with a view to preventing isolation, which can lead to institutionalization.

111. The Institute also has the authority to regulate and validate physical education and sport programmes for beneficiaries and non-beneficiaries. There is currently enough capacity to provide spaces (social security centres and sports facilities) for community inclusion and sports and cultural activities. This strengthens the right to inclusion and social participation.

112. As an example of implementation at the local government level, the government of Mexico City has begun to develop the country's most comprehensive public care system, laying the foundations for a transition from institutionalization to support systems for living independently and in the community.

113. Strategic objectives include the social redistribution of care work, the freeing up of time for women caregivers and the provision of high-quality care for dependent persons, including persons with disabilities. This approach aims to prevent a lack of support from leading to practices such as substitute decision-making, involuntary confinement and institutionalization.

114. In August 2025, a bill on the Mexico City public care system was introduced, along with proposed amendments to the constitution of Mexico City that envisage the provision of free services, including specialized care and rehabilitation centres for persons with disabilities. The territorial planning of these services follows a community-based, decentralized and interconnected care model aimed at ensuring support close to individuals' living environments. In March 2026, the Mexico City congress approved the launch of the bill's information, deliberation and consultation phases, with public participation and priority given to children, older persons, persons with disabilities and caregivers.

115. Since 2020, the Institute for Persons with Disabilities in Mexico City has been applying a comprehensive care model in basic rehabilitation units and at the Care Centre for Persons with Disabilities with the aim of promoting autonomy, independent living and quality of life. There is also a labour inclusion process for persons with disabilities and their families, which has helped them to develop skills and competencies to secure employment or become self-employed.

Labour inclusion of persons with disabilities

116. Regarding the Committee's observation concerning the percentage of persons with disabilities working in the informal economy, the available statistical source containing information on the employment status of persons with disabilities aged 12 years and older is the population and housing census.[2] According to figures from the 2020 census, the total

[2] National Institute of Statistics and Geography, 2020 population and housing census, available at www.inegi.org.mx/programas/ccpv/2020/#tabulados.

population aged 12 and older stood at 100.5 million, of whom 62.3 million made up the economically active population (61.1 million employed and 1.2 million unemployed individuals).

117. The census recorded 19.3 million people with a disability, impairment or mental health issue or condition, accounting for 19.2% of the total population aged 12 and older. Of this group, 10.4 million (54.0%) were women and 8.9 million (46.0%) were men.

118. Of the total population aged 12 and older with a disability, 51.5% (9.9 million) were economically active: approximately 9.8 million persons were employed and 184,000 unemployed. By gender, the economically active population was 57.6% male and 42.4% female. The employed population with disabilities was composed of 5.6 million men (57.3%) and 4.2 million women (42.7%). Among the unemployed, the proportion was 74.5% male (137,000) and 25.5% female (47,000).

119. Another source of information on disability is the national survey of demographic trends conducted in 2023, which provides statistical information on the level and behaviour of components of demographic dynamics such as fertility, mortality and migration (internal and international). With regard to disability, information was collected primarily on the following activities: walking up and down stairs; remembering and concentrating; bathing, dressing and eating; and speaking and communicating; as well as difficulty performing daily activities due to emotional or mental health problems. However, the survey did not address employment status.[3]

120. The Committee noted that persons with disabilities lack opportunities to enter the labour market. In that regard, the Government, through the Ministry of Labour and Social Security, is pursuing the “Opening Spaces” strategy, whose purpose is to provide guidance to jobseekers. Under this strategy, 80,757 persons with disabilities received assistance and 15,545 were placed in formal employment between December 2019 and December 2025.

121. The goals of this strategy include the provision of advice and support to employers so that they adopt hiring practices that are fair and inclusive of people in vulnerable situations, including persons with disabilities, and the development of job descriptions that can be adapted to accommodate these individuals.

