

Ruined Lives

Segregation from Society in Argentina's Psychiatric Asylums

A REPORT ON HUMAN RIGHTS AND MENTAL HEALTH IN ARGENTINA

MENTAL DISABILITY RIGHTS INTERNATIONAL (MDRI)

CENTER FOR LEGAL AND SOCIAL STUDIES (CELS)

Ruined Lives: Segregation from Society in Argentina's Psychiatric Asylums

Copyright © 2007 by Mental Disability Rights International
All rights reserved.

Printed in the United States of America

ISBN: 978-1-60461-304-9

Library of Congress Control Number: 2007936404

Cover photo: Eugene Richards, Many Voices, Inc. © 2006.

Cover design by Bussolati Associates

Copies of this report are available from:

Mental Disability Rights International
1156 15th Street, NW, Suite 1001
Washington, DC 20005, U.S.A.
Tel.: (202) 296-0800
Fax: (202) 728-3053
Email: mdri@mdri.org
www.mdri.org

Center for Legal and Social Studies
Piedras 547 piso 1 (C1070AAJ)
Buenos Aires, Argentina
Tel/Fax: (54) 11-4334-4200
Email: cels@cels.org.ar
www.cels.org.ar

MENTAL DISABILITY RIGHTS INTERNATIONAL

Mental Disability Rights International (MDRI) is an advocacy organization dedicated to the international recognition and enforcement of the rights of people with mental disabilities. MDRI documents human rights abuses, supports the development of mental disability advocacy abroad, assists advocates seeking legal and service systems reforms, and promotes international oversight of the rights of people with mental disabilities in the United States and abroad. Drawing on the skills and experience of attorneys, mental health

professionals, human rights advocates, people with mental disabilities and their families, MDRI is forging an alliance to challenge discrimination and abuse of people with mental disabilities worldwide.

CENTER FOR LEGAL AND SOCIAL STUDIES

The Center for Legal and Social Studies (CELS) is a nongovernmental organization founded in 1979 to foster and protect human rights and to strengthen the democratic system and the rule of law.

The work of CELS consists of denouncing human rights violations; influencing the formulation of public policies based on the respect for fundamental rights; driving legal and institutional reforms toward the improvement in the quality of democratic institutions; and promoting greater exercise of the rights of the most marginalized sectors of society.

Priority activities are the litigation of cases before local and international tribunals, the investigation and construction of tools for civil society to exercise control over public institutions, and the training of social organizations, members of the judiciary and state institutions.

On March 30, 2007, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) opened for signature.* Argentina was one of the first countries in the world to sign the CRPD. The following are some of the important rights protected by this historic new convention:

States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities. . . .

–
Article
4(1)

States Parties shall ensure that persons with disabilities, on an equal basis with others:
Enjoy the right to liberty and security of person; (a)
(b) Are not deprived of their liberty unlawfully or arbitrarily . . . and that the existence of a disability shall in no case justify a deprivation of liberty.

– Article
14(1)

States Parties shall take all effective . . . measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

– Article

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective appropriate measures to facilitate full inclusion and participation in the community. . . .

–
Article
19

* Convention on the Rights of Persons with Disabilities, adopted by the United Nations General Assembly December 13, 2006, at <http://www.un.org/esa/socdev/enable/documents/tccconve.pdf> [hereinafter CRPD]. Argentina signed the Convention on March 30, 2007, although it has not yet entered into force.

TABLE OF CONTENTS

Executive summary	i
Methodology	x
I. Background	1
A. Argentina's health system	2

B. Mental health legislation 4

II. Inappropriate institutionalization 6

A. The “medicalization” of social problems and the lack of community services .. 6

B. The right to community integration 14

C. A lost opportunity 17

III. Conditions and abuses in institutions..... 18

A. Deaths in institutions	18
B. Dangerous use of isolation cells	20
C. Physical and sexual violence	23
D. Dangerous conditions	26
1. Lack of medical care	26
2. Unsanitary conditions	28

3. Unsafe conditions	30
E. Lack of rehabilitation	31
F. Lack of appropriate treatment and referral	32
G. Overcrowding in psychiatric institutions	34
IV. Arbitrary detention in psychiatric institutions	36
A. Overbroad and ill-defined grounds for commitment	38

B. Insufficient procedural protections	39
1. Lack of an independent hearing within a reasonable period	40
2. Lack of representation by counsel	41
3. Lack of independent periodic review of admissions	42
V. Insufficient oversight and monitoring of detainees' rights	43
VI. Mental health reform	46

A. Promising mental health reform initiatives	46
1. National sphere	46
2. The Autonomous City of Buenos Aires	47
3. The province of Buenos Aires	48
4. The province of Rio Negro	50
5. The province of San Luis	51

B. Deinstitutionalization movement	52
1. Consumer and ex-patient groups	53
2. Active professional organizations	54
3. Institution directors	55
VII. The right to self advocacy.....	57
VIII. Conclusion.....	58
Recommendations	60
Acknowledgments	67

Executive summary

*The philosophy of the asylum still predominates. The people who entered the institution, died here.*¹

– Jorge Rossetto, Director, *Colonia Montes de Oca*

*I had a good job. I don't know if they'll ever let me go. My life is ruined.*²

– Person hospitalized at Cabred Hospital³

Ruined Lives: Segregation from Society in Argentina's Psychiatric Asylums, documents human rights violations perpetrated against approximately 25,000 people detained in Argentina's psychiatric institutions. More than 80 percent of these people are detained⁴ for more than a year— and many are detained for life. Two-thirds of all psychiatric beds are part of the public health system. While large psychiatric asylums have been closed down in much of the world, 75 percent of people in Argentina's public mental health system are still detained in facilities of 1,000 beds or more.

This report documents egregious cases of abuse and neglect in Argentina's psychiatric institutions, including people burning to death in isolation cells, the use of sensory deprivation⁵ in long-term isolation, and physical and sexual violence. This report also details dangerous, filthy and unhygienic conditions, including the lack of running water, non-functioning sewer systems,

1 Interview with Jorge Rossetto, Director, National *Colonia Dr. Manuel A. Montes de Oca (Colonia Montes de Oca)*, province of Buenos Aires (June 3, 2004). A *Colonia* is a public asylum located in the countryside.

2 Interview with man hospitalized at Interzonal Psychiatric Hospital *Colonia Dr. Domingo Cabred (Cabred Hospital)*, province of Buenos Aires (Dec. 11, 2004).

3 Cabred Hospital is a men's psychiatric institution; at the time of the writing of this report there were 1070 men hospitalized there.

4 In this report the terms “institutionalized persons,” “committed persons” or “detained persons” will be used interchangeably. This takes into account international human rights standards applicable in the area of children's rights, which establish that: “Deprivation of liberty is interpreted as any form of detention or imprisonment as well as commitment in a public or private establishment where the child [the person] is not allowed to leave under his own will, by order of any judicial, administrative or other public authority.” United Nations rules for the protection of minors deprived of liberty. Adopted by the General Assembly in its resolution 45/113, on December 14, 1990, 11b).

5 Sensory deprivation is the total or partial restriction of stimuli on one or more of the senses. Prolonged sensory deprivation exacerbates psychiatric symptoms or induces severe psychiatric harm, including, intense agitation, anxiety, paranoia, panic attacks, depression, disorganized thoughts, and antisocial personality disorder. The harm caused by isolation and sensory deprivation “may result in prolonged or permanent psychiatric disability, including impairments which may seriously reduce [one’s] capacity to reintegrate into the broader community upon release. . .”. Stuart Grassian, M.D., “Psychiatric Effects of Solitary Confinement,” at http://www.prisoncommission.org/statements/grassian_stuart_long.pdf [hereinafter Grassian], p. 13. *See also*, S Grassian, N Friedman, “Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement,” *International Journal of Law and Psychiatry*, 8, 49-65 (1986).

and fire and safety hazards in institutions. The vast majority of people detained in Argentina’s psychiatric institutions languish in conditions of near total inactivity, and without the possibility of a future outside the institution.

This large-scale institutionalization and the accompanying abuses are due, fundamentally, to decades of investing in large, segregative institutions rather than the creation of policies and the development of necessary community-based mental health care services and supports.

Segregation from society in psychiatric institutions

Very recently, I was at Open Door, Colonia Cabred. There, talking to the director, he told me, “here there are around 1,064,” or a number thereabouts, “of institutionalized persons.” He said, more or less 750 are poor; that is, they’re there because they’ve been there for a long time, and they’re there because no one goes to look for them, and because they don’t have anywhere to go if they leave. All told, the time they’ve spent there, the loneliness, becoming accustomed to this loneliness or this way of life and not having family members that are interested in them . . . so, they’re not crazy, they’re poor and alone, which is a good

6

way to make someone crazy.

– Felipe Solá, Governor of the province of Buenos Aires

The permanent segregation of people in Argentina’s psychiatric institutions violates international human rights standards and contributes to increased disability. Cut off from society, people lose the ties that bind them to family, friends, and their communities. Once subjected to the regimented life of the institution, people lose essential life skills that they would otherwise need to survive in the community, thus facing even greater difficulties in rehabilitation.

The large-scale segregation from society and poor treatment in Argentina’s mental health system are unjustifiable, given the country’s wealth of trained mental health

professionals and the existence of alternative community-based programs in different regions of the country. Per capita, Argentina ranks among the countries with the greatest number of psychiatrists and psychologists in the world. Large numbers of Argentina's urban population pay for their own long-term, individual psychotherapy. Nevertheless, these vast resources do not translate into appropriate public policies. People with mental disabilities⁷ who lack funds to pay for these services are forced to receive attention in the public mental health system that frequently is inadequate, segregates them from society, and violates their fundamental human rights.

6 Intervention of Governor Felipe Solá at the opening of the 135th period of ordinary sessions of the Buenos Aires' Legislature (March 1, 2007) at <http://www.spd.gba.gov.ar/cgi-bin/noticias/viewnews.cgi?newsid1172793522,83252>.

7 In this report, the term "people with mental disabilities" includes: individuals with psychiatric disabilities; individuals with intellectual or developmental disabilities; individuals with no disability who may be subject to discrimination based upon the perception that they have a mental illness or disability; and those who may be subject to discrimination based upon a record or prior history of mental disability.

The development of innovative strategies in mental health care—such as economic subsidies for housing, psychosocial rehabilitation, and peer support—has proven that the vast majority of individuals with mental disabilities can live and thrive in the community. Yet these alternative services are almost entirely absent in Argentina (although this report discusses exceptions to this general rule in the provinces of Rio Negro, San Luis and Buenos Aires). Without personal resources or a family to pay for private care, many people with mental disabilities have no option but the asylum.

The high rate of long-term hospitalization in large institutions saps public resources that should instead be used for developing services in the community. There are a handful of community-based programs, which demonstrate that Argentina has the technical resources necessary to reform services and successfully integrate people with mental disabilities into the community. Yet based on interviews with authorities and mental health professionals, as well as an examination of implemented mental health policies, investigators conclude that there are still no general policies conducive to the widespread community integration of people with mental disabilities. As example, within the city of Buenos Aires, the three largest psychiatric institutions account for 80 percent of the city's mental health budget.

Impact of the economic crisis

*We had a shaky situation when the crisis hit. Problems came when many employees lost their jobs, so there was no funding for the [social security system]. The number of people who needed health care in the public sector shot way up. This resulted in a total collapse of the system.*⁸

– Dr. Julio Ainstein, then Director of Mental Health for the province of Buenos Aires

*We have a “medicalization” of social problems in today’s mental health system.*⁹

– Dr. Ricardo Soriano, then Director of Mental Health for the city of Buenos Aires

Argentina’s social and economic crisis—with the resulting increase in unemployment and attendant loss of health insurance—led to an increase in the number of people requiring attention in the public mental health system, putting even greater pressure on an already inadequate system. Authorities concede that between 60 and 90 percent of people detained in institutions are “social patients,”¹⁰ kept in the institutions because they have no place else to go. Institution directors reported that the majority of people now institutionalized could be discharged if the necessary services and supports were available in the community. In the absence of these services, people

8 Interview with Dr. Julio Ainstein, then Director of Mental Health of the province of Buenos Aires (June 1, 2004).

9 Interview with Dr. Ricardo Soriano, then Director of Mental Health of the city of Buenos Aires (June 2, 2004).

10 “Social patients” is what authorities and mental health professionals call persons who have no family ties and who remain institutionalized due to inadequate resources to help support them in the community.

detained in institutions have little or no hope of ever returning to their communities. The large number of “social patients” makes it even more difficult for people in need of acute mental health services to receive the care they need.

Arbitrary detention

Argentina’s national involuntary commitment laws fall short of international standards that protect persons against arbitrary detention. In Argentina, people may be detained for life without ever getting a judicial hearing. National laws do not regulate the right to independent or impartial review of a psychiatric commitment. The Argentine Civil Code is so broad that it permits the detention of anyone who could “affect public tranquility.” Individuals committed to psychiatric facilities are not guaranteed the right to counsel or to present evidence on their own behalf. In the absence of these basic legal protections, nearly everyone in Argentina’s psychiatric asylums is arbitrarily detained.

Abuses within institutions

*We need to prevent violence and abuse, which is now a problem in the institution.*¹¹

– Jorge Rossetto, Director, *Colonia Montes de Oca*

*In one room, I found a 16 year-old boy in a crib with his arms and legs tied to his body with strips of cloth. He was completely immobilized. Staff on the ward told me he had been kept that way since being admitted to the institution a year ago.*¹²

– Investigator's observations, *Colonia Montes de Oca*

Over the last three years, investigators documented a wide array of abuses against persons detained in Argentina's psychiatric institutions. When confronted with serious violations, some authorities have taken significant steps to address them. Yet there are still insufficient oversight mechanisms necessary to monitor people's treatment and the conditions of their detention, and to ensure that their rights are enforced. As such, abuses of the kind described in this report doubtless are still taking place in the majority of institutions in the country. Among the most egregious abuses investigators documented are:

• Uninvestigated deaths in institutions

At Diego Alcorta Hospital, in the province of Santiago del Estero, between 2000 and 2003, four people died while locked in isolation cells: three burned to death in unrelated incidents, and the fourth died from unknown causes. At *Colonia Dr. Domingo Cabred Interzonal Psychiatric Hospital (Cabred Hospital)*, in the province of Buenos Aires, three people were found dead in and around the asylum during the first six months of 2005. The first body was found in the woods, the

¹¹ Interview with Jorge Rossetto, Director, *Colonia Montes de Oca*, province of Buenos Aires (June 3, 2004).

¹² Investigator's observations, *Colonia Montes de Oca*, province of Buenos Aires (June 3, 2004). second in a field, and the third was discovered in an abandoned warehouse on the hospital grounds. Authorities determined that the third individual had died five to ten days before the discovery of the body.

Also at Cabred as of 2006, there were approximately 70 deaths a year, out of an inpatient population of 1,200 men. The death rate was four times higher during the winter months than in the summer. Authorities attributed these deaths to "old age" and offered no explanation for the seasonal spike in deaths.

• Detention in isolation cells

At Psychiatric Penal Unit 20 (Penal Unit 20),¹³ in the city of Buenos Aires, in June 2004, investigators observed men locked in dark, tiny isolation cells. These cells measured less than one-and-a-half meters by two meters and had no natural light or ventilation. They were so overheated that the nearly naked detainees were drenched in sweat. There were no toilets and the men had to urinate and defecate in small plastic jugs on the floor. The cells were filthy and infested with cockroaches. Detainees' only contact with the outside world was through a tiny peephole in the door. In Psychiatric Penal Unit 27 (Penal Unit 27),¹⁴ in the city of Buenos Aires, investigators also observed the abusive use of isolation cells.

In 2005, following investigators' complaints, authorities began to renovate Penal Unit 20 and amend the policies for the use of the isolation cells. Nonetheless, at the time of the writing of this report, the renovations to these cells had not been completed, and the legal reforms necessary to prevent similar abuses from recurring in this or other institutions had not been implemented.

- **Physical and sexual abuse**

At Penal Unit 20, detainees told investigators that security staff rape and beat them. Investigators observed large bruises on several detainees' torsos and backs, and one detainee had stitches in his head; all reported that their injuries were the result of staff abuse. At Braulio A. Moyano Psychiatric Hospital (Moyano Hospital), in the city of Buenos Aires, a psychiatric hospital with more than 1,000 beds,¹⁵ investigators documented—through authorities' statements and those of various women institutionalized there—reports of sexual abuse against the women perpetrated by staff and by people outside the institution.

13 Penal Unit 20 is a men's forensic ward located on the grounds of Municipal Jose Tiburcio Borda Hospital (Borda Hospital) operated by the Federal Penitentiary Service, under the National Ministry of Justice.

14 Penal Unit 27 is a women's forensic ward located on the grounds of Braulio A. Moyano Neuro-Psychiatric Hospital (Moyano Hospital) operated by the Federal Penitentiary Service, under the National Ministry of Justice.

15 Available at http://www.buenosaires.gov.ar/areas/salud/estadisticas/1er_sem_2007/?menu_id=21300.

- **Lack of medical care**

At Penal Unit 20, Diego Alcorta, Jose Tiburcio Borda Interdisciplinary Psychiatric Hospital (Borda Hospital), and Moyano Hospitals, investigators observed large numbers of institutionalized persons with open, infected sores, and rotting or missing teeth.

Investigators also documented instances of people whose limbs were in advanced stages of decay from gangrene. At Diego Alcorta Hospital, investigators arrived the morning that a woman institutionalized there died due to lack of medical attention; she had waited two months to have an operation on a dislocated leg. At Penal Unit 20, a detainee reported that he had not received the specific medications that he needed to treat his HIV/AIDS while he was detained in isolation.

- **Dangerous physical conditions**

At Diego Alcorta Hospital, during a visit in December 2004, bathrooms were unusable, toilets overflowed with excrement and the floors were flooded with urine. Sink handles were broken, showers did not work, and in some places there was no running water. The grounds of the facility were littered with piles of excrement and reeked of urine. When investigators returned in September 2006, Diego Alcorta had new bathroom fixtures, which appeared to improve the institution's hygienic conditions; nevertheless, the grounds remained covered with excrement and still reeked of urine. At Moyano Hospital and National *Colonia* Dr. Manuel A. Montes de Oca (*Colonia* Montes de Oca), during visits in 2004 and 2005, investigators observed decaying roofs, broken windows, loose cables hanging from the roofs and walls, and places that reeked of urine and feces. Following an intervention at Moyano Hospital in December 2005, the government of the city of Buenos Aires began repairs to the wards, which, at the time of the writing of this report, has not been finished.¹⁶ In visits during 2007, investigators observed physical improvements at *Colonia* Montes de Oca.

- **Lack of rehabilitation**

At most institutions, no meaningful rehabilitation is provided to the vast majority of the institutionalized persons. Pervasive inactivity is the most common problem, evidenced by the overwhelming number of persons lying in their beds or on institution grounds, completely idle.

- **Misuse of medications**

Authorities, mental health workers and institutionalized persons reported that psychotropic medications are frequently used for punitive rather than therapeutic purposes. At Penal Unit 20, detainees reported that, as punishment for any minor offence, such as "answering back" to staff, they are injected with heavy doses of tranquilizers that leave them immobilized for days.

16 Interview with Dr. Carlos de Lajonquiere, Director General of Mental Health, Ministry of Health of the city of Buenos Aires (July 18, 2007).

- **Overcrowding**

Overcrowding in institutions is commonplace. During three separate visits to Penal Unit 20 in 2004, 2005 and 2006, for example, the ward was overcrowded by approximately 75 percent, 40 percent, and 30 percent respectively. In 2007, according to information provided by the National Prosecutor in charge of Prisons,¹⁷ the overcrowding had risen again to 40 percent. The director of Dr. Carolina Tobar Garcia Children's Hospital (Tobar Garcia Hospital), a psychiatric hospital in the city of Buenos Aires, stated that, with a capacity of 64 beds, the hospital was also providing intensive ambulatory care for an additional 100 children and adolescents.¹⁸

Hope for reform

Notwithstanding the size and complexity of the challenges detailed in this report, Argentina is a promising country for mental health reform. The highly trained base of mental health professionals currently providing services on an individual basis are an invaluable resource that, with redirection, could be mobilized to provide community-based care.

Argentine lawyers and mental health professionals have often taken the lead in developing profoundly innovative laws, policies, and service programs. On a municipal level, in the city of Buenos Aires, the 1996 Constitution, the Basic Health Law No. 153, and the Mental Health Law No. 448 call for progressive deinstitutionalization and the creation of community-integrated services.

Importantly, there are significant resources to implement mental health reform in the city of Buenos Aires. During a meeting in January 2006, the then office of the city's Secretary of Health, which became the Ministry of Health in April 2006, declared its intention to collaborate in the social reinsertion of institutionalized persons, stating that the local government would provide the necessary resources through different programs and subsidies to implement mental health reform. Recognizing that, historically, there has been a lack of political will to carry out reform efforts, the Head of the Cabinet of the city's former Secretary of Health stated, "There is money [to implement reform], we have to make the changes, we have to do it now."¹⁹ Another step toward the implementation of Mental Health Law 448 has been that what was formerly the Direction of Mental Health has become the General Direction of Mental Health. As a result, the agency should have more resources, a larger budget and greater authority within the area of health to implement the Law.

17 In June 2007, the National Prosecutor in charge of Prisons imposed a corrective *habeas corpus* after receiving an anonymous letter from family members complaining about the abuse of persons institutionalized in Penal Unit 20.

18 Interview with Dr. Roberto A. Yunes, Director, Dr. Carolina Tobar Garcia Children's Hospital (Tobar Garcia Hospital), city of Buenos Aires (Jan. 24, 2006). *Clarín*, "Tras 40 años sin obras, empezó la

remodelación en el Tobar García” [“After 40 years without repairs, the remodeling of Tobar Garcia has begun”] (April 8, 2006).

19 Interview with Dr. Velez Carreras, Head of the Cabinet for the then Secretary of Health of the city of Buenos Aires (Jan. 26, 2006).

Argentina also has an array of policymakers, service providers, specialized academics, and human rights organizations lobbying for far-reaching, sustained and integral mental health reform. Some of the continent’s most recognized mental health reform initiatives have been implemented in the provinces of Rio Negro and San Luis. These programs are models for reform in other parts of the country, and the individuals driving these mental health reforms are now working with institutions elsewhere in Argentina to help them in their reform efforts.

Tremendous potential support also exists among families of people with mental disabilities, as well as among consumers of mental health services and ex-patients. Families are the mainstay for most individuals with mental disabilities. Nevertheless, without government support, many of these families are left impoverished and socially marginalized. Likewise, there are a number of active consumer or ex-patient groups, including the *Frente Artistas del Borda* (Borda Artists’ Front), *Radio La Colifata* (Radio Colifata), and *Pan del Borda* (Bread of Borda). These groups provide hope and a legitimate voice for change in mental health services. With a small investment, family member and consumer or ex-patient groups could be a tremendous and low-cost resource for developing community support and advocacy initiatives.

Despite these hopeful circumstances, some opportunities for reform have already been squandered. Buenos Aires city authorities reported that a loan from the Inter-American Development Bank (IDB) was being used to renovate four psychiatric institutions in the city. According to these authorities, the amount being spent on these renovations was more than 60 percent of the annual mental health budget for the entire city. Instead of rebuilding inpatient facilities—with the exception of reconstruction and repairs that are absolutely necessary for safety reasons— international funding should be invested in furthering the transition to a community-based system of care, as required by the city’s laws and international human rights standards. Authors urge the government of Argentina to respect its own legislation and internationally accepted standards and invest existing resources in the implementation of deinstitutionalization programs. The IDB, in order to comply with international human rights norms, should shift course and dedicate itself to the development of services that promote the full community integration of people with mental disabilities.

As long as resources remain directed almost exclusively toward institutional care, wide-scale reform will be unachievable and the segregation and abuses such as those documented in this report will continue unabated.

Summary of recommendations

The following recommendations propose concrete measures that should be adopted to implement a profound reform in Argentina's mental health services. MDRI and CELS recommend that the government of Argentina take immediate action to end conditions that violate the human rights of those institutionalized.

The government of Argentina should:

- . • Eradicate the dangerous, filthy and inhuman environments in which institutionalized persons are forced to live;
- . • Guarantee adequate food, medical care and staffing to protect the health and safety of institutionalized persons;
- . • Investigate recent deaths and establish protocol to ensure full investigations of any future deaths;
- . • Eliminate the use of long-term isolation cells and sensory deprivation in these cells and ensure that the use of involuntary seclusion²⁰ and physical restraint²¹ adheres strictly to international human rights standards;
- . • Create independent oversight mechanisms toward the prevention of abuses in institutions and establish procedures that will protect institutionalized persons from sexual and physical abuse;
- . • Adopt procedures for psychiatric commitment that strictly adhere to international standards, including the right to independent review in all commitment proceedings;
- . • Adopt enforceable mental health laws that will apply throughout the country, consistent with international human rights standards.

The government of Argentina should commit to the full inclusion of people with mental disabilities into all aspects of Argentine society, including people with both psychiatric and intellectual disabilities. Protecting the human rights of this population will require a paradigm shift from custodial institutionalization and arbitrary detention to the development of services that are comprehensive, community-based, include mental health attention as part of primary care, and provide social services that contribute to strengthening social networks. Investigators recommend that the national government create a high-level national commission to plan and implement mental health service reform that would allow people with mental disabilities to live, work and receive health and mental health attention in their own communities.

