



OPD Leadership in Deinstitutionalization

A Case Study of Process, Design and Practice



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ISBN: 978-9392971-98-3

Citation:

*TCI, & CBM-A. (2026). OPD Leadership in
Deinstitutionalization A Case Study of Process,
Design and Practice [Case Study].*

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Abbreviations

Acronym	Description
CoP	Community of Practice
DFAT	Department of Foreign Affairs and Trade
DI	Deinstitutionalization
IDEARS	International Disability Equity and Rights Strategy
OPD	Organization of Persons with Disabilities
TCI	Transforming Communities for Inclusion
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

Glossary of Terms

Term	Description
Community support services	Supports and services that enable persons with disabilities to live independently and be included in the community, including peer support, personal assistance, housing, social protection, livelihood assistance, crisis support, and supported decision-making.
Community support systems	Relational and collective networks within families, neighbourhoods, and communities that provide non-coercive support grounded in social connection, trust, mutual aid, and belonging.
Coercive intervention	Practices that restrict liberty or autonomy including involuntary admission, forced treatment, restraint, seclusion, and substituted decision-making.
Deinstitutionalization	A rights-based process to end institutionalization and enable independent community living by restoring autonomy, choice, dignity, and control through system transformation.
Independent living	The right of people with disabilities to choose where and with whom they live and to access the supports required to exercise this choice on an equal basis with others.

Term	Description
Institutionalization	Any situation where people with disabilities are deprived of liberty, autonomy, choice, or control due to segregation, coercion, or substituted decision-making, regardless of setting.
Legal capacity	The right to be recognised as a person before the law and to make decisions about one's own life.
Meaningful participation	Effective, informed, and safe involvement of people with disabilities and their representative organizations in decision-making process, supported by reasonable accommodation.
Organization of Persons with Disabilities	An organization led and governed by people with disabilities, representing their interests in advocacy, policy and practice.
Peer Support	Support provided by people with psychosocial disabilities to others with shared lived experience, based on mutuality and non-hierarchical relationships.
Procedural safeguards	Legal or administrative measures intended to protect individual rights within systems of authority, such as legal aid, review mechanisms, and monitoring.
Reasonable accommodations	Necessary and appropriate modifications or supports enabling equal participation without imposing a disproportionate burden.
Substituted decision making	Decision-making on behalf of a person's based on perceived incapacity, replacing the persons will and preferences.
Supported decision making	An approach that respects legal capacity by providing assistance to understand, make, and communicate decisions based on will and preferences.
Psychosocial disability	Disability arising from the interaction between psychosocial distress experiences and social, legal, and environmental barriers.
Trauma-informed practices	An approach that recognises trauma, prioritises safety and agency, and avoids re-traumatisation.

About TCI Global:

Transforming Communities for Inclusion (TCI Global) is an Organization of Persons with Psychosocial Disabilities (an OPD) and post-CRPD inclusion movement of persons with psychosocial disabilities and its cross-disability supporters. It is a membership-based organization from the Global South, with a presence in **21 countries** spread across various sub regions of South Asia, South-East Asia, Pacific, East Asia, East Africa, and Latin America. TCI also has a small set of members from

Europe and United States of America. Our identity of person with psychosocial disabilities is derived from the CRPD description of the disability and is inclusive of persons who identify as 'users and survivors of psychiatry, 'mad persons', persons who have been targeted as 'of unsound mind', autistic persons, persons with intersectional and neurodiverse identities, including persons with psychosocial disabilities.

About the Community of Practice on Deinstitutionalization (CoP)

The Community of Practice on Deinstitutionalization was developed by TCI Global and grew out of the observed need to bring together TCI members working on deinstitutionalization processes for greater support, knowledge sharing, and networking. The CoP ran virtually from July 2024-December 2025 with support from CBM Australia provided under the CBM-Nossal – DFAT

partnership on disability inclusive development. Members representing organizations in the Asia-Pacific region were invited and participants included organizations from Fiji, Taiwan, Sri Lanka, Indonesia, Nepal, and India. The group was facilitated by TCI Global with co-facilitation support from CBM Australia, and met quarterly online, and once in-person during TCI Global's annual plenary and strategic meetings.