122. The strategy works by identifying comprehensive profiles and career guidance through the application of specialized assessment tools, notably the VALPAR Work Sample System, whose findings are used to guide individuals towards their best career options and to carry out activities that enhance their employability. To expand these employment opportunities, the National Employment Service participates in the National Labour Link Network, a strategy of the Ministry of Labour and Social Security that creates synergies between the plans, programmes and initiatives of public, private and social institutions and organizations, generating joint efforts to promote labour inclusion.

123. In addition, under the “Young Persons Building the Future” programme, administered by the Ministry of Labour and Social Security, financial support is provided to young people between the ages of 18 and 29 who are not in education or employment. This support is provided for a 12-month period, during which the young people receive on-the-job training with social security coverage provided by the Mexican Social Security Institute. Since the programme commenced in 2019, 17,701 young persons with disabilities have benefited from a monthly allowance, the amount of which has increased every year from 3,600 pesos in 2019 to 9,582 pesos in 2026.

124. As the State designs and implements measures to promote the autonomy and independent living of persons with disabilities, it cannot be said that it is failing to take action to enable the participation of persons with disabilities in public life. Such action requires a gradual effort to bring about positive changes in the lives of persons with disabilities.

[3] National survey of demographic trends 2023, available at www.inegi.org.mx/programas/enadid/2023/.

V. Legal personality and exercise of legal capacity

125. The report states that persons with disabilities continue to be deprived of their legal capacity through legal proceedings and in practice and, as a result, they lack the freedom to choose where they live and remain systematically vulnerable to forced institutionalization.

126. In this regard, the courts have taken measures – forming a robust body of case law – that have succeeded in promoting and consolidating the social and human rights model of disability, with the aim of guaranteeing the exercise of the right to legal capacity and eradicating the institutionalization of persons with disabilities.

127. In a case decided in 2019, the Supreme Court ruled that the procedure for declaring a person legally incompetent was based on a model of substitute decision-making that was neither consistent with the Convention and nor allowed for any interpretation in conformity with the federal Constitution, as it violated the right to equality and non-discrimination, among other rights. The Court also noted that the procedure disproportionately restricted the right to legal capacity and had a multifaceted impact that perpetuated stereotypes regarding the decision-making ability of persons with intellectual and psychosocial disabilities.[4]

128. Consequently, the Supreme Court decided in this specific case to replace the declaration of legal incompetence with a voluntary procedure in which a support system would be established, on the basis of the individual's wishes and preferences, to facilitate the exercise of his rights to legal capacity and to live independently.[5]

129. This important precedent marks the first step in breaking the automatic link between disability, mental capacity and the restriction of legal capacity by establishing that a person's mental capacity cannot be used to deny him or her legal capacity.[6] This judgment is useful because it challenges the legal grounds that historically have justified deprivation of legal capacity and, consequently, practices of involuntary confinement.

130. The Supreme Court also issued non-binding guidance in which it reiterated that declaring a person to be legally incompetent is unconstitutional and incompatible with international treaties and determined that the principle of the best interests of the child should not be applied to make decisions regarding an adult with a disability, as this would amount to substitute decision-making and would violate their right to exercise legal capacity. Instead, the standard of "best possible interpretation of the person's will and preferences" should be applied, so that when a person with a disability expresses his or her will in any way, the necessary mechanisms must be adopted so that such expression is not diminished or replaced.[7]

131. In 2021, the Court established for the first time a binding standard for judges in Mexico, ruling that the termination of a state of legal incompetence cannot be contingent upon maintaining control over the person's mental health through medical treatment, nor is it permissible, without the person's consent, to establish a support system that contributes to such control.[8]

132. Subsequently, the Supreme Court ruled that it is unconstitutional for persons with intellectual and/or psychosocial disabilities to be held in involuntary confinement, as this violates their human rights to health, to informed consent and to legal capacity, given that it is based on the false belief that they cannot and should not make their own decisions. Accordingly, persons with disabilities must be able to make informed choices about matters related to their health and to give their consent to any medical treatment.[9] Although this

[4] Supreme Court, *amparo* appeal No. 1368/2015, First Chamber, 13 March 2019, unanimous vote (five votes), paras. 90–97.