At the end of this report, these proposed recommendations are developed in greater detail.

20 "Involuntary seclusion" refers to "[t]he involuntary confinement of a person in a room or an area where the person is physically prevented from leaving." Restraint and Seclusion, HCFA Rules for Hospitals, at <http://www.bazelon.org/RandSrules.pdf>.

21 "Physical restraint" refers to "any manual method or physical or mechanical device, material or

equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body." *Id.*

Methodology

This report is the product of research conducted jointly by Mental Disability Rights International (MDRI) and the Center for Legal and Social Studies (CELS). During six fact-finding trips to Argentina—which occurred in June 2004, December 2004, June 2005, January 2006, September 2006, and July 2007—research teams visited numerous facilities for people with psychiatric and developmental disabilities in the city of Buenos Aires, and the provinces of Buenos Aires, Santiago del Estero, Rio Negro and San Luis. These institutions included: Jose Tiburcio Borda Interdisciplinary Psychiatric Hospital, Braulio A. Moyano Psychiatric Hospital, Dr. Carolina Tobar Garcia Children's Hospital, the half-way house *Centro Psicopatologico* (Psychopathologic Center) Aranguren, and psychiatric Penal Units 20 and 27 in the city of Buenos Aires; a psychiatric ward in Paroissien Hospital, the National *Colonia* (a public asylum located in the countryside) Dr. Manuel Montes de Oca, the *Colonia* Dr. Domingo Cabred Interzonal Psychiatric Hospital, Jose Estevez Interzonal Hospital (Estevez Hospital), San Gabriel Neuro-psychiatric Medical Center, and a half-way house in Moreno in the province of Buenos Aires; Diego Alcorta Hospital, a psychiatric ward in Independencia Hospital, and a private clinic in the province of Santiago del Estero; and mental health system reform models in the provinces of Rio Negro and San Luis.

Investigators met with Argentine government officials responsible for providing health and social services to people with mental disabilities, as well as with representatives of non-governmental advocacy groups, including human rights organizations, mental disability rights groups, and family and professional organizations. During hospital visits, investigators interviewed hospital directors, medical directors, psychologists, psychiatrists, nurses, social workers, institutionalized persons and family members. Investigators also reviewed medical histories and collected data through direct observation.

This report analyzes the data collected and Argentina's laws and policies under international human rights standards that are binding on Argentina.²² Particular attention is given to the rights contained in the American Convention on Human Rights (American Convention),²³ the International Covenant on Civil and Political Rights (ICCPR),²⁴ the International Covenant on Economic,

22 All international treaties ratified by the Argentine government are incorporated into the Argentine judicial order, and have hierarchy over national laws. In addition, certain human rights treaties that are specially mentioned in article 75 inc. 22 of the National Constitution have the same rank as the Constitution. The National Congress may also—through a special majority of votes—grant constitutional hierarchy to other human rights treaties. (CONSTITUTION OF THE REPUBLIC OF ARGENTINA, art. 75 inc. 22 (1994) [hereinafter CONSTITUTION OF THE REPUBLIC]).

23 American Convention on Human Rights, Nov. 22, 1969, 1144 U.N.T.S. 123, O.A.S.T.S. No. 36, at 1, OEA/ Ser.L/V/II.23 doc. Rev. 2, 9 I.L.M. 673 (1970), *entered into force* July 18, 1978 [hereinafter American Convention]. Argentina ratified the American Convention on Sept. 5, 1984, and with the constitutional reform in 1994, assigned the Convention constitutional hierarchy.

24 International Covenant on Civil and Political Rights (ICCPR), G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 59, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 302, *entered into force* March 23, 1976 [hereinafter ICCPR]. Argentina ratified the ICCPR on Nov. 8, 1986, and with the constitutional reform in 1994, assigned the Convention constitutional hierarchy.

Social and Cultural Rights (ICESCR),²⁵ and the Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (Inter-American Convention on Disability).²⁶ In addition, the report identifies human rights principles applied directly to persons with disabilities under the Convention on the Rights of Persons with Disabilities (CRPD), adopted by the United Nations (UN) General Assembly December 13, 2006 and signed by the Argentine government on March 30, 2007.²⁷

The report also analyses conditions, treatment, and legislation in light of specialized standards adopted by the UN, such as the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles),²⁸ and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (the Standard Rules),²⁹ as well as policy documents drafted by the World Health Organization—including the Declaration of Caracas³⁰ and the Montreal Declaration on Intellectual Disabilities³¹—and the Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Mentally Ill.³²

25 International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976 [hereinafter ICESCR]. Argentina ratified the ICESCR on Nov. 8, 1986, and with the constitutional reform in 1994, assigned the Convention constitutional hierarchy.

26 Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities, June 7, 1999, AG/RES. 1608, *entered into force* Sept. 14, 2001 [hereinafter Inter-American Convention on Disability]. Argentina ratified the Inter-American Convention on Disability on January 10, 2001.

27 Convention on the Rights of Persons with Disabilities, adopted by the United Nations General Assembly December 13, 2006, at <http://www.un.org/esa/socdev/enable/documents/tccconve.pdf> [hereinafter CRPD]. Argentina signed the Convention on March 30, 2007, although it has not yet entered into force.

28 *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, G.A. Res. 119, U.N. GAOR, 46th Sess., No. 49, Annex, at 188-92, U.N. Doc. A/46/49 (1991) [hereinafter *MI Principles*].

29 *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, G.A. Res. 96, U.N. GAOR, 48th Sess., U.N. Doc. A/Res/48/96 (1993) [hereinafter *Standard Rules*].

30 *Declaration of Caracas* (1990), reproduced in RODRIGO JIMÉNEZ, *LOS DERECHOS HUMANOS DE LAS PERSONAS CON DISCAPACIDAD [THE HUMAN RIGHTS OF PEOPLE WITH DISABILITIES]* 186 (1996) [hereinafter *Declaration of Caracas*]. In 1990, the Pan American Health Organization (PAHO/WHO) convened mental health organizations, associations, professionals and jurists to the Regional Conference on Restructuring Psychiatric Care in Latin America, held in Caracas, Venezuela. The Declaration of Caracas was adopted in the framework of that Conference.

31 *The Montreal Declaration on Intellectual Disability* (2004) at <http://www.mdri.org/pdf/montrealdeclaration.pdf> [hereinafter *Montreal Declaration*]. In October 2004, the Pan American Health Organization (PAHO/WHO) sponsored a conference in Montreal, Canada, which declared that people with intellectual disabilities “as other human beings, are born free and equal in dignity and rights” (art. 1) and that “intellectual disabilities are an integral part of the human experience and diversity,” which require “the international community to respect values of dignity, self-determination, equality and justice for all. . . .” (art. 2).

32 *Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Mentally Ill*, INTER-AM. COMM. H.R., 111th Sess., Apr. 4, 2001 [hereinafter *IACHR Recommendation*].

Based on this analysis, and in consultation with local advisors, the report details recommendations to help bring Argentina’s mental health system into compliance with international human rights standards, and proposes specific steps Argentine actors can take to transform the asylum-based care model. These recommendations are grounded in authors’ past experience, and incorporate interviews with service providers, consumers, ex-patients, family members, and government officials over the course of the investigations. The report draws from extensive international experience in the areas of mental disability rights specifically and international human rights more generally, as well as local expertise, to recommend strategies to complement and build on the resources available in Argentina.

Over the course of the research for this report, investigators met many mental health workers who are dedicated to delivering quality services to people with mental disabilities, including several professionals who are engaged in pioneering reform efforts. Investigators recognize that conditions in institutions that are harmful to persons with mental disabilities can also be harmful to the staff employed there, and that care models and services must be transformed to protect and enhance the rights of the consumers and providers of mental health services alike. Increased funding for community-integrated mental health services and social supports, housing alternatives to segregative institutionalization, oversight to enforce human rights protections, and enhanced training will benefit staff as well as those receiving services.

These findings and recommendations are based upon observed mental health systems and services. Investigators could not visit all mental health programs in the country, and this report does not intend to provide an evaluation of all existing programs. Authors recognize that there can be tremendous variation between the mental health services of different provinces, as under Argentine law each province determines its own mental health policy and there is still no national mental health legislation. This report focuses heavily on services in the city and province of Buenos Aires, where the largest institutions are located.

In the interests of brevity and clarity, this report does not discuss every facility visited. Rather, the report describes some key areas for broad-based reform, documenting several egregious violations encountered as well as highlighting some successful reform models. Authors hope that this report contributes to promoting mental health reform throughout the country.

I. Background

During much of the twentieth century, Argentina was one of the most prosperous countries in Latin America, with relatively low levels of poverty, inequality and unemployment.

Over the last three decades, however, the country has experienced a sharp deterioration of labor and social conditions. Inequality, poverty, and unemployment increased even during periods of economic growth.³³ During the 1990s, the country underwent a series of social and economic changes that led to a downturn in the growth of the labor force, extreme variations in income distribution, and an increase in the percentage of the population living in poverty.³⁴

The economic and social crisis that deepened during the final years of the 1990s “exploded” in the month of December 2001, when Argentina experienced a series of events that marked its institutional and political history. This economic and political instability brought about the rapid downfall of successive governments in 2001 and 2002, until the current president, Nestor Kirchner, was elected in 2003.

Despite the sustained economic recovery of the country since 2003, a deep social divide between the wealthiest and poorest sectors of the population remains intact, and high levels of poverty, indigence and social exclusion persist.³⁵

This economic and political instability has affected all sectors of Argentine society. However, economically and socially marginalized populations—such as people with disabilities— have been even more vulnerable to the effects of this instability. Poverty not only accentuates some of the negative consequences of disability, but it is also a factor leading to increased incidences of disability, as accessing health care, education, and rehabilitation services becomes more

33 Leonardo Gasparini et al., Centro de Estudios Distributivos, Laborales y Sociales, Universidad Nacional de La Plata, *Monitoring socio-economic conditions in Argentina, Chile, Paraguay and Uruguay*, Vol. 1 (2005) at http://www-wds.worldbank.org/servlet/WDS_IBank_Servlet?pcont=details&eid=000011823_20050715164315 [hereinafter Gasparini].

34 Daniel Filmus, et al., *La transición entre la escuela secundaria y el empleo: los recorridos de los jóvenes en el Gran Buenos Aires* [The transition between secondary school and work: the paths of young people in Greater Buenos Aires], in REVISTA ESTUDIOS DE TRABAJO, No. 26 – Second Semester 2003, Asociación

Argentina de Estudios de Trabajo (ASET) [Argentine Association of Employment Studies]. As means of comparison, in 1958, the aggregate wealth of the wealthiest sector of Argentine society was approximately eight times that of the poorest sector. By 2002, the aggregate wealth of the richest sector had jumped to more than 37 times that of the poorest sector. According to the National Institute of Statistics (INDEC), before the devaluation of the peso in 2002, 53 percent of the population was under the poverty line (approximately 18.5 million people) and almost 25 percent (8.7 million people) of the population was considered indigent; between December 2001 and April 2002, there was a 40 percent drop in salaries.

35 In the second half of 2006, more than 19.2 percent of households were below the poverty line, representing 26.9 percent of the population. More than 6 percent of households and 8.7 percent of people were considered indigent. At <http://www.indec.gov.ar>.

difficult with the growth in unemployment and poverty.³⁶ As these ripple effects of Argentina's socio-economic collapse manifest, vulnerable groups such as people with mental disabilities are particularly susceptible to abandonment and abuse.

A. Argentina's health system

Argentina's health system is complex, fragmented, and decentralized. Each of the country's 24 provinces has its own Ministry or Secretary of Health, which controls most of the health policy decisions for its region. Health care in Argentina is financed largely through payroll deductions. For approximately 50 percent of the population, "*obras sociales sindicales*," or union-sponsored not-for-profit employee benefit programs regulated by the government, finance health care. Yet since the economic crisis, many people have lost their jobs and the income for these programs has decreased drastically, while the population without any health insurance coverage has seen a dramatic increase. In addition, programs that previously recovered costs through collective quotas paid by those who used their services are no longer able to do so, as their members can no longer afford to pay for the services.³⁷

Federal mental health planning in Argentina is carried out by the *Unidad Coordinadora Ejecutora de Salud Mental y Comportamiento Saludable del Ministerio de Salud de la Nación* (Mental Health and Healthy Behavior Executing Coordinating Unit within the federal Ministry of Health, hereinafter, Coordinating Unit). The Coordinating Unit's total annual budget for 2006 was a mere 700,000 pesos (approximately US\$233,000).³⁸ In 2005, the Coordinating Unit lacked sufficient resources to implement policy or collect and centralize mental health data from the provinces.³⁹ Without reliable data about the scope of mental health issues and available mental health services, policy planning and implementation are practically impossible. Most policy decisions and budget allocations are therefore made at the provincial level. At present, the Coordinating Unit has signed an agreement with eight national universities to carry out epidemiological research on psychic malaise in children, which has demanded nearly 65 percent of its total budget. In addition, in the framework of the National Mental Health, Justice and Human Rights Roundtable,⁴⁰ the

36 The proportion of stable jobs with rights to pensions and health insurance is markedly lower for the poor. For example, 60 percent of the working non-poor have access to health insurance through their employment, while a mere 12 percent of the poor have this benefit. Gasparini, *supra* note 33.

37 Interview with Dr. Julio Ainstein, then Director of Mental Health, Ministry of Health of the province of Buenos Aires, and Dr. Patricia Esmerado, then Associate Director, Jose Estevez Interzonal Hospital (June 1, 2004).

38 Interview with Dr. Antonio E. Di Nanno, Coordinator of the Mental Health and Healthy Behavior Executing Coordinating Unit within the federal Ministry of Health, city of Buenos Aires (June 27, 2005).

39 *Id.*

40 The National Mental Health, Justice and Human Rights Roundtable is an intergovernmental and inter-sectoral initiative, created in 2006, whose objectives are the promotion of mental health policies from a human rights perspective and good mental health praxis. See *infra* section VI.A.1 of this report, “Promising reform initiatives in the mental health system.”

Coordinating Unit is participating in a series of regional colloquia to determine how to prioritize mental health policies from a human rights perspective.⁴¹

The World Health Organization recommends that 10 percent of a country’s health budget be allocated to mental health.⁴² However, several provinces allocate only a fraction of this amount for mental health services. In the province of Buenos Aires, for example, according to figures from 2005, only 2 percent of the health budget was allocated to mental health.⁴³ For 2007, the budget for mental health had increased to 4.2 percent.⁴⁴

The rise in poverty since the 2001 economic and political crisis has led to an increase in demand for public health services. Whereas before the crisis 40 percent of the population received attention through public hospitals, since the crisis, 60 percent of the population has been using public hospital services.⁴⁵ At the same time, the health budget has been cut, compounding the problem of rising demand. There has been an increase in psychiatric symptoms and the prevalence of certain illnesses associated with poverty and unemployment, as the socio-economic situation in Argentina has worsened.⁴⁶

In the last few years, the Argentine government has taken a number of measures in an effort to minimize the impact of the economic crisis on the health sector. These measures have focused on access to pharmaceuticals. The national Ministry of Health, the principal producer of medications consumed in Argentina, increased its production of medications as a response to the

41 Interview with Dr. Antonio E. Di Nanno, Coordinator of the Mental Health and Healthy Behavior Executing Coordinating Unit within the federal Ministry of Health and Environment, city of Buenos Aires (July 16, 2007).

42 World Health Organization, *Mental Health Atlas-2005: Country Profile, Argentina* (2005) [hereinafter,

Mental Health Atlas], at http://www.who.int/mental_health/evidence/atlas/profiles_countries_a_b.pdf.

43 *Id.*

44 Interview with Dr. Leo Zavattaro, Director, Cabred Hospital, province of Buenos Aires (July 25, 2007); Consejo Directivo Provincial, “No. 44/2006: *El presupuesto de salud previsto para el 2007 significa la muerte*” [“No. 44/2006: The health budget provided for 2007 signifies the death”] (Dec. 18, 2006) at <http://www.cicop.org.ar/modules.php?name=News&file=print&sid=91>.

45 Interview with Dr. Julio Ainstein, then Director of Mental Health, Ministry of Health of the province of Buenos Aires, and Dr. Patricia Esmerado, then Associate Director, Jose Estevez Interzonal Hospital (June 1, 2004).

46 “In Argentina, taking just a few relevant data, according to a report by the Association of Argentine Psychiatrists (APSA), in the first quarter of 2002, psychiatric consultations had increased almost 300 percent. In the province of Tucumán, the provincial Director of Mental Health, Marcela Lemaitre, reported a 30 percent increase in mental health consultations in the public sector for the same period. Something similar happened in Mendoza, where consults in the neuro-psychiatric hospitals increased between 20 and 25 percent. In Córdoba, thus far in 2004, the provinces’ Director of Mental Health, Osvaldo Navarro, states that more than 50 percent of the demand in the health centers at the periphery of Córdoba’s capital is related with economic and housing problems, as a consequence of unemployment or instability in the labor market.” CELS, *Derechos Humanos en Argentina* [Human Rights in Argentina]. Informe 2004, Editorial Siglo XXI, Argentina, 2004, p. 533 [translation ours].

crisis.⁴⁷ The Ministry also centralized the purchase of medicines allowing for lower prices through bulk purchases, whereas previously each hospital purchased for its own use.⁴⁸ Additionally, the Ministry has instituted a policy of using generic medicines whenever possible, and is taking part in a program to purchase medicines through the United Nations Development Program (UNDP).⁴⁹ Participation in the UNDP program has resulted in a 21 percent savings for the government, as there is no value added tax paid on the medications.⁵⁰ These government initiatives are important, but access to medications does not address the basic needs of many institutionalized individuals, which include healthy and hygienic conditions and personalized rehabilitation. Even more important, pharmaceuticals alone are no substitute for the range of community supports—such as access to affordable housing and employment opportunities—needed to prevent unnecessary hospitalizations.

Today, two out of three of the country’s 25,000 psychiatric beds are publicly managed, and three out of four of those public beds are found in large institutions of 1,000 beds or more.⁵¹ There are eight psychiatric institutions with more than 1,000 beds each, four of which are located in the province of Buenos Aires and two in the city of Buenos Aires.⁵² The vast majority of individuals housed in Argentina’s psychiatric institutions are long-term residents. People who have been institutionalized longer than one year occupy 80 percent of psychiatric beds.⁵³ Only 5 percent of people are hospitalized for less than three months.⁵⁴

B. Mental health legislation

Argentina has a federal form of government. As such, the national Constitution, the international treaties ratified by the federal government, and national laws have superiority to laws enacted at the provincial level.⁵⁵ Provincial governments, however, maintain all powers not delegated to the federal government by the Constitution.

47 Interview with Dr. Julio Ainstein, then Director of Mental Health, Ministry of Health of the province of Buenos Aires, and Dr. Patricia Esmerado, then Associate Director, Jose Estevez Interzonal Hospital (June 1, 2004).

48 *Id.*

49 *Id.*

50 *Id.*

51 Source: *Unidad Coordinadora Ejecutora de Salud Mental y Comportamiento Saludable del Ministerio de Salud de la Nación* [Mental Health and Healthy Behavior Executing Coordinating Unit within the federal Ministry of Health and Environment] (June 27, 2005).

52 *Id.*

53 *Mental Health Atlas*, *supra* note 42, at 63.

54 *Id.*

55 CONSTITUTION OF THE REPUBLIC, *supra* note 22, art. 31.

Argentina boasts progressive federal mental health legislation, which establishes guidelines for the implementation of mental health reform. The *Programa de Asistencia Primaria en Salud Mental ley 25.421* (Program for Mental Health Services in Primary Care, Law 25.421), enacted in 2001, establishes that all persons have the right to receive mental health care as part of primary care services, and provides for the rehabilitation and social reinsertion of persons with mental illness.⁵⁶ The Law also establishes the Program of Mental Health Services in Primary Care, and designates the national Ministry of Health as the agency responsible for enforcing the Law.⁵⁷ However, at the time of the writing of this report, the federal government had not yet established the regulations for Law 25.421, and the Law had yet to be enforced.

In the Autonomous City of Buenos Aires, the *Ley Básica de Salud, N° 153* (Basic Health Law 153) requires that the city government implement progressive deinstitutionalization.⁵⁸ Toward this end, Law 153 calls for the implementation of alternative mental health models focused on social integration, such as half-way houses, protected workshops, therapeutic communities and day hospitals.⁵⁹

In 2000, in compliance with Law 153, *Ley de Salud Mental de la Ciudad de Buenos Aires, N° 448* (Mental Health Law of the City of Buenos Aires, Law 448) was passed. Law 448 guarantees the right to mental health, and calls for deinstitutionalization and the rehabilitation and social reinsertion of institutionalized persons.⁶⁰ This Law also establishes that the mental health system in the city of Buenos Aires be one based principally on prevention, promotion, and the protection of mental health.⁶¹ Article 3 of Law 448 sets forth human rights protections specific to persons with mental disabilities and looks to transform the current asylum-based model and promote community mental health services.⁶²

Despite the language of Laws 25.421, 153 and 448, the model of public mental health provision, both nationally and in the city of Buenos Aires, continues to be based almost exclusively on institutional care. Throughout the country, there is a dearth of adequate mental health attention

56 *Programa de Asistencia Primaria en Salud Mental ley 25.421* [Program for Mental Health Services in Primary Care, Law 25.421] (2001) [hereinafter Law 25.421].

57 *Id.*

58 *Ley Básica de Salud de la Ciudad de Buenos Aires, N° 153* [Basic Health Law of the City of Buenos Aires, Law No. 153] (1999) [hereinafter Law 153], art. 48.

59 *Id.*

60 *Ley de Salud Mental de la Ciudad de Buenos Aires, N° 448* [Mental Health Law of the City of Buenos Aires, Law No. 448] (2000) [hereinafter Law 448], arts. 12 and 13(a).

61 *Id.* art. 2(c).

62 *Id.* art. 2(e).

within primary care. With a few exceptions,⁶³ no strategies or action plans exist for the incorporation of mental health into primary care, and there is no training of primary care health professionals in mental health issues.⁶⁴ The 2007 working budget for the city of Buenos Aires, presented in October 2006, allocated less than 2.2 billion pesos (approximately US\$722 million) to health;⁶⁵ of which, 146 million pesos (approximately US\$49 million) would be allotted to mental health, representing 6.9 percent of the total

health budget.⁶⁶ Of the overall health budget, 81 percent would be designated to hospital services and 4.2 percent to primary care.⁶⁷ Taking the city of Buenos Aires as an example, only two general hospitals of the 33 hospitals in the health network provide in-patient mental health services.⁶⁸

II. Inappropriate institutionalization

A. The “medicalization” of social problems and the lack of community services

Social factors, more often than psychiatric considerations, can be decisive in admissions to and discharges from psychiatric hospitals.⁶⁹ Government authorities and hospital directors told investigators that the majority of people in institutions remain institutionalized for long periods due to social problems.

In 2004, at Estevez Hospital, a women’s psychiatric hospital in the province of Buenos Aires,⁷⁰ then Assistant Director Dr. Patricia Esmerado estimated that 70 percent of the institutionalized

63 See § VI. A. for further information about these initiatives.

64 Interview with members of the Forum of Mental Health Professional Institutions of the City of Buenos Aires (FORO), city of Buenos Aires (June 4, 2004 and Sept. 28, 2006). The FORO is a consortium of mental health sector employees, comprising 20 groups representing approximately 9,000 professionals.

65 Law No. 2180 in the Budget of the City Government’s Administration, 2007. Official Bulletin No. 2594 of the Legislature of the Autonomous City of Buenos Aires, Dec. 28, 2006. *Available at:* http://www.buenosaires.gov.ar/areas/leg_tecnica/boletines/20061228.htm.

66 According to the information provided by the General Direction of Mental Health of the city of Buenos Aires, the amount allocated to mental health includes the ordinary budget as well as credits given by international lending institutions (Aug. 1, 2007).

67 Interview with Dr. Carlos de Lajonquiere, Director General of Mental Health, Ministry of Health of the city of Buenos Aires (July 18, 2007).

68 Interview with Dr. Ricardo Soriano, then Director of Mental Health of the city of Buenos Aires (June 2, 2004).

69 Investigators collected data underscoring this point in every facility visited. This phenomenon, however, is not exclusive to Argentina. For more than 35 years, in different countries around the world experts in mental health and human rights have documented that social factors are often decisive in admissions to and discharges from psychiatric facilities. *See, e.g.,* THOMAS SCHEFF, EL ROL DEL ENFERMO MENTAL [THE ROLE OF THE MENTALLY ILL] 154 (1970) *cited in* ALFREDO JORGE KRAUT, LOS DERECHOS DE LOS PACIENTES [THE RIGHTS

70 Estevez Hospital was originally founded as an annex to Braulio A. Moyano Psychiatric Hospital, a women's psychiatric institution in the city of Buenos Aires.

persons are "social patients,"⁷¹ meaning that their continued hospitalization is grounded in socioeconomic considerations rather than medical or mental health criteria. Dr. Ricardo Soriano, then Director of Mental Health for the city of Buenos Aires, reported that approximately 60 percent of the individuals institutionalized are in this situation because of a "medicalization of social problems,"⁷² and Dr. Antonio Di Nanno, Coordinator of National Mental Health Coordinating Unit, reported that 80 percent of those hospitalized are there because of failures in the social support system.⁷³ Dr. Carlos de Lajonquiere, General Director of Mental Health for the city of Buenos Aires, cited a list of persons hospitalized in Borda and Moyano Hospitals that had been drawn up based on evaluations by different ward directors from both hospitals, stating that between 15 and 20 percent of those institutionalized would be able to be discharged were it not for social factors.⁷⁴ Nonetheless, he considered these numbers very low, and not reflective of reality.⁷⁵

One woman at Moyano Hospital described her plight:

*I have been here for ten years. I was admitted after I tried to commit suicide. I had a job as a professor of English and Italian, but I had to quit my job after ten years to care for my elderly parents. After they died, I fell into a deep depression and tried to end my life. I have had a medical discharge for five years, but there is a little paperwork that remains to be done.*⁷⁶

At Borda Hospital, a man in a one of the "chronic" wards told investigators:

I've been going from hospital to hospital since 1985. I was discharged in 1998, but my father died the following year and I fell [into depression]. This time I have been hospitalized for five or six years. I have four sisters. One sister is my legal guardian. If I have a place to go and a way to control [my medication] I can leave. My sister is doing the paperwork for my release. The paperwork is very expensive.⁷⁷ For the last five years she has been working for my release.

