Submission

CRPD Review of Sri Lanka
35th Session of the United Nations Committee on the
Rights of Persons with Disabilities

SHADOW/ALTERNATIVE REPORT
[Rights of Persons with Psychosocial Disabilities]

20th July 2026

Nidahas Chinthana Sansadaya – Consumer Action Forum (NCS-CAF),
We for Rights, and Open Minds, Sri Lanka
with
Transforming Communities for Inclusion (TCI) - Global

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(19th July 2026)

Submitted by:

Nidahas Chinthana Sansadaya - Consumer Action Forum (NCS-CAF), We for Rights, Open Minds - Sri Lanka with Transforming Communities for Inclusion (TCI) - Global

Introduction

This report is submitted NCS-CAF, We for Rights, and Open Minds Sri Lanka, with the support of TCI Global. The report was developed through a nationwide consultative process with the participation of persons living with psychosocial disabilities/consumers of mental health services, their representative organizations and caregiver networks, organizations of persons with disabilities, healthcare workers, experts, and other national stakeholders.

Nidahas Chinthana Sansadaya – Consumer Action Forum (NCS-CAF) is a Sri Lankan organisation of persons with psychosocial disabilities established in 2005 and formally registered in 2008. Founded by participants of the BasicNeeds Mental Health and Development Programme, the organisation is rooted in lived experience and peer leadership. NCS-CAF works to advance the dignity, autonomy, and meaningful participation of persons with psychosocial disabilities through a rights-based, community-led approach. Its work focuses particularly on community inclusion and deinstitutionalization, bringing together persons with psychosocial disabilities, families, Organisations of Persons with Disabilities (OPDs), government institutions, service providers, and civil society actors to strengthen community-based support systems and access to mainstream services. NCS-CAF combines grassroots mobilization with capacity development, public awareness, evidence-informed advocacy, and institutional partnerships. Its programmes have established community inclusion volunteer committees and peer-support structures, strengthened access to health, social protection, livelihood and other services, and used innovative participatory approaches such as the Human Library, lived-experience storytelling, and Forum Theatre to challenge stigma and promote social inclusion. The organisation also contributes to policy and advocacy platforms at the divisional, district, provincial, national, and international levels, and has strengthened its monitoring and learning systems by developing and applying the Community Inclusion Indicator Tool (CII-T). Through this combination of lived-experience leadership, community-based action, advocacy, and collaboration with mainstream institutions, NCS-CAF seeks to create sustainable pathways for persons with psychosocial disabilities to exercise choice, live independently, and participate fully in social, economic, and civic life.

We for Rights is a Sri Lankan Organisation of Persons with Disabilities (OPD) working to advance the rights, inclusion, and meaningful participation of persons with disabilities, with a

particular focus on strengthening community-level leadership and advocacy. Based in Kandy and working in partnership with organisations such as NCS-CAF, We for Rights supports persons with disabilities in identifying and addressing barriers within their communities, engaging with government institutions and service providers, and advocating for greater access to mainstream services and development opportunities. Through community mobilization, networking, capacity development, awareness raising, peer engagement, and collaboration with other OPDs and civil society actors, the organisation seeks to challenge stigma and discrimination, strengthen the collective voice and leadership of persons with disabilities, and promote communities in which persons with disabilities can exercise their rights and participate fully and equally in social, economic, and civic life.

Open Minds is a newly established independent, cross-disability civil society organization committed to advancing the rights, inclusion, and empowerment of persons with disabilities in Sri Lanka. Founded by a team of advocates, professionals, researchers, and people with lived experience, Open Minds promotes a rights-based, inclusive, and participatory approach to disability and mental health. The work of Open Minds focuses on two interconnected pillars: advocacy and empowerment. The organization advocates for the realization of the rights of persons with disabilities through policy engagement, awareness raising, research, strategic partnerships, and systems change, while also strengthening the capacity of persons with disabilities, OPDs, caregivers, and communities through leadership development, training, mentoring, and community-based initiatives. Open Minds works across all disability groups, recognizing the diversity of lived experiences and the importance of intersectionality. Open Minds collaborates with organizations of persons with disabilities, civil society organizations, government institutions, academic partners, development agencies, and community groups to promote equality, accessibility, social justice, and the full realization of the rights enshrined in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Transforming Communities for Inclusion (TCI) - Global is a global organisation of persons with psychosocial disabilities that works to advance the human rights, full inclusion, and meaningful participation of people with psychosocial disabilities worldwide. TCI Global promotes the implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), particularly the rights to legal capacity, independent living, community inclusion, and freedom from coercion and institutionalization. The organisation combines global advocacy and movement-building with capacity development, peer leadership, research, knowledge generation, and technical support for grassroots organisations and OPDs. Through partnerships with national, regional, and international stakeholders, TCI Global works to strengthen the collective voice and leadership of persons with psychosocial disabilities, influence laws and policies, and promote a transition from institutional and medicalized approaches towards rights-based, person-centre, and community-based inclusion.

Executive Summary

This shadow report presents the lived experiences, priorities and recommendations of persons with psychosocial disabilities concerning Sri Lanka's implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Developed through a peer-led, participatory and rights-based process, it draws on consultations conducted across all nine provinces. The report seeks to inform the Committee on the Rights of Persons with Disabilities by providing independent evidence from a constituency that has historically been excluded from disability policy, mental health reform and human rights monitoring.

Despite Sri Lanka's ratification of the CRPD in 2016, persons with psychosocial disabilities continue to experience systemic and intersectional discrimination across virtually every area of life. Participants described stigma, ableism and paternalistic assumptions of incapacity affecting healthcare, education, employment, housing, family life, property, social protection, access to justice and political participation. Their experiences demonstrate that these barriers arise from discriminatory laws, inadequate support, failures of implementation and institutional practices that do not recognise them as equal rights holders.

Sri Lanka's legal framework remains substantially inconsistent with the CRPD. Disability is not expressly prohibited as a ground of discrimination under article 12(2) of the Constitution, while article 89(c) permits disenfranchisement based on "unsoundness of mind." The Protection of the Rights of Persons with Disabilities Act No. 28 of 1996 adopts an outdated definition based on individual "deficiency," incapacity and dependence. The Mental Diseases Ordinance, Penal Code, Code of Criminal Procedure, Civil Procedure Code and Judicature Act employ derogatory and medicalized concepts such as "unsound mind," "mentally deficient" and "idiot" and authorize disability-based detention, substitute decision-making, guardianship and control over persons and property. The proposed Mental Health Act has been developed without the close consultation and active involvement of persons with psychosocial disabilities and their representative organisations and continues to permit involuntary admission, forced treatment, restraint, seclusion and substitute decision-making. The problem is therefore not limited to weak implementation: existing laws and proposed reforms themselves require fundamental amendment or repeal.

The consultations revealed serious denials of legal capacity, liberty, bodily integrity and access to justice. Participants reported that decisions concerning treatment, residence, finances, property, education and public services are frequently made by families, professionals and authorities without regard to their will and preferences. Complaints are often regarded as less credible because of psychiatric histories, while independent and affordable legal aid, procedural accommodations and accessible mechanisms to challenge institutionalization and forced treatment remain inadequate. Involuntary admission, forced medication, chemical and mechanical restraint, seclusion, and electroconvulsive therapy without free and informed consent directly engage articles 14–17 and may amount to violence, abuse, or torture or other

cruel, inhuman or degrading treatment. The reported death of a patient following suspected extreme restraint at the National Institute of Mental Health in 2023 illustrates the potentially grave consequences of coercive institutional practices.

Independent living remains one of the most significantly unrealized rights. Residents consulted within the rehabilitation facility expressed a strong desire to leave institutional care and return to their communities or obtain homes of their own. All seven residents who participated in a drawing exercise independently drew a house or home, while one participant feared losing a government job because of prolonged institutionalization. Continued residence was linked to treatment compliance, family acceptance and the absence of alternatives; however, family unwillingness or inability cannot justify institutionalization. The underlying failure is the State's inadequate provision of accessible housing, income support, personal assistance, peer support and other voluntary, person-directed services. Institutionalization is not a permissible substitute for unavailable community support, and smaller congregate facilities must not reproduce the segregation, surveillance and control of larger institutions.

Participants further reported unequal access to general healthcare, sexual and reproductive healthcare, education, employment, transport, social protection and public life. Social-protection and disability-assessment systems do not consistently recognise psychosocial disability or compensate for disability-related additional costs, contributing to poverty and institutional dependence. Education systems frequently fail to provide reasonable accommodation, individualized support, accessible anti-bullying and complaint mechanisms or equal access to tertiary, vocational and lifelong learning. Employment barriers include discriminatory recruitment and dismissal, inadequate accommodation, inflexible working arrangements and limited supported-employment and return-to-work programmes. Persons with psychosocial disabilities also remain underrepresented in policy processes, public bodies and political leadership, while legal-capacity restrictions and inaccessible electoral systems impede political participation.