[5] Ibid., para. 126.

[6] Ibid., paras. 95–97.

[7] Supreme Court, direct *amparo* appeal No. 44/2018, First Chamber, 13 March 2019, unanimous vote (five votes), pp. 47, 87 and 88. Link.

[8] Supreme Court, direct *amparo* No. 4/2021, First Chamber, 16 June 2021, unanimous vote (five votes), paras. 152–156. Link.

[9] Supreme Court, *amparo* appeal No. 323/2024, First Chamber, 6 November 2024, majority vote (by three votes), paras. 93–97, 111, 119, 129 and 130. Link.

judgment does not constitute a binding standard, it does provide a reasoning that should be taken into account by all federal courts when considering cases that might involve a violation of the rights of persons with disabilities, particularly when they are institutionalized in healthcare facilities.

133. Besides issuing guidance on the protection of legal capacity, the Supreme Court has developed a body of case law relating to the establishment of a system of support and safeguards for decision-making, which reflects the importance of ensuring the right of persons with disabilities to live independently, while respecting their will and preferences.

134. As part of its reasoning, the Court has noted that States have an obligation to establish a support system for persons with disabilities in accordance with article 12 (3) of the Convention. Support should be focused on facilitating the expression of will and on helping persons with disabilities to exercise their legal capacity on an equal basis with others, as well as other rights enshrined in the Convention. In all cases, the support system should be based on the needs of the person, who must be able to choose and control his or her support, including the provider and the level of support desired. This requires that safeguards be established to prevent abuses in the provision of support and to ensure that the rights, the will and the preferences of persons with disabilities are respected.[10]

135. The Ministry of Social Welfare has clarified that the rules of the welfare allowance programme for persons with permanent disabilities ensure that support is provided directly to beneficiaries or, if necessary, through an adult caregiver appointed with their consent. This mechanism respects the autonomy, legal capacity and dignity of persons with disabilities, in accordance with national laws.

136. In keeping with these standards, the National Commission on Mental Health and Addiction amended the technical and regulatory documents relating to the services provided by its medical care facilities to ensure that these services are provided on the basis of free and informed consent. Key priorities and actions have been consolidated in relation to quality of care and regulatory compliance, informed consent and the humanization of services. In this framework, an advance directives form is currently being developed with the primary goal of safeguarding the autonomy of mental health service users. The fundamental purpose of this tool is to respect and support individuals' preferences in decision-making, ensuring that their wishes serve as the guiding principle of the care process and are not arbitrarily substituted. To ensure proper implementation, training and awareness strategies are being carried out through programmes for health workers with a focus on rights and autonomy.

137. At the local level, Mexico City was the first federative entity to declare the entry into force and application of the National Code of Civil and Family Procedure, having undertaken the necessary reforms to ensure regulatory harmonization. As a result, its local legislation expressly recognizes the legal capacity of all persons and their right to request supported decision-making, while provisions incompatible with the principle of equality and non-discrimination were repealed. These reforms are in accordance with article 11 (G) of the constitution of Mexico City, which establishes the obligation of authorities to implement a safeguard and support system in decision-making that respects the will and preferences of persons with disabilities.

138. The federative entities, to a greater or lesser extent, continue to apply provisions that run counter to the recognition of the legal capacity of persons with disabilities. However, as can be seen, judicial remedies and guidelines are in place that recognize their legal capacity in accordance with the principles established in the Convention.

VI. Access to justice

139. In response to the Committee's statement regarding the lack of access to justice for persons with disabilities in institutions, the State reiterates that effective access to judicial

[10] Supreme Court, *amparo* appeal No. 1082/2019, First Chamber, 20 May 2020, unanimous vote (five votes), paras. 72–88.

remedies is crucial to ensuring the full exercise of their rights, including the ability to challenge decisions related to their admission, treatment or discharge.