71 Interview with Dr. Patricia Esmerado, then Assistant Director, José Estevez Hospital, province of Buenos Aires (June 1, 2004).

72 Interview with Dr. Ricardo Soriano, then Director of Mental Health of the city of Buenos Aires (June 2, 2004). 73 Interview with Dr. Antonio E. Di Nanno, Coordinator of the Mental Health and Healthy Behavior Executing Coordinating Unit within the federal Ministry of Health and Environment, city of Buenos Aires (June 4, 2004).

74 This percentage was calculated based on different evaluations, by service directors, carried out in both

hospitals. Interview with Dr. Carlos de Lajonquiere, General Director of Mental Health, Ministry of Health of the city of Buenos Aires (July 18, 2007).

75 *Id.*

76 Interview with patient in ward Tomasa II, Moyano Hospital, city of Buenos Aires (June 6, 2004).

77 Interview with patient in Ward 25A, Borda Hospital, city of Buenos Aires (Jan. 25, 2006).

The ward director countered,

*The paperwork is not the problem; we do the paperwork from one day to the next. The problem is that [the patients] don't have anywhere to go because they don't have anyone or their families reject them. . . . Sixty percent of them are in conditions to have a medical discharge but they don't have anywhere to go. They are "social cases." In no other specialty does this problem exist. When someone is hospitalized for an appendectomy, the family does not abandon the person in the hospital.*⁷⁸

In 2004, at *Colonia Montes de Oca*,⁷⁹ in Ward 3, one member of the nursing staff estimated that approximately half of the people were then hospitalized due to social problems. Some people were unable to afford medication and some were malnourished due to poverty, she reported.⁸⁰ In 2007, the governor of the province of Buenos Aires estimated that more than 70 percent of the 1,070 persons institutionalized at Cabred Hospital were there because of poverty.⁸¹

During interviews conducted in 2004 at Estevez Hospital, in an acute ward housing 78 women, staff informed investigators that 30 percent of the women in the ward had a medical release, but there was nowhere for them to go.⁸² In 2006, at Penal Unit 20, staff said that of the 114 persons institutionalized, 20 were in conditions for discharge, but they were not released because there were no intermediary places to release them to. Penal Unit 20 staff also said that there was no average period of institutionalization and they reported cases of persons who had been housed on the Unit for more than 20 years.⁸³

Based on interviews with authorities, professionals, family members and institutionalized persons, investigators deduce that approximately 70 percent of those institutionalized remain segregated from the community for social reasons. Within this percentage exists a large number of people hospitalized who receive no medications or other treatment, yet continue to be institutionalized for decades. As such, this report finds that Argentina's psychiatric institutions have become "human warehouses" for people who lack the means to support themselves, or family members able or willing to take them in.⁸⁴

78 Interview with director of service for Ward 25A, Borda Hospital, city of Buenos Aires (Jan. 25, 2006).

79 *Colonia Montes de Oca* is an institution for men and women with psychiatric and intellectual disabilities. In July 2007, 860 persons were institutionalized there.

80 Interview with nurse in Ward 3, *Colonia Montes de Oca*, province of Buenos Aires (June 3, 2004).

81 Intervention of Governor Felipe Solá at the opening of the 135th period of ordinary sessions of the Buenos Aires' Legislature (March 1, 2007) at <http://www.spd.gba.gov.ar/cgi-bin/noticias/viewnews.cgi?newsid1172793522,83252>.

82 Interview with staff at Estevez Hospital, province of Buenos Aires (June 1, 2004).

83 Interview with staff at Penal Unit 20, city of Buenos Aires (Aug. 29, 2006).

84 *Id.*

The main factor contributing to long-term institutionalization is the lack of adequate services and support mechanisms in the community. According to a member of the *Foro de Instituciones de Profesionales en Salud Mental de la Ciudad de Buenos Aires* (FORO—Forum of Mental Health Professional Institutions of the City of Buenos Aires), “there are patients who need assisted residences who will need monitoring. They need half-way houses and economic subsidies. [If these are] well implemented, it will lead to the resocialization of a patient who has been isolated.”⁸⁵ Adequate community services would enable individuals with initial outbreaks of mental illness to receive appropriate care before their health deteriorates, and allow those who have been institutionalized for many years to become reintegrated into the community.⁸⁶

This lack of community-based services is complicated by the fact that, in general, mental health training in Argentina focuses on psychoanalysis. As a treatment modality, psychoanalysis is oriented toward individual therapy rather than psycho-social rehabilitation, which is an important element of what people discharged from psychiatric institutions need. Further, based on interviews and a review of the programs offered at national universities, investigators found that interdisciplinary mental health treatment is generally not taught in Argentina's universities.⁸⁷ Investigators collected information regarding how professionals trained in psychoanalysis have difficulty working in interdisciplinary teams. They see patients on an individual basis, are not trained to work with groups, and are resistant to working in promotion and prevention.⁸⁸ One FORO member commented, “The tendency is to hospitalize people with psychiatric illness, and there is a lack of training in alternatives.”⁸⁹ The General Director of Mental Health for the city of Buenos Aires reported that the creation of interdisciplinary teams, day hospitals and psychiatric beds in general hospitals, all commitments made by the city's Ministry of Health in 2005, were not implemented due to budgetary shortfalls. He reported that there was only one interdisciplinary team formed in one general hospital in the city.⁹⁰

85 Interview with members of FORO, city of Buenos Aires (June 4, 2004).

86 *Id.*

87 There are exceptions. For example, the Faculty of Psychology of the University of Buenos Aires offers several advanced courses in mental health, prevention and epidemiology. Psychoanalysis should not be understood as incompatible with psycho-social rehabilitation, as is demonstrated, through the work of CELS' Mental Health Team, among others.

88 Different actors in the mental health field identified the lack of training for personnel and the absence of consciousness-raising campaigns for the public on stigma and human rights violations against people with mental disabilities as obstacles to mental health reform.

89 Interview with members of FORO, city of Buenos Aires (June 4, 2004).

90 Interview with Dr. Carlos de Lajonquiere, General Director of Mental Health, Ministry of Health of the city of Buenos Aires (July 18, 2007). Over the course of the investigation, various actors in the mental health field said that there is strong resistance on the part of general hospitals to treat people with mental disabilities, and that there is an absence of strategies and action plans for the inclusion of mental health treatment in primary care. Both factors were identified as significant obstacles to health system reform.

At Moyano Hospital, staff and residents reported that hundreds of women remained hospitalized for many years. One psychiatrist interviewed stated that of the 1,750 women institutionalized at Moyano, 1,500 were in chronic wards, where they stayed indefinitely.⁹¹ He estimated that 60 to 70 percent of them could be discharged if there were adequate mental health services and housing alternatives in the community.⁹² A psychiatrist who has been working at Moyano for 25 years stated:

*There are no half-way houses, there is no place [the women] can go. Law 448 is not enforced. [The women] would need to have a subsidy to rent a room in a hotel or a small apartment.*⁹³

The lengths of hospitalization in the city of Buenos Aires range from three months to 66 years. Of the 2,424 persons institutionalized in August 2005, almost 10 percent had been institutionalized longer than 25 years; more than 25 percent between 10 and 25 years. The average institutionalization was nine years.⁹⁴ During the first six months of 2007, the average number of persons institutionalized in the public system was approximately 2,460.⁹⁵ Disaggregated by hospital, the average lengths of stay are:

Hospital	Average length of hospitalization
Torcuato de Alvear Emergency Hospital	1 month, 3 weeks
Borda Hospital	10.5 years
Moyano Hospital	9 years, 3 months

Tobar García Hospital	4 months, 3 weeks
-----------------------	-------------------

One woman's story illustrates the urgent need for housing alternatives in the community:

I have been hospitalized here for four years, since 2001. They hospitalized me because I heard voices. [My family] threw me out of the house because they didn't want to take care of me. I went to look for my grandmother. When I got to Buenos Aires I got lost

91 Interview with psychiatrist, Moyano Hospital, city of Buenos Aires (June 6, 2004).

92 *Id.*

93 Interview with psychiatrist in the Night Hospital, Moyano Hospital, city of Buenos Aires (Jan. 23, 2006).

94 This takes into account the period of time from the start of the last period of hospitalization; it does not reflect

the sum of lengths of different hospitalizations. In Barraco, Ángel, *Desmanicomialización: los límites de la ley*

[*Deinstitutionalization: the limits of the law*], Revista Topía, No. 45, Nov. 2005.

95 Interview with Dr. Carlos de Lajonquiere, General Director of Mental Health, Ministry of Health of the city of

Buenos Aires (July 18, 2007).

looking for her house. The police found me in the street. I was hearing voices and I had just started menstruating and I was all bloody and delirious. The police called my house and my mother said that it had been four years since they had seen me and they didn't want to have anything else to do with me. When I entered [the hospital] I was in the admissions unit for 15 days and then they hospitalized me in [the ward] Bosch I. It's a ward that has a little bit of everything. . . . I don't have anywhere to go. I have had a medical discharge for two years. I work in the protected workshops. I want to study now that I don't hear voices. I want to study to be a technical assistant in odontology.

In 2006, the city of Buenos Aires initiated the *Programa de Externación Asistida para la Integración Social* (PREASIS—Program on Assisted Discharge for Social Integration) to help reintegrate persons formerly institutionalized into the community.⁹⁷ By July 2007, this program had opened two half-way houses for women who had been discharged from Moyano Hospital within the *Dirección General del Sistema de Atención Inmediata del Ministerio de Derechos Humanos y Sociales* (General Direction of the Immediate Attention System of the Ministry of Human and Social Rights).⁹⁸ Both houses accommodate up to eight people. The creation of a third house for men is planned before the end of 2007.

At Estevez Hospital, investigators interviewed women who appeared able to live in the community, yet had been institutionalized for many years. In Ward 1, deemed by administrators to be a “mid-term” ward—with average stays between three and six months—investigators interviewed several women who had been hospitalized much longer:

*I've been here nine months. There are people who've been in this ward for 11 years.*⁹⁹

Another woman reported:

*My family abandoned me here eight years ago when my mother died. They don't visit me, don't send me anything. I don't know if they sold my house. I want to leave this place. I've lived in Ward 1 for eight years. . . . There's an old woman who's been here for about 40 years; she's about 90. There are at least ten women who've been in this ward for many years; they're left over from the past, when this wasn't a mid-term ward.*¹⁰⁰

96 Interview with a woman hospitalized in Moyano Hospital, city of Buenos Aires (Jan. 23, 2006).

97 See http://www.buenosaires.gov.ar/areas/des_social/atencion_inmediata/preasis.php?menu_id=19122.

98 The legislative backing for the creation of the half-way houses comes from Law 448, *supra* note 60, Chapter III, Mental Health System, article 15° [Rehabilitation and reintegration]: Those persons who at the moment of discharge do not have a stable family, will be housed in establishments that will be made available by the area of Social Promotion. [Translation ours].

99 Interview with a woman hospitalized in Ward 1, Estevez Hospital, province of Buenos Aires (June 1, 2004).

100 Interview with a woman hospitalized in Ward 1, Estevez Hospital, province of Buenos Aires (June 1, 2004).

The vast majority of women at Estevez Hospital remain hospitalized for many years. In October 2006, of the hospital's 1,020 beds, more than 800 were located in the

“asylum” sector of the hospital. Once there, women typically remain for life.¹⁰¹ The hospital, however, is involved in a program to help reintegrate these women into the community. The *Programa de Rehabilitación y Externación Asistida* (PREA—Program on Rehabilitation and Assisted Discharge), operating under the Ministry of Health of the province of Buenos Aires, helps women integrate into a collective environment in houses in the community and assisting them in learning or re-learning essential life skills. As told by one of the PREA participants:

*I've been hospitalized here for three years. I'm now in the PREA program; there are only six of us in the program at the hospital. I've been in PREA since January 1, 2003. They spend a year or so teaching you how to deal with money, with living outside [the hospital]. I'm going to live with three other women. We don't know yet when we're moving out.*¹⁰²

According to Estevez Hospital staff, at the time of investigators' June 2004 visit, there were 45 women living in houses in the community as part of the PREA program.¹⁰³ In October 2006, the number of persons discharged living in these communal residences had increased to 50.¹⁰⁴

At Tobar Garcia Hospital, 70 to 80 percent of the children and adolescents receiving treatment at the hospital come from outside the city of Buenos Aires.¹⁰⁵ There are no mental health services specific to children and adolescents outside the city limits, and there is no infrastructure to provide follow-up on an outpatient basis. Tobar Garcia Hospital's Director, Dr. Roberto A. Yunes, reported, “The province of Buenos Aires has absolutely nothing” in terms of mental health services for young people.¹⁰⁶

The lack of services for children in their local communities contributes to the difficulty in discharging them, and complicates rehabilitative treatment exponentially.¹⁰⁷ Dr. Yunes added that the economic crisis has further complicated the problem: “people don't have money for food, don't have money for transportation, much less for psychiatric attention. . . . It takes one to two hours to get to Tobar [Garcia from the province of Buenos Aires].”¹⁰⁸ Once children are discharged,

101 Interview with members of PREA, city of Buenos Aires (Oct. 20, 2006).

102 Interview with a woman hospitalized in Ward 1, Estevez Hospital, province of Buenos Aires (June 1, 2004).

103 Interview with Dr. Patricia Esmerado, then Associate Director, Jose Estevez Interzonal Hospital (June 1, 2004).

104 Interview with members of PREA, city of Buenos Aires (Oct. 20, 2006).

105 Interview with Dr. Roberto A. Yunes, Director, Tobar Garcia Hospital, city of Buenos Aires (Jan. 24, 2006).

106 *Id.*

107 *Id.*

108 *Id.*

often their families do not have the resources that would allow them to continue a recommended course of treatment.

At Borda Hospital, staff complained about the lack of services for the persons discharged. According to one staff member in Ward 14.22,

*The problem is that the patient in condition for discharge doesn't have a path for reintegration into the community where he can recuperate. Where will they go? Who's going to give them work? It's discrimination. They say that if they're from 14.22, worse yet. There would have to be a space for rehabilitation. When [Penal] Unit 20 is full, they're sent here. There's a lack of follow-up, without this, nothing can move.*¹⁰⁹

At *Colonia Montes de Oca*, 85 percent of the nearly 1,000 persons institutionalized have intellectual disabilities.¹¹⁰ As with persons diagnosed with mental illness, once admitted, persons with intellectual disabilities generally remain institutionalized for life. In the aggregate setting of the institution, people lose any skills or independence they may have had. During investigators' visits to *Colonia Montes de Oca* in 2004, there were practically no community-based services in the area to support people with intellectual disabilities, thus all but guaranteeing a lifetime of institutionalization.

Beginning in 2005, however, proactive steps have been taken toward the creation of community-based health services for people with intellectual disabilities. In September 2006, Jorge Rossetto, Director of *Colonia Montes de Oca*, informed investigators that the institution had begun a day treatment program in a nearby town. The program accommodates 30 people considered to have the greatest disabilities. He noted that these individuals were making tremendous progress with the more individualized attention they received from the program. By July 2007, five day hospitals—one in the nearby town of Torres—and a hostel had been created. A second half-way house was projected by the end of 2007. Between 2004 and 2007 the census at *Colonia Montes de Oca* decreased from 961 to 864.¹¹¹

The lack of community mental health services also impacts individuals with intellectual disabilities. Generally, neither those hospitalized nor persons with intellectual disabilities who remain in the community receive the necessary attention that would allow them greater independence. Members of the nongovernmental organization *Red por los Derechos de las Personas con Discapacidad* (REDI—Network for the Rights of Persons with Disability) informed investigators that, despite the fact that the right to health is recognized in Argentina, this right

109 Interview with staff at Ward 14.22, Borda Hospital, city of Buenos Aires (Jan. 25, 2006).

110 Interview with Jorge Rossetto, Director, *Colonia Montes de Oca*, province of Buenos Aires (June 3, 2004 and July 17, 2007).

111 Interview with Jorge Rossetto, Director, *Colonia Montes de Oca*, province of Buenos Aires (Sept. 27, 2006 and July 17, 2007).

is largely unfulfilled for people with intellectual disabilities.¹¹² There are no early intervention programs in public hospitals, and children with intellectual disabilities do not receive adequate habilitative therapies at an early age. In general, professionals are not educated in diagnosing intellectual disabilities, and most universities do not have faculty trained to address the needs of children with intellectual disabilities.¹¹³ Without early intervention programs and other specialized supports available in the community, the chances that children with intellectual disabilities will become participating members of society are vastly diminished.

The right to community integration B.

Throughout the world, there is a growing consensus that the overwhelming majority of people with mental disabilities—including both people with psychiatric and intellectual disabilities— can live in the community with appropriate services and support systems.¹¹⁴ The United Nations' Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur on the Right to Health) Paul Hunt has observed that:

As a result of increased knowledge about mental disabilities and new models of community-based services and support systems, many people with mental disabilities, once relegated to living in closed institutions, have demonstrated that they can live full and meaningful lives in the community. People once thought incapable of making decisions for themselves have shattered stereotypes by showing that they are capable of living independently if provided with appropriate legal protections and supportive services. Moreover, many people once thought permanently or inherently limited by a diagnosis of major mental illness have demonstrated that full recovery is possible.¹¹⁵

These ideas have taken hold in the Americas and have been endorsed by the Pan American Health Organization (PAHO). In 1990, PAHO organized a regional conference on restructuring psychiatric care in Latin America, which brought together legislators, health authorities, mental health professionals, jurists, and non-governmental activists. That conference adopted the Declaration of Caracas, which called on all governments to restructure mental health care to

112 Interview with Maria Cristina Prado and Ana Maria Dones, members of Network for the Rights of Persons with Disability (REDI) (May 31, 2004).

113 *Id.* e.g., the University of Buenos Aires does train professionals for these cases.

114 WHO, World Health Report 89-91 (2001).

115 *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, U.N. Commission on Human Rights, 61st Sess., Agenda Item 10, U.N. Doc. E/CN.4/2005/51 (2005) [hereinafter *Report of the Special Rapporteur*], para. 15.

promote “alternative service models that are community-based and integrated into social and health networks.”¹¹⁶ The Declaration found that:

[T]he mental hospital, when it is the only form of psychiatric care provided, hampers fulfillment of the forgoing objectives in that it: isolates patients from their natural environment, thus generating greater social (a)

disability; creates unfavorable conditions that imperil the human and civil rights of patients; (b)
(c) absorbs the bulk of financial and human resources allotted by the countries for mental health care; and
fails to provide professional training that is adequately geared to the mental health (d) needs of the population, the general health services, and other sectors.¹¹⁷

Over the last few decades, not only has community mental health come to be regarded as good mental health practice, but the right of persons with disabilities to community integration has been identified as a basic human right, and the denial of this right has been recognized as discrimination.

As early as 1971, the UN adopted the Declaration on the Rights of Mentally Retarded Persons to promote the integration of people with intellectual disabilities “as far as possible” in community life.¹¹⁸ In 1991, the UN General Assembly stated that “[e]very person with a mental illness shall have the right to live and work, as far as possible, in the community.”¹¹⁹ The very purpose of the Inter-American Disability Convention, which entered into force in 2001, is to promote the full integration into society of persons with disabilities.¹²⁰ The Montreal Declaration on Intellectual Disability, adopted in 2004, states that “[f]or persons with intellectual disabilities, as for other persons, the exercise of the right to health requires full social integration. . . .”¹²¹ Most recently, the CRPD, adopted by the UN General Assembly in December 2006, mandates that States party take “effective and appropriate measures” to promote the “full inclusion and participation in the community” of persons with disabilities.¹²²

116 *Declaration of Caracas*, *supra* note 30, art. 1.

117 *Id.* introductory note 2.

118 *Declaration on the Rights of Mentally Retarded Persons*, G.A. Res. 2856 (XXVI), 26 U.N. GAOR, Supp. No. 29 at 99, U.N. Doc. A/8429 (1971).

119 *MI Principles*, *supra* note 28, principle 3.

120 Inter-American Convention on Disability, *supra* note 26, art. II.

121 *Montreal Declaration*, *supra* note 31, para. 4.

122 CRPD, *supra* note 27, art. 19.

The Inter-American Disability Convention defines discrimination against people with disabilities as “any distinction, restriction, or exclusion based on disability . . . which has the effect or objective of impairing or nullifying the recognition, enjoyment, or exercise by a person with a disability of his or her human rights and fundamental freedoms.”¹²³ In order to achieve the Convention’s objectives of eradicating discrimination against persons with disabilities and promoting their complete integration into society,¹²⁴ the States party commit to collaborating in developing “the means and resources to facilitate or promote the independence, self-sufficiency, and total integration into society of persons with disabilities, under conditions of equality.”¹²⁵

The CRPD mandates that States party take “effective and appropriate measures” to promote the “full inclusion and participation in the community” of persons with disabilities, including guaranteeing that:

- .(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- .(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- .(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.¹²⁶

In General Comment 5, the UN Committee on Economic, Social, and Cultural Rights recommends that to protect against discrimination, States should adopt policies and legislation that “enable persons with disabilities to live an integrated, self-determined and independent life.”¹²⁷ Quoting the World Programme of Action concerning Disabled Persons, General Comment 5 establishes that:

Anti-discrimination measures should be based on the principle of equal rights for

persons with disabilities and the non-disabled, which implies that the needs of each and every individual are of equal importance, that these needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure, for every individual, equal opportunity for participation. Disability policies should ensure the access of [persons with disabilities] to all community services.¹²⁸

123 Inter-American Convention on Disability, *supra* note 26, art. I.2.a).

124 *Id.* art. II.

125 *Id.* art. IV.2.b).

126 CRPD, *supra* note 27, art. 19.

127 Committee on Economic, Social and Cultural Rights, *General Comment No. 5, Persons with disabilities*, 11th Sess., Supp. No. 2, U.N. Doc E/C.12/1994/13 (1994) [hereinafter *General Comment No. 5*], para. 16.

128 *Id.* para. 17.

The Special Rapporteur on the Right to Health has recognized that, “Decisions to isolate or segregate persons with mental disabilities, including through unnecessary institutionalization, are inherently discriminatory and contrary to the right of community integration enshrined in international standards.”¹²⁹ To avoid such discrimination, “[s]tates should take steps to ensure a full package of community-based mental health care and support services conducive to health, dignity, and inclusion.”¹³⁰

C. A lost opportunity

Recently, the city of Buenos Aires government may have lost an opportunity to stem the tide of discrimination and invest in the creation of community-based mental health services.

During a period of transition to community-based services, significant additional funding will be needed to maintain existing services while the necessary community supports and services are created. Dr. Ricardo Soriano, Director of Mental Health for the city of Buenos Aires, informed investigators that the Inter-American Development Bank (IDB) was furnishing the city government with a loan of more than 40 million pesos (US\$14 million) to renovate and equip the four large mental health hospitals in the city. This loan, however, allotted no money for the creation of community-based services.¹³¹ The amount of the IDB loan, at the time of its approval in 2004, was equivalent to 60 percent of the entire mental health budget of the city for one year (approximately 68 million pesos or US\$22.7 million).¹³²

129 *Report of the Special Rapporteur, supra* note 115, para. 54.

130 *Id.* para. 43. UN Special Rapporteur on the Right to Health, Paul Hunt, describes the “full package” of community-based mental health services as “including medication, psychotherapy, ambulatory services, hospital care for acute admissions, residential facilities, rehabilitation for persons with psychiatric disabilities, programmes to maximize the independence and skills of persons with intellectual disabilities, supported housing and employment, income support, inclusive and appropriate education for children with intellectual disabilities, and respite care for families looking after a person with a mental disability 24 hours a day. In this way, unnecessary institutionalization can be avoided.” *Id.* “Persons with intellectual disabilities often require specialized support services which are tailored to their individual needs. This might include habilitation, speech pathology, occupational therapy, physiotherapy, and behavioral therapy.... Support is also essential for the families of persons with severe intellectual disabilities, given the acute demands that care and support can place on them. For some individuals with intellectual disabilities and their families, a good environment may include access to a small, open community house with a stable staff and specialized support services.” *Id.* para. 81.

131 Interview with Dr. Ricardo Soriano, Director of Mental Health, City of Buenos Aires (June 2, 2004). Dr. Soriano gave the example of Borda Hospital, with 1,000 beds, saying that the loan would pay for restructuring the hospital. Under Borda’s new structure, he explained, there would be 350 beds for ninety-day maximum stays; 270 beds for older adults (60 and older); 200 beds for hospitalizations longer than 90 days; 90 beds for rehabilitation and social reinsertion; and 180 beds as a protected residence for chronic patients who do not have anywhere to live and who work in the hospital.