Women and children experience particularly acute and intersecting violations. Seven of the eight women individually consulted within the residential facility disclosed violence in their family homes before admission. Women with psychosocial disabilities may also face forced treatment and institutionalization, denial of sexual and reproductive autonomy, economic and property exploitation, loss of parenting or custody rights, and barriers to survivor-centre protection and justice. Returning women to family homes may expose them to renewed violence, control or rejection; deinstitutionalization must therefore include safe housing, income support and survivor-centre community support. Children encounter bullying, educational exclusion, segregation and decisions concerning healthcare, education and placement made without adequate regard to their evolving capacities, will and preferences. Early support must be voluntary, child-centre and community-based and must not

automatically lead to psychiatric labelling, medication or coercive treatment. These barriers are further intensified by age, poverty, rural residence, ethnicity, language, conflict-related experiences and institutional status. Deaf persons with psychosocial disabilities face additional communication barriers, including the absence of qualified sign-language interpretation.

The report calls for a fundamental transformation of Sri Lanka's legal, policy and support systems. Priority actions include harmonizing the Constitution and all relevant legislation with the CRPD; abolishing disability-based detention, forced treatment and substitute decision-making; ratifying the Optional Protocol to the CRPD; and implementing an adequately funded, time-bound deinstitutionalization strategy that prevents new admissions, closes institutions and redirects resources towards living in the community. The State must also guarantee legal capacity, effective remedies and reparation; ensure equal access to general healthcare, education, employment, housing, transport and social protection; and establish accountable, disability-disaggregated data and monitoring systems. These reforms must be designed, implemented, monitored and evaluated through the close consultation, active involvement and leadership of persons with psychosocial disabilities and their representative organisations. Persons with psychosocial disabilities are not passive recipients of treatment or care, but equal rights holders whose knowledge, agency and leadership must shape all laws, policies and decisions affecting their lives.

Methodology

The CRPD shadow reporting process adopted a peer-led, participatory, and rights-based methodology that placed persons with psychosocial disabilities and their representative organisations at the centre of the reporting process. Consistent with the principle of *"Nothing About Us Without Us,"* persons with psychosocial disabilities were invited to participate not merely as respondents or sources of information, but as contributors to the identification of priority issues, development of research tools, evidence collection, validation of findings, formulation of recommendations, and subsequent advocacy.

The methodology combined primary qualitative evidence with secondary documentary analysis. Primary evidence was gathered through a national consultation that brought together a total of forty-eight (48) participants, including sixteen (16) persons with psychosocial disabilities and their representative organisations, five cross-disability Organisations of Persons with Disabilities (OPDs), service providers in the sectors of community mental health, vocational training, economic development and other relevant stakeholders. In addition, seventeen (17) persons with psychosocial disabilities living in a residential care facility in the Kandy District were identified in consultation with the OPDs

based in Kandy.[1] These residents were consulted separately within the institution with the cooperation of the healthcare staff serving at the facility. The purpose of including these individuals was to ensure that the report reflected a crucial demographic of persons with psychosocial disabilities in Sri Lanka, i.e. those who are living in institutional settings. The participants were informed that their participation was voluntary. To minimize the risk of adverse consequences, they were not asked questions about the institution, its facilities or the care they received. It is acknowledged that this limitation could have restricted participants' ability to discuss their institutional experiences. Separately, three (03) healthcare staff attached to the institution were consulted as service-provider respondents to obtain information on institutional practices, service delivery and systemic challenges; their perspectives were analyzed independently from those of the residents.

Secondary evidence was gathered through a review of national legislation, policies, institutional frameworks, available research and data, and previous list of issues in relation to the report of Sri Lanka by the CRPD Committee[2] The documentary review was used to assess progress in implementing the Convention, identify gaps between CRPD standards and national laws, policies, and practices, and contextualize and triangulate the evidence emerging from the consultation process.

Particular attention was given to accessibility, psychological safety, and trauma-informed participation throughout the evidence-gathering process. Consultation materials and discussions used plain, accessible language, and peer-support mechanisms were incorporated into consultation activities to facilitate meaningful participation and foster a supportive environment in which participants could share their experiences, concerns, and recommendations. Informed verbal consent was obtained from all the participants, where they agreed to their input being used in this shadow report.

The evidence generated through the consultation process and documentary review was subjected to qualitative thematic analysis. Recurring themes and patterns were identified, including systemic barriers, rights violations, implementation gaps, good practices, and emerging priorities concerning Sri Lanka's obligations under the CRPD. The findings were then organised and analyzed against relevant CRPD provisions and standards and used to formulate evidence-based recommendations for consideration by the CRPD Committee.

The methodology enabled the shadow reporting process to extend beyond evidence gathering and report preparation. It also provided a platform for strengthening peer leadership, building advocacy capacity, generating an evidence base for future monitoring

[1] Many major district hospitals in Sri Lanka operate intermediate-stay residential rehabilitation facilities. Consultant psychiatrists refer persons with psychosocial disabilities to these facilities for intermediate support intended to prevent prolonged institutionalization. However, these referrals are not governed by a formal protocol for obtaining the person's free and informed consent.

[2] CRPD/C/LKA/Q/1 <https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/TBSearch.aspx?Lang=En&CountryID=164>

and advocacy, and enabling persons with psychosocial disabilities to participate directly in national and international human rights monitoring and accountability processes.

Legal and Policy Framework

Sri Lanka ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2016, thereby accepting binding obligations to respect, protect, and fulfil the rights of persons with disabilities and to harmonize domestic laws, policies, and institutions with the Convention. The CRPD represents a paradigm shift from medical and welfare-based approaches towards a human rights model that recognises persons with disabilities as autonomous rights holders entitled to equality, legal capacity, dignity, independent living, and meaningful participation in decisions affecting their lives. Despite this commitment, much of Sri Lanka's legal framework governing psychosocial disability predates the CRPD and continues to reflect institutional, paternalistic, and medically driven approaches that are inconsistent with contemporary international human rights standards.

Although the Constitution of Sri Lanka guarantees equality before the law and equal protection of the law under Article 12, disability is not expressly recognized as a prohibited ground of discrimination. Consequently, persons with psychosocial disabilities continue to rely on general constitutional protections rather than comprehensive disability equality legislation. Sri Lanka's principal disability-specific legislation, the Protection of the Rights of Persons with Disabilities Act No 28 of 1996, predates the CRPD and does not adequately recognise or protect several rights guaranteed by the Convention, including equal recognition before the law, access to supported decision-making, independent living and inclusion in the community, and effective protection against disability-based discrimination. Moreover, its definition of a "person with disability" is based on the outdated concepts of individual "deficiency," physical and mental (sic.) incapacity and dependency, rather than the CRPD's human-rights-based understanding of disability as arising from the interaction between impairments and attitudinal and environmental barriers. Moreover, discrimination against persons with psychosocial disabilities extends well beyond mental health legislation and affects their enjoyment of rights across multiple areas across multiple legislation. These laws conflate psychosocial disability with incapacity and apply status-based restrictions and substitute decision-making across legal, economic, property and political life, contrary to articles 5, 12, 13, 19 and 29 of the CRPD.

As a result, constitutional and statutory protections remain fragmented and have not kept pace with the human rights model of disability embodied in the CRPD.

Sri Lanka's mental health and criminal law frameworks also continue to reflect outdated understandings of psychosocial disability. Mental health legislation remains principally governed by the Mental Diseases Ordinance of 1873, a colonial law centre on institutionalization, involuntary detention, and custodial care.

Although several attempts have been made to develop a Mental Health Act to replace the Mental Diseases Ordinance, the drafting process has been dominated by medical professionals, without the meaningful participation of persons with psychosocial disabilities and their representative organisations.[3] This exclusion constitutes a failure to comply with article 4(3) of the CRPD and risks reinforcing paternalistic assumptions that persons with psychosocial disabilities lack the knowledge or capacity to contribute meaningfully to legal and policy reform, while privileging professional expertise over their lived experience and expertise. Furthermore, the draft continues to permit involuntary admission, compulsory treatment, restraint, seclusion and substitute decision-making, notwithstanding the introduction of additional procedural safeguards. In criminal law, the insanity defense under Section 77 of the Penal Code, based on the nineteenth-century McNaughten Rules, excludes criminal responsibility where a person, by reason of "unsoundness of mind", was incapable of knowing the nature of the act or that it was wrong. While intended as a safeguard, the provision reflects an outdated binary conception of mental incapacity and is frequently accompanied by detention and institutional responses rather than rights-based supports.[4] Together with provisions governing fitness to stand trial and forensic detention, these laws continue to conceptualize persons with psychosocial disabilities primarily through incapacity and risk rather than autonomy, participation, and equal recognition before the law.

The CRPD also requires States to replace coercive and institutional models of care with voluntary, community-based, and rights-based systems of support. However, Sri Lanka's legal and policy framework continues to priorities institutional models and clinical decision-making over community inclusion. The proposed Draft Mental Health Act retains extensive coercive powers, while rights-based community support, peer support, supported housing, rights-based crisis support, and mechanisms for independent living remain underdeveloped. Similarly, governance structures proposed under the draft legislation provide only limited representation for persons with psychosocial disabilities, falling short of the CRPD principle of "Nothing About Us Without Us" and Article 4(3), which requires the active involvement of persons with disabilities in all decisions affecting them.