140. In this context, judicial guidance have been strengthened to ensure that persons with disabilities have access to accessible mechanisms, procedural accommodations and appropriate support to participate directly in proceedings that affect them, in accordance with the standards established by the Supreme Court and the obligations arising from the Convention.

141. In addition, the Supreme Court adopted a decision requiring the intervention of legal advisers from the Federal Public Defender Service to serve as special representatives of 94 women admitted to the Dr. Adolfo M. Nieto Psychiatric Hospital in Tepexpan, Mexico State, so that they could express whether they wished to assent to the *amparo* application filed on their behalf against their possible involuntary confinement and, subsequently, decide whether to retain this legal assistance or appoint their own legal representatives.

142. In that case, the Court recognized that involuntary confinement can constitute an attack on personal liberty and an act of torture or cruel, inhuman or degrading treatment, since it can involve keeping users of mental health services in a public psychiatric institution, restricting their freedom of movement against their will and subjecting them to unnecessary treatment harmful to their life and health, without due process.[11]

143. Consequently, it decided that involuntary confinement was an urgent matter that entitled any person to file an application for *amparo* on behalf of the individual in that situation, provided that the aggrieved party is prevented from doing so, so that the courts may act accordingly.[12] This imposes a duty on the judge to gather evidence on his or her own initiative to verify that the case is indeed urgent.[13]

144. In compliance with the Court's decision and in recognition of the rights of persons with disabilities to make their own decisions and to live independently, personnel from the Federal Public Defender Service conducted visits to assess the living conditions of the women concerned, with the aim of upholding their rights.[14]

145. In follow-up, a plan was prepared to ensure that women with disabilities can express their will and exercise their legal capacity through interviews. After an initial analysis of the information, a report was submitted to the district court containing observations and proposing reasonable accommodations in the procedure and support systems for patients in general, with emphasis on those women for whom greater barriers to substantive and direct communication had been identified.

146. It should also be noted that the Supreme Court overturned a decision to dismiss a lawsuit for non-material damage filed by a woman for violations of her human rights during her involuntary confinement in a care facility – a decision taken on the grounds that she could not file a lawsuit on her own because she had been declared legally incompetent at the request of the head of the facility, who had been appointed her guardian.

147. The Court ruled that the unconstitutional nature of the declaration of legal incompetence should be recognized in all cases in which the status of legal incompetence was a decisive factor that impaired the exercise of legal capacity, and not only when the substance of the case concerned the declaration or termination of legal incompetence. Therefore, it is not necessary for persons who have been declared legally incompetent to have that status revoked before they file a lawsuit, as this would impede their right of access to justice. This does not prevent them from requesting the revocation of the declaration of legal incompetence if they require it for other purposes.[15]

[11] Supreme Court, remedy of complaint No. 7/2023, Second Chamber, 21 February 2024, unanimous vote (five votes), para. 67.
[12] Ibid., paras. 72 and 82.
[13] Ibid., para. 67.
[14] Supreme Court, remedy of complaint No. 7/2023, Second Chamber, February 2024.
[15] Supreme Court, direct *amparo* appeal No. 4193/2021, First Chamber, 27 April 2022, unanimous vote (five votes), paras. 44, 56 and 59. Link.

148. In a similar vein, the National Council for the Prevention of Discrimination has a framework for addressing cases of discrimination, providing guidance and assistance and, where appropriate, investigating potential acts or omissions of a discriminatory nature by federal public servants or private individuals. This mechanism allows for the identification of discriminatory practices and the promotion of corrective, conciliatory or protective measures that ensure respect for the rights of persons belonging to groups that have historically faced discrimination.

149. The Council has also developed a protocol on priority, accessible and high-quality care for groups historically subjected to discrimination, which establishes guiding principles for institutional action, such as dignified, respectful and empathetic treatment; the removal of barriers to access; and consideration of people's specific needs based on their age, gender, disability or other conditions.