132 *Id.*

III. Conditions and abuses in institutions

Over the course of the research for this report, investigators documented a range of inadequate conditions of detention and abuses of people with mental disabilities in psychiatric institutions in Argentina. These abuses violate the rights to life, personal integrity, liberty, health and rehabilitation.

Deaths in institutions A.

During the December 2004 visit to Cabred Hospital, hospital administrators told investigators that death rates were four times higher in the winter months than in the summer. Cabred Hospital’s director, Dr. Leo Zavattaro, said that, on average, 70 people institutionalized there died each year.¹³³ Dr. Zavattaro claimed that 99 percent of the deaths were due to old age, with other causes being heart attacks and sudden deaths among the young men.¹³⁴ However, on average, during the winter, approximately two people died per week, while during the summer one person died every two weeks.¹³⁵ These statistics suggest that wintertime deaths may not be due primarily to “old age” but rather to insufficient heating, or contagious diseases spread in colder environments. Dr. Zavattaro

informed investigators that autopsies are not generally performed for these deaths.¹³⁶ During investigators' follow-up visit in July 2007, Dr. Zavattaro told investigators that the number of deaths had fallen, although he could not say by how much.¹³⁷

Also at Cabred, according to news reports, three people were found dead in and around the hospital during the first six months of 2005.¹³⁸ The first body was found in the woods surrounding the hospital on January 25, 2005, and the second body was found in a field on the hospital grounds on February 15, 2005.¹³⁹ The third body was discovered in an abandoned warehouse on the hospital grounds, dressed in pajamas and barefoot, as reported in *La Nación* online on June 15, 2005.¹⁴⁰ In

133 Interview with Dr. Leo Zavattaro, Director, Cabred Hospital, province of Buenos Aires (Dec. 11, 2004).

134 *Id.*

135 *Id.*

136 *Id.*

137 Interview with Dr. Leo Zavattaro, Director, Cabred Hospital, province of Buenos Aires (July 25, 2007).

138 "Encuentran un cadáver en un neuropsiquiátrico de Open Door: El cuerpo fue hallado en un galpón abandonado de la Colonia Cabred; es el tercer caso de este tipo en lo que va del año," ["Cadaver found at the Neuro-Psychiatric Hospital Open Door; it is the third case of this type so far this year"] *La Nación* Line, June 15, 2005, at <http://www.lanacion.com.ar/713116>.

139 *Id.*

140 *Id.*

this case, the police determined that the individual had died five to ten days before the discovery of the body.¹⁴¹

In 2005, Cabred Hospital administrators reported that judicial investigations were being carried out in relation to these suspicious deaths. Yet during investigators' visit to the institution more than two years later, in July 2007, Dr. Zavattaro told investigators that he did not know the outcome of the judicial investigations and that no administrative indictments had been undertaken by the institution.¹⁴²

In 2004, then Interim Director of Diego Alcorta Hospital, Dr. Abraham Stoliar, informed investigators that in the previous five years, four people detained in isolation cells had died.¹⁴³ Hospital staff told investigators that in 2000, an individual—who had no mental illness but was sent to the institution by a judge as a form of punishment—burned to death in an isolation cell after setting fire to a mattress.¹⁴⁴ Eight months later, a second

individual who was sent to the hospital for drug addiction problems burned to death in an isolation cell.¹⁴⁵ In 2001, a third person, who, according to hospital staff was agitated, was placed in an isolation cell and later found dead; the cause of this death was never clarified.¹⁴⁶ In 2003, a fourth individual burned to death in an isolation cell.¹⁴⁷ None of these deaths has been fully investigated, and no individual in a position of authority has assumed responsibility or been attributed liability for the suspicious circumstances of these four deaths.¹⁴⁸

At Moyano Hospital, administrators and staff reported that in 1991, within a span of one-and-a-half months, 32 women institutionalized died of malnutrition. In 1991-1992—during a government intervention in the hospital—an investigation was initiated into these deaths, yet investigators confirmed that no one was held accountable, and the administrators that had directed Moyano Hospital before the intervention returned to the directorship when the intervention ended in 1992.¹⁴⁹

141 *Id.*

142 Interview with Dr. Leo Zavattaro, Director, Cabred Hospital, province of Buenos Aires (July 25, 2007).

143 Interview with Dr. Abraham Stoliar, then Interim Director, Diego Alcorta Hospital, province of Santiago del Estero (Dec. 6, 2004).

144 *Id.*

145 *Id.*

146 *Id.*

147 *Id.*

148 *Id.*

149 Interview with administrators and staff, Moyano Hospital, city of Buenos Aires (Jan. 23, 2006).

These deaths suggest a disturbing pattern of abuse, neglect, and lack of accountability. Individuals who are in state custody—theoretically for their health and safety—are not receiving the personalized care and protection that they should. The failure to investigate and document the causes of deaths in these cases makes it impossible for the institutions to take measures that would prevent these kinds of deaths in the future.

Under the American Convention, the failure to protect against deaths of this kind violates the right to life.¹⁵⁰ The Inter-American Court on Human Rights (the Inter-American Court) has interpreted the right to life broadly, recognizing a State's duty not only to refrain from arbitrarily depriving an individual of life, but also to take affirmative measures to

guarantee life and life opportunities. The Inter-American Court has determined that, while in State custody, the State is the “guarantor” of the right to life.¹⁵¹

B. Dangerous use of isolation cells

An additional problem investigators documented is the improper and prolonged use of isolation cells without adequate staff monitoring, which represents significant risks to the rights to life and humane treatment of those so detained.¹⁵²

In Penal Unit 20—during visits in 2004, 2005, and 2006—investigators documented the use of tiny, barren, and very hot isolation cells. Investigators found persons locked naked in these isolation cells, which measured approximately by one-and-a-half by two meters.¹⁵³ During the

150 The right to life has been recognized as one of the most fundamental of all human rights, and “the supreme right from which no derogation is permitted even in time of public emergency which threatens the life of the nation.” Human Rights Committee, *General Comment No. 6, The right to life Article 6*, 16th Sess., 1982, U.N. Doc. HRI/ GEN/1/Rev.1 at 6 (1994) para. 1. The right to life is guaranteed in article 4 of the American Convention (“every person has the right to have his life respected”) and article 6 of the ICCPR (“every human being has the inherent right to life”), among other international instruments.

151 *See, e.g.,* Inter-Am. Ct. H.R., *Neira Alegría et al. Case*, Judgment of Jan. 19, 1995 (Ser. C) No 20, para. 60. The Inter-American Court has ruled that the State has a “heightened responsibility” to ensure the right to life of those in detention. The State’s failure to protect the lives of those in state custody and to conduct full, independent investigations of reported deaths sends a signal to institutional authorities that they will not be held accountable for the lives of those institutionalized. Without full investigations, it is difficult to formulate effective measures to protect against future avoidable deaths. In the words of the Inter-American Court:

. . . the State, being responsible for detention centers, is the guarantor of these rights of the detainees, which involves, among other things, the obligation to explain what happens to persons who are under its custody. State authorities exercise total control over persons under their custody. The way a detainee is treated must be subject to the closest scrutiny, taking into account the detainee’s vulnerability. . . .

Inter-Am. Ct. H.R., *Walter Bulacio Case*, Judgment of Sept. 18, 2003, para. 126.

152 This risk is evident from the information documented at Diego Alcorta Hospital, where, within a three-year period, four individuals died while detained in isolation cells: three burned to death and the fourth died of unknown causes. See discussion of “Deaths in institutions” § III. A.

153 Observations during visit to Penal Unit 20, city of Buenos Aires (June 4 and Dec. 10, 2004; June 29, 2005;

June 2004 visit, staff reported that these persons had been locked inside these cells for periods ranging from ten days to more than one year; one man told investigators that he had been locked in an isolation cell since November 2003.¹⁵⁴ Another man had been detained in isolation for the previous three months as the result of a suicide attempt.¹⁵⁵

These cells possessed neither running water nor toilets.¹⁵⁶ Detainees were given plastic jugs in which to urinate in lieu of regular access to bathrooms.¹⁵⁷ Staff asserted that detainees were unclothed to “prevent suicide” and that this isolated detention was used “for observation.”¹⁵⁸ These isolation cells were devoid of natural light, had no ventilation, and “observation” would have been possible only through a tiny hole in the door.¹⁵⁹ There was no staff stationed in the area of the isolation cells, making regular observation impossible.¹⁶⁰ Staff justified this isolated detention as “necessary” for assessing the status of new detainees prior to placing them in a communal cell with others.¹⁶¹ In fact, the staff’s inability to observe conditions in the cells rendered it impossible for them to conduct the close assessment necessary to determine what measures were appropriate to protect others. As a result of a number of follow-up actions investigators undertook, the use of these isolation cells in Penal Unit 20 is being reformed.¹⁶²

In Penal Unit 27, investigators also observed a troublesome use of isolation cells. According to staff, cells were used, at maximum, for two days. Nevertheless, during a visit in 2004, investigators observed two women in isolation cells, one of whom had been detained in isolation for over a year by judicial order because she was considered a danger to herself and others. The other woman had been detained in isolation for a year-and-a-half due to her difficulties relating to others.¹⁶³

Aug. 29, 2006).

154 Interviews with staff at Penal Unit 20, city of Buenos Aires (June 4, 2004).

155 *Id.*

156 Observations during visit to Penal Unit 20, city of Buenos Aires (June 4 and Dec. 10, 2004; June 29, 2005;

Aug. 29, 2006).

157 *Id.*

158 Interviews with staff at Penal Unit 20, city of Buenos Aires (June 4, 2004).

159 Investigators’ observations during visit to Penal Unit 20, city of Buenos Aires (June 4 and Dec. 10, 2004; June

29, 2005; Aug. 29, 2006).

160 *Id.*

161 Interviews with staff at Penal Unit 20, city of Buenos Aires (June 4, 2004).

162 Among these activities were: meetings with authorities from the Ministry of Justice and Human Rights, a

letter to the Ministry enumerating the grave violations observed, the publication of information about the situation in

the press, and repeated visits to the Unit between 2004 and 2006.

163 Investigators' observations during visit to Psychiatric Penal Unit 27, city of Buenos Aires (June 4, 2004).

At *Colonia Montes de Oca*, also in 2004, staff informed investigators that people were detained in isolation cells for several days at a time.¹⁶⁴ A number of psychiatrists at the institution defended the use of isolation cells, and stated that sometimes the cells were used because there was insufficient staff.¹⁶⁵ Investigators were able to corroborate the insufficient staffing; in several wards 80 to 100 persons were institutionalized with only one or two staff on duty.¹⁶⁶ Upon a return visit in July 2007, investigators found that the isolation cells had been dismantled.¹⁶⁷

The inappropriate and prolonged use of isolation cells without sufficient staff monitoring constitute violations of the right for all persons to be free from “cruel, inhuman or degrading treatment.”¹⁶⁸

Long term isolation and sensory deprivation—the total or partial restriction of stimuli on one or more of the senses—can exacerbate psychiatric symptoms or induce severe psychiatric harm, including intense agitation, anxiety, paranoia, panic attacks, depression, disorganized thoughts, and antisocial personality disorder. The harm caused by isolation and sensory deprivation “may result in prolonged or permanent psychiatric disability, including impairments which may seriously reduce [one’s] capacity to reintegrate into the broader community upon release. . . .”¹⁶⁹ Furthermore, seclusion and restraint should never be used as a form of discipline or coercion, for staff convenience, or as a substitute for adequate staffing or active treatment.¹⁷⁰

164 Interview with staff at *Colonia Montes de Oca*, province of Buenos Aires (June 3, 2004).

165 *Id.*

166 Observations from visit to *Colonia* Montes de Oca, province of Buenos Aires (June 3, 2004). In September 2006, in an interview with Jorge Rossetto, he reported that the *Colonia* is abolishing the isolation cells. Interview with Jorge Rossetto, Director, *Colonia* Montes de Oca, city of Buenos Aires (Sept. 27, 2006).

167 Observations from visits to *Colonia* Montes de Oca, province of Buenos Aires (June 3, 2004, and July 17, 2007).

168 American Convention, *supra* note 23, art. 5(2). The Inter-American Court has found violations of the right to be free from “cruel, inhuman or degrading treatment” where an individual is isolated “in a tiny cell with no natural light.” Inter-Am. Ct. H.R., *Loayza Tomayo Case*, Judgment of Sept. 17, 1997 (Ser. C) No. 33, para. 58. The MI Principles state that physical restraint or involuntary seclusion shall be used solely “when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period strictly necessary for this purpose.” *MI Principles*, *supra* note 28, principle 11(11).

169 Stuart Grassian, M.D., “Psychiatric Effects of Solitary Confinement,” at http://www.prisoncommission.org/statements/grassian_stuart_long.pdf, p. 13. *See also*, S Grassian, N Friedman, “Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement,” *International Journal of Law and Psychiatry*, 8, 49-65 (1986); Wanda K. Mohr, et al., *Adverse Effects Associated with Physical Restraint*, 48 *CAN. J. PSYCHIATRY* 5 (2003). For a reference on guidelines on the use of seclusion and restraint, see, WHO, *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*, at vi, WHO/MNH/MND/95.4 (1996) pp. 26-27. *See also* National Association of State Mental Health Program Directors, *Position Statement on Seclusion and Restraint*, (visited Oct. 19, 2005) at http://www.nasmhpd.org/general_files/position_statement/posses1.htm.

170 National Association of State Mental Health Program Directors, *Position Statement on Seclusion and Restraint*, (visited Oct. 19, 2005) at http://www.nasmhpd.org/general_files/position_statement/posses1.htm. “Active

The MI Principles require that all instances of seclusion and restraint be documented in a patient’s medical record, along with the reasons for, nature, and extent of usage.¹⁷¹ Such detailed documentation allows for the monitoring of the use of seclusion and restraint, and the implementation of essential safeguards. Argentina has no legislation that addresses the topics of seclusion and restraint, and during the research for this report investigators found no evidence of the use of uniform standards to govern the use of seclusion and restraint.¹⁷²

C. Physical and sexual violence

During visits to Penal Unit 20, detainees reported incidents of physical and sexual abuse, including rapes, beatings, and other forms of physical violence. Two detainees reported having been raped while they were in the admission cell block.¹⁷³ One of these detainees also reported that guards had forced him to parade in women’s lingerie and act effeminate for them.¹⁷⁴ During the June 2004 visit, investigators observed large bruises covering vast areas of the backs and torsos of several of the detainees.¹⁷⁵ These men

reported that they had been beaten by staff.¹⁷⁶ A number of detainees specified that guards had forced them to sit under showers of freezing water, while the guards beat them with nightsticks or other blunt instruments.¹⁷⁷ One man with stitches in his head reported that he had been clubbed by a guard.¹⁷⁸

treatment” as a concept in mental health care refers to:

an aggressive and organized effort to maximize each client’s fullest developmental potential. It requires an integrated, individually tailored plan of services directed to achieving measurable, behaviorally stated objectives. It requires an environment approximating everyday life in mainstream society. The goal is the development of those skills, behaviors, and attitudes essential to independent living in contemporary society. . . .

M. True, *Introduction to Active Treatment* (2005), at <http://www.ilresources.com/ACTreat1NR.htm>.

[hereinafter

True].

171 *MI Principles*, *supra* note 28, principle 11(11).

172 *See* KRAUT, *supra* note 69, at 356.

173 Interviews with detainees at Penal Unit 20, city of Buenos Aires (June 4, 2004).

174 *Id.*

175 Investigators’ observations during visit to Penal Unit 20, city of Buenos Aires (June 4, 2004).

176 Interviews with detainees at Penal Unit 20, city of Buenos Aires (June 4, 2004).

177

Id.

178

Id.

At Moyano Hospital, investigators received reports of sexual abuse of the women institutionalized allegedly perpetrated by hospital staff. One woman told investigators:

This is what happened to me in 2002, when I was offered work in the kitchen. I was

*told that I would be a helper in the kitchen, and that they would pay me for holidays and weekends. I went to collect my pay from the hospital “cooperadora.” I didn’t have money to buy soap, sanitary napkins, toilet paper, or shampoo or anything and it seemed good to begin working. The first week, everything was fine. The second week also. The third week my supervisor closed the door when I tried to leave and said, “Now we’re going to have sex.” I said no, how are we going to have sex if we haven’t agreed to it beforehand? He said that if we didn’t have sex they weren’t going to continue giving me work. This happened between 2002 and 2003. In 2003, I registered a complaint. It was an improper use of my body. I didn’t understand why I had to have sex with them if I was paid by the “cooperadora.” He also made me have sex with his brother, and another brother who worked in maintenance in the ward. Then they brought in another man from outside [the hospital]. They raped me between the four of them.*¹⁷⁹

In December 2005, there was a government intervention in Moyano Hospital after complaints of serious human rights violations against the women hospitalized there. These complaints included allegations of staff forcing some women into prostitution, drug trials on the women without their informed consent, rape presumably committed by hospital staff, and women dying of malnutrition.

These complaints are currently under judicial investigation. When interviewed in July 2007, the General Director of Mental Health of the city of Buenos Aires did not know the status of these investigations.¹⁸⁰

Dr. Luis Osvaldo Mazzarella, a member of Moyano Hospital’s interim directorship of 2005, told investigators that he had received a complaint of sexual abuse from a woman institutionalized there. Dr. Mazzarella said that the woman had been raped by two staff members.¹⁸¹ The staff denied this, and fabricated a story that the rape had been the result of a fight between two women. Dr. Mazzarella told investigators that the woman who had been raped was then transferred to Psychiatric Penal Unit 27 to “shut her up.”¹⁸² Eventually she was transferred back into the Hospital, but continued to receive threats of reprisals.¹⁸³

179 Interview with woman hospitalized at Moyano Hospital, city of Buenos Aires (Jan. 23, 2006).

180 Interview with Dr. Carlos de Lajonquiere, Director General of Mental Health, Ministry of Health of the city of Buenos Aires (July 18, 2007).

181 Interview with Dr. Luis Osvaldo Mazzarella, Interim Director of Moyano Hospital, city of Buenos Aires (Jan. 23, 2006).

182 *Id.*

183 *Id.*

Several newspaper articles and television stations reported allegations of prostitution of women institutionalized in Moyano Hospital by staff.¹⁸⁴ Investigators were

not able to document first hand accounts of such abuse. One woman said that she knew of others who had been prostituted, saying, “They’re afraid to talk.”¹⁸⁵ She also remarked that some women were prostituted or prostituted themselves to staff.

*The one who drives the ambulance . . . ropes in the patients to prostitute them. He gives them money, five pesos and has sex with them. . . . I know seven women that are prostituted. One patient from the ward got pregnant by a man who works in plumbing. . . . The women that smoke, who need money to smoke, [the men] pay them five pesos for oral sex.*¹⁸⁶

At Diego Alcorta, in December 2004, investigators observed two women in the later stages of pregnancy. Upon review of their medical records, it was clear that both women had become pregnant after being committed to the hospital. In response to investigators’ questions, a male member of the support staff commented, referring to the size of one of the women’s bellies, “She drinks a lot of water.”¹⁸⁷ During investigators’ return visit in September 2006, one of the women who had been pregnant in December 2004 was recovering from a caesarean section she had undergone the day before. The Director of Diego Alcorta, Dr. Marta Mocchi, told investigators that she had ordered that the woman have a tubal ligation, “because she’s promiscuous.”¹⁸⁸

At Cabred Hospital, the Director informed investigators that three nurses had recently been transferred to other hospitals as the result of abuse. Although these employees were not dismissed, he stated that this is the first time that any action had been taken against staff, despite union opposition.¹⁸⁹ During investigators’ visit in July 2007, the Director said that there were no new complaints against the staff.¹⁹⁰ However, one man investigators interviewed said that on several occasions staff beat the men “when one of them gets upset.” He said that when this happens, staff

184 See, e.g., *Intervienen el hospital Moyano y relevan a su director* [Intervention in Moyano Hospital, Director relieved], CLARÍN.COM, Dec. 20, 2005.

185 Interview with woman hospitalized at Moyano Hospital, city of Buenos Aires (Jan. 23, 2006).

186 *Id.*

187 Investigators’ observations during visit to Diego Alcorta Hospital, province of Santiago del Estero (Dec. 7, 2004).

188 Interview with Dr. Marta Mocchi, Director, Diego Alcorta Hospital, Santiago del Estero (Sept. 29, 2006). A report denouncing this and other serious situations was sent by CELS and MDRI to the governor of the province of Santiago del Estero with a copy to the National Ministry of Health and the Sub secretary on Human Rights on December 22, 2006. To date, investigators have received no response.

189 Interview with Dr. Leo Zavattaro, Director Cabred Hospital, province of Buenos Aires (Dec. 11, 2004). It is important to note that transferring personnel from one institution to another does not imply any type of

punishment, and entails the risk that similar acts are repeated at another institution.

190 Interview with Dr. Leo Zavattaro, Director Cabred Hospital, province of Buenos Aires (July 25, 2007).

apply “knots” by choking the men with strips of cloth or rope to stop them from breathing and “calm” them. He said that eight months before investigators’ visit, a man had died of strangulation inside Cabred Hospital’s Medical Clinic as the result of a “knot” applied by a nurse with the help of other patients.¹⁹¹

The existence of physical and sexual abuse against institutionalized persons in State psychiatric institutions is undeniable, and violates the American Convention and the ICCPR, which provide that no one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment.¹⁹² Argentina does not have effective mechanisms to protect institutionalized persons, in State custody, from these abuses. As such, the State is failing in its obligation to prevent human rights violations and to investigate and punish those responsible.¹⁹³

D. Dangerous conditions

During visits to several institutions, investigators documented dangerous conditions that violate individuals’ rights to health and to humane treatment. These conditions included the lack of adequate medical care, and unsanitary and unsafe conditions of confinement.

1. Lack of medical care

The lack of medical care is a serious concern in many of the institutions investigators visited. At Penal Unit 20, Diego Alcorta, Moyano and Borda Hospitals, investigators observed large numbers of institutionalized persons with open sores, rotting or missing teeth, and even some with extremities in advanced stages of decay from gangrene.

While investigators were visiting the province of Santiago del Estero in December 2004, Digna Ledesma, a woman who had been institutionalized in Diego Alcorta Hospital for the previous 24 years, died.¹⁹⁴ Information obtained through investigators’ interviews indicated that Ms. Ledesma’s death was most probably due to extreme neglect by personnel at Diego Alcorta Hospital,

191 Interview with a man hospitalized at Cabred Hospital, Open Door, province of Buenos Aires (July 25, 2007). Investigators could not confirm this complaint with other sources.

192 American Convention, *supra* note 23, art. 5(2), ICCPR, *supra* note 24, art. 7. Governments are required to treat all persons in detention “with respect for the inherent dignity of the human person.” American Convention, *supra* note 23, art. 5(2), *MI Principles*, *supra* note 28, principle 1(2). Under the CRPD, States are

required to adopt all appropriate measures to protect persons with disabilities from “all forms of exploitation, violence and abuse. . . .” CRPD, *supra* note 27, art. 16(1). Similarly, the MI Principles provide that States have an obligation to protect persons with mental disabilities from physical or sexual abuse, degrading treatment, and other forms of exploitation. *MI Principles, supra* note 28, principle 1(3).

193 *MI Principles, supra* note 28, principle 8(2).

194 Interview with Dr. Lucia Abduljad, treating physician at Independencia Hospital, province of Santiago del Estero (Dec. 7, 2004). Ms. Ledesma’s medical records indicate her date of admission to Diego Alcorta Hospital as July 29, 1980.

as well as the discriminatory attitudes of personnel at other hospitals in the area.¹⁹⁵ According to Dr. Lucia Abduljad, the treating physician, Ms. Ledesma was admitted to Independencia Hospital on December 3, 2004, malnourished, filthy, and in critical condition.¹⁹⁶ Dr. Abduljad reported that Ms. Ledesma had arrived at the hospital without a complete clinical history, and with an infection in the femur of her left leg, a consequence of a recent operation that had not been properly treated or cleaned.¹⁹⁷ Dr. Abduljad stated that Ms. Ledesma’s leg still had sutures near her left hip from the operation and that her leg was loose in its socket.¹⁹⁸ Dr. David Yanelli, a former director of Diego Alcorta Hospital, informed investigators that Ms. Ledesma’s leg was fractured during an accident inside the hospital, and that she had waited two months for the surgery at the Regional Hospital.¹⁹⁹ Ms. Ledesma died during her transport in ambulance from Independencia Hospital to the Regional Hospital.²⁰⁰

During a visit to Moyano Hospital in January 2006, a woman institutionalized there told investigators, “Another patient was complaining about headaches but they didn’t attend to her. Then it was found out that she had a tumor, but she never received [medical] attention.”²⁰¹

Investigators also received reports of the denial of medical care at Penal Unit 20.²⁰² In June 2004, one HIV positive detainee reported he was not receiving antiretroviral medications. A doctor escorting investigators through the Unit responded, “Not all people with HIV need antiretrovirals.” This doctor did not state whether the necessary medical exams had been conducted that would determine whether or not a specific medication was indicated.²⁰³ During investigator’s June 2005 visit, a detainee reported that for four days, while he was locked in an isolation cell, staff did not provide him with his antiretroviral drugs for HIV/AIDS.²⁰⁴

195 *Id.*

196 *Id.*

197 *Id.*

198 *Id.*

199 Interview with Dr. David Yanelli, former director of Diego Alcorta Hospital, province of Santiago del Estero (Dec. 7, 2004).