Overall, Sri Lanka's legal and policy framework remains in transition. While important reform initiatives are underway, particularly in relation to mental health legislation, significant inconsistencies remain between domestic law and the requirements of the CRPD. Achieving compliance will require more than replacing outdated legislation; it necessitates a

[3] An official version of the Draft Mental Health Act of Sri Lanka is available in the Ministry of Health website, however, there is evidence of an updated version as at 2026 which has not been shared with the public by the health authorities < https://www.health.gov.lk/wp-content/uploads/2022/08/Draft-Mental-Health-Act-03.05.2026-Final-compressed.pdf>

[4] T V Asokan, "Daniel McNaughton (1813–1865)", *Indian Journal of Psychiatry*, vol. 49, No. 3 (2007), pp. 223–224. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC2902100/
Section 77 of the Penal Code of Sri Lanka (1883) "Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law."

fundamental shift towards recognising persons with psychosocial disabilities as equal rights holders. This includes guaranteeing legal capacity through supported decision-making, progressively eliminating coercive and institutional practices, strengthening community-based supports, ensuring effective access to justice, and embedding the meaningful participation of persons with psychosocial disabilities in law reform, governance, implementation, and monitoring.

Lived Experiences

- **Article 1-4: Purpose, General Principles and Obligations**

Articles 1–4 of the Convention on the Rights of Persons with Disabilities (CRPD) establish the overarching framework for implementation of the Convention. They require States Parties to harmonize domestic legislation, policies and administrative practices with the CRPD; eliminate discriminatory laws and practices; mainstream disability rights across all sectors; and closely consult with and actively involve persons with disabilities, through their representative organisations, in all decision-making processes affecting them.

Although Sri Lanka ratified the CRPD in 2016, thereby committing to harmonize its legal and institutional framework with the Convention, the consultation findings indicate that implementation of these general obligations remains incomplete. While participants acknowledged the development of disability-related policies and ongoing legislative reform initiatives, they consistently observed that these efforts have not translated into meaningful improvements in the lives of persons with psychosocial disabilities. Existing legal and policy frameworks continue to be influenced by medical, charity, and welfare-oriented approaches that priorities treatment, institutional care models, and substitute decision-making over autonomy, participation, and community inclusion. As a result, persons with psychosocial disabilities continue to experience barriers across multiple areas of life, including healthcare, education, employment, access to justice, housing and social protection.

Participants emphasized that the principal challenge lies not in the absence of policies, but in their implementation. They described fragmented institutional responsibilities, weak coordination between government agencies, inadequate allocation of resources, and inconsistent implementation at national, provincial and local levels. These systemic weaknesses are further compounded by the continued dominance of medical approaches to psychosocial disability, persistent stigma within public institutions and society, and the limited recognition of persons with psychosocial disabilities as equal rights holders capable of making decisions and participating fully in public life.

The consultation further highlighted that persons with psychosocial disabilities remain underrepresented in legislative reform, policy development, implementation, monitoring and

evaluation processes. Although opportunities for consultation have increased, participants considered that engagement often remains tokenistic, with decisions continuing to be driven primarily by professionals and institutional actors rather than the lived experiences of persons with psychosocial disabilities. Organisations representing persons with psychosocial disabilities also face significant resource and capacity constraints, limiting their ability to participate effectively in national policy dialogue. Participants therefore emphasized the need to strengthen representative organisations, establish permanent participation mechanisms, and ensure that the principle of "*Nothing About Us Without Us*" is reflected throughout government decision-making.

Finally, participants identified the absence of reliable disability-disaggregated data and effective monitoring systems as significant barriers to implementation. Existing data collection mechanisms rarely capture the experiences, support needs or outcomes of persons with psychosocial disabilities, limiting evidence-based planning, resource allocation and accountability. Participants stressed that strengthening data systems, promoting participatory research, and embedding lived experience within monitoring and evaluation processes are essential to ensuring that future reforms respond to the priorities of persons with psychosocial disabilities themselves.

Overall, the consultation demonstrates that while Sri Lanka has established an important legislative and policy foundation for implementing the CRPD, significant gaps remain in translating these commitments into practice. Achieving compliance with Articles 1–4 requires a coordinated whole-of-government approach that replaces medical and paternalistic models with a human rights-based approach, strengthens institutional accountability, improves inter-agency coordination, invests in representative organisations of persons with psychosocial disabilities, and ensures their meaningful participation in every stage of law reform, policy development, implementation and monitoring.

- **Article 5: Equality and non-discrimination**

Article 5 of the Convention on the Rights of Persons with Disabilities (CRPD) guarantees equality before and under the law, equal protection and equal benefit of the law without discrimination, and requires States Parties to prohibit discrimination on the basis of disability and ensure reasonable accommodation. The consultation findings demonstrate that, for persons with psychosocial disabilities in Sri Lanka, discrimination is not experienced as isolated incidents but as a continuous reality that shapes nearly every aspect of daily life. Participants consistently described discrimination as the primary barrier preventing them from enjoying the rights guaranteed under the Convention. Participants reported that stigma and prejudice continue to define how persons with psychosocial disabilities are perceived and treated within families, communities, workplaces and public institutions. Many described being viewed as incapable, unreliable, dangerous or permanently dependent on others, rather than as individuals with equal rights, opportunities, aspirations and abilities. These

attitudes often result in exclusion from education, employment, family decision-making, community life and public participation, while their opinions, choices and life decisions are routinely disregarded. Participants repeatedly emphasized that the greatest barriers they face are the discriminatory assumptions and attitudes of others.

The consultation further revealed that discrimination has become embedded within communities, institutions and public systems. Participants described encountering unequal treatment when accessing justice, healthcare, social protection and other public services, where their credibility, decision-making ability and entitlement to support are frequently questioned. Many expressed frustration that disability-related policies continue to be developed and implemented without the meaningful participation of persons with psychosocial disabilities, resulting in services and programmes that fail to reflect their lived realities and priorities. Participants also highlighted persistent inequalities in accessing government assistance, noting that psychosocial disabilities are often overlooked within disability assessment and social protection schemes, particularly in rural and conflict-affected areas such as the Northern and Eastern provinces.

Participants consistently called for a shift away from charity and medical approaches towards recognition of persons with psychosocial disabilities as equal rights holders. They stressed that legal reform needs to be complemented by fundamental changes in public attitudes, institutional culture and governance. This includes recognising the expertise of lived experience, ensuring meaningful participation in decision-making, strengthening community-based support systems, eliminating stigma through sustained public awareness initiatives, and embedding psychosocial disability within all disability-inclusive policies and programmes. Participants also identified the absence of reliable data on persons with psychosocial disabilities as a continuing barrier to evidence-based policymaking and accountability, reinforcing their invisibility within national planning and resource allocation.

The consultation demonstrates that discrimination against persons with psychosocial disabilities in Sri Lanka is systemic, structural and intersectional. It is experienced not only through individual prejudice but also through laws, institutions, policies and practices that continue to exclude persons with psychosocial disabilities from equal participation in society. Achieving substantive equality therefore requires more than prohibiting discrimination; it requires transforming the systems, attitudes and power structures that continue to deny persons with psychosocial disabilities equal recognition, equal opportunity and equal participation in all areas of life.

- **Article 10: Right to life**

Article 10 of the Convention on the Rights of Persons with Disabilities (CRPD) recognises the inherent right to life of all persons with disabilities and requires States Parties to take all necessary measures to ensure that they enjoy this right on an equal basis with others. For

persons with psychosocial disabilities, the right to life extends beyond protection against arbitrary deprivation of life to include access to general healthcare, protection from violence and neglect, suicide prevention, and the availability of community-based support that enables individuals to live safely, independently and with dignity.

The consultation findings demonstrate that participants perceive the right to life as being closely linked to the broader social conditions in which they live. Participants consistently described how stigma, discrimination, social isolation and inadequate community support increase vulnerability and undermine wellbeing. Many observed that mental health services continue to focus primarily on responding to crises rather than preventing them, with sustained community-based support. Participants further highlighted significant gaps in child and adolescent mental health services, limited CRPD-compliant care systems, and the absence of comprehensive prevention strategies targeting highly vulnerable groups.

Participants also expressed concern regarding violence, neglect and abuse experienced by persons with psychosocial disabilities, noting that these violations frequently remain hidden because of stigma, fear and limited access to protection and justice. They also highlighted that women, children, and older persons with psychosocial disabilities are at a heightened risk of facing violence. Participants emphasized that individuals experiencing mental health crises, including those who attempt suicide, often do not receive adequate follow-up or long-term psychosocial support after leaving the hospital, increasing the likelihood of repeated crises and further harm. They considered that protecting the right to life requires a shift from crisis-driven responses towards continuous, recovery-oriented support within the community. Furthermore, social, environmental, and systemic barriers that create heightened vulnerabilities need to be identified, and necessary support mobilized accordingly

> *"During crisis situations, a person with a psychosocial disability who has been victimized is often treated as the perpetrator by service providers and the community. As a result, immediate action may be taken—without the person's consent—to institutionalize them or subject them to involuntary treatment, without first investigating the underlying cause of the incident. This remains a common practice in community settings."*

The consultation further highlighted the need to strengthen community mental health systems through multidisciplinary services, family support, peer support networks, school-based mental health promotion, and public awareness initiatives aimed at reducing stigma and encouraging support-seeking behaviour. Participants stressed that protecting life is inseparable from protecting dignity, autonomy and social inclusion, and that a rights-based mental health system must priorities prevention, recovery and community participation rather than institutional care alone.