150. These guidelines are based on article 15 bis of the Federal Act on the Prevention and Elimination of Discrimination, which establishes the obligation of federal public authorities to adopt remedial measures, inclusion measures and affirmative action aimed at guaranteeing genuine equality of opportunity and the right to non-discrimination. These measures include, inter alia, the provision of reasonable accommodation to ensure accessibility in the physical environment, communications and information; the removal of barriers that hinder the exercise of rights; and the adoption of public policies that prioritize groups facing discrimination, including children and adolescents with disabilities.

151. From this perspective, providing reasonable accommodation, accessible complaint mechanisms and specialized care is not only good administrative practice, but the fulfilment of a legal obligation designed to ensure that individuals belonging to groups that have historically faced discrimination can exercise their rights in conditions of genuine equality.

Specific reparation for persons with disabilities

152. With regard to the Committee's observation concerning the lack of reparation for persons with disabilities, it is worth noting that the federal courts have issued two significant judgments that, although not originating in cases of harm caused by institutionalization, nonetheless establish that where persons with disabilities are in vulnerable situations, the courts must ensure full reparation for any harm suffered.

153. Compensation and reparation serve a dual purpose. On the one hand, they have a deterrent effect, helping to prevent future unlawful conduct; on the other, they are designed to provide satisfaction and restitution, insofar as they seek to reverse, to the greatest extent possible, the harm suffered by the victim and to address his or her specific needs and the consequences of the harm. According to the interpretation of the Inter-American Court of Human Rights regarding the scope of reparation, the authorities must ensure that reparation is comprehensive and effectively responds to the victim's specific needs.

154. When the victim is a person with a disability in a vulnerable situation, the courts have a heightened obligation to ensure full reparation. To this end, they should call upon the competent authorities to ensure that victims have effective access to government programmes, particularly in the field of education, by taking the necessary steps and, where appropriate, exercising the enforcement powers provided for by law.

155. This is supported by article 3 of the Constitution and article 62 (IV) of the General Victims Act, which recognize access to educational programmes as a rehabilitation measure. Such measures are essential to promoting the social reintegration of victims and helping them to build or rebuild their life plans, especially when, as a consequence of the disability, they were unable to access adequate schooling, which limited their opportunities and affected their psychological health and personal development.

VII. Role of the National Human Rights Commission

156. The National Human Rights Commission strongly disagrees with the Committee's interpretation of its role, particularly in the following statement:

> The Committee notes … difficulties hampering the actions of the National Human Rights Commission to monitor institutions, including with regard to the sustainability of its activities and the lack of regular (or, in some cases, any) oversight visits to all categories of institutions. The Commission's recommendations do not appear to be duly acted upon and information on violations is only sporadically referred to the investigative authorities. The Commission exercises self-censorship with regard to its findings for fear of reprisals. Disparities are observed in the monitoring carried out by state-level human rights commissions and the impact on the prevention of human rights violations in institutions is limited.

157. The independent national monitoring mechanism under the Convention and the national mechanism for the prevention of torture work every day to prevent violations of the human rights of persons with disabilities, particularly those who find themselves in places of detention or confinement.

158. The mechanism monitors and oversees the authorities' implementation of the Convention in cooperation with local authorities and public human rights bodies. Proof can be seen in the visits that the Commission has undertaken to hospitals administered by the National Commission on Mental Health and Addiction, which have benefited from monitoring and assistance, with priority given at all times to the implementation of informed consent, including that of children and adolescents, taking their views into account whenever hospital care is necessary.

159. In its capacity as national mechanism for the prevention of torture, the Commission has engaged in continuous monitoring and coordination with the authorities responsible for places of deprivation of liberty, with the aim of improving the institutional functioning of these facilities and ensuring the proper implementation of the amended General Health Act in respect of mental health and addiction.