200 Interview with Dr. Lucia Abduljad, treating physician at Independencia Hospital, province of Santiago del Estero (Dec. 7, 2004).

201 Interview with woman hospitalized in Moyano Hospital, city of Buenos Aires (Jan. 23, 2006).

202 Interviews at Penal Unit 20, city of Buenos Aires (June 4, 2004).

203 Interviews with staff, Penal Unit 20, city of Buenos Aires (June 2004). Depending upon the stage of the HIV infection, antiretroviral therapy may not be necessary. See WHO, *Scaling Up Antiretroviral Therapy in Resource-Limited Settings: Treatment guidelines for a public health approach* (2004), at http://www.who.int/hiv/pub/prev_care/en/arvrevision2003en.pdf.

204 Interview with detainee, Penal Unit 20, city of Buenos Aires (June 29, 2005).

The failure to provide adequate medical care violates the right to health, which is guaranteed under article 42 of Argentina's National Constitution²⁰⁵ and international treaties ratified by Argentina.²⁰⁶ Under the American Convention, the right to humane treatment entails the right to have one's "physical, mental and moral integrity" respected.²⁰⁷

The Inter-American Commission on Human Rights (Inter-American Commission) has determined that a State violates the right to physical integrity when it denies medical care to an individual in its custody.²⁰⁸

2. Unsanitary conditions

During investigators' December 2004 visit to Diego Alcorta Hospital, the infrastructure of the institution was in a state of extreme disrepair and was devoid of minimum conditions to guarantee proper hygiene. Bathrooms in the men's ward were unusable: toilets overflowed with excrement, the floors were flooded with urine, the sink handles were broken, and the showers did not work. Piles of excrement overflowed in the non-functioning toilets, and urine inundated the floors. The bathroom's stench made the atmosphere practically un-breathable. As a result,

205 CONSTITUTION OF THE REPUBLIC, *supra* note 22, chap. II, art. 42.

206 Under the ICESCR, States party to the Convention "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." ICESCR, *supra* note 25, art. 12(1). This includes the implementation of policies toward realizing equal opportunity for all to benefit from the highest achievable level of health. The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, also known as the Protocol of San Salvador, likewise provides in article 10 that everyone has the right to attain the maximum standard of "physical, mental and social well-being." Governments commit to take measures to guarantee the right to health, and specifically toward satisfying the needs of the most vulnerable populations (art. 10(2)(f)). Under the Additional Protocol, governments have an obligation to adopt measures that ensure the "full observance" of the rights guaranteed therein (art. 1). This obligation includes, where necessary, the commitment to enact domestic

legislation for the full implementation of these rights (art. 2). Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, Nov. 17, 1988, O.A.S.T.S. No. 69 (1988), 28 I.L.M. 156 (1989), *entered into force* Nov. 16, 1999 [hereinafter Protocol of San Salvador]. Argentina ratified the Protocol of San Salvador on October 23, 2003. International standards pertaining specifically to people with disabilities reinforce governments' obligations to supply health care under conditions of equity to this population. MI Principle 8(1) states that governments must provide individuals with mental disabilities health and social care suitable to their needs and in accordance with identical standards as the care received by other ill persons. *MI Principles, supra* note 28, principle 8(1). The Committee on Economic, Social and Cultural Rights, interpreting this right, has asserted that States have a "specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization" of the right to health. Argentina's economic difficulties do not excuse the government from providing services to its less privileged populations. On the contrary, a State's obligation to protect its most vulnerable populations acquires increased importance in periods of economic hardship. Committee on Economic, Social and Cultural Rights, *General Comment No. 14, The Right to the Highest Attainable Standard of Health*, 22nd Sess., U.N. Doc E/C.12/2000/4 (2000), para. 31.

207 American Convention, *supra* note 23, art. 5(1).

208 Inter-Am. Ct. H.R., *Cesti Hurtado Case*, Preliminary Objections, Judgment of Jan. 26, 1999 (Ser. C) No. 49, para. 7(6). In the case of *Victor Rosario Congo*, the Commission found that a State violates a detainee's right to physical, mental, and moral integrity by placing him in an isolation cell and denying him proper medical attention, a violation that is particularly serious where the detainee has a mental illness. IACHR, *Case 11.427, Report 63/99, Victor Rosario Congo* (Ecuador), para. 67-68 in ANNUAL REPORT OF THE INTER-AMERICAN COMMISSION ON HUMAN RIGHTS 1998, OEA/Ser.L/V/II.102, doc. 6 rev. (1999) [hereinafter *Congo*].

many individuals hospitalized in the institution preferred to use its grassy areas and walkways to defecate and urinate. Thus, the garden, patios, and areas surrounding the hospital's installations were littered with piles of human feces and reeked of urine.²⁰⁹ Days after this visit, investigators sent a letter to the province's Interim Minister of Health describing these atrocious conditions and calling for immediate action to remedy the clear health hazards implicit in such conditions.

Investigators returned to Diego Alcorta in September 2006 and found that the bathrooms had been renovated and that the hygienic conditions in the institution appeared to have improved. Nonetheless, staff disclosed that the institution had been thoroughly cleaned in preparation for the visit, and that, under normal circumstances, conditions were "never" that clean.²¹⁰ Investigators noted that the gardens of the institution still reeked of excrement and urine.²¹¹

During visits to Penal Unit 20 in 2004 and 2006, investigators observed that the Unit did not provide detainees with the minimum conditions essential for proper hygiene. In June 2004, detainees reported that they had been without water to wash or bathe for five days.²¹² Investigators observed a lack of hot water, soap, towels, and implements of personal hygiene. Investigators also observed a multitude of cockroaches crawling over the walls, door jambs, and throughout the isolation cells and communal cells.²¹³ In September 2006, investigators observed that reforms were taking place and that new communal cells were being built with bathrooms; nevertheless, many detainees remained housed in communal cells without bathrooms and they continued to have difficulty obtaining access

to basic items necessary for personal hygiene.²¹⁴

The failure to provide clean and healthy conditions to individuals in detention also violates the right to health and the right to humane treatment.²¹⁵ In addition to the rights provided by

209 Investigators' observations during visit to Diego Alcorta Hospital, province of Santiago del Estero (Dec. 6-7, 2004).

210 Interview with staff at Diego Alcorta Hospital, province of Santiago del Estero (Sept. 29, 2006).

211 Investigators' observations of Diego Alcorta Hospital, province of Santiago del Estero (Sept. 29, 2006).

212 Interviews with detainees at Penal Unit 20, city of Buenos Aires (June 4, 2004).

213 Investigators' observations of Penal Unit 20, city of Buenos Aires (June 4, 2004).

214 Investigators' observations of Penal Unit 20, city of Buenos Aires (Sept. 29, 2006).

215 The European Commission on Human Rights has stated that the detention of a person with a mental disability in "appalling conditions with no consideration being given his treatment" can constitute inhuman or degrading treatment. *Congo, supra* note 208, para. 66, n. 14 (citing European Commission of D.H., *Ashingdane vs. United Kingdom*. Application N° 8225/78 (Ser. A) No. 93, 6 E.H.R.R. 50 (1984)). In August 2004, the Inter-American Commission found the unsanitary conditions in the prison in the province of Mendoza, Argentina to jeopardize the psycho-physical safety of the detainees. The Commission granted precautionary measures in part because of the unhygienic conditions of confinement in the prison. In its recommendations to the government of Argentina, the Commission requested that the State guarantee the prisoners access to adequate conditions of health and hygiene toward preventing irreparable harm to the detainees' life and personal safety. These precautionary measures were later ratified by the Inter-American Court on Human Rights, which issued provisional measures on November 22, 2004 and that were renewed on June 18, 2005 and again on March 30, 2006. "Precautionary measures"

international human rights instruments, the Constitution of Argentina provides that prisons shall be healthy and clean, and maintained for the security and not the punishment of detainees.²¹⁶

3. Unsafe conditions

The infrastructure of many wards at Moyano Hospital was in a state of extreme disrepair at the time of investigators' 2004 and 2006 visits. The installation's precarious physical conditions presented dangers for staff and the women detained in the facility. These precarious conditions included electrical and gas safety hazards, structural failings, broken windows, and loose cables hanging from the walls and ceilings.²¹⁷ When investigators returned to the hospital in January 2006, a nurse on one of the wards reported being struck on the head with a block of masonry that fell from the ceiling. She reported that since this incident she has had epileptic seizures and has not been able to return to work.²¹⁸

According to a report by the Federal Police's Superintendent of Firemen, the buildings of Moyano Hospital presented exposed cables and did not have sufficient fire extinguishers.²¹⁹ According to the newspaper *Clarín*, "The problems of infrastructure in the hospital are of such magnitude that the city's general guardianship advisor of the Public Ministry of the City of Buenos Aires, Roberto Cabiche, requested that Aníbal Ibarra [then Mayor of Buenos Aires] close Moyano Hospital as soon as possible."²²⁰ At the time of the writing of this report, repairs to the infrastructure at Moyano Hospital had not been completed.²²¹

and "provisional measures" are instruments of the inter-American human rights system to address urgent and grave human rights violations that require immediate attention to protect against irreparable harm to persons.

Precautionary measures granted or extended by the Commission during 2004: Argentina, Mendoza Penitentiaries, in ANNUAL REPORT OF THE INTER-AMERICAN COMMISSION ON HUMAN RIGHTS, OEA/Ser.L/V/II.122, doc. 5., rev. 1 (2005), ch. III.C(1), para. 11 [hereinafter *Precautionary measures: Argentina*] and INTER-AMERICAN COURT ON HUMAN RIGHTS, Provisional Measures, "Case of the Penitentiaries in Mendoza," http://www.corteidh.or.cr/serieepdf/penitenciariamendoza_se_01.pdf).

216 CONSTITUTION OF THE REPUBLIC, *supra* note 22, chap. I, art. 18.

217 Investigators' observations of Moyano Hospital, city of Buenos Aires (June 6, 2004).

218 Interview with Leonor Iribarne, nurse on Riglos ward, Moyano Hospital (Jan. 23, 2006).

219 Vivian Urfeig, *Intervinieron el Moyano tras una polémica por falta de seguridad* [*Intervention at El Moyano after controversy over safety*], DIARIO CLARÍN, May 7, 2005.

220 Daniel Gutman, *Cortaron el gas en otros 4 pabellones del Moyano* [*Gas cut in 4 wards of El Moyano*], DIARIO CLARÍN, May 11, 2005. Dr. Cabiche was the head of the legal advisors of minors and the incapable of the city of Buenos Aires. He no longer occupies this function.

221 Interview with Dr. Carlos de Lajonquiere, Director General of Mental Health, Ministry of Health of the city of Buenos Aires (July 18, 2007).

Torcuato de Alvear Emergency Psychiatric Hospital (Alvear Hospital), in the city of Buenos Aires, also presents dangerous conditions.²²² In 2007, the legal counsel of the city's Contentious Administrative Tribunal presented a complaint ordering the city of Buenos Aires' government to renovate the Hospital, which presented serious structural, security and quality of care issues. The court upheld the right to health guaranteed by the National Constitution and various international treaties, and determined that allegations of budgetary shortfalls did not excuse human rights abuses.²²³

E. Lack of rehabilitation

At most institutions, no meaningful rehabilitation is provided to the vast majority of persons hospitalized.²²⁴ Pervasive inactivity was the most common problem investigators observed at Diego Alcorta, Borda, Moyano, Domingo Cabred, and Estevez Hospitals. At these institutions, investigators found an overwhelming number of persons lying in their beds or on the institution grounds, completely idle.²²⁵

Persons who are institutionalized are not provided with the supportive care or assistance they need to develop or relearn the personal skills needed to become independent or return to the community. In the absence of such support, people lose ties with their communities over time and become more dependent on institutions. As a result, custodial institutionalization diminishes autonomy, contributes to the chronicity of illness and increases disabilities, making it all the more difficult for these individuals to reintegrate into the community.²²⁶

222 Alvear Hospital is the only psychiatric facility in the city of Buenos Aires designated as an emergency hospital.

223 This decision is available at <http://www.diariojudicial.com/nota.asp?IDNoticia=33214>. (Opinion of June 25, 2007).

224 The Standard Rules state:

The term ‘rehabilitation’ refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.

Standard Rules, *supra* note 29, introduction, para. 23.

225 In visits to *Colonia Montes de Oca* during 2004 and 2005, there was also a lack any meaningful activity for the persons hospitalized. During the visit in July 2007, investigators noted that this had changed substantially. At this time, a large part of the persons hospitalized were involved in activities and few were lying in their beds.

226 *See, e.g.*, ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1961); CÁRDENAS *cited in* KRAUT, *supra* note 69, at 361.

The failure to provide individuals with disabilities appropriate services to ensure their integration into community life and enhance their independence violates the right to rehabilitation, guaranteed in national law and under international treaties to which Argentina has binding obligations.²²⁷ National Law 25.421 calls for the provision of mental

health services in primary care, with an aim toward the rehabilitation and social reinsertion of persons with mental illness.²²⁸ In the case of the city of Buenos Aires, the city's Constitution guarantees the right to rehabilitation as a component of the right to health,²²⁹ and Law 448 provides for the right to rehabilitation along with the right to community reinsertion.²³⁰

F. Lack of appropriate treatment and referral

Long-term hospitalization accentuates the deterioration and chronicity of mental disability, which mental health practices that are solely oriented to medicating illness often reinforce.²³¹ The Training Team for PREA has documented that psychotropic medications, which should be considered as a part of an individual's overall rehabilitation plan, are used as a "tool of discipline

227 The Convention on the Rights of the Child (CRC) states that children with disabilities have a right to "special care," including the right to rehabilitative services. Convention on the Rights of the Child, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/25 (1989) [hereinafter CRC], art. 23. Argentina ratified the CRC on Jan. 3, 1991 and with the constitutional reform of 1994, assigned the CRC constitutional hierarchy. Likewise, the Inter-American Convention on Disability sets forth the right to comprehensive rehabilitative services, including early intervention programs, treatment, education and job training to "ensure the optimal level of independence and quality of life for persons with disabilities." Inter-American Convention on Disability, *supra* note 26, art. III(2)(b). The CRPD calls on States parties to "take effective and appropriate measures, including through peer support" to provide "comprehensive habilitation and rehabilitation services and programmes" to persons with disabilities. These services should ensure that persons with disabilities achieve "maximum independence . . . and full inclusion and participation in all aspects of life." CRPD, *supra* note 27, art. 26. Other international human rights standards similarly provide for the right to rehabilitation. The Standard Rules, for example, state that governments should ensure people with disabilities access to rehabilitative services so that they "reach and sustain their optimum level of independence and functioning." Rehabilitation programs should be designed to accommodate individual needs and include an array of activities including basic skills training, counseling of persons with disabilities and their families, and training toward developing self-reliance. The Standard Rules also stipulate that "persons with disabilities and their families should be able to participate in the design and organization of rehabilitation services concerning themselves." *Standard Rules*, *supra* note 29, rule 3. The MI Principles provide that mental health facilities should take measures to enable "appropriate vocational rehabilitation," clarifying, "[t]hese measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community." *MI Principles*, *supra* note 28, principle 13(2)(d).

228 Law 25.421, *supra* note 56.

229 Constitution of the Autonomous City of Buenos Aires (1996), art. 20.

230 Law 448, *supra* note 60, art. 3(j). Law 448 goes on to mention rehabilitation and social reinsertion as two of the primary goals of the Law, *see, e.g.*, arts. 10(f) and 10(g), art. 13(a) and (c), art. 15.

231 Training Team, Program for Rehabilitation and Assisted Discharge (PREA), Ministry of Health of the

province of Buenos Aires, (work initiated in April 1999) (unpublished manuscript on file with author) [hereinafter PREA document].

and control. . . .”²³² One ex-patient described his experience, saying, “[t]hey gave me 20 pills a day in the clinic so that I would stay half dumb, so that I wouldn’t bother anyone.”²³³

In Penal Unit 20, one detainee reported that as punishment for any minor offense, such as “answering back” to staff, detainees were injected with heavy tranquilizers that left them immobilized for days.²³⁴ The seven other detainees in his cell confirmed his allegation.

Approximately one-half of the population of Penal Unit 20 was drug dependent as of 2004.²³⁵ These individuals were presumably hospitalized in the Unit to receive treatment. Staff admitted, however, that these individuals could not receive suitable treatment as the Unit did not possess the human or economic resources to administer drug treatment and rehabilitation services.²³⁶

During the June 2005 visit to the Unit, investigators reviewed records registering the diagnoses of the detainees on the ward. Forty-six of the 104 detainees whose diagnoses appeared on a spreadsheet that staff shared with investigators had a dual diagnosis of drug addiction and personality disorder. Another eight detainees had diagnoses of mild mental retardation and drug addiction. Altogether, 54 people had no diagnosis of a major psychiatric disorder, and the Unit does not provide addiction treatment for them.²³⁷ During the August 2006 visit, staff confirmed that the number of detainees with drug addiction problems continued to be high—they commented that 50 percent of detainees were drug addicted. Several staff confirmed that the Unit is still unable to provide appropriate treatment for these persons.²³⁸

Staff at Penal Unit 20 also described a lack of follow-through with regard to referrals for detainees’ alternative placement. On the same spreadsheet recording diagnosis, staff had written that more than half of the detainees (74 of 128) should not be detained in the Unit. Staff indicated that 20 of the detainees should be in a normal prison, 19 should be placed in drug addiction centers, and 35 in non-forensic psychiatric wards. Only 61 of the 128 detainees had no indication for alternative placement from the staff.²³⁹ Staff told investigators that they had written many requests for discharge of these detainees to the district judge, but most of these requests had not

232 *Id.*

233 Interview with Hugo, member of Radio Colifata, city of Buenos Aires (Jan. 23, 2006).

234 Interviews with detainees at Penal Unit 20, city of Buenos Aires (June 4, 2004).

235 Interviews with staff, Penal Unit 20, city of Buenos Aires (June 4, 2004). Fifty-six of 146 individuals

detained in Penal Unit 20 were drug dependent during investigators' December 10, 2004 visit to the facility.

236 *Id.*

237 Investigators' observations, Penal Unit 20, city of Buenos Aires (June 29, 2005).

238 Interviews with staff, Penal Unit 20, city of Buenos Aires (Aug. 29, 2006).

239 Investigators' observations, Penal Unit 20, city of Buenos Aires (June 29, 2005).

been addressed. In some cases, this lack of response was due to the lack of places to send persons leaving the Unit.²⁴⁰

Under Argentine law, the national judiciary is obligated to verify that people with mental disabilities receive adequate treatment and that their fundamental rights linked to their hospitalizations are respected. Nationally, the *Ley de Internación y Egresos en Establecimientos de Salud Mental, Ley 22.914* (Law of Hospitalization and Discharges in Mental Health Establishments, Law 22.914)²⁴¹ guarantees the right to appropriate medical treatment.²⁴² Under article 10, judges are required to verify that treatment is appropriate and that it is actually carried out.²⁴³ Article 12 requires that the Advisor for Minors and the Incapacitated verify the evolution of the detainee's health, the medical treatment provided and conditions of care.²⁴⁴

G. Overcrowding in psychiatric institutions

During investigators' visits to Penal Unit 20, the Unit was severely overcrowded. The Unit has a stated capacity of 87. In June 2004, staff reported that 158 individuals were detained on the Unit, representing an overcrowding level of more than 75 percent.²⁴⁵ By June 2005, the population of the Unit had dropped to 128, primarily due to discharges of drug addicted detainees,²⁴⁶ yet

240 Interviews with staff, Penal Unit 20, city of Buenos Aires (June 29, 2005).

241 *Ley de Internación y Egresos en Establecimientos de Salud Mental, Ley 22.914* [Law of Hospitalization and Discharges in Mental Health Establishments, Law 22.914] (1983) [hereinafter Law 22.914].

242 The authorization of Law 448 did not presume derogation in the legal regimen implemented by Decree-Law 22.914 as both laws—the first a local law, the second a federal law—are not contradictory, rather they complement each other toward the same end. Although, at the time of the local Law's regulation, 22.914 will become obsolete. Law 448 possesses framework for action that is much broader than Decree-Law 22.914, that was limited to psychiatric hospitalizations, discharges and hospital visits; functions of the legal guardians; and the responsibilities of institutions, among others. Alfredo Kraut and Diana Nicolás, *La salud mental ante la ley en la Ciudad Autónoma de Buenos Aires. ¿Permanece como un problema de*

interpretación judicial? [Mental Health in light of the law of the Autonomous City of Buenos Aires. Will the problem of legal interpretation persist?] REVISTA LEXISNEXIS, III, Pamphlet 11 (2004). International law also requires that medical and psychiatric treatment be appropriate to the individual's mental health condition. The MI Principles establish that people with mental disabilities shall be protected from all forms of abuse, including the abuse of unjustified medication. *MI Principles*, *supra* note 28, principle 8(2). Medication shall be dispensed for the patient's optimum health needs and "shall be given only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others." *Id.* principle 10. Mental health facilities will provide "access to the same level of resources as any other health establishment," including: a) qualified and sufficient numbers of medical and other staff and adequate facilities to provide each patient with privacy and a program of appropriate and active therapy; b) diagnostic and therapeutic equipment; c) appropriate professional care; and d) adequate, regular and comprehensive treatment, including medication. *Id.* principle 14.

243 Law 22.914, *supra* note 241, art. 10.

244 *Id.* art. 12.

245 Interviews with staff, Penal Unit 20, city of Buenos Aires (June 4, 2004).

246 Interview with staff, Penal Unit 20, city of Buenos Aires (June 29, 2005).

the Unit was still at more than 40 percent over capacity. By September 2006, the population had decreased to 114, which represented overcrowding by 30 percent, but by June 2007, the census had increased again to 121.²⁴⁷

The communal cells at Penal Unit 20 house between 7 and 12 detainees, but typically have only 6 beds. As a result, many detainees are forced to sleep on the floor on thin, dirty foam mattresses, one against the other, with almost no space between them to move. The dining room of Ward 2, which doubles as an activity room, housed two detainees sleeping on mattresses on the floor.²⁴⁸ Although the number of detainees decreased in 2006, there were still mattresses on the floor in several communal cells.²⁴⁹

Tobar Garcia Hospital also experiences severe overcrowding. Dr. Roberto A. Yunes, the Hospital's director explained that Tobar Garcia has a total of 64 beds divided among three floors.²⁵⁰ At the time of investigators' January 2006 visit, the hospital was providing treatment for approximately 150 children and adolescents. "We're way over capacity," Dr. Yunes stated, "There's been a huge explosion in numbers in recent years."²⁵¹

Newspaper reports from July 2005 documented severe overcrowding at Alvear Hospital. According to press reports, one official responsible for defending the rights of minors and the incapacitated reported that in four surprise visits to the hospital, the overcrowding situation was so extreme that he found people sleeping on the floors in the hallways.²⁵²

Statistics provided by the National Ministry of Health indicate that Moyano Hospital has a capacity of 1,550 beds.²⁵³ In June 2004, the psychiatrist who accompanied investigators on a tour of the facility stated that there were 1,750 women

institutionalized.²⁵⁴ Overcrowding was apparent in every ward, with the exception of the emergency ward and the night hospital. In the “chronic”

247 Data collected during visit to Penal Unit 20 conducted by the National Prosecutor in charge of Prisons on June

13, 2007.

248 Investigators’ observations of Penal Unit 20, city of Buenos Aires (Aug. 29, 2006).

249 *Id.*

250 Interview with Dr. Roberto A. Yunes, Director, Dr. Carolina Tobar Garcia Children’s Hospital, city of Buenos

Aires (Jan. 24, 2006).

251 *Id.*

252 Daniel Gutman, *Un hospital psiquiátrico, con pacientes durmiendo en el piso* [A psychiatric hospital with patients sleeping on the floor], CLARÍN.COM, July 22, 2005 [hereinafter CLARÍN.COM, July 22, 2005].

253 Spreadsheet with information on all psychiatric hospital beds in Argentina, public and private, provided by the

Ministry of Health in June 2005, on file with authors.

254 Interview with psychiatrist, Moyano Hospital, city of Buenos Aires (June 6, 2004).

wards of Moyano Hospital, expansive rooms were crowded with rows and rows of beds, with almost no room to walk between them. During the first half of 2007, the average number of women institutionalized had decreased to 993.²⁵⁵ Nevertheless, overcrowding continued to be a problem, despite the fact that nearly 200 women had been sent to private clinics while renovations that had begun in 2005 were being completed.²⁵⁶

According to international standards on the rights of persons in detention, every person “shall, in accordance with local or national standards, be provided with a separate bed and with separate and sufficient bedding which shall be clean when issued, kept in

good order and changed often enough to ensure its cleanliness.”²⁵⁷ Overcrowding is one of the factors that contribute to violations of the detainees’ human rights, and can lead to serious health consequences. Disease transmission increases among people living in close proximity, and overcrowding and the associated lack of privacy are likely to aggravate mental disabilities.²⁵⁸

Several factors contribute to the severe overcrowding investigators documented in the psychiatric institutions they visited. These factors include, among others: government authorities’ lack of political will to promote change; overly broad admissions criteria; the lack of periodic review of involuntary hospitalizations; and the absence of adequate community-based mental health services and housing alternatives.