Acknowledgments

We would like to thank the following organizations that participated in the CoP and generously shared their time, experience and insights.



KOSHISH,
Nepal



Psychiatric Survivors
Association, Fiji



Indonesia Revolution and
Education for Social Inclusion,
Indonesia



The Red Door,
India



Ya_All,
India



Taiwan
Mad Alliance, Taiwan



Bapu Trust for Research
on Mind & Discourse, India



Indonesia Mental
Health Association,
Indonesia



NIDAHAS CHINTHANA SANSADAYA
Consumer Action Forum (CAF)

Nidahas Chinthana Sansaday
Consumer Action Forum, Sri Lanka

This report was prepared by Aleisha Carroll (CBM Australia) with peer review from Lucy Daniels (CBM Australia), Dr. Richa Sharma-Dhamorikar (TCI Global) and Waqar Shahid Puri (TCI Global).

Disclaimer

This publication was prepared under the DFAT – CBM Inclusion Advisory Group Disability Inclusion Technical Partnership, an Australian aid initiative implemented by CBM Inclusion Advisory Group and the Nossal

Institute for Global Health at the University of Melbourne.

This publication has been funded by the Australian Government through the Department of Foreign Affairs and Trade. The views expressed are the authors' alone and are not necessarily the views of the Australian Government.

Please respect the integrity of the content and refrain from editing or altering in any way.

Executive Summary

This case study examines how organizations of people with disabilities (OPDs), specifically those representing people with psychosocial disabilities, are engaging in deinstitutionalization (DI) processes across the Asia Pacific region. It draws on interviews with disability leaders from Sri Lanka, India, Indonesia, Nepal, Taiwan and Fiji, as well as insights generated through TCI Global's CoP on Deinstitutionalization, which ran from 2024–2025.

Despite broad ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), institutionalization remains one of the most significant and persistent human rights violations experienced by people with disabilities in the region. OPDs are at the forefront of advocating for rights based alternatives and challenging systems that continue to legitimize segregation, coercion, and denial of legal capacity.

This study fills an important gap by documenting how OPDs conceptualize institutionalization, how they are leading complex, multi layered strategies to advance community inclusion and DI in their contexts, and the challenges they are facing in doing so.

Across contexts, OPDs emphasised that **institutionalization is not defined by buildings but by loss of liberty, choice, autonomy, and control**. Institutionalization can occur in homes, hospitals, shelters, monasteries, rehabilitation centres, and other facilities where people experience control, coercion, restraints, isolation, substituted decision making, restrictions on their movement and contacts, and medicalization and forced treatment. **DI therefore is not understood as simply being about closing facilities, but rather as restoring choice, control, and dignity** by transforming the systems and social structures that perpetuate segregation and providing supports required to enable community inclusion.

OPDs described **institutionalization as arising from intersecting structural, economic, cultural and systemic drivers**, including:

- Lack of accessible, community based support options
- Medicalized responses to distress and crisis
- Poverty, housing insecurity, and inadequate social protection
- Stigma and misconceptions about psychosocial disability, including perceptions that people with disability are dangerous or incapable
- Charitable or “protective” approaches by families, service providers, religious organizations, and the state
- Lack of dialogue, skills or support for families during times of crises
- Policy frameworks that reinforce confinement, not inclusion

A “**revolving door**” pattern where people with psychosocial disabilities cycle between home, hospitals, shelters, and institutions was repeatedly identified. This is sustained by the absence of alternatives and entrenched discriminatory systems.

The study identified that DI processes involve multiple, interlinked strategies and approaches, and it is important that OPDs have agency to adopt these in line with their organizational capacity and contextual factors.

Key strategies include **identifying and analyzing the drivers of institutionalization, as well as building inclusive community based support systems**. Activities here include mobilising village level or neighbourhood support systems, training “inclusion champions” and building local referral pathways, creating safe spaces and psychosocial wellbeing groups, peer to peer support (universally prioritized across OPDs), economic and housing assistance to prevent institutionalization, supporting family members through education, crisis planning and access to social protection, and individual advocacy, including securing release from institutions.