160. To this end, the national preventive mechanism has conducted 39 supervisory visits in hospitals and health facilities that provide psychiatric care, at both the local and federal levels. The main aim of these inspections was to assess the facilities' compliance with the General Health Act, particularly with regard to voluntary admission to residential treatment, informed consent, advance directives (prior to a crisis situation) and the prohibition of isolation within care models. The corresponding reports on these inspections are currently being prepared.

161. The national preventive mechanism has also monitored facilities specializing in the treatment of problematic substance use. Such monitoring has been focused on the identification of risk factors associated with the prevalence of involuntary admissions, the lack of informed consent in the delivery of care and the existence of punitive approaches.

162. In this context, the national preventive mechanism developed an monitoring methodology that provides for joint and coordinated inter-institutional action with health authorities (the National Commission on Mental Health and Addiction and the Federal Commission for Protection against Health Risks), missing persons commissions, offices for the protection of children and adolescents, public security authorities, justice authorities (prosecutors' offices) and local human rights bodies, with the aim of ensuring an immediate response upon detection of a serious risk to the physical or psychological well-being of the persons using these facilities.

163. The national preventive mechanism has published monitoring reports (No. 01/2022 and No. 02/2022) and a special report (No. 04/2022). In these documents, it called on the public health authorities to implement policies to strengthen the regulatory framework governing specialized treatment of problematic substance use, taking into account the autonomy of the person and the voluntary nature of treatment and prioritizing outpatient care and the reduction of involuntary confinement. It also called for public policy initiatives in the area of prevention and treatment of addiction, targeting women and children and adolescents.

164. It has also published regular reports with the aim of strengthening mental healthcare in other places of deprivation of liberty, such as social rehabilitation centres, recognizing that this is a cross-cutting obligation that must be fulfilled in any place of detention.

165. Of these documents, special report No. 01/2023 is particularly noteworthy. In it, the national preventive mechanism called for prison authorities to develop a comprehensive mental healthcare programme for women deprived of their liberty, geared towards the recovery of emotional stability while addressing the social and structural determinants of mental health, such as interpersonal relations, education, living conditions, the community, spirituality and artistic and intellectual activities. It also reiterated the importance of mainstreaming a human rights-based approach, the gender perspective and the social model of disability in such a programme.

166. In special report No. 02/2023, the Commission, in its capacity as national preventive mechanism, highlighted the risk of abuse to which persons deprived of their liberty – particularly those with psychosocial disabilities – are exposed when physical restraint is used. The document also contained public policy proposals for prison authorities to build their institutional capacity to respond to crisis situations or acute agitation among persons with psychosocial disabilities, thereby mitigating the identified risk factor.

167. The proposed capacity-building measures included the requirement to develop a specialized protocol for the proper care of persons with psychosocial disabilities, underpinned by the standards set forth in the Convention and the General Health Act, as well as the human rights-based approach and the social model of disability. The authorities were also requested, in developing the care protocol, to coordinate with specialized public mental health institutions to strengthen the technical and medical capacity of prison staff.

168. As a result, the federal prison authority informed the national preventive mechanism of various training initiatives for staff of Federal Social Rehabilitation Centres on the use of physical restraint. These measures were complemented by the harmonization of protocols and general guidelines, including a handbook on suicide risk identification, assessment and intervention among prisoners in Federal Social Rehabilitation Centres and a procedure for the therapeutic restraint of patients deprived of liberty.

169. The information provided by the federal prison authority was verified during a field visit conducted by staff of the national preventive mechanism, demonstrating the outcomes of the work and follow-up undertaken after the report was issued. This is discussed in detail in the follow-up report to special report No. 02/2023.

170. Furthermore, all monitoring activities carried out by the national preventive mechanism incorporate an analysis of how the authorities responsible for places of deprivation of liberty verify the physical and mental well-being of persons in their custody and identify and address risk factors associated with their mental health.

171. Special report No. 01/2025, for example, which advocated the development of specialized compulsory guidelines for the prevention, detection and management of suicide risk and suicidal behaviour in social rehabilitation centres. The public policy proposals formulated by the national preventive mechanism call for local prison authorities to develop care guidelines based on the aforementioned standards established by their federal counterparts. They also request them to consider, among other measures, the creation of rapid crisis response and first aid teams, emphasizing that such teams should operate in keeping with a therapeutic approach rather than one based on the use of force.