IV. Arbitrary detention in psychiatric institutions

Involuntary commitment to a psychiatric institution constitutes a massive deprivation of individual liberty—cutting a person off from family, friends, job opportunities, and all other aspects of community life. Accordingly, international human rights law provides important protections against arbitrary or improper detention in a psychiatric facility.²⁵⁹ Article 7 of the American Convention protects the right to “personal liberty and security” and makes clear that “[a]ny one who is deprived of his liberty shall be entitled to recourse to a competent court. . . .”²⁶⁰ In applying

255 Available at http://www.buenosaires.gov.ar/areas/salud/estadisticas/1er_sem_2007/?menu_id=21300.

256 Interview with Dr. Carlos de Lajonquiere, Director General of Mental Health, Ministry of Health of the city of Buenos Aires (July 18, 2007).

257 *Standard Minimum Rules for the Treatment of Prisoners*, U.N. Doc. A/CONF/611, Annex I, E.S.C. res. 663C, 24 U.N. ESCOR Supp. (No. 1) at 11, U.N. Doc. E/3048 (1957), amended E.S.C. res. 2076, 62 U.N. ESCOR Supp. (No. 1) at 35, U.N. Doc. E/5988 (1977), rule 19. The UN has clarified that these standards apply to all individuals in detention, not exclusively to those in prison.

258 *Report of the Special Rapporteur*, *supra* note 115, para. 11.

259 For an overview of the protections against arbitrary detention under international human rights law as they apply to psychiatric commitment, see Eric Rosenthal & Clarence Sundram, *The Role of International Human Rights in National Mental Health Legislation*, DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE DEPENDENCE, WORLD HEALTH ORGANIZATION 61-67 (2004) [hereinafter Rosenthal & Sundram] available at http://www.mdri.org/pdf/WHO%20chapter%20in%20English_r1.pdf.

260 American Convention, art. 7(6). Likewise, the preamble of the National Constitution of Argentina provides that the general protections of the American Convention to people with mental disabilities, the Inter-American Commission has established that the UN’s MI Principles should be used as

a guide to interpret the Convention's requirements regarding the protection of the right to liberty of people with mental disabilities.²⁶¹

The MI Principles guarantee a right to independent judicial review of all psychiatric commitments and include an array of procedural protections for that review process, such as the right to representation by counsel. The MI Principles also create standards strictly limiting who may be involuntarily detained. Under the MI Principles, a person with a psychiatric diagnosis of “mental illness” can be detained only if he or she presents a “serious likelihood of immediate or imminent harm” to themselves or others.²⁶² Involuntary commitment may also be allowable, under limited circumstances, where necessary to prevent “serious deterioration” of a person's mental condition.²⁶³ Such detention is permissible only when treatment could not otherwise be provided in the community.²⁶⁴

Argentine statutory law on a national level falls significantly short of what is required by international standards.²⁶⁵ National statutes permit the commitment of persons who could “affect public tranquility” and do not establish adequate procedural safeguards that would provide for a hearing within a reasonable period, the right to legal representation,²⁶⁶ or the right to periodic review of commitment decisions.

the government will ensure the “benefits of liberty” to all those in the country. CONSTITUTION OF THE REPUBLIC, *supra* note 22, preamble.

261 *Congo*, *supra* note 208. With regard to the right to liberty, the American Convention guarantees: the right not to be arbitrarily deprived of one's liberty (art. 7.3); the right “to trial within a reasonable time or to be released without prejudice to the continuation of the proceedings” (art. 7.5) by “a judge or other officer authorized by law to exercise judicial power” (art. 7.6); the right to counsel (art. 8.2); the right to an appeal (art. 8.2); and “effective recourse” for the violation of fundamental rights (art. 25).

262 *MI Principles*, *supra* note 28, principle 16(1)(a).

263 The MI Principles also require that one's “judgment [be] impaired,” principle 16(1)(b).

264 *Id.* The new CRPD specifies that States parties must guarantee, “on an equal basis with others” that people with disabilities “[e]njoy the right to liberty and security of the person.” It creates no exceptions to this general rule. The Disability Rights Convention also states that “the existence of a disability shall in no case justify a deprivation of liberty.” CRPD, *supra* note 27, art. 14(1). The reach of this provision will depend on how the treaty is interpreted. Since more than a disability is required for detention, however, under the Convention, the deprivation of liberty for the sole purpose of providing treatment—i.e., because of “serious deterioration” of the person's condition—would not be justified.

265 This report only examines the standards for involuntary commitment established in Argentina's federal Civil Code and involuntary commitment provisions that govern the Autonomous City of Buenos Aires. While the Civil Code applies to the entire country, different provinces may establish their own laws, as long as they meet the procedural standards established in federal legislation.

266 ARGENTINE CIVIL CODE, Title XIII, art. 482, para. 2.

In 2005, the Supreme Court of Justice issued a landmark decision on civil commitment in the case of *Ricardo Alberto Tufano*.²⁶⁷ Under *Tufano*, civil commitments to psychiatric institutions must comply with international human rights standards with regard to the right to liberty. While some Argentine judges are beginning to apply the precedent in the *Tufano* case, this application is not uniform,²⁶⁸ and the vast majority of persons hospitalized in psychiatric institutions continue to be arbitrarily detained.

A. Overbroad and ill-defined grounds for commitment

The legal standards established in Argentina's Civil Code on civil commitment are extremely broad and ambiguous, allowing the detention of persons in psychiatric institutions under a wide array of circumstances. The original text of article 482 establishes that "the demented shall not be deprived of personal liberty except in cases where it is feared that he will harm himself or others."²⁶⁹ While the requisite of 'harming self or others' complies with international standards, article 482 never defines "the demented," itself a term that is extremely ambiguous and highly stigmatizing. A legislative reform added two paragraphs to the law—the possibility of committing persons who could "affect public tranquility" or those who engage in alcohol or substance abuse—thereby expanding the parameters of who may be involuntarily committed under the Law.²⁷⁰ Article 482 of the Civil Code also permits a judge to hospitalize a person in a psychiatric facility if the judge determines that the individual "needs assistance," regardless of whether the person is at

267 *Tufano, Ricardo Alberto s/ internación*, Expte. C. 1511 XL, 27/12/2005 (Sup. Ct. Arg. Dec. 27, 2005) [hereinafter *Tufano*] In the *Tufano* decision, the Supreme Court stated that in instances of involuntary or coercive psychiatric hospitalization, "the respect for the rule of due process in protecting fundamental rights is essential." *Id.* at 6. The observance of due process guarantees, the Court stated, are even more important in coercive psychiatric hospitalizations given the "vulnerability, fragility, impotence and abandonment" affecting persons subjected to involuntary commitment. Accordingly, the Supreme Court viewed careful control by judges of the procedures in these cases "essential." *Id.* at 7.

268 *See, Hermosa, Luis Alberto s/ insania-proceso especial*, (Sup. Ct. Arg. June 12, 2007).

269 ARGENTINE CIVIL CODE, Title XIII, art. 482.

270 Law 17.711 added two paragraphs to article 482 of the Civil Code that allude to two supposed different cases: the hospitalization by police order (paragraph two) and by judicial order (paragraph three). Paragraph two provides that: "Police authorities can hospitalize, immediately informing a judge, of those persons who suffer mental illnesses, are chronic alcoholics or drug addicts and could harm their health or the health of others or affect public tranquility. Such hospitalization may only be ordered following an official medical opinion." (art. 482, para. 2). Paragraph three provides that: "Upon request of those persons enumerated in article 144 [the individual's immediate family; an advisor for minors (a public officer designed to protect minors and the "incapacitated" in specific situations); or neighbors who feel uncomfortable] the judge may, following a summary of information, hospitalize those who are affected by mental illnesses, although not justifying a declaration of dementia, chronic alcoholics and drug addicts what require assistance in adequate

establishments. A special defender should be assigned to ensure that the hospitalization does not last longer than necessary and even avoid it altogether, if proper attention can be provided by those obliged to sustain the person.” (art. 482, para. 3). [Translation ours].

risk of serious psychiatric deterioration, or whether less restrictive alternatives have already been attempted.²⁷¹

When, as in Argentina, psychiatric commitment is not strictly limited to cases where people are an imminent danger to themselves or others, it opens the door to a wide array of abuses. People may be committed simply for the convenience of neighbors or family members, or because of others’ irrational fears of people with mental disabilities. And a person with a mental disability may be committed even though he or she is capable of living in the community. Furthermore, under Argentina’s legislation, commitment to a psychiatric facility is permissible for people without a diagnosis of mental illness if they have alcohol or substance abuse problems, even though the mental health facility may not provide appropriate treatment for these problems.

The Supreme Court of Argentina cited the MI Principles in the *Tufano* case, stating that grounds for involuntary commitment must be limited only to cases “when [there is] a serious risk of immediate or imminent harm to that person or others.”²⁷² Despite this decision, in practice, the general and ill-defined clauses of Argentina’s Civil Code are still being applied in psychiatric commitment proceedings.

B. Insufficient procedural protections

Argentina’s legislation contains few procedural protections to safeguard the rights of individuals involved in involuntary commitment proceedings.²⁷³ This legislation does not guarantee the right to a hearing within a reasonable period, does not provide for the right to appoint counsel, and does not provide for a periodic review of involuntary commitments, as required by international human rights law.²⁷⁴

271 ARGENTINE CIVIL CODE, art. 144.

272 *Tufano*, *supra* note 267. See also the decision commentary on this case in Alfredo Kraut, *Hacia una transformación a favor de la legalidad de los pacientes mentales* [Toward a legal transformation to favor the rights of mental health patients] in REVISTA LA LEY No. 44, June 2, 2006.

273 See exceptions described in § VI. A. of this report.

274 For an in-depth analysis of the due process requirements for psychiatric institutionalization, see Rosenthal & Sundram, *supra* note 259. The MI Principles specify that any involuntary commitment can only be ordered by a “judicial or other independent and impartial body established by domestic law.” *MI Principles*, *supra* note 28, principle 17(1). The Inter-American Court of Human Rights has determined that no one may be “deprived of his or her personal freedom except for reasons, cases, or circumstances expressly defined by law (material aspect) and, furthermore, subject to strict adherence to procedures set forth in that law (formal aspect).” Inter-Am. Ct. H.R., *Gangaram Panday Case*, Judgment of June 21,

1994 (Ser. C) No. 16, para. 47. According to the Inter-American Court, detention may still be “arbitrary” even when sanctioned by governing law, when it is imposed in an unjustified, disproportional, or capricious manner, or when due process is not guaranteed. Persons who are facing involuntary commitment proceedings must have the right to appeal a commitment to a “higher court,” (*MI Principles*, principle 17(7)) to representation by counsel (principle 18(1)), and a right to periodic review of commitment decisions at “reasonable intervals.” (principle 17(3)).

1. Lack of an independent hearing within a reasonable period

International law establishes that detainees have a right to a hearing from an independent and impartial tribunal within a reasonable period.²⁷⁵ However, Argentina’s Civil Code allows a broad array of people to initiate the commitment process, for almost any reason. The police may hospitalize any person who suffers from mental illness or is a chronic alcoholic or drug addict, so long as they immediately inform a judge and so long as the hospitalization is based on an official medical opinion.²⁷⁶ A judge may also order the hospitalization of such an individual, based on a summary of prior information, even if these persons have not been declared demented, chronic alcoholics, or drug addicts. Family members and “neighbors who feel uncomfortable”²⁷⁷ may petition a judge for an individual’s involuntary commitment.²⁷⁸

However, the Civil Code does not provide for the detainees’ right to a hearing within a reasonable time before an independent and impartial tribunal.²⁷⁹

Law 22.914—that only governs in the city of Buenos Aires²⁸⁰—is somewhat more protective than the Civil Code. The Law requires that the hospital’s director must provide a medical opinion, or confirm an opinion of another establishment, within 48 hours of a hospitalization.²⁸¹ Law 22.914 also establishes that, in certain cases, notice of such hospitalization must be communicated to the Public Ministry²⁸² within 72 hours,²⁸³ and in general when the hospitalization exceeds 20 days.²⁸⁴

275 Article 7 of the American Convention guarantees a detainee’s right to a hearing within a reasonable period. The *MI Principles* provide that an independent and impartial review body shall be established in accordance with domestic law to review involuntary admissions, and that independent mental health professionals shall advise the review body. *MI Principles, supra* note 28, principle 17(1). An initial review shall occur “as soon as possible” after a decision to admit or retain an individual involuntarily, in compliance with “simple and expeditious procedures as specified by domestic law.” *Id.* principle 17(2).

276 ARGENTINE CIVIL CODE, Title XIII, art. 482.

277 ARGENTINE CIVIL CODE, Title X, art. 141.

278 *Id.* Article 482, paragraph three provides that: “Upon request of those persons listed in article 144 [the individual’s immediate family; an advisor for minors (a public officer designed to protect minors and the “incapacitated” in specific situations); or neighbors who feel uncomfortable] the judge may, following a summary of information, hospitalize those who are affected by mental illnesses, although not justifying a

declaration of dementia, chronic alcoholics and drug addicts that require assistance in adequate establishments.” [Translation ours].

279 *Id.*

280 Law 22.914, *supra* note 243, art. 15.

281 *Id.* art. 2(b)(1).

282 *Id.* art. 12(c).

283 *Id.* art. 2(b)(2).

284 *Id.* art. 2(b)(3).

Nonetheless, these limited protections are still inadequate in that they fail to guarantee the right to independent review.

Similarly, the Mental Health Law of the Autonomous City of Buenos Aires, Law 448, contains solid guarantees regarding the rights of persons with mental disabilities, yet it fails to provide adequate protections against arbitrary detention.²⁸⁵ The only procedural protection provided by this Law is that involuntary institutionalizations “must be certified by two professionals, who cannot pertain to the same institution....”²⁸⁶ Law 448 does not provide for the review of detentions by a judicial or other independent and impartial review body.²⁸⁷

2. Lack of representation by counsel

Argentine statutes fail to adequately guarantee detainees the right to representation by counsel of his or her choosing in involuntary commitment proceedings. Under Argentina’s Civil Code, the judge must appoint a special defender whose role is to ensure that the hospitalization is not longer than necessary, or, where possible, to avoid the hospitalization altogether.²⁸⁸ However, the Code does not require that the special counsel represent the interests of the individual, and does not guarantee the individual’s right to present testimony or evidence on his or her behalf. Similarly, in the Autonomous City of Buenos Aires, Law 448 does not provide an express right to counsel for persons involved in involuntary commitment proceedings.

In practice, according to Dr. Alejandro Molina, the Public Defender of Minors and the Incapacitated at the National Civil Appellate Chamber, there is no true legal representation for individuals detained in psychiatric institutions. There is only one official attorney before the Chamber, for all of the cases that are presented, and this attorney is not required to represent the views of the person subject to commitment. Instead, the attorney is charged with coming up with “an adequate synthesis” of the individual’s desires and what the attorney feels is best for the individual.²⁸⁹ Dr. Molina explained that attorneys at the Chamber try to “achieve consensus”

285 Law 448, *supra* note 60. With regard to all psychiatric hospitalizations, Law 448 requires an interdisciplinary team to evaluate hospitalized individuals within 24 hours of their admissions, verifying if conditions exist to warrant their continued hospitalizations (art. 22). Within 15 days of the hospitalization, and thereafter at least once per month, the mental health team is required to reevaluate the individual to determine whether continued hospitalization is still warranted (art. 23). Under Law 448, hospitalizations cannot last more than one month, although this period is renewable (art. 24).

286 *Id.* art. 31.

287 *MI Principles*, *supra* note 28, principle 17(1).

288 ARGENTINE CIVIL CODE, Title XIII, art. 482.

289 Public defenders interviewed stated that adequate representation is practically impossible, as each defender is in charge of between 800 and 1,000 judicial cases. Interview with public defenders, city of Buenos Aires (Dec. 12, 2006 and July 19, 2007). According to the *Informe Anual 2005 de la Defensoría General de la Nación* [2005 Annual Report of the National Public Defender Office] there are seven public defenders for Minors and the Incapacitated who represent clients before 216 lower courts in the national capital in the realms of: civil law (110 courts); commercial law (26 courts); and labor law (80 courts). There is a Public Defender Office for Minors

among the parties, stating: “We think more about the well being of the group, not about individual rights.”²⁹⁰

The MI Principles provide that during the review of an individual’s detention, the individual is entitled to “choose and appoint a counsel” to represent him or her “including representation in any complaint procedure or appeal.”²⁹¹ To the extent that the individual lacks the funds to pay for counsel, one shall be provided by the State.²⁹² The individual, his or her personal representative, and counsel are “entitled to attend, participate and be heard personally in any hearing.”²⁹³

The Argentine Supreme Court in *Tufano* determined that the MI Principles provide basic rights and procedural guarantees of persons “presumably affected by mental suffering,” including the right to counsel and to an independent determination of mental illness.²⁹⁴ The Supreme Court also found violations of fundamental procedural guarantees where an immediate hearing with personal or other representation is not provided.²⁹⁵

3. Lack of independent periodic review of admissions

Symptoms of psychiatric distress may vary enormously over a lifetime. Accordingly, systematic and periodic review of admissions by an independent review body is necessary to protect detainees’ right to liberty, and to ensure that they do not remain detained even when they no longer pose an imminent danger to themselves or others.²⁹⁶

and the Incapacitated at the Appellate Chamber level. The only defender before the Chamber represents

clients in 28 National Appellate Chambers: 13 in civil; 5 in commercial; and 10 in labor. The number of defenders is extremely limited considering the number of cases and the diversity of jurisdictions in which each one must work. As such, specialization and dedication to a single issue, such as mental health, are all but impossible. Eduardo Madar, General Director of Guardians and Public Defenders of the National Public Defender Service, confirmed this information, and stated that, although there continue to be difficulties, there have been some advances. The number of professionals comprising the technical team had practically doubled, and steps were taken to increase the transparency in the office's work. Interview with Eduardo Madar, General Director of Guardians and Public Defenders of the National Public Defender Service (Aug. 16, 2007).

290 Interview with Dr. Alejandro Molina, Public Defender of Minors and the Incapacitated at the National Civil Appellate Chamber, city of Buenos Aires (June 2, 2004).

291 *Id.* principle 18(1).

292 *Id.*

293 *Id.* principle 18(5).

294 *Tufano*, *supra* note 267.

295 *Id.* citing *Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) (1979).

296 In the report on Mental Disability and the Right to Health by the UN Special Rapporteur on the Right to Health, Paul Hunt urges that, "An independent review body must be made accessible to persons with mental disabilities, or other appropriate persons, to periodically review cases of involuntary admission and treatment," which must have the ability to overturn an involuntary admission, if it determines that continued detention is

Nevertheless, there are no provisions under Argentina's national statutes providing for periodic review of psychiatric admissions decisions by an independent and impartial review body. In the city of Buenos Aires, Law 22.914 provides that judges²⁹⁷ and Advisors for Minors and the Incapacitated are required to verify the evolution of the patient's health, the regimen of attention, the living conditions, and the personal and medical care provided.²⁹⁸ But neither Law 22.914 nor Law 448 contains explicit provisions guaranteeing the right to the periodic review of admissions decisions by an independent and impartial review body.²⁹⁹

In all the facilities investigators visited, institutionalized persons and staff remarked that there was no periodic review of involuntary admissions. At Penal Unit 20, staff and detainees informed investigators that there was no system in place to allow for periodic review of detentions, and that the judges assigned to the cases of those on the Unit "almost never come to visit the detainees and do they do not ask about their cases."³⁰⁰ In the few cases that a judge does manage to visit, staff indicated, such visits are infrequent.³⁰¹ With respect to Tobar Garcia Hospital, Dr. Molina, the Public Defender, told investigators that, "the judges go very infrequently, perhaps once per year."³⁰² At Diego Alcorta Hospital, staff also stated that patients receive no periodic reviews of their admissions.³⁰³ As testament to the seriousness of the situation, each public defender is in charge of

approximately 1,000 cases.³⁰⁴ It is important to note that even regular visits, such as those made to Penal Unit 20, do not fulfill the requisites of an independent and impartial periodic review.

V. Insufficient oversight and monitoring of detainees' rights

Effective oversight and monitoring is essential to ensure the protection of the rights of people detained in institutions. It is well established that people detained in psychiatric institutions and

“inappropriate or unnecessary.” *Report of the Special Rapporteur, supra* note 115, para. 71.

297 Law 22.914, *supra* note 243, art. 10.

298 *Id.* art. 12.

299 For an analysis of the consequences of a lack of periodic review of psychiatric commitments, see, *Página 12*,

“La justicia había ordenado su libertad, pero seguían presos por años,” [“The courts have ordered their release, but

they remained detained for years”], Aug. 7, 2006.

300 *Id.*

301 *Id.*

302 Interview with Dr. Alejandro Molina, Public Defender of Minors and the Incapacitated at the National Civil Appellate Chamber, city of Buenos Aires (June 2, 2004).

303 Interview with Dr. Abraham Stoliar, then Interim Director, Diego Alcorta Hospital, province of Santiago del Estero (Dec. 6, 2004).

304 Interviews with public defenders, city of Buenos Aires (Dec. 12, 2006 and July 19, 2007).

other closed facilities are particularly vulnerable to human rights abuses.³⁰⁵ Individuals detained in long-term institutions are dependent upon these institutions for their basic needs, including food, clothing, shelter, protection from harm, and medical care. These facilities control individuals' access to communication and their contact with the outside world. As a result, individuals detained in institutions face a variety of difficulties in attempting to report abuses: many do not have the ability to communicate freely, fear reprisals for speaking out, or simply do not know of mechanisms through which they can report abuse. When individuals diagnosed with a mental illness or those with developmental disabilities do speak out, they often find that they are dismissed as lacking credibility, or as being delusional or out of touch with reality. Hence, human rights abuses may go undocumented and unaddressed for years.

In Argentina, government institutions generally fail to adequately monitor the conditions and treatment of detainees in psychiatric institutions. In principle, individuals could direct complaints of human rights violations to a variety of officials.³⁰⁶ However, for the reasons described above, it is rare and difficult for persons detained in psychiatric institutions to do so.

In the city of Buenos Aires, under Law 22.914, judges and the Advisors for Minors and the Incapacitated assigned to the cases of institutionalized persons are required to provide oversight and monitoring of the conditions and treatment of detainees in mental health facilities.³⁰⁷ However, staff and institutionalized persons alike told investigators that these procedures are either not followed (as the staff at Penal Unit 20 reported) or that they result in no notable change in the conditions and treatment of those institutionalized.

A few instances of monitoring, however, appear to have been effective. In 2005, Buenos Aires city authorities made four unannounced visits to Alvear Hospital, triggering a lawsuit.³⁰⁸

305 See, e.g., *Report of the Special Rapporteur, supra* note 115. See also, MENTAL DISABILITY RIGHTS INTERNATIONAL, HUMAN RIGHTS & MENTAL HEALTH: URUGUAY (1995); MDRI, HUMAN RIGHTS & MENTAL HEALTH: HUNGARY (1997); MDRI, CHILDREN IN RUSSIA'S INSTITUTIONS: HUMAN RIGHTS AND OPPORTUNITIES FOR REFORM (1999); MDRI, HUMAN RIGHTS & MENTAL HEALTH: MEXICO (2000); MDRI, NOT ON THE AGENDA: HUMAN RIGHTS OF PEOPLE WITH MENTAL DISABILITIES IN KOSOVO (2002); MDRI AND APRODEH, HUMAN RIGHTS & MENTAL HEALTH IN PERU (2004); MDRI, BEHIND CLOSED DOORS: HUMAN RIGHTS ABUSES IN THE PSYCHIATRIC FACILITIES, ORPHANAGES AND REHABILITATION CENTERS OF TURKEY (2005).

306 Those who can receive complaints are, for example "the competent judge, the Public Defender, the city ombudsman, the Secretary of Human Rights, and human rights organizations." [not official translation] KRAUT, *supra* note 69, at 367.

307 Law 22.914, *supra* note 243. Under article 10, judges are required to inspect hospitalization facilities and verify the housing conditions, personal care and medical attention offered. Article 12 provides that, every six months, the advisor for minors and the incapacitated must verify the patient's evolution, the living conditions, and the personal care and medical attention offered. The advisors must then inform the intervening judge of their findings.

308 On June 25, 2007, the Appellate Chamber of the Contentious Administrative and Tributary Court of the city of Buenos Aires upheld a lower court's ruling in a collective complaint on behalf of persons institutionalized in Alvear Hospital, presented by the Public Defender Service. The Appellate Chamber found the government of the city of Buenos Aires responsible for violations of the rights to physical integrity, mental health, privacy and dignity, and ordered the city to take the necessary steps to guarantee the security of the persons institutionalized,

During these visits, one city official found the hospital so overcrowded that persons hospitalized were sleeping on the floor in the hallways.³⁰⁹ The need for greater oversight and monitoring of conditions in psychiatric institutions is captured in the official's comments to the press: "The public mental health system in Buenos Aires is in a state of abandonment."³¹⁰ Also in 2005, the Commission on Jails of the Public Defender Service and the National Penitentiary Attorney's Office drafted reports denouncing the deplorable conditions in which persons detained in Penal Unit 20 were housed.³¹¹

International human rights standards obligate States to ensure the safety and well-being of individuals in detention.³¹² The CRPD requires States party to prevent "all forms of exploitation, violence and abuse" by ensuring the effective monitoring by independent authorities of all institutions and programs providing services to persons with disabilities.³¹³ Similarly, the MI Principles call for the establishment of mechanisms "for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient."³¹⁴

According to the Inter-American Commission, States should monitor the enforcement of the rights of people with mental disabilities in institutions through State human rights ombudsmen's offices.³¹⁵ The Commission recommends that States "[s]upport the establishment of organs that supervise compliance with human rights norms in all psychiatric care institutions and services."³¹⁶

provide sufficient personnel for the adequate functioning of the hospital, and to ensure that each person in need of hospitalization be housed in adequate conditions, guaranteeing an effective treatment, care and attention in medical, psychological and social realms. *See* CCAyT, Sala I, "Asesoría Tutelar Contencioso Administrativo y Tributario c/ GCBA s/ amparo - Exp.17.091/0," Sentence of June 25, 2007.