Case examples from Fiji, India, Nepal, Sri Lanka, Taiwan and Indonesia illustrate how OPDs respond directly to crises, disrupt institutional placement, and support individuals to rebuild networks and autonomy in community settings. Influencing legal and policy environments is another critical strategy, with OPDs driving reforms that recognize confinement and isolation as rights violations, promote supported decision making, reduce or challenge forced

treatment and involuntary detention, and embed DI within social protection, gender justice, and community development policies. Cross movement collaboration and evidence generation, as well as reflexive approaches including adopting framing of DI and addressing the needs of those experiencing compounding discrimination, are also key.

OPDs face many challenges in undertaking this work. There are ethical dilemmas around participating in mental health systems that violate rights, as well as pressure around balancing the need to respond to immediate crises while also advancing long term reforms. Chronic underinvestment in community based support systems, and skill gaps in peer support and community based services, place huge strains on OPDs and services, as do donor funding structures that prioritise short term or activity based projects that do not necessarily align with the OPDs’ own agenda. Emotional burnout and vulnerability due to lived experience and resource scarcity are apparent.

Despite this, OPDs continue to demonstrate resilience, creativity, and leadership.

This study provides critical insight into how OPDs in the Asia Pacific region are playing a central, indispensable role in advancing deinstitutionalization, how they understand this, and what supports are needed to advance DI in ways that are sustainable, rights based and locally grounded. It provides insights and opportunities for actions that State Parties, OPDs and development partners can take to progress deinstitutionalization, including:

- Deinstitutionalization can be reframed as building inclusive, rights-based community support systems rather than simply closing buildings.
- OPDs should lead this transformation by strengthening cross-movement alliances, investing in practice-based evidence and advocacy, and piloting scalable community support models in partnership with local governance.
- States parties are urged to embed DI within broader development agendas, redirect budgets from institutions to community-based services, repeal coercive laws, and ensure OPDs have a central role in design, implementation and monitoring of DI efforts.
- Development partners should provide flexible, multi-year funding to OPDs, create dedicated funding streams for DI, and support systems-change initiatives, legal advocacy and attitudinal campaigns.
- Across all stakeholders, emphasis must be placed on intersectional and gender-responsive approaches, evidence generation, and convening national and regional dialogues to sustain reform efforts.

These actions collectively advance autonomy, dignity, and social inclusion, aligning with international human rights standards and promoting sustainable alternatives to institutionalization.

A woman with dark hair tied back, wearing a grey shirt and a patterned orange and brown sari, is seated at a desk. She is focused on drawing on a piece of white paper with a red marker. She has several red and white bangles on her left wrist. In the background, other students are visible, also working at their desks. The scene is set in a classroom or workshop environment.

Introduction

The adoption of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) by the UN General Assembly in December 2006 was the culmination of decades of activism and advocacy for the rights of persons with disabilities. Most countries in the Asia-Pacific region have since ratified the UNCRPD and are State Parties to the Convention and the remaining countries have signed with intention to ratify. Despite this, institutionalization continues to be one of the gravest human rights violations facing persons with disabilities in the Asia-Pacific. In September 2022, the United Nations Committee on the Rights of Persons with Disabilities, under the Human Rights Council, issued *Guidelines for Deinstitutionalization, including in Emergencies* ('the Guidelines'). These Guidelines clearly lay out the process of deinstitutionalization and calls on State Parties to "abolish all forms of institutionalization, end new placements in institutions and refrain from investing in institutions."

Across the Asia-Pacific region, many persons with disabilities—particularly those with psychosocial disabilities and intellectual disabilities—are still denied the right to live freely in the community. Institutionalization is not just about restrictive physical spaces; it is about the loss of choice and control over one's life. Whether in large facilities or smaller group homes, people can still experience segregation, restrictions on decision-making, and violations of basic rights. The Guidelines, therefore, emphasize that deinstitutionalization requires more than closing institutions. It requires dismantling discriminatory laws and systems, investing in community-based supports, and ensuring that persons with disabilities and their representative organizations hold power, are adequately resourced and can exercise autonomy, legal capacity, support in the community and choice, on an equal basis with others.