172. In addition, in various reports, the national preventive mechanism has requested the authorities to take institutional measures to enhance universal accessibility in detention facilities, taking into account the mobility needs of persons with physical and visual impairments. These documents include, for example, monitoring report No. 01/2023[8] (immigration authorities), monitoring report No. 04/2023 (local prison authorities) and special report No. 02/2024 (municipal administrative detention centres).

173. The foregoing is a description of the monitoring work carried out by the National Human Rights Commission, through the national mechanism for the prevention of torture, and its impact in terms of strengthening institutional capacity in places of deprivation of liberty in order to reduce the risk of human rights violations against persons who are held in such facilities.

174. The Commission categorically rejects the Committee's observation regarding alleged self-censorship. Evidence to the contrary includes the launch of the National Human Rights Violation Alert System[16] – a platform for transparent and responsible information-sharing on complaints and recommendations relating to various human rights issues, including those affecting persons with disabilities, so that any individual or institution can access and analyse this information. In addition, the Commission's recommendations are made public and information on its work is compiled in annual reports, which the President of the Commission submits to Congress and which are easily accessible on the institution's website.

Conclusions

175. The findings of fact of the Committee's inquiry conducted under article 6 of the Optional Protocol to the Convention and the recommendations issued serve to guide the measures and policies that State institutions must implement to improve inter-institutional coordination and to consolidate health and care models with a human rights-based approach and gender and child rights perspectives, moving beyond the welfare approach that still persists in certain spheres.

176. The State therefore appreciates the Committee's efforts to conduct a comprehensive and in-depth inquiry that recognizes the most significant legislative developments affecting the Mexican population, while also identifying challenges that require specific attention. These considerations are taken into account with a view to enhancing the State's compliance with its obligations, particularly in terms of protecting and upholding the rights of persons with disabilities.

177. As the Committee rightly points out, State intervention plays a decisive role in addressing various structural issues. In particular, the State recognizes that it must address persistent institutionalization as a structural challenge, given that historically it was used as a response to persons with disabilities.

178. The fact that there have been cases of serious violations of the rights of persons with disabilities does not imply that these acts are part of an organized pattern; rather, they are isolated incidents. As has been described in this report, the State has implemented measures and policies aimed at progressively and comprehensively transitioning to an alternative model to institutionalization, and therefore it cannot be said that the State has engaged in acts of a systematic nature that permit and perpetuate institutionalization.

179. While progress is being made in the transition towards a community-based care model that is person-centred and that strictly adheres to human rights, the State recognizes that advancing towards models of independent living and full inclusion in the community requires systematic and specialized assessments that, with an individualized and person-centred approach, allow for the precise identification of the specific needs, required support and actual living conditions of persons with disabilities. This process entails a broad and sustained mobilization of financial, material, human and technical resources and the strengthening of institutional capacity and coordination mechanisms between various authorities. All of this is essential to ensure that this transition proceeds in a planned, gradual and safe manner, avoiding situations of defencelessness, neglect or further human rights violations.

180. Consolidating this process also requires a robust, coherent and integrated legal framework that expands and clearly defines the responsibilities of authorities at all levels of government, enabling the provision of comprehensive and effective care outside of institutional settings, in accordance with applicable international standards.

181. In this context, the State takes note of the observations and recommendations made by the Committee in the framework of its inquiry under article 6 of the Optional Protocol and reiterates its full willingness to maintain a constructive, open and transparent dialogue. Mexico reaffirms its determination to make steady and sustained progress in fully guaranteeing the rights of persons with disabilities, on the basis of the principles of dignity, autonomy, inclusion and non-discrimination enshrined in the Convention.

[16] National Human Rights Violation Alert System, available at https://sna.cndh.org.mx.