309 CLARÍN.COM, July 22, 2005, *supra* note 252.

310 *Id.*

311 During 2005 and 2006, the *National Prosecutor in charge of Prisons* presented amicus curiae briefs before each judge in charge of the cases of persons detained in Penal Unit 20 that are in conditions for

discharge. This required re-examinations of the health conditions, discharges and, where necessary, ongoing treatment in non-incarceration health establishments. The Prosecutor in charge of Prisons presented a collective habeas corpus petition and lodged a criminal complaint. Presently, an evaluation is under way of the structural reforms that are being implemented in this Unit. (Informe Anual 2005 - 2006 de la Procuración Penitenciaria al Congreso de la Nación, en preparación [Annual Report 2005-2006 of the National Prosecutor in charge of Prisons to Congress, in draft form]).

312 American Convention, *supra* note 23, art. 1 (requiring governments to ensure treaty-based rights).

313 CRPD, *supra* note 27, art. 16(3).

314 *MI Principles*, *supra* note 28, principle 22.

315 *IACHR Recommendation*, *supra* note 32, para. 5.

316 *Id.* para. 7.

Such organs should involve consumers, family members, representatives of consumers, and mental health workers.³¹⁷

According to the Special Rapporteur on the Right to Health, due to the “acute vulnerability of some persons with mental disabilities” it is critical that “effective, transparent and accessible monitoring and accountability arrangements are available.”³¹⁸ The enhanced monitoring and accountability in psychiatric hospitals is “[o]ne of the most urgent steps which many States need to take to facilitate the realization of the right to health of persons with mental disabilities.”³¹⁹

VI. Mental health reform

A. Promising mental health reform initiatives

1. National sphere

In February 2006, the National Mental Health, Justice and Human Rights Roundtable was created.³²⁰ The Roundtable’s objectives are promoting mental health policies that include a human rights perspective and endorsing policy changes toward implementing good mental health praxis. The Roundtable proposes to develop national strategies for the dissemination of programs on mental health and human rights emphasizing stigma and discrimination against people with mental disabilities. The Roundtable also intends to promote an analysis of the situation of human rights and mental health throughout the country.

Toward these goals, regional colloquia have been developed in different parts of the country to promote the strengthening of local organizations and the formation of regional

roundtables. Based on direct participation in activities organized by the Roundtable, investigators affirm that, while the project is still in its initial phase and lacks institutional support,³²¹ the initiative has awakened interest and hope to achieve long-term integral mental health system reform. The Roundtable has also provided a space for the public sector to be heard on these issues.

317 *Id.*

318 *Report of the Special Rapporteur, supra* note 115, para. 67.

319 *Id.* para. 68.

320 The creation of the Roundtable was a joint initiative of the Directorship for Direct Assistance to Vulnerable Persons and Groups of the National Secretary of Human Rights and the Mental Health and the Healthy Behavior Executing Coordinating Unit of the National Ministry of Health. Representatives of these government entities, together with hospital directors, and provincial and local authorities in the fields of mental health and human rights participate in the Roundtable. Family member groups, users, volunteers, non-governmental organizations and the Office of Mental Health for South America of the Pan American Health Organization also participate in the Roundtable.

321 This is seen in the non-obligatory attendance and lack of participation by State authorities from different jurisdictions in the activities of the Roundtable.

2. The Autonomous City of Buenos Aires

In 1994, the city of Buenos Aires was granted autonomy through the reform of the National Constitution. Since then, the city has enacted several valuable legal provisions containing language supportive of mental health reform initiatives. The city's 1996 Constitution establishes a basis for mental health reform, providing that mental health policies should not be instituted for the ends of social control or punishment, but rather, they should be directed toward progressive deinstitutionalization and creating a service network of social protection.³²² Article 48 of Basic Health Law 153, enacted in 1999, states that mental health care should avoid segregative institutions and work toward progressive deinstitutionalization.³²³ The Law calls for the city to implement alternative models of care focused on social integration, such as half-way houses, protected workshops, therapeutic communities and day hospitals.³²⁴

In 2000, the city enacted progressive legislation, Law 448, outlining rights and protections for people receiving treatment in the city's mental health system.³²⁵ This law echoes many international human rights standards, including: the right to the respect of one's dignity, the right to informed consent,³²⁶ the right to personalized attention, and the right to rehabilitation and community integration.³²⁷ The Law states that treatment should be provided by all means possible on an outpatient basis. The Law also provides that the rights established in the "National Constitution, the Convention on the Rights of the Child, and all other international treaties, the Constitution of the City of Buenos Aires, and article 4 of Law 153" are rights possessed by all persons provided services by the mental health system.³²⁸ And Law 448 calls for the creation of a General Council on Mental Health,

charged with: “a) the formulation of mental health policies, programs and activities; b) the evaluation and follow-up of the Mental Health Plan; c) aspects linked with ethical considerations; d) the framework for the general policies in with the General Council on Mental Health.”³²⁹

Unfortunately, while Law 448 is an important step forward in mental health reform, it has not been implemented in an articulated manner. Law 448 calls for mental health care to be delivered

322 Constitution of the Autonomous City of Buenos Aires, *supra* note 229, art. 21, para. 12.

323 Law 153, *supra* note 58 art. 48(c)(2).

324 *Id.* art. 48(c)(3).

325 Law 448, *supra* note 60.

326 Informed consent is consent obtained free from threats or coercion, after the person has been informed, in a way and language that the person understands, of the characteristics and nature of the treatment prescribed. *MI Principles*, *supra* note 28, principle 11(11).

327 Law 448, *supra* note 60, art. 3.

328 *Id.*

329 *Id.* art. 7 [translation ours].

by interdisciplinary teams, eradicating any hierarchical status among mental health professions. Nevertheless, there are professional groups that are opposed to Law 448.³³⁰

In 2006, in the City of Buenos Aires, PREASIS was created.³³¹ The policies established through PREASIS support planned discharges toward promoting the autonomy and community reintegration of persons discharged from psychiatric institutions.³³² At the time of the writing of this report, PREASIS had implemented two half-way houses for women. Both houses have the capacity to house eight people. The program is planning the creation of a third house for men.

3. The province of Buenos Aires

In 1999, the Ministry of Health of the province of Buenos Aires, established PREA. This initiative is based on the premise that hospitalized individuals suffer from two significant problems: “the deterioration that institutionalization produces, with a consequent loss of autonomy, abilities and skills,” and the loss of “socio-familial” ties.³³³ To overcome these problems, the program promotes the reintegration of persons who have been hospitalized into the community through social networks to support their reintegration.

PREA has established various forms of assistance to those discharged from the hospital, including financial support to cover housing and related expenses, and assistance in finding jobs for the program's participants. Before discharge, PREA works with those in the program to regain skills they need to live independently.

During investigators' visit to Estevez Hospital, one woman who was involved in the program stated that she was relearning skills that years of hospitalization had erased. "[The program staff] spend a year or so teaching you how to deal with money, with living outside [the hospital]," she explained.³³⁴

330 The *Asociación Gremial de Psiquiatras de la Capital Federal* (Association of Psychiatrists' Unions of the Federal Capital), the *Asociación Argentina de Psiquiatras* (Argentine Association of Psychiatrists), the *Confederación Médica de la República Argentina* (Medical Confederation of the Republic of Argentina), and the *Asociación de Médicos Municipales de la Ciudad de Buenos Aires* (Association of Municipal Doctors of the City of Buenos Aires) presented a lawsuit asserting that the Mental Health Law was unconstitutional. The Superior Court of the City of Buenos Aires, however, declared this lawsuit inadmissible. See CELS: DERECHOS HUMANOS EN ARGENTINA. INFORME 2007 342-343 (Siglo XXI, ed., Buenos Aires). Different actors in the mental health field identified strong union opposition as a significant obstacle to mental health system reform.

331 Law 448, *supra* note 60, Chapter III, Mental Health System, article 15 [Rehabilitation and reintegration]: Those persons that, at the moment of discharge do not have a stable family, will be housed in establishments that will be made available by the area of Social Promotion. At http://www.buenosaires.gov.ar/areas/des_social/atencion_inmediata/preasis.php?menu_id=19122.

332 *Id.*

333 PREA document, *supra* note 231.

334 Interview with woman institutionalized in José Estevez Hospital, province of Buenos Aires (June 1, 2004).

In June 2004, PREA's Coordinator, Dr. Patricia Esmerado told investigators that there were 45 women from Estevez Hospital alone living in houses in the community as part of the program, and that they were working to incorporate more women into the program.³³⁵ By October 2006, the number of persons discharged, living in these communal residences had increased to 50.³³⁶

At the time of the writing of this report, Cabred Hospital was planning the *Primeras Jornadas Nacionales e Internacionales: Salud Mental y Derechos Humanos. Experiencias de reforma para la inclusión* (First National and International Workshop: Mental Health and Human Rights. Reform experiences for inclusion). Topics of discussion included mental health from a human rights perspective, public policy agendas, judicial problems, and the incorporation of persons directly affected by policies in their planning and implementation. This workshop was based on the May 2007 *Precoloquio en Salud Mental* (Preliminary Discussion on Mental Health), where participants debated many of the same topics and their relation to mental health system reform.

Additionally, the mayor of the city of Moron, Martín Sabbatella, and the Minister of Health of the province of Buenos Aires, Claudio Mate, signed an agreement establishing a community residence project. The project aims to integrate persons discharged from psychiatric institutions into community life,³³⁷ avoid prolonged institutionalization and promote the autonomy of those discharged.

Together, the Workshop, the Preliminary Discussion and the agreement between the city of Moron and the Ministry of Health of the province of Buenos Aires are part of a therapeutic program that includes agreements between Cabred Hospital and other cities.³³⁸ This program proposes to facilitate the social inclusion of institutionalized personas through half-way houses, subsidies, mental health attention in decentralized health centers, and work with Family Courts.³³⁹

335 Interview with Dr. Patricia Esmerado, then Assistant Director, José Estevez Hospital, province of Buenos Aires
(June 1, 2004).

336 Interviews with professionals, members of PREA (Oct. 20, 2006).

337 Available at <http://www.moron.gov.ar/detalle.php?action=fullnews&id=1172>, May 7, 2007.

338 These cities are: Moreno, Morón, La Matanza, José C. Paz, Malvinas Argentinas, Luján, José C. Paz, Pilar and San Isidro.

339 *Página 12*, “Pacientes externados” [“Patients Discharged”] (July 1, 2007). Interview with Dr. Leo Zavattaro, Director, Cabred Hospital, province of Buenos Aires (July 18, 2007).

4. The province of Rio Negro³⁴⁰

The province of Rio Negro, in the north of Patagonia, provides another positive model of community care for people with mental disabilities.³⁴¹ In 1991, the province passed Law 2.440, *Promoción Sanitaria y Social de las Personas que Padecen Sufrimiento Mental* (Health and Social Promotion of Persons who Experience Mental Suffering). This

legislation outlaws public mental hospitals and outlines a system for social reintegration of persons with mental illness.³⁴²

Today, the region offers mental health services in 33 general hospitals, 178 health centers, 6 half-way houses, and 6 social enterprises or micro enterprises aimed at the social reintegration of persons discharged from psychiatric hospitals. These services attend to Rio Negro's population of just over half a million persons.³⁴³

The mental health services in the city of El Bolson are a good example of the Rio Negro model. Bolson's chief psychiatrist participated in the movement leading to the enactment of Law 2.440, and has worked on implementing its reforms ever since.³⁴⁴ In 2005, Bolson's mental health services consisted of a team of five psychologists, five mental health workers and one psychiatrist. The professionals worked as members of an interdisciplinary team along with families, doctors, psychologists, social workers, educators, the police, lawyers, and employers with the goal of integrating the users of its mental health services into the community. One-third of the therapy sessions with professionals involved at least one member of the person's family. In addition to traditional therapy, the team also offered artistic workshops, and part-time job opportunities in a snack bar and catering service. Mental health workers played a crucial role in helping users transition between the hospital and the community, often performing home visits or accompanying them as they go about their daily chores.

While Rio Negro provides an encouraging model of mental health reform, it is not without its problems. An independent study on the mental health services in the province concluded that increased funding is needed to fully comply with law 2.440.³⁴⁵ Greater investment is needed

340 Material for the first two paragraphs of this section of the report was researched and prepared by Victoria de Menil, Masters of Public Health, Harvard University.

341 The World Bank recognized El Bolson's innovative approach to mental health care, granting its mental health services an award in the World Bank's 2005 Development Fair.

342 Law 2440, *Promoción Sanitaria y Social de las Personas que Padecen Sufrimiento Mental* [Health and Social Promotion of Persons who Experience Mental Suffering] (1991) at http://www.legisrn.gov.ar/detallado_ley.php?ejecutar=DOCU.SECU%3D7548&tablas=leddocu+as+DOCU.

343 Interview with Dr. Ana Lia Broide, Chief of Psychiatry, El Bolson, province of Rio Negro (July 25, 2005).

344 *Id.*

345 Pamela Y. Collins, *Waving the banner of the mental health revolution: Psychiatric reform and community mental health in the Province of Rio Negro, Argentina*, in *INNOVATIVE COMMUNITY MENTAL HEALTH SERVICES IN LATIN AMERICA AND THE CARIBBEAN* (JM Caldas de Almeida & A. Cohen eds., in press).

particularly with regard to housing alternatives for individuals with chronic mental illness who do not have families that can support them.³⁴⁶ The study also found that users of mental health services are not adequately involved in decision-making concerning the delivery of services.³⁴⁷

5. The province of San Luis

The *Hospital Escuela de Salud Mental* (Mental Health Teaching Hospital), in the province of San Luis, may be another promising deinstitutionalization model. Since 1993, the psychiatric hospital in San Luis has undergone significant reform, largely under the direction of Dr. Jorge Luis Pellegrini. The hospital has been transformed from a locked institution with more than 100 long-term residents, to a clinic with ten beds for acute care.³⁴⁸ Dr. Pellegrini told investigators that the current average stay was three to seven days. Today the hospital functions more as a community clinic than as an inpatient psychiatric hospital. Apart from mental health care, the Teaching Hospital offers general health services, including immunizations, pregnancy screenings, and alcoholism recovery workshops.³⁴⁹

At the beginning of the reform effort, Dr. Pellegrini said “[the staff] saw the users as children, they didn’t know their names, only their nicknames, and the majority of those hospitalized were punished [by staff].”³⁵⁰ Describing the conditions in the hospital at the start of the reform, he told investigators, “the walls were covered with fecal matter and urine.”³⁵¹ To begin the reform, Dr. Pellegrini installed his office in one of the institution’s isolation cells. The Teaching Hospital then unlocked the institution’s doors, bought new clothes for the residents, eliminated the hospital logo from the clothing, and injected a sense of dignity into the care and treatment they provided.³⁵²

The hospital pharmacist, Enrique A. Capella, also described serious problems with the improper and excessive use of medication before the reform: “When I arrived I found many medications that were expired or about to expire. It took me three hours each day to prepare the medications for 106 patients . . . there was a chemical straightjacket over the patients, they were like zombies.”³⁵³ The first course of action, according to Mr. Capella, was to decrease the amount

346 *Id.*

347 *Id.*

348 Interview with Dr. Jorge Luis Pellegrini, Director, Mental Health Teaching Hospital, province of San Luis (Dec. 8, 2004).

349 *Id.*

350 *Id.*

351 *Id.*

352 *Id.*

353 Interview with Enrique A. Capella, Pharmacist, Mental Health Teaching Hospital, province of San Luis (Dec. 9, 2004).

of medication given to the persons institutionalized. The process began with a reevaluation of the diagnosis of each person and a review of the medications each person took.³⁵⁴

Investigators were unable to confirm what had happened to all the individuals who had been hospitalized in the Teaching Hospital before the reform. Dr. Pellegrini told investigators that the vast majority of the persons went to live with their families, while Mr. Capella stated that of the 106 persons, 80 went to live in community-based homes.³⁵⁵ Investigators did not have the opportunity to visit these homes and could not confirm the actual conditions of people who had been discharged from the hospital.

In December 2006, the legislature of the province of San Luis ratified a *Ley de Desinstitucionalización* (Deinstitutionalization Law), which contains progressive provisions regarding mental health treatment and the rights of persons with mental disabilities.³⁵⁶ The Law prohibits the institutionalization of persons with mental disabilities in public and private institutions anywhere in the province.³⁵⁷ It also endorses the fundamental rights to life, liberty and security of the person and the presumption that persons with mental disabilities are capable of making decisions, save evidence to the contrary—although the Law does not define what evidence is necessary, who determines incompetence, or how this determination is to be made.³⁵⁸ The Law does specify that a determination of incapacity in one circumstance does not indicate that a person is incapable of exercising self-determination in other contexts.³⁵⁹

B. Deinstitutionalization movement

Many consumer and ex-patient groups, professional organizations, disability rights activists and human rights groups are actively engaged in a movement for the deinstitutionalization of mental health services in Argentina. Some of these groups and organizations are highlighted below.

354 *Id.*

355 *Id.*

356 *Ley de Desinstitucionalización* [Deinstitutionalization Law], province of San Luis (2006).

357 *Id.* art. 3. Institutionalization is defined as “the detention, hospitalization, or similar measure against persons,

restricting their liberty and/or disregarding their self-determination and autonomy, and creating a process contrary to recuperation, rehabilitation, social reintegration or treatment of the person and leading to discrimination, the chronification of illness, abandonment and social exclusion in institutions.” *Id.* art. 7 [translation ours].

358 *Id.* art. 5

(e). 359 *Id.*

art. 5 (f).

1. Consumer and ex-patient groups

Investigators met with a number of consumer and ex-patient organizations supportive of deinstitutionalization.

For example, members of Radio Colifata, a radio program founded in 1993 on the grounds of Borda Hospital to give voice to patients and ex-patients, described to investigators how their experiences with the radio had impacted their lives and helped them organize in support of deinstitutionalization.

*[This is] how the radio helped us. We found a family. Alfredo’s [Olivera] idea for the radio arose when he was a psychology student. Thanks to him we could see the other side of the world. That those outside could hear we who were hospitalized. The good thing about the radio is that it shows us that we can do professional things, demonstrate to society that we can do them.*³⁶⁰

Hugo, an ex-patient who belongs to Radio Colifata, said:

*The government is paying almost 3,000 pesos [a month] per [hospitalized] patient. If they pay me 1,000 pesos to live in an apartment, I can live very well, and the government saves 2,000 pesos.*³⁶¹

Another member commented, “in the Colifata I felt that it was not only about combating the [model of the] psychiatric hospital but of proposing alternatives.”³⁶²

Members of these organizations are acutely aware of the stigma and prejudice they encounter as a result of having received mental health services. In talking about the

discrimination that he has faced, Fernando, a member of Radio Colifata related:

In '97-'98 I got a job in a delivery pizzeria. I started to work, kept to myself, and I started to recover. On Radio Colifata they interviewed us and the interview was shown on television and a woman who worked the register saw it. She told the owners and the next week they

363

asked for the uniform back and they never call me again.

360 Interview with Julio, member of Radio Colifata, city of Buenos Aires (Jan. 23, 2006).

361 Interview with Hugo, member of Radio Colifata, city of Buenos Aires (Jan. 23, 2006). The Director General of Mental of the city of Buenos Aires, Carlos de Lajonquiere, confirmed this figure in an interview with investigators on July 18, 2007.

362 Interview with Fernando, member of Radio Colifata, city of Buenos Aires (Jan. 23, 2006).

363 *Id.*

Another member of Radio Colifata commented,

*A year ago I submitted the paperwork for my disability pension. I don't know what else to do. We are unprotected from all sides. We are discriminated against. We can't get work anywhere. For the past four years I've been looking for work. Society also creates obstacles for us.*³⁶⁴

In May 2007, Radio Colifata, together with *Tea Imagen Escuela Integral de Televisión* (Tea Image Integral School of Television) and the Deputy Secretary of Human Rights of the city of Buenos Aires, organized the *Primer Encuentro Mundial de "Colifatas" o Radios Realizadas por Usuarios de Salud Mental* (First Worldwide Encounter of "Colifatas" or Radios run by Mental Health Consumers).³⁶⁵ The encounter was a worldwide forum of radio transmitters that operate in psychiatric institutions with the objective of sharing experiences between the participants. During the encounter there were debates, artistic presentations, and a poster display reflecting diverse social perceptions on madness.

2. Active professional organizations

A number of professional organizations support mental health reform efforts. The FORO is one example. The FORO is comprised of 20 institutions that work in the mental health sector and represents approximately 9,000 professionals. The group was formed in 1997 with the objective of preserving the right to mental health. The government of the city

of Buenos Aires called on this organization to participate as advisors in the drafting of Law 448, and its members have been integrated into the *Consejo General de Salud Mental* (General Council on Mental Health) established in Article 5(k) of Law 448.³⁶⁶

The FORO maintains what its members described as a “sociopolitical” concept of mental health, and is engaged in examining the non-medical effects of mental illness. Members of the organization are proponents of deinstitutionalization, the prevention of illness and the promotion of mental health. Members stated that Tobar Garcia, Borda and Moyano Hospitals account for 80 percent of the mental health budget for the city of Buenos Aires. FORO members told investigators that the expenditures for mental health care in an institution were approximately 2,500 pesos (US\$833) per person institutionalized per month. This money, they argue, could be better invested in community services and providing housing alternatives to those institutionalized.³⁶⁷

364 Interview with Julio, member of Radio Colifata, city of Buenos Aires (Jan. 23, 2006).

365 Available at <http://www.gacemail.com.ar/Detalle.asp?NotaID=7657>
http://www.buenosaires.gov.ar/areas/jef_gabinete/derechos_humanos/noticias/?modulo=ver&item_id=7540&contenido_id=18128&idioma=es
y <http://www.lanacion.com.ar/912112>.

366 Interview with members of FORO, city of Buenos Aires (June 4, 2004).

367 *Id.*

The *Asociación de Psiquiatras Argentinos* (APSA—Argentine Association of Psychiatrists), an association with 2,400 members, including psychologists, anthropologists, and lawyers, has also been supportive of mental health reform. APSA coordinates a forum on mental health policy, including training in mental health services administration and policy implementation. APSA has been instrumental in bringing the government’s attention to human rights abuses taking place in psychiatric hospitals and has been involved in the deinstitutionalization process at the Mental Health Teaching Hospital in the province of San Luis.³⁶⁸

In 2004, Dr. Graciela Lucatelli, APSA’s president, estimated that with the national mental health budget of approximately 1.5 million pesos (US\$500,000) per year there could be attention for acute patients, half-way houses, and ambulatory teams for attention in the home “and we would have money to spare.”³⁶⁹ Dr. Lucatelli noted the importance of establishing alliances with other non-governmental organizations and scientific societies to press for mental health reform. “Workers think that if the hospitals are closed they will be without a job,” she said, adding, “the leaders have the unions as a good excuse not to advance with these changes.”³⁷⁰

The *Asociación en Defensa de los Derechos en Salud Mental* (ADESAM—

Association for the Defense of Rights in Mental Health), is another organization that supports a transformation in mental health services. ADESAM's members are psychologists, psychiatrists, and lawyers dedicated to the promotion and defense of the rights of persons with mental illness.³⁷¹ In December 2005, investigators participated in the first encounter of the *Movimiento de Desmanicomialización y Transformación Institucional* (Movement for Deinstitutionalization and Institutional Transformation) in which organizations from different sectors and with different work experiences came together to discuss deinstitutionalization efforts.

3. Institution directors

Investigators also found tremendous support for reform among individual mental health professionals, including many institution directors. At *Colonia Montes de Oca*, Director Jorge Rossetto is actively engaged in changing the paradigm of mental health attention. "The people who entered the institution, died here," Rossetto noted. Now work is being done to discharge institutionalized persons. At the time of investigators' visit in 2004, one house on the grounds of *Colonia Montes de Oca* had been renovated and housed three individuals in the discharge process. Two of these individuals attended school in the nearby town of Torres, and one worked for the city. *Colonia Montes de Oca* was working to discharge all three and place them in the community. "We want patients to return to the community," Rossetto commented, "we want to demonstrate that

368 Interview with Dr. Graciela Lucatelli, President, Argentine Association of Psychiatrists (APSA), city of Buenos Aires (June 5, 2004).