At the same time, OPDs across the region are leading efforts to challenge institutional models and promote inclusive and rights-based alternatives. There are also encouraging signs of growing momentum in support of deinstitutionalization. For instance, Australia's International Disability Equity and Rights Strategy (IDEARS) signals a renewed commitment to ending segregation and supporting community-led change. The UN Guidelines on Deinstitutionalization also emphasize centering OPD leadership in DI processes, yet there is little documented information on how OPDs are engaging in DI processes in the Asia-Pacific region.

This case study is situated within TCI's efforts to strengthen collective learning and advocacy on deinstitutionalization through its Community of Practice, supported by DFAT and CBM Australia. It seeks to address this gap by drawing on the collective knowledge and experience of CoP members, and by contributing to a stronger evidence base on OPD-led deinstitutionalization in the region.



Methodology

Study Aims



Explore the experiences of OPDs in engaging with DI processes at the national and/or regional levels.



Document strategies, challenges and successes of OPDs, in advocating for and contributing to the transition from institutional to community-living.



Identify enabling factors and barriers to meaningful OPD participation in these processes.



Generate practical recommendations and opportunities to strengthen the role of OPDs in future deinstitutionalization efforts, aligned with the principles of the CRPD.

Data Collection and Analysis:

The study used a combination of:

- Key informant interviews with leaders of OPDs that were identified through the TCI CoP, and
- Desk-based review of knowledge and advocacy products, case studies, program documents provided by TCI Global and their member organizations, and webinars and discussion notes from the CoP meetings, to build a contextual understanding of OPD engagement.

The ***Guidelines for Deinstitutionalization, including in Emergencies*** were used as a theoretical lens to examine how OPDs engage with deinstitutionalization processes in practice. They also shaped the interview protocols to explore how OPDs interpret, advocate for, and apply these principles in their national or regional context.

A woman in a red jacket is standing at the front of a room, gesturing while presenting to a group of people seated at a long table. A projector screen on the left shows a woman in a white lab coat. A banner on the right reads "Action for change" with a red logo above it. The audience members are seen from behind, wearing patterned clothing. The word "Findings" is overlaid in the center in a bold, blue, italicized font, flanked by two vertical blue lines.

Findings

Participants

Six key informant interviews were conducted with leaders of OPDs of persons with psychosocial disabilities from **Sri Lanka (1), India (1), Indonesia (2), Nepal (1), and Fiji (1)** and one OPD leader from **Taiwan** completed a written questionnaire (three men, four women). The content of four CoP meetings held over the period July 2024-September 2025 was also analyzed, including presentation materials and group discussion notes that included a further two organizations from India.

Themes

1 Conceptualization of institutionalization

1.1 Institutionalization as a system of control, not only a physical setting

CoP members highlighted that conceptual clarity around what is meant by institutionalization was an important factor in deinstitutionalization processes, *“because we learnt that there are different understandings about what institutionalization is, and this can hamper progress.”* (CoP presentation). The Guidelines provide an important source of truth and are being used by the OPDs. The concept of DI contained in the guidelines is informed by key international human rights conventions and extensive OPD consultations. Historically, institutionalization has frequently been associated with mental ‘asylums’, and the Guidelines clarify that institutionalization can occur in a range of settings: social care establishments, psychiatric hospitals, long stay hospitals, nursing homes, ‘secure’ wards, special boarding schools, rehabilitation centers, halfway homes, group homes, orphanages, shelters, protected living homes, religious conversion homes, forensic psychiatric settings, and transit homes. CoP participants reinforced this conceptualization, describing institutions as any setting where individuals with disabilities are deprived of their liberty and choices over their daily activities and other aspects of life. Key features of institutionalization discussed within the CoP were strong ‘control’ mechanisms (i.e. use of restraints, gate keeping, substituted decision making, etc.), coercion, and force.

The key aspect to all [institutionalized] settings is that there is: control, coercion, restraints, gatekeeping, substituted decision making. It is not just in the physical structure and the arrangement, but it is in the mindset. Any mindset which seeks to control, force, restrain, isolate - all of this - any mindset, any attitude which is exerting this kind of actions, behaviours, attitudes towards persons with psychosocial disabilities