The consultation demonstrates that the realization of Article 10 requires a comprehensive public health and human rights approach that addresses the social determinants of mental health alongside accessible healthcare and community support. Participants consistently emphasized that persons with psychosocial disabilities should not merely survive but should be supported to live safe, meaningful and fulfilling lives within their communities.

- **Articles 12 and 13: Equal Recognition before the Law and Access to Justice**

Articles 12 and 13 of the Convention recognise that persons with disabilities have the right to enjoy legal capacity on an equal basis with others and to access justice without discrimination. Together, these provisions require States Parties to abolish substitute decision-making regimes and replace them with access to support for exercising legal capacity, while ensuring that justice systems are accessible, responsive and inclusive.

The consultation findings demonstrate that persons with psychosocial disabilities continue to experience significant barriers to being recognized as equal rights holders. Participants consistently described how decisions affecting their lives, including healthcare, finances, property, education and access to public services, are frequently made without their meaningful involvement. This denial of legal capacity is reinforced by the legal framework that permits persons labelled as being of “unsound mind” or “mentally deficient” to be placed under guardianship or made wards of court, with guardians or managers appointed to control their personal and property-related affairs. These provisions should be repealed or amended to replace substitute decision-making with supported decision-making arrangements consistent with Article 12 of the CRPD. Supported decision-making enables a person to choose and control the support they require, in forms appropriate to their circumstances and in accordance with their will and preferences. It must include safeguards against undue influence without reverting to substitute decision-making. However, participants reported that, instead of receiving such support, they were frequently presumed by family members, professionals and public authorities to be unable to understand, communicate or make legally valid decisions solely because of their psychosocial disability. These assumptions restrict personal autonomy and undermine their equal recognition before the law.

Participants further highlighted that limited legal literacy, coupled with laws that permit others to override their decisions, remains a significant barrier to exercising their rights. Knowledge of disability rights and existing legal protections was reported to be inadequate not only among persons with psychosocial disabilities themselves, but also among family members, caregivers, healthcare professionals, police officers and other public officials responsible for implementing the law. Consequently, many participants described barriers to healthcare, public services, social protection and legal remedies, as well as exploitation related to property, finances and other personal affairs. These concerns are particularly significant for persons living in institutional settings, where legal capacity and access to justice may be restricted through involuntary admission and treatment, substitute decision-making,

limitations on movement and control over daily life, finances and property, limited access to independent legal advice and inaccessible complaint mechanisms. The issue is therefore not limited to whether rights holders and duty bearers understand and implement existing protections, but extends to whether Sri Lanka's laws and institutional practices themselves comply with articles 12 and 13 of the CRPD.

"People with psychosocial disabilities are often described as lacking insight. When they report abuse, particularly in cases involving women, perpetrators may exploit their diagnosis by claiming that they are hallucinating or misinterpreting events. As a result, their complaints are frequently dismissed or not taken seriously."

The consultation also revealed persistent barriers in accessing justice. Participants reported that complaints made by persons with psychosocial disabilities are frequently not taken seriously, are inadequately recorded, or are considered less credible because of their recorded 'psychiatric history'. Several participants described instances in which complaints were diverted to mediation rather than investigated through formal legal processes, while others expressed concern that inconsistent interpretations of laws and policies across public institutions result in unequal access to justice and government services. Participants further observed that legal information and administrative procedures are rarely available in accessible and user-friendly formats, limiting their ability to understand and exercise their rights. Legal assistance, legal aid, and affordable legal services are not available for persons with psychosocial disabilities in Sri Lanka in order for victimized individuals to challenge institutionalization, forced treatment, violence, exploitation, or loss of property rights.

A recurring concern throughout the consultation was the disconnect between legislative commitments and implementation. Participants acknowledged that disability-related laws and policies exist but considered that many remain poorly implemented, inconsistently applied and inadequately updated to reflect changing social realities and the CRPD. They emphasized the need for clear operational guidance, regular legislative review, strengthened institutional accountability and systematic monitoring to ensure that legal protections translate into meaningful improvements in the daily lives of persons with psychosocial disabilities.

The consultations demonstrate that barriers to legal capacity and access to justice arise from both discriminatory and CRPD-incompatible laws and deficiencies in their implementation, compounded by paternalistic attitudes, limited awareness and institutional practices that fail to recognise persons with psychosocial disabilities as equal rights holders. Consequently, they are denied equal recognition before the law and excluded from justice processes, including investigation, redress, compensation and protection from retaliation. Realizing articles 12 and 13, therefore, requires the repeal or amendment of discriminatory laws, replacement of

substitute decision-making with supported decision-making, improved legal literacy among rights holders and duty bearers, accessible justice and complaint mechanisms and the integration of autonomy, equality and meaningful participation throughout the legal and administrative framework.

- **Articles 14–17: Liberty and Security of the Person; Freedom from Torture, Cruel, Inhuman or Degrading Treatment; Freedom from Exploitation, Violence and Abuse; and Protecting the Integrity of the Person**

Articles 14–17 collectively protect the liberty, security, dignity and physical and mental integrity of persons with disabilities. Involuntary admission and institutionalization on the basis of actual or perceived psychosocial disability constitute a deprivation of liberty contrary to Article 14, irrespective of whether community-based alternatives are presently available. The absence of such alternatives is itself a failure to implement the right to live independently and be included in the community, and cannot justify disability-based detention. Forced treatment and medication, chemical or mechanical restraint, seclusion and electroconvulsive therapy without free and informed consent also engage articles 15–17 and may amount to violence, abuse, or torture or other cruel, inhuman or degrading treatment.

Participants reported that psychosocial disabilities continue to be associated with fear, unpredictability and dangerousness, leading families, service providers and public authorities to restrict decisions concerning education, employment, marriage, finances, movement and participation in community life. These concerns must be viewed against documented institutional practices: in July 2023, a 48-year-old patient died at the National Institute of Mental Health in Angoda following an alleged assault during restraint, and four health workers were arrested.[5] The Human Rights Commission of Sri Lanka subsequently reported concerns regarding the use of restraints, methods of obtaining consent and inappropriate treatment by staff, observing that some reported practices could amount to torture or degrading treatment.[6] This incident illustrates the potentially grave consequences of institutional practices grounded in coercion, control and assumptions of incapacity and reinforces the need for independent monitoring, accessible complaints mechanisms, effective investigations and remedies, and community-based support that respects autonomy and free and informed consent.

Violence and abuse emerged as recurring themes throughout the consultation. Participants described experiences of physical violence, verbal abuse, economic exploitation, social isolation and sexual abuse occurring within families, workplaces and communities. Older

[5] https://www.dailymirror.lk/print/breaking-news/Two-more-health-workers-arrested-over-patients-death-at-NIMH/108-264193?utm_source=chatgpt.com

[6] Human Rights Commission of Sri Lanka, *Interim Report: Fact-Finding Mission on the Right to Health and Liberty of Patients at the National Institute of Mental Health* (2023). Available at: https://www.hrcsl.lk/wp-content/uploads/2023/12/HRCSLL-Interim-Report-%E2%80%93-Fact-Finding-Mission-on-Right-to-Health-and-Liberty-of-Patients-at-NIMH.pdf

persons with psychosocial disabilities were found to face heightened risks in this regard. The majority of the women residents in the institutional care setting (05) indicated that they faced violence at home. Some reported being hidden from public view, isolated because of stigma, or subjected to degrading language and discriminatory treatment. Economic exploitation, including denial of employment, loss of employment, withholding of wages and exploitation of property, was also identified as a significant concern. Participants considered these experiences to be rooted in persistent societal misconceptions regarding psychosocial disability rather than in the disability itself.

The consultation further highlighted the significant challenges encountered by persons with psychosocial disabilities in obtaining protection and justice following abuse. Participants reported that survivors of violence, particularly sexual violence, frequently experience difficulties reporting incidents, presenting evidence and navigating legal processes. Persons with psychosocial disabilities are most often discredited or not believed on the basis of their disability. Many expressed concern that discriminatory attitudes within institutions undermine the credibility of persons with psychosocial disabilities, leaving abuse unreported, inadequately investigated or unresolved. Participants therefore emphasized the need for accessible reporting mechanisms, trauma-informed support services and procedural safeguards that enable survivors to participate effectively in justice processes. The Human Rights Commission of Sri Lanka has the mandate to monitor places of detention as part of the National Preventive Mechanism (NPM). The 2020-2025 progress report of the Commission records seven (07) visits in 2023 and two (02) visits in 2025 to 'Mental Health Hospitals'. No further evidence is available of frequent visits to psychiatric hospitals, residential facilities, or other places where people with psychosocial disabilities are being confined.

> *"For many young women with psychosocial disabilities, involuntary sterilization occurs upon admission to specialized or rehabilitation institutions. Although the practice is often justified as necessary for their safety and protection, it may also shield perpetrators from accountability."*

Beyond specific incidents of abuse, participants repeatedly described experiences of dehumanization that undermined their dignity and personal integrity. They reported being treated as incapable, burdensome or less deserving of respect, with decisions routinely made without their participation and their wishes frequently disregarded. Homeless persons with psychosocial disabilities are subjected to dehumanizing treatment across age groups. These experiences illustrate that violations of liberty, security and integrity are not confined to institutional settings but are embedded within everyday interactions across families, communities and public institutions.

The consultation demonstrates that the realization of Articles 14–17 requires a fundamental shift away from control, coercion and paternalism towards approaches grounded in autonomy, dignity and human rights. Participants consistently identified the need for repealing legal provisions that authorize disability-based detention and forced treatment and the prohibition and elimination of restraint and seclusion, accessible protection mechanisms, voluntary, non-coercive and rights-based community-based support, public awareness initiatives and professional training to prevent abuse and ensure that persons with psychosocial disabilities can live free from violence, coercion and discrimination.

- **Articles 19, 20, 22 and 23: Living Independently and Being Included in the Community; Personal Mobility; Respect for Privacy; and Respect for Home and the Family**

Article 19 of the Convention on the Rights of Persons with Disabilities (CRPD) recognises the equal right of all persons with disabilities to live independently and be included in the community, with the freedom to choose where and with whom they live and access the individualized support necessary to exercise that choice. Article 20 requires measures to facilitate personal mobility with the greatest possible independence; Article 22 protects privacy, correspondence and the confidentiality of personal, health and rehabilitation information; and Article 23 requires respect for marriage, intimate relationships, parenthood, reproductive autonomy, home and family life on an equal basis with others.

The consultation findings demonstrate that independent living remains one of the most significantly unrealized rights of persons with psychosocial disabilities in Sri Lanka. Participants described exclusion from community life, homelessness, institutionalization and loss of autonomy as consequences not of psychosocial disability itself, but of legislative and policy frameworks that enable institutionalization, deny legal capacity and privilege the decisions of families and service providers, compounded by inadequate community-based services and support. Many reported that decisions concerning where they live, the treatment they receive and whether they remain in the community are made by families, institutions or service providers without meaningful consideration of their will and preferences.

Although Sri Lanka has no single guardianship statute, the Civil Procedure Code and the Judicature Act permit courts to classify persons with psychosocial disabilities as “persons of unsound mind” or “mentally deficient persons,” to make them wards of court, and to appoint guardians or managers over their persons and property. These substitute decision-making mechanisms reinforce the denial of legal capacity and enable others to exercise control over fundamental aspects of their lives, including residence, finances and property.

Participants identified stigma within families and communities as a major barrier to independent living, describing exclusion from family decision-making, community activities and social relationships, as well as overprotective practices that create isolation and unnecessary dependence. They emphasized the lack of accessible housing, income support, personal assistance, peer support, disability-specific services and equal access to mainstream public services, particularly in rural areas. Community-based mental health and psychosocial support must be voluntary, rights-based, individualized and non-coercive, as merely transferring institutional practices and systems of control into community settings does not realise article 19. Institutionalization is not a permissible substitute for unavailable community support; the State must ensure access to adequate housing and the supports necessary for persons with psychosocial disabilities to choose where, how and with whom they live.

The consultation conducted within a residential institution provided particularly powerful evidence of the desire to live and be included in the community. When residents were invited to express their aspirations through drawings, all seven participants independently drew a house or home, conveying a shared wish to return to their communities rather than remain institutionalized. Participants in a separate discussion similarly identified returning home or having a home of their own as a primary aspiration. One participant expressed anxiety that prolonged institutionalization could result in the loss of a government job, illustrating the wider social and economic consequences of institutional care. These findings demonstrate that institutionalization is experienced not as protection, but as separation from home, family, employment, community life and personal identity.

Participants further emphasized that institutionalization is frequently driven by poverty, the absence of appropriate support and inadequate community services rather than by their own needs or preferences. State-funded, person-directed support remains minimal, while community-based services and coordinated follow-up are fragmented and insufficient. Participants therefore called for greater investment in supported housing, personal assistance, peer support, day services, voluntary community-based mental health and psychosocial support, multidisciplinary follow-up, income support and equal access to mainstream services. Deinstitutionalization must encompass not only assisting people to leave institutions, but also preventing new admissions, closing institutional settings, redirecting funding towards community-based support, ensuring genuine choice over residence and preventing smaller residential or congregate facilities from reproducing institutional practices.

Although families can provide essential support, they may also be sources of control, violence or exclusion. Measures to support families must therefore strengthen their capacity to respect the autonomy, will and preferences of persons with psychosocial disabilities, rather than reinforce family authority or substitute decision-making.

Barriers to personal mobility under Article 20 further restrict independent living and community participation. Poverty, inaccessible or unaffordable transport, the absence of individualized mobility assistance and dependence on family members or institutions can prevent persons with psychosocial disabilities from travelling independently to workplaces, educational institutions, healthcare facilities, public services and community activities. Within institutional settings, restrictions on leaving the premises, rigid routines and dependence on staff permission may further limit freedom of movement. The State must therefore ensure access to affordable and accessible transport, person-directed mobility assistance and reasonable accommodation, while removing institutional and administrative restrictions that impede movement on the basis of psychosocial disability.

The consultation also raised serious concerns regarding privacy under Article 22. Restrictions on personal decision-making, communication, movement and control over finances and property can erode privacy and autonomy both within families and institutional settings. Institutional models may enable surveillance, searches of personal belongings, monitoring of telephone calls or correspondence, limited opportunities for private communication and the disclosure of medical or personal information to family members or third parties without consent. Persons with psychosocial disabilities must retain control over their personal, medical and institutional records and be able to communicate privately with family members, peers, advocates and legal representatives. Confidential health and rehabilitation information must not be disclosed without the person's free and informed consent, subject only to the same lawful and narrowly defined limitations applicable to others.

Article 23 concerns extend beyond participation in family activities to the right to form and maintain intimate relationships, marry, establish a family and make reproductive and parenting decisions. Assumptions that persons with psychosocial disabilities are incapable of consenting to relationships, raising children or making reproductive decisions may expose them to restrictions imposed by families, institutions and professionals. These may include interference with intimate relationships, pressure concerning marriage or separation, contraception or reproductive healthcare without free and informed consent, and separation from children based on disability or diagnosis. Sri Lanka must ensure that psychosocial disability is never treated as sufficient grounds for restricting marriage, reproductive autonomy, parenting or contact with children and must provide parents with the individualized support necessary to exercise their parental responsibilities.

The continued reliance on institutional responses reflects failures in law, policy and community-based support rather than the needs or preferences of persons with psychosocial disabilities. In accordance with the Committee's *Guidelines on deinstitutionalization, including in emergencies* (CRPD/C/5), the State should adopt an adequately funded and time-bound deinstitutionalization strategy. This must include the immediate cessation of new

disability-based admissions and recognition of each person's choice of residence, alongside the development of voluntary, individualized and non-coercive community support, accessible housing, personal assistance, mobility support and mainstream services that respect privacy, autonomy, home and family life, and full participation in the community.

- **Articles 25, 26 and 28: Health, Habilitation and Rehabilitation, and Adequate Standard of Living and Social Protection**

Articles 25, 26 and 28 of the Convention recognise the right of persons with disabilities to the highest attainable standard of health without discrimination, access to habilitation and rehabilitation services that promote independence and participation and an adequate standard of living and social protection. The consultation findings demonstrate that persons with psychosocial disabilities continue to encounter significant barriers across all three areas, reflecting a mental health system that remains predominantly within the medical and charity models, primarily focused on treatment and medication compliance.

Participants consistently observed that persons with psychosocial disabilities remain confined within a narrowly medicalized system focused primarily on psychiatric diagnosis, medication and hospital-based treatment, rather than being included across general healthcare and disability-support systems. They reported unequal access to general healthcare, counselling, peer support, psychosocial support and other services necessary for recovery and community inclusion. Community-based services remain geographically uneven and insufficient, particularly in rural areas. Moreover, the location of a service in the community does not itself establish CRPD compliance: community mental health services may reproduce institutional practices through coercive treatment, professional control, surveillance and decision-making that disregards the person's will and preferences. Post-discharge follow-up must therefore be voluntary, person-directed and rights-based and must not extend institutional control into the person's home or community.

Access to health, rehabilitation and social protection is further affected by how psychosocial disability is identified and assessed. Disability identity cards and several forms of assistance are accessed through the Divisional Secretariat system and generally require certification or a recommendation from a government medical practitioner, reinforcing professional control over recognition and eligibility. Although the 2025 *Disability Classification Framework for Sri Lanka* expressly recognises "psychosocial/mental health disabilities" and proposes that assessments consider self-reported experience, functional impact and participation barriers, its implementation, including who conducts assessments, the composition of assessment panels, review and appeal procedures, and its application to identity cards and benefits, requires transparent monitoring and the meaningful participation of persons with psychosocial disabilities. Assessments must not define persons solely by diagnosis, severity or

presumed incapacity, but should identify the environmental barriers and individualized support required for equal participation.

The absence of reliable disability-disaggregated data, including data specifically concerning persons with psychosocial disabilities, contributes to under-identification and exclusion from disability cards, income support, disability allowances, workplace accommodation, vocational training and other public programmes. As beneficiary numbers and official data influence planning, budgeting and evaluation, undercounting can result in inadequate allocations for disability-related costs and community-based support. These additional costs, including medication, counselling, transport, personal assistance, housing and support to access employment and public services, can reduce household income and push individuals and families further into poverty. Social protection must therefore compensate for disability-related additional costs independently of general poverty assistance and should not be limited to persons who satisfy narrowly medical or income-based eligibility criteria.

Participants also identified the cost and availability of transport as barriers to healthcare, employment, vocational training, public services and community participation. Persons with psychosocial disabilities should have equal access to disability-related transport concessions, allowances and individualized mobility support, including where their disability is non-visible or episodic. Disability pensions and allowances must be adequate and accessible, while employers and vocational training providers must provide reasonable accommodation and refrain from excluding persons on the basis of diagnosis or perceived risk.

Public expenditure must be reoriented away from institutional and predominantly clinical responses towards voluntary, non-coercive and individualized support, including accessible general healthcare, adequate housing, income support, personal assistance, peer support, psychosocial support, reasonable accommodation and supported employment. The State should also collect and publish disaggregated data on eligibility, applications, approvals, refusals, appeals, expenditure and outcomes to determine whether persons with psychosocial disabilities benefit equitably from disability identity cards, health services, social protection and community-based support.

Residents described prolonged separation from their homes and communities and consistently expressed a desire to return home or secure housing of their own. Their accounts raise serious concerns regarding the legal basis and voluntariness of their continued residence, whether their free and informed consent has been obtained, and whether placement is subject to regular independent review and to an accessible process for challenging continued institutionalization. Requiring residents to complete or comply with approximately six months of treatment before being permitted to return to the community improperly makes liberty and choice of residence conditional upon treatment compliance. Healthcare staff subsequently reported that referrals by consultant psychiatrists are often

followed by little or no specialist follow-up and that some residents remain beyond six months when families are unwilling or unable to receive them. However, family circumstances are not the fundamental cause of continued institutionalization; the deeper failure lies in the State's lack of accessible housing, income support, person-directed assistance and voluntary community-based alternatives necessary for residents to leave institutions and live independently.

Participants also identified significant inequalities in access to health services for specific groups. Child and adolescent support services remain limited, with insufficient rights-based, age-appropriate and non-coercive support that respects children's evolving capacities, will and preferences and enables their inclusion within families, schools and communities. Deaf persons with psychosocial disabilities reported considerable communication barriers in accessing counselling and mental health services due to the lack of sign language interpretation. Participants further emphasized that prevention, mental health promotion and community awareness continue to receive inadequate attention despite growing mental health needs across the country.

Consultation participants further emphasized that, in alignment with Universal Health Coverage (UHC) principles, the right to health must encompass the full continuum of care, including preventive, promotive, curative, rehabilitative, and palliative mental healthcare. They highlighted that these fundamental requirements remain significantly unmet across the country. Consequently, systemic gaps in public service provision place an acute financial burden on individuals and their families. Participants reported that high out-of-pocket expenditure (OOPE) for essential medications, private consultations, and travel to distant facilities routinely leads to catastrophic health expenditure (CHE). This financial strain rapidly depletes household resources, pushes families deeper into poverty, and directly undermines the capacity of persons with psychosocial disabilities to achieve recovery and independent living.[7]

The consultation further highlighted the close relationship between health, poverty and social protection. Participants described difficulties accessing disability allowances, housing assistance and other welfare programmes because psychosocial disabilities are often inadequately recognized within disability assessment systems. Financial insecurity, unemployment and limited community support frequently increase dependence on families or institutions, undermining opportunities for recovery and independent living.

[7] Fernando, P. T., & Kurukulasooriya, K. N. (2025). *Determinants of out-of-pocket payments for healthcare in Sri Lanka* (Master's thesis, University of Gothenburg). Gothenburg University Publications Electronic Archive (GUPEA). https://hdl.handle.net/2077/89628
Gamage AU, et al. Healthcare access, patient experiences and economic impacts due to COVID-19 pandemic in Sri Lanka. Anuradhapura Medical Journal. 2023;17(1):11–22. DOI: http://doi.org/10.4038/amj.v17i1.7748.

The consultation demonstrates that achieving the rights recognized under Articles 25, 26 and 28 requires a transition from institution-based care towards recovery-oriented, community-based services that integrate healthcare, psychosocial rehabilitation, peer support and social protection. Participants consistently emphasized that recovery is influenced not only by treatment, but also by family support, secure housing, employment, social inclusion and economic security.

- **Articles 9, 21, 29 and 30: Accessibility, Information and Participation in Public, Cultural and Community Life**

Articles 9, 21, 29 and 30 require States parties to remove accessibility barriers, ensure access to information and freedom of expression and guarantee the full participation of persons with disabilities in political, public, cultural and community life. Article 4(3), read with the Committee's general comment No. 7, further requires States to closely consult and actively involve persons with disabilities, through their representative organisations, in the development and implementation of legislation and policies and in all decision-making processes concerning them. This participation must extend to the monitoring and evaluation of laws, policies, programmes and budgets.

Participants understood accessibility as extending beyond the physical environment to include accessible information, clear communication, coordinated public services, reasonable accommodation and individualized support. Many reported that disability-related laws, policies, services and complaint mechanisms are difficult to understand or are not communicated in accessible formats. Limited awareness among public officials and service providers further restricts access to government programmes and legal protections. The State must provide reasonable accommodation and, where required, procedural accommodations to enable persons with psychosocial disabilities to access information, public services, consultations and decision-making processes on an equal basis with others.

Participants also highlighted their limited involvement in decisions affecting their lives. Although consultation opportunities have increased, persons with psychosocial disabilities and their representative organisations remain underrepresented in national policy processes, advisory bodies and governance structures. Mental health and disability policies continue to be predominantly designed and implemented by professionals and service providers, without the close consultation and active involvement of persons with psychosocial disabilities. Participation must not be limited to attendance at one-off consultations or the validation of decisions already made; persons with psychosocial disabilities and their organisations must exercise leadership and have an effective role in setting priorities, allocating resources and designing, implementing, monitoring and evaluating laws, policies and services.

Significant barriers also remain in exercising political rights under Article 29. Article 89(c) of the Constitution excludes persons found or declared to be of "unsound mind" from voting,

thereby linking political participation to legal-capacity status. Persons with psychosocial disabilities may also encounter barriers in registering and voting, accessing political information, joining political parties, standing for elected office and participating in public bodies because of stigma, inaccessible procedures, inadequate reasonable accommodation and assumptions regarding their capacity. The State must repeal disability-based restrictions on political rights and ensure accessible electoral information, voting procedures, political meetings and support for participation and leadership.

Participants further described exclusion from community activities, recreation, cultural events and public life because of stigma and persistent misconceptions regarding psychosocial disabilities. They emphasized that community inclusion requires more than access to services: it requires equal opportunities to contribute, organise, represent others and exercise leadership in political, cultural and community life.

These barriers are intensified by intersecting forms of discrimination. Women, young and older persons with psychosocial disabilities, persons living in rural and estate communities, persons experiencing poverty and those living in institutions may face additional barriers to information, mobility, technology, public services, representation and leadership. Consultation and participation mechanisms must therefore be accessible, geographically inclusive, gender- and age-responsive and supported with the accommodations and resources necessary to ensure that persons who are most marginalized are not excluded.
Accessibility, participation and leadership are mutually reinforcing rights. Compliance requires not only removing communication and institutional barriers, but also recognising representative organisations of persons with psychosocial disabilities as equal partners and resourcing their sustained and independent participation throughout the entire decision-making cycle.

- **Articles 6, 7 and 8: Women, Children and Awareness-Raising**

Articles 6, 7 and 8 recognise the multiple and intersecting forms of discrimination experienced by women and children with disabilities and require States Parties to promote awareness and combat harmful stereotypes. The consultation findings demonstrate that women and children with psychosocial disabilities experience intersecting discrimination arising from stigma, gender and age-based inequality, limited awareness of their rights and inadequate knowledge and capacity within families, schools and communities to provide the support and reasonable accommodation necessary for their full participation in everyday life.
Consultations at the residential rehabilitation facility were conducted individually with each woman, rather than in a group setting, to facilitate confidential and sensitive disclosure. Seven of the eight women disclosed violence within their family homes before admission, including physical abuse by fathers, brothers or other male relatives. Women also described community stigma, social rejection, loss of employment and inadequate family support. Several reported that they could not return home after completing treatment because their

families were unwilling to receive them. These accounts demonstrate that returning to the family home cannot automatically be regarded as safe or consistent with the woman's will and preferences, as it may expose her to renewed violence, control or rejection. Deinstitutionalization must therefore include safe and accessible housing, income support, survivor-centre services and voluntary, person-directed community support, rather than relying solely on family reunification.

The concerns under Article 6 extend beyond domestic and gender-based violence. Women with psychosocial disabilities may also experience forced treatment and institutionalization; denial of sexual and reproductive autonomy, including forced contraception, sterilization or abortion; loss of child custody or parenting rights; economic dependence and exploitation involving income, finances or property; and barriers to police, courts, shelters, healthcare and other protection and redress mechanisms. These violations arise at the intersection of gender, disability and assumptions of incapacity and must be addressed across mental health, disability, family, property, social-protection and justice systems.

Children with psychosocial disabilities emerged as a priority concern throughout the consultation. Participants described discrimination, bullying, exclusion and interrupted education arising from ableism, gender inequality, stigma and the denial of children's autonomy, rather than merely from insufficient knowledge of mental health. Any early support must be voluntary, child-centre, community-based and appropriate to the child's age and evolving capacities. It should not automatically result in psychiatric diagnosis, segregation, medication or other medical intervention, but should priorities reasonable accommodation, inclusive education and non-medical forms of family, peer and community support.

Schools should be required to prevent and respond to exclusion through enforceable anti-bullying policies, accessible and child-sensitive complaint mechanisms, reasonable accommodation and clear accountability procedures. Teacher training should therefore address the rights of children with psychosocial disabilities and how to provide inclusive, non-coercive support, rather than focusing solely on identifying symptoms or referring children to psychiatric services. In accordance with article 7, children must also receive age-appropriate support to express their views and participate meaningfully in decisions concerning their education, healthcare, family life and any proposed institutional placement, with due weight given to their will and preferences.

Awareness-raising was identified as a cross-cutting priority. Participants observed that stigma and stereotypes portraying persons with psychosocial disabilities as incapable, dependent, dangerous, burdensome or objects of ridicule continue to shape family relationships, public services, employment, education and community participation. Government policies, public communications, educational materials and media reporting should therefore be

systematically reviewed to determine whether their language and representations reinforce these stereotypes or promote autonomy, equality and inclusion. In accordance with article 8, sustained awareness-raising must affirm the rights, dignity, agency and contributions of persons with psychosocial disabilities and recognise them as equal rights holders and full members of their communities, rather than focusing only on correcting medical misconceptions.

- **Articles 24 and 27: Education and Work and Employment**

Articles 24 and 27 recognise the rights of persons with disabilities to inclusive education and to work and employment on an equal basis with others. The consultation findings demonstrate that exclusion from education has lifelong consequences, restricting access to decent work, income, economic independence and participation in society. Although section 23 of the Protection of the Rights of Persons with Disabilities Act prohibits discrimination in admission to educational institutions and recruitment for employment, it does not establish a comprehensive and enforceable duty to provide reasonable accommodation or protect against discrimination throughout education and employment.

Among residents consulted within the rehabilitation facility, eight of the nine men reported having received little or no meaningful education. Participants attributed interrupted schooling and exclusion to stigma and inadequate educational support. Although many women had accessed education, they subsequently encountered employment barriers arising from discrimination, domestic violence, family rejection and community stigma. These findings demonstrate how gender, disability and socio-economic circumstances create different pathways towards similar outcomes of unemployment, dependence and economic insecurity.

Educational inclusion requires more than admission to school. Participants' experiences raise concerns regarding whether schools provide reasonable accommodation, individualized support, flexible teaching and assessment, accessible counselling, anti-bullying protections and inclusive learning environments. Persons with psychosocial disabilities must also have equal access to universities and other tertiary institutions, mainstream technical and vocational education, adult education and lifelong learning. Available research has identified continuing limitations in the capacity, accessibility and range of vocational training for persons with disabilities in Sri Lanka, while existing programmes do not consistently address the requirements of persons with psychosocial disabilities. Education and vocational institutions should provide support based on individual requirements and preferences rather than diagnosis, segregation or assumptions of incapacity.

Participants also described discrimination in recruitment and employment, including dismissal following the onset or disclosure of psychosocial disability, denial of reasonable accommodation, reduced benefits and employer reluctance to retain workers. Inaccessible

recruitment procedures, inflexible working hours and attendance requirements, the absence of confidential accommodation processes and the limited availability of supported employment and return-to-work programmes create additional barriers. Necessary accommodations may include flexible schedules, modified duties, gradual return to work, remote or hybrid arrangements, changes in supervisory practices, leave for disability-related requirements and access to peer or workplace support. These measures should be determined with the employee and must not be conditioned on unnecessary disclosure of confidential medical information.

Restrictions on legal capacity and substitute decision-making may further prevent persons classified as being of “unsound mind” or “mentally deficient” from entering or exercising control over employment contracts, bank accounts, wages and other income. Employment support must therefore be accompanied by recognition of legal capacity and access to supported decision-making, ensuring that persons with psychosocial disabilities retain control over their work, earnings and financial affairs.

The existing public-sector employment quota has not resulted in equal access to public employment, and participants reported an absence of effective enforcement, monitoring and structured support for recruitment, retention and career advancement. The State should collect disability-disaggregated data, including data on psychosocial disability, across school completion, tertiary and vocational education, recruitment, retention, accommodation, promotion, wages and dismissal. Compliance with articles 24 and 27 requires enforceable reasonable-accommodation duties, inclusive mainstream education and training, accessible recruitment, supported employment and job-retention programmes, and protection against discrimination throughout the entire education and employment cycle, not merely at the points of admission or recruitment.

Recommendations

1. **Harmonize domestic legislation with the CRPD**

Undertake, in close consultation with and with the active involvement of persons with psychosocial disabilities and their representative organisations, a time-bound review and reform of the Constitution; the Protection of the Rights of Persons with Disabilities Act No. 28 of 1996; the Mental Diseases Ordinance; the draft Mental Health Act; the Penal Code; the Code of Criminal Procedure Act; the Civil Procedure Code; and the Judicature Act. The review should:

- amend articles 12 and 89(c) of the Constitution to expressly prohibit disability-based discrimination and remove disenfranchisement based on “unsoundness of mind”;
- repeal provisions authorizing deprivation of liberty, involuntary admission, forced treatment or detention on the basis of actual or perceived psychosocial disability,

including relevant provisions of the Mental Diseases Ordinance and sections 374–386 of the Code of Criminal Procedure;

- ensure that any future Mental Health Act prohibits forced treatment, medication, restraint, seclusion and electroconvulsive therapy without free and informed consent;
- repeal guardianship and other substitute decision-making provisions, including relevant provisions of the Civil Procedure Code and Judicature Act, and establish supported decision-making arrangements based on the person's will and preferences;
- remove derogatory and medicalized terminology, including "unsound mind," "mentally deficient," "idiot," "deficiency" and similar expressions, from all legislation and policies; and
- adopt a CRPD-compliant understanding of disability that recognises disability as arising from the interaction between impairments and attitudinal and environmental barriers and affirms the autonomy, legal capacity and equality of persons with psychosocial disabilities.

2. Ratify the Optional Protocol to the CRPD

Ratify the Optional Protocol to the CRPD without further delay, thereby recognising the competence of the Committee to receive individual communications and conduct inquiries into grave or systematic violations, and establish accessible mechanisms to inform persons with disabilities and their representative organisations about the procedures available under the Protocol.

3. Recognise persons with psychosocial disabilities as equal rights holders

Adopt comprehensive anti-discrimination legislation that explicitly prohibits direct, indirect, multiple and intersectional discrimination, including the denial of reasonable accommodations on the basis of psychosocial disability in all areas of public and private life and guarantees the right to reasonable accommodation.

4. Ensure meaningful participation

Establish permanent mechanisms to ensure the meaningful participation and leadership of persons with psychosocial disabilities and their representative organisations in the design, implementation, monitoring and evaluation of legislation, policies, programmes and budgets affecting them, consistent with Article 4(3) of the Convention. Furthermore, caregivers, professionals, and service providers should not be considered within the ambit of representative OPDs.

5. Implement deinstitutionalization with the aim of transitioning towards living in the community

Adopt and implement an adequately funded, time-bound national deinstitutionalization strategy, consistent with the Committee's *Guidelines on deinstitutionalization, including in emergencies* (CRPD/C/5). The strategy should:

- immediately end new disability-based institutional admissions;
- develop individualized, person-directed plans and provide the support necessary for every person to leave institutional settings;
- establish clear timelines and measurable targets for closing all institutions;
- redirect public funding from institutions towards accessible housing, income support, personal assistance, peer support and voluntary, individualized community-based services;
- guarantee each person's genuine choice over where, how and with whom they live, in accordance with their will and preferences;
- ensure access to mainstream healthcare, education, employment, social protection and other public services; and
- prevent large institutions from being replaced by smaller residential, congregate or "community-based" settings that reproduce segregation, coercion, surveillance or institutional control.

6. Ensure voluntary, person-directed and rights-based community support

Develop accessible, voluntary, person-directed and non-coercive community-based support systems that respect the autonomy, legal capacity, will and preferences of persons with psychosocial disabilities and enable their full participation in community life. Repeal or amend all legislation, policies and professional protocols that authorize involuntary admission, forced treatment or medication, chemical or mechanical restraint, seclusion or electroconvulsive therapy without the person's free and informed consent. These practices must not be permitted on the basis of disability, diagnosis, perceived risk, family consent or professional decision-making. Redirect resources towards peer support, personal assistance, supported housing, income support and other individualized services chosen and controlled by the person.

7. Strengthen family and community support

Develop comprehensive support programmes for persons with psychosocial disabilities and their chosen support networks, including counselling, respite services, parenting support, community rehabilitation and post-discharge follow-up, to prevent and eliminate institutionalization and facilitate successful inclusion and living in the community.

8. Guarantee legal capacity and equal access to justice

Recognise and protect the legal capacity of persons with psychosocial disabilities on an equal basis with others in all areas of life. Repeal discriminatory laws that restrict or deny legal capacity, abolish guardianship and other substitute decision-making regimes, and establish supported decision-making arrangements based on the person's will and preferences. Ensure reasonable and procedural accommodations throughout all legal and administrative proceedings, accessible legal information, and independent, affordable and adequately funded legal aid. Establish accessible and independent mechanisms through which persons

may promptly challenge institutionalization, deprivation of liberty, forced treatment and other coercive practices, without fear of retaliation. Ensure effective investigation, accountability and access to remedies and reparations, including compensation, rehabilitation, restitution, satisfaction and guarantees of non-repetition, for persons subjected to institutionalization, coercion, violence or other rights violations. Provide mandatory CRPD-based training for police officers, lawyers, judges, prosecutors, healthcare professionals and other relevant personnel.

9. Prevent violence, abuse and coercion

Strengthen legislative, policy and institutional safeguards to prevent physical, psychological, sexual and economic violence, exploitation and abuse against persons with psychosocial disabilities.

Establish accessible, confidential and trauma-informed reporting, protection and redress mechanisms, while strengthening independent monitoring of mental health and residential institutions.

10. Ensure equal access to inclusive healthcare and voluntary support services

Ensure that persons with psychosocial disabilities have equal access to affordable, quality general healthcare, sexual and reproductive healthcare, preventive care, emergency services, specialist care and voluntary habilitation and rehabilitation, without discrimination, segregation or diagnostic overshadowing. Healthcare must be trauma-informed, gender-responsive, age-appropriate and culturally and linguistically accessible, with reasonable accommodation and accessible communication, including sign-language interpretation for Deaf persons with psychosocial disabilities.

Ensure access to all essential medicines required for general and disability-related healthcare, not only psychotropic medication, while preventing a medication-centre model of support. All services, including counselling, peer support and other person-directed community support, must be voluntary, non-coercive and based on free and informed consent. Access to healthcare, social protection or community services must never be conditional upon psychiatric medication, treatment compliance or participation in rehabilitation programmes.

11. Guarantee inclusive education and equal access to employment

Ensure that children with psychosocial disabilities receive voluntary, child-centre and non-coercive support that respects their rights, evolving capacities, will and preferences. Require educational institutions to provide reasonable accommodation and individualized support, prohibit disability-based exclusion and segregation, establish accessible anti-bullying and complaint mechanisms, and enable children to participate meaningfully in decisions affecting their education and support. Ensure equal access to tertiary education, vocational training, adult education and lifelong learning without making participation conditional upon diagnosis, medication or treatment.

Amend and effectively implement the Protection of the Rights of Persons with Disabilities Act and all employment laws, policies, quotas and programmes to expressly include persons with psychosocial disabilities. Prohibit discrimination throughout recruitment, employment, retention, promotion and return to work; require reasonable accommodation, including flexible working arrangements; and develop voluntary, person-directed supported-employment programmes. Collect disaggregated data and establish effective monitoring, complaint and remedy mechanisms to ensure that public- and private-sector employers comply with these obligations.

12. Guarantee the rights and economic inclusion of women with psychosocial disabilities

Ensure that women with psychosocial disabilities enjoy sexual and reproductive autonomy, parental and child-custody rights, and economic and property rights on an equal basis with others. Prohibit forced or coerced contraception, sterilization, abortion, pregnancy termination and other reproductive procedures and ensure that all sexual and reproductive healthcare is based on free and informed consent. Psychosocial disability must never be used to justify separation from children, denial of custody or restrictions on parenting; instead, women must receive the individualized support necessary to exercise their parental responsibilities.

Reform disability assessments and eligibility criteria to ensure equitable access to disability allowances, safe and accessible housing, income support, legal aid, livelihood and employment programmes, and other social-protection measures. Establish accessible mechanisms to prevent and remedy economic abuse, property exploitation and the denial of control over income, benefits and assets, particularly for women experiencing violence, poverty, institutionalization or family rejection.

13. Protect the full range of rights of women and children with psychosocial disabilities

Adopt targeted, gender-responsive and age-appropriate measures to prevent, investigate and remedy all forms of violence, exploitation and abuse against women and children with psychosocial disabilities, with accessible, trauma-informed and survivor-centre protection, complaint and justice mechanisms. Guarantee women's sexual and reproductive autonomy and prohibit forced or coerced contraception, sterilization, abortion, treatment and other medical or reproductive procedures. Ensure equal rights to marriage, intimate relationships, parenthood, child custody, property, inheritance, income and economic participation, and prohibit the restriction of these rights on the basis of psychosocial disability.

Ensure that children with psychosocial disabilities receive voluntary, child-centre, community-based and non-coercive support that respects their rights, evolving capacities, will and preferences. Prohibit forced treatment, unnecessary family separation, institutionalization and exclusion from education and provide reasonable accommodation, inclusive learning

environments and accessible complaint mechanisms. Women and children must be supported to participate meaningfully in all decisions affecting their healthcare, education, family life, residence and access to justice.

14. Guarantee accessibility of information, communication and public services

Adopt enforceable accessibility standards requiring all public authorities and service providers to provide information, communications, administrative procedures, complaint mechanisms and public services in plain language and other accessible formats. Ensure reasonable accommodation, communication assistance and procedural accommodation according to individual requirements, including in healthcare, education, justice, social protection, cultural life and recreation. Establish accessible complaints and remedy mechanisms, dedicated budgets, trained personnel and independent monitoring of compliance.

15. Remove barriers to political participation and leadership

Repeal article 89(c) of the Constitution and all other laws and policies that restrict voting, candidacy, public office or political participation on the basis of "unsoundness of mind," psychosocial disability or legal-capacity status. Ensure accessible voter registration, electoral information, polling procedures, political meetings and party processes, with reasonable accommodation and support chosen by the person. Promote the representation and leadership of persons with psychosocial disabilities within Parliament, local government, political parties, public bodies and other decision-making structures.

In accordance with article 4(3) and general comment No. 7, establish legally mandated mechanisms for close consultation and active involvement of persons with psychosocial disabilities through their representative organisations in the design, implementation, budgeting, monitoring and evaluation of all relevant laws, policies and programmes. Their participation must extend beyond one-off consultation and include leadership, agenda-setting and decision-making authority.

16. Transform public attitudes and representations of psychosocial disability

Develop and fund a long-term national strategy that affirms the rights, dignity, autonomy, agency, leadership and contributions of persons with psychosocial disabilities as equal members of society. Systematically review and amend derogatory, medicalized and paternalistic language in legislation, government policies, official communications, educational materials and public campaigns, including terminology that portrays persons as incapable, dependent, dangerous or burdensome.

Establish rights-based standards for media reporting and public communications, developed with representative organisations of persons with psychosocial disabilities, to prevent ridicule, sensationalism, disclosure of confidential information and the reinforcement of

harmful stereotypes. Integrate disability equality and human-rights education into school curricula and mandatory professional training for healthcare personnel, educators, police officers, judges, lawyers, social workers, journalists and public officials. Persons with psychosocial disabilities and their organisations should lead the design, delivery and evaluation of these initiatives.

17. Establish accountable whole-of-government CRPD implementation

Establish, through legislation, a permanent whole-of-government mechanism with a clear mandate to coordinate implementation of the CRPD across health, justice, education, employment, housing, transport, disability affairs, social protection and local government. Define the responsibilities, timelines and measurable obligations of each institution and provide dedicated budget lines, adequately trained staff and transparent implementation plans.

Ensure the full and effective participation and leadership of representative organisations of persons with psychosocial disabilities at every level of the mechanism. Establish independent monitoring consistent with article 33(2), accessible complaint and accountability procedures and mandatory public reporting on expenditure, progress, barriers and outcomes. Coordination must not weaken the responsibility of individual ministries and public bodies to comply with the CRPD.

18. Establish participatory and rights-based data, monitoring and research systems

Require the Department of Census and Statistics, in collaboration with the National Secretariat for Persons with Disabilities and representative organisations of persons with psychosocial disabilities, to establish a coordinated, CRPD-compliant national framework for disability-disaggregated data, monitoring and research. Within 12 months, audit existing census, disability-card, administrative, health, education, employment, justice and social-protection databases to determine how persons with psychosocial disabilities are recognized, classified, counted or excluded, and revise the definitions, questions and indicators used.

The framework should require:

- regular publication of anonymized data on institutionalization, involuntary admission and treatment, restraint, seclusion, deaths and injuries in institutions, complaints, investigations, remedies and deinstitutionalization outcomes;
- disaggregated data on access to housing, income support, disability allowances, healthcare, education, employment, reasonable accommodation, legal aid, protection from violence and political participation;
- further disaggregation by sex, age, ethnicity, language, district, rural or urban residence, socio-economic status and institutional residence;
- dedicated budget lines and indicators showing how public expenditure is distributed between institutions and voluntary, individualized support for independent living;

- independent monitoring and public reporting by the national human rights institution and the mechanism designated under article 33(2); and
- dedicated funding for participatory and peer-led research.

Persons with psychosocial disabilities and their representative organisations must be closely consulted and actively involved, including through paid leadership roles, in determining research priorities, definitions, indicators and collection methods and in analyzing, interpreting and publishing findings. All data collection must ensure informed participation, privacy, confidentiality and data protection and must not create identifiable registries or be used to justify surveillance, coercive intervention, denial of legal capacity or institutionalization. Findings, budgets and outcomes should be published regularly in accessible formats and used to guide policy, resource allocation, independent monitoring and reporting under the CRPD.