369 *Id.*

370 *Id.*

371 *At* <http://www.adesam.org.ar/objetivos.html>.

everyone is able to be rehabilitated."³⁷² By July 2007, two of the three persons who had been living in the house had been discharged.³⁷³

Toward implementing his vision, Rossetto established an agreement with the Mental Health Teaching Hospital in San Luis that provides training for staff at the *Colonia* in how to implement mental health reform. As part of this reform plan, five day treatment centers and a half-way house have been created, and a second half-way house is planned. "*Regreso a casa*," ("I return home") is another component of the plan. "*Regreso a casa*" will provide stipends of 360 pesos (US\$120) per month to persons being discharged who have families, yet whose families would not be able to help in their discharge without economic support. As of the writing of this report, 41 persons were involved in this program.³⁷⁴

In 2002, a reform program was launched at Cabred Hospital. Until that time, there were no therapy programs, and those institutionalized short-term and long-term were housed in the same wards. Dr. Leo Zavattaro, the Director of Cabred Hospital, said that the hospital's current strategic plan includes reform and deinstitutionalization processes, through agreements between the Hospital and nearby cities to create group housing for individuals being discharged. By 2005, the Hospital had already signed such an agreement with the cities of Moreno and Pilar, and was about to sign another with the city of Morón. Cabred Hospital's draft strategic plan goes through the year 2010, by which time the plan proposes that the Hospital's capacity be reduced from 1,320 to 500 beds, 200 of which will be designated to provide geriatric care. Dr. Zavattaro reported that a subsidy from the Ministry of Human Development of the province of Buenos Aires will permit the discharge of 300 individuals with economic difficulties. He estimated that another 200 persons could be discharged due to the agreements reached with the cities. By 2007, Dr. Zavattaro said that more than ³⁷⁵ 250 persons were discharged and that agreements had been signed with five additional cities.

At Borda Hospital, Director Dr. Miguel Angel Materazzi reported that in 1998 there were 1,250 people institutionalized there; at the time of investigators' 2004 visit the number had dropped to 1,050. During the first half of 2007, the average number of persons hospitalized had been reduced to 853.³⁷⁶ "My emphasis is attention in the home," Dr. Materazzi stated.³⁷⁷ Dr. Materazzi

372 Interview with Jorge Rossetto, Director, *Colonia Montes de Oca*, province of Buenos Aires (June 3, 2004).

373 Interview with Jorge Rossetto, Director, *Colonia Montes de Oca*, province of Buenos Aires (July 17, 2007).

374 Interview with Jorge Rossetto, Director, *Colonia Montes de Oca*, province of Buenos Aires (Sept. 27, 2006 and July 17, 2007).

375 These cities are: Morón, La Matanza, José C. Paz, Malvinas and San Isidro. *Página 12*, "Pacientes externados" ["Patients discharged"], July 1, 2007.

376 Data available at http://www.buenosaires.gov.ar/areas/salud/estadisticas/1er_sem_2007/?menu_id=21300.

377 Interview with Dr. Miguel Angel Materazzi, Director, Borda Hospital, city of Buenos Aires (June 4, 2004).

also expressed support for the city's legislation on mental health reform, saying, "we are applying Law 448. I'm in complete agreement with [Law] 448."³⁷⁸

VII. The right to self advocacy

While Argentina has a vibrant consumer and ex-patient movement, groups that comprise this movement are not consulted by the government in service planning or development. Although administrators at Cabred Hospital stated that the family-run group *Asociación Argentina de Ayuda a la Persona que Padece de Esquizofrenia y a su Familia* (APEF—Argentine Association to Help those with Schizophrenia and their Families) had an advisory relationship at the hospital, investigators could not confirm that any user organizations had a substantive role in policy formulation at a hospital or government level.

According to international standards, people with disabilities have a right to be involved in the planning and execution of services that affect them. The Inter-American Convention on Disability establishes unequivocally the right of people with disabilities to participate in the “development, execution, and evaluation of measures and policies” to implement the Convention.³⁷⁹ The Convention further affirms that governments shall promote the participation of people with disabilities in this policy planning and implementation.³⁸⁰

The UN Standard Rules also make clear that people with disabilities themselves have a right to participate in public policy-making, and appeal to governments to “encourage and support economically and in other ways the formation and strengthening of organizations of persons with disabilities, family members and/or advocates.”³⁸¹ Mere token representation without actual participation in policy planning by persons with disabilities is insufficient.³⁸² Throughout the Standard Rules, the importance of self-advocacy for persons with disabilities in local, national, and international arenas is emphasized. The Standard Rules also characterize as being of “utmost importance,”³⁸³ the participation of persons with disabilities in the development of government programs that affect them. This participation should include an active role in policy-making and planning, the elaboration of economic policies, information gathering, personnel training, and the monitoring and evaluation of disability programs.

The Pan American Health Organization (PAHO) also acknowledges that mental health services users play an essential role in formulating policy. While family members, mental health

378 Interview with Dr. Miguel Angel Materazzi, Director, Borda Hospital, city of Buenos Aires (Jan. 25, 2006).

379 Inter-American Convention on Disability, *supra* note 26, art. V(1).

380 *Id.*

381 *Standard Rules*, *supra* note 29, rule 18.

382 *Id.* rules 13-22.

383 *Id.*

workers, and the community in general have a role in shaping policy, PAHO recognizes that, “In first place are the people (patient, client, user) around whom all policy should be structured.”³⁸⁴

VIII. Conclusion

Argentina’s mental health and social service system for people with psychiatric and intellectual disabilities is out-of-step with changes that have taken place around the world over the last 30 years. Largely due to the lack of community-based mental health services, people with mental disabilities are segregated from society in psychiatric institutions. This segregation constitutes a form of discrimination against people with mental disabilities as well as people improperly labeled with a psychiatric diagnosis, a practice prohibited under international human rights law.³⁸⁵

By warehousing thousands of individuals in large institutions, instead of providing alternatives to institutionalization—including housing and community-based mental health services and supports—Argentina is doing incalculable damage to people who could, with the proper services and supports, live productive and healthy lives. The segregation of these people from their families, opportunities, and their communities furthers their isolation, contributes to their disabilities, and makes the likelihood of their ever returning to independent life all the more remote.

This massive institutionalization is the result, fundamentally, of misguided policy decisions that translate into the misallocation of significant government resources, and the failure to develop specific policies directed toward community-based mental health care.

Argentina’s laws regulating involuntary commitments to psychiatric hospitals do not provide adequate protections against arbitrary detention. Substantive provisions allowing for detention are overly broad and ill-defined. Procedural provisions in force do not guarantee the right to review of a detention decision by an independent authority, do not provide for the right to representation, and do not provide the right to periodic review of commitment decisions by a judicial or other independent authority.

Inside many Argentine institutions, people are subjected to serious human rights violations, including violations of the right to life, the right to health, and the right to humane treatment. Perpetrators are rarely, if ever, caught or sanctioned. Insufficient monitoring and oversight in

384 ORGANIZACIÓN PANAMERICANA DE LA SALUD, REESTRUCTURACIÓN DE LA ATENCIÓN PSIQUIÁTRICA: BASES CONCEPTUALES Y GUÍAS PARA SU IMPLEMENTACIÓN, MEMORIAS DE LA CONFERENCIA REGIONAL PARA LA REESTRUCTURACIÓN DE LA ATENCIÓN PSIQUIÁTRICA [PAN AMERICAN HEALTH ORGANIZATION, RESTRUCTURING PSYCHIATRIC ATTENTION: CONCEPTUAL BASES AND GUIDES FOR ITS IMPLEMENTATION, REPORTS OF THE REGIONAL CONFERENCE FOR THE RESTRUCTURING OF PSYCHIATRIC ATTENTION], CARACAS, VENEZUELA, 11 AL 14 DE NOVIEMBRE DE 1990, 67 (1991).

385 Eric Rosenthal & Clarence J. Sundram, *International Human Rights in Mental Health Legislation*, 21 N.Y.L. SCH. J. INT'L & COMP. L. 469, 504 (2002).

institutional facilities contributes to a climate of lawlessness, both with respect to the abuses inflicted on institutionalized persons, as well as malfeasance in the administration of the institutions.

Yet, while there are significant obstacles to overcome, Argentina has the resources to engage in a dramatic shift in the way it approaches public mental health services. The country has a large base of mental health professionals; renowned models of mental health reform; and progressive laws endorsing the promotion of mental health attention in primary care, the formation of community-based services, and deinstitutionalization. In the city and province of Buenos Aires, where 75 percent of the largest psychiatric institutions exist, authorities are generally supportive of mental health reform, and several are taking proactive steps toward transforming their mental health services. Numerous professional, human rights, family member, and consumer/ex-patient organizations are actively engaged in actions to support this paradigm shift. In the words of one Buenos Aires city official, “There is money [to implement reform], we have to make the changes, we have to do it now.”³⁸⁶

Recommendations

The following recommendations list concrete steps that federal, provincial, and city governments, directors of psychiatric institutions, and international financial institutions should take to reform Argentina's mental health system to make it one that is respectful of human rights and prevents future abuses:

TO THE EXECUTIVE BRANCH OF THE FEDERAL GOVERNMENT, AND SPECIFICALLY THE NATIONAL MINISTRY OF HEALTH:

Create a high level National Commission to plan for mental health service system reform

The federal government should create a high level National Commission to plan for mental health service system reform, in coordination with the Mental Health and Healthy Behavior Executing Coordinating Unit of the National Ministry of Health. The government will only resolve the problem of custodial institutionalization and the improper detention of individuals when it commits itself to creating community-based support systems that assist people with mental disabilities to live integrated in the community. The National Commission should include the broad participation of professionals, human rights organizations, provider organizations, lawyers, families, users and advocates consistent with the UN Standard Rules.³⁸⁷ In turn, the National Commission should develop a national policy for the provision of services to people with mental disabilities in the least restrictive environment. The plan should, at a minimum, provide for:

- i. the development of community residential and day program services for people who are currently institutionalized;
- ii. the development of vocational rehabilitation programs, job opportunities and active participation of users in their treatment and rehabilitation;
- iii. the development of support services to enable families to continue their care-giving roles for family members with mental disabilities;
- .iv. the opening of short-term acute care psychiatric beds in general hospitals or community-based clinics;
- .v. a schedule of planned discharges, policy of no new admissions to long-term care, and phase down of long-term care institutions in collaboration with directors of psychiatric institutions; and

- vi. a national public education campaign to combat stigmatization of and discrimination against people with mental disabilities, including human rights and disability awareness training for health care professionals, teachers, and others serving persons with mental disabilities.

 **Review all psychiatric commitments**

This National Commission should conduct a review of all residents in intermediate and long-term care beds in institutions to identify their needs for community services and priority for discharge in collaboration with directors of psychiatric hospitals. The Mental Health Law of the City of Buenos

387 *Standard Rules, supra* note 29.

Aires, Law 448, calls for such a review of psychiatric hospital admissions. Such a review should be implemented, not only in the federal capital, but throughout the country.

 **Implement a national program to develop community-based mental health services**

The National Commission should also implement a nationwide program to develop community-based mental health services and services ensuring the social reinsertion of people with mental disabilities.

 **Shift funding to community-based services**

The National Commission should develop and implement a policy requiring the reinvestment of the savings in the management of institutional services that will result from to the discharge of persons who have been institutionalized long-term. Such resources should instead be directed toward the development of community residential and other support services.

 **Provide greater resources to the Mental Health and Healthy Behavior Executing Coordinating Unit within the federal Ministry of Health**

The federal government should provide the necessary resources to the Coordinating Unit to gather and centralize mental health data from the provinces, which is essential to ensure effective planning and implementation of sound mental health policies throughout the country.

 **Support the development of consumer-directed advocacy**

The federal government should provide financial and logistical support to groups of mental health consumers, ex-patients and family members to enable them to develop as self-directed advocates. The government should open opportunities for such groups to actively participate in the development and implementation of policies, programs, and services affecting them.

 **Develop a program for training staff**

The federal government should implement a training program for mental health workers, from professionals to technicians, to implement rehabilitative programs for residents of psychiatric institutions. This program should include training in basic principles of human rights and non-discrimination.³⁸⁸

 **Ensure safe, clean and humane living environments in all psychiatric institutions**

The federal government should establish enforceable standards for the eradication of dangerous, filthy, and unhygienic conditions in institutions throughout the country. All institutions should be held strictly accountable for compliance with these standards, including:

- i. the immediate repair of non-functioning toilets, sinks, and showers;
- ii. the daily cleaning of living spaces and bathing areas with disinfectant products;
- iii. the access of each detained individual to a bed with a clean mattress, sheets and blankets;
- .iv. clothing and shoes that are clean and in good condition;
- .v. immediate access to soap, towels, toilet paper, and personal hygiene products for each detained individual;

388 Under the UN Disability Rights Convention, States must promote the initial and on-going training of staff working in rehabilitative services. CRPD, *supra* note 27, art. 26(2).

-
- vi. sufficient food with a nutritional balance adapted to the particular needs of each individual; and
 - vii. immediate and regular fumigation to rid institutions of cockroaches and other insects.

 **Provide appropriate medical and psychiatric care**

The federal government should order the provision of medical and psychiatric care to ensure the safety and health of all people hospitalized in psychiatric institutions.

TO THE LEGISLATIVE BRANCH OF THE FEDERAL GOVERNMENT:

 **Enact a national mental health law**

The legislative branch of the federal government should enact a national mental health law in compliance with international human rights standards. At minimum, this law should provide:

- i. due process guarantees in involuntary civil commitments, including:
 1. the right to judicial review of all involuntary admissions before an

independent authority within 72 hours of admission;

2. 2. the right to periodic review of involuntary admissions by an independent and impartial entity at reasonable intervals;

3. 3. the right to client-centered legal representation in initial commitment hearings and all subsequent review hearings. The State should provide an attorney if the individual cannot afford one.

- ii. principles guaranteeing mental health attention, including adequate community-based treatment and rehabilitation focused around the needs and desires of the individual receiving the services, along with guarantees that all services be provided only after obtaining the informed consent of the person receiving the services; and
- iii. the other rights recognized in international standards pertaining to people with mental disabilities.³⁸⁹

TO THE NATIONAL MINISTRY OF JUSTICE AND THE MINISTRIES OF JUSTICE OF THE PROVINCES:

Investigate recent deaths in institutions and establish protocol to ensure full investigations of any future deaths

Independent authorities should investigate all deaths of individuals in institutions. Investigators documented four unexplained deaths at Diego Alcorta Hospital and a death rate four times higher during the winter months than during the summer at Cabred Hospital. Prosecutors, under the corresponding jurisdictions, should investigate these and other deaths and establish a protocol to ensure the full and independent investigation of any future deaths in institutions.

Investigate and report on particularly abusive facilities

Prosecutors should investigate allegations of abuse at psychiatric institutions—investigators identified particularly abusive conditions at Diego Alcorta Hospital, Moyano Hospital and at

389 See e.g., the *MI Principles* and the *Montreal Declaration*, *supra* notes 28 and 31 respectively. For more on the rights of persons with mental disabilities, see also Alfredo Kraut, *Salud Mental: Tutela Jurídica [Mental Health: Legal Guardianship]*, 490-534 (Rubinzal et al. eds., 2006).

Penal Unit 20—and hold accountable those responsible for such abuse, including through criminal prosecutions where necessary. Prosecutors, under their corresponding jurisdictions, should analyze patterns of violations and evaluate the possibility of releasing public reports of their findings toward ending abusive conditions in psychiatric institutions.

TO THE NATIONAL AND PROVINCIAL PUBLIC DEFENDER SERVICES

Guarantee free and effective counsel for people hospitalized in institutions

The National General Ministry of Public Defense should guarantee that all persons deprived of their liberty in psychiatric institutions have access to counsel who are responsible for making periodic visits to the institutions, assisting those hospitalized and their families in the filing and resolution of complaints, and investigating complaints of abuse, neglect, or suspicious deaths. Similar measures should be taken in each of the provinces that have psychiatric institutions. Public defenders, under their corresponding jurisdictions, should analyze patterns of violations and evaluate the possibility of releasing public reports of their findings toward ending abusive conditions in psychiatric institutions.

TO THE NATIONAL HUMAN RIGHTS OMBUDSMAN'S OFFICE:

Create a program to protect against further abuses in psychiatric institutions

The Human Rights Ombudsman should actively monitor conditions in all facilities serving persons with psychiatric or intellectual disabilities and evaluate the possibility of providing assistance and free legal counsel for those institutionalized and their families. In addition, the ombudsman should be authorized to perform unannounced on-site inspections day or night on a regular basis at all institutions; similar to the function of the Prosecutor in charge of Prisons regarding psychiatric penal units. Reports of findings should be made public.

TO THE GOVERNMENT OF THE CITY OF BUENOS AIRES:

Enforce article 48 of Basic Health Law No. 153

The government of the city of Buenos Aires should enforce article 48 of Basic Health Law No. 153, which mandates that the government work toward progressive deinstitutionalization. The Law further calls on the government to implement alternative models of attention focused on social integration, such as half-way houses, protected workshops, therapeutic communities and day hospitals.

Take all steps necessary to effectively enforce Law 448

The government of the city of Buenos Aires should implement Law 448 and take proactive steps toward its implementation, creating a program of community mental health services and community reintegration of persons with mental disabilities.³⁹⁰ Law 448 calls for progressive deinstitutionalization and guarantees the human rights of people receiving treatment in the city's mental health system, including the right to the respect of one's dignity; the right to informed consent; the right to personalized attention; and the right to rehabilitation and community integration.

390 Law 448, *supra* note 60, art. 3, paras. I, J; art. 10, para. G.

 **Comply with the temporary dispositions of Law 448**

The government of the city of Buenos Aires should comply with the temporary dispositions of Law 448. In particular, it should implement the second temporary disposition, which calls for an inventory of the total number of persons hospitalized in psychiatric institutions, with the goal of determining the causes and duration of each person's hospitalization, and the necessity of continued hospitalization.

 **Inform the public regarding the implementation of Law 448**

The government of the city of Buenos Aires should make public information regarding the implementation of Law 448. In particular:

- i. the budget assigned to different mental health programs;
- ii. the creation of the commission to follow-up on Law 448;
- iii. the status of the professional bids for teams providing public mental health services;
- .iv. the programs and activities undertaken toward deinstitutionalization and the community reintegration of persons hospitalized; and
- .v. the steps taken to prevent human rights violations in the provision of mental health services.

 **Implement article 21 of the Constitution of the city of Buenos Aires**

The government of the city of Buenos Aires should implement article 21, paragraph twelve of the Constitution of the city of Buenos Aires that refers to mental health policies. This provision states that mental health policies will recognize those receiving mental health services as holders of rights; guarantees the provision of mental health services in government facilities; states that the goals of such facilities are not social control and that they will eradicate punishment; and endorses progressive deinstitutionalization and the creation of a network of mental health services and supports.

TO THE PROVINCIAL GOVERNMENTS:

 **Adopt and enforce laws promoting human rights in the context of mental health**

The governments of the provinces should adopt and enforce mental health laws that respect the human rights of persons with mental disabilities. These laws should endorse progressive deinstitutionalization and guarantee the human rights of people receiving mental health treatment in the provinces. Provincial governments should also guarantee compliance with these laws.

TO DIRECTORS OF PSYCHIATRIC INSTITUTIONS:

Eliminate the use of long-term isolation

Directors of psychiatric institutions should eliminate the use of long-term isolation and ensure safe and humane conditions of confinement. Any use of isolation cells must comply strictly with the internationally accepted procedures to protect against the dangers of inhumane isolation, and should only be used “to prevent immediate or imminent harm to the patient or others.”³⁹¹ Alternative

391 *MI Principles*, *supra* note 28, principle 11(11).

means of protection must be attempted first, and seclusion may be used solely “when it is the only means available” to protect against such harm.³⁹² Isolation should “not be prolonged beyond the period strictly necessary for this purpose.”³⁹³ Under no circumstances should isolation be used for periods of days or weeks. Seclusion and restraint should never be used as a form of discipline or coercion, for staff convenience, or as a substitute for adequate staffing or active treatment.³⁹⁴ Directors should implement the procedural protections in the MI Principles to ensure that people held in isolation are kept under “humane conditions.”

Implement measures to avoid physical and sexual abuse

Directors of psychiatric institutions should take immediate measures to protect institutionalized persons from physical and sexual abuse. Staff should be trained to identify and protect those persons hospitalized against such abuse.

Conduct a review of all persons in intermediate and long-term care wards

Directors of psychiatric institutions should order a review of all institutionalized persons to identify the need for community services and create a plan prioritizing the discharge of persons in intermediate and long-term care beds. Institution directors should enforce a schedule of planned discharges and institute a policy of no new admissions to long-term care wards.

Procure the necessary resources for their hospitals

Directors of psychiatric institutions should procure sufficient staff and the resources necessary to ensure the adequate functioning of their hospitals.

TO THE INTERNATIONAL LENDING INSTITUTIONS, AND SPECIFICALLY THE INTER-AMERICAN DEVELOPMENT BANK (IDB):

International lending institutions should redirect to community-based services the bulk of the funds currently allocated to rebuilding psychiatric institutions

Except for essential repairs to infrastructure to existing psychiatric institutions necessary to

ensure safety, international financial institutions should, in concert with the Argentinean government, direct loans to the creation and implementation of community-based mental health services. In the particular case of the funds from the IDB loan, Argentinean government officials should renegotiate the terms of the loan so that the bulk of the funding can be allocated toward the pressing need for community-based services. The IDB should provide its loans in a manner that promotes respect for international human rights principles, directing funding toward the creation and strengthening of community-based services for people with mental disabilities.

392 *Id.*

393 *Id.*

394 True, *supra* note 170.

Acknowledgments

This report is a joint endeavor by Mental Disability Rights International (MDRI) and the Center for Legal and Social Studies (CELS). The primary author and researcher of this report was Alison A. Hillman de Velásquez, Director of MDRI's Programs in the Americas.

The bulk of the research for this report was conducted during six fact-finding investigations over a three year span in Argentina, from June 2004 to August 2007. In the many institutions and community-based mental health initiatives investigators visited, administrators, staff and people with mental disabilities were exceedingly generous with their time. Investigators returned to many institutions over the course of the research. Institution administrators, in particular, were gracious and welcoming, even when investigators covered similar ground on return visits. Many government officials and organizations of professionals, family members, and ex-patients also agreed to be interviewed for this report. Their candid assessments of mental health services available in Argentina shaped much of the content of this report.

Without the meticulous logistical support coordinated by Roxana Amendolaro, Coordinator of CELS' Mental Health Team, research for this report would not have been possible. Roxana demonstrated tremendous commitment to this project, participating in five investigations, despite being eight months pregnant with her first child, Carla, during one of these, and spearheading a final round of fact-checking as the report went to press. Alfredo Jorge Kraut, currently Secretary of the Supreme Court of Justice of Argentina, and the

country's principal specialist on the rights of people with mental disabilities, opened numerous doors that offered access to policy makers and mental health professionals alike. Alfredo provided insightful comments from his vast knowledge of the intricacies of Argentina's legal system and its approach to issues relevant to people with mental disabilities. Had it not been for Alfredo's energy, enthusiasm, and contacts, the daunting task of compiling information about Argentina's mental health services system would have seemed a Herculean task.

Eric Rosenthal, Executive Director of MDRI, provided careful guidance and support throughout the report-writing process, reviewing numerous drafts and offering valuable insights to sharpen and polish the final product. Laurie Ahern, MDRI's Associate Director, also offered expertise from her background as a journalist, emphasizing the need to highlight individual testimonies as part of the research data. Andrea Pochak, Adjunct Director at CELS, lent institutional support to this project and provided meticulous and detailed revisions to the numerous report drafts. Joanne Mariner, former Deputy Director of Human Rights Watch's Americas Program, offered thoughtful comments, suggesting many improvements in the early stages of the drafting process. Daniel Wilkinson and Maria McFarland of Human Rights Watch also provided important editorial and stylistic recommendations that made the report more cohesive and easier to read.

Authors must thank the numerous individuals who both participated in the investigation and documentation of this report, and who reviewed report drafts and offered their comments and corrections. These individuals include: Ana Laura Aiello, J.D., human rights doctoral candidate, Carlos III University of Madrid; Graciela Guilis, ex-Director of CELS' Mental Health Team; Mariano Laufer Cabrera, attorney at CELS; Humberto L. Martinez, M.D., Executive Director, South Bronx Mental Health Council; Victoria de Menil, MPH; Clarence Sundram, J.D., President, Board of Directors, MDRI; Willians Valentini, M.D., psychiatrist, consultant to the World Health Organization; and Alicia Ely Yamin, J.D., MPH, MDRI Board member and Instructor, Harvard School of Public Health. Additionally, members of CELS' Mental Health Team Adelqui del Do, psychologist, and Laura Sobredo, M.D., psychiatrist, and CELS' legal intern Pablo Alvarez, participated in the investigation of this report.

Marcel Velásquez Landmann, anthropologist, candidate for a Master's in Public Policy, Georgetown University, participated as an investigator and interpreter, and translated this report from English to Spanish. He displayed undying patience in incorporating what at points seemed like interminable revisions from a variety of reviewers. Without Marcel's loving support, this report would never have made it past the initial draft.

Freelance photographer Eugene Richards captured several of the compelling images that accompany this report. Weeks of his donated time and his decade-long interest in exposing abuses against people with mental disabilities have been invaluable for lending a human face to the silent suffering of thousands of institutionalized individuals. MDRI is

particularly grateful to Gene for his dedication and tireless support of our work. The report also benefits from the important contributions of photographers Elizabeth Mallow and Jeremy Robbins.

Brian Cooper provided careful copy editing of the report. Adrienne Jones, MDRI's Office Manager, helped with formatting and provided valuable technical assistance.

Essential support for the research and writing of this report was provided by a grant from the Overbrook Foundation. In addition, the Morton K. & Jane Blaustein Foundation, and the Merck Fund provided sustaining support without which the completion and dissemination of this report would not have been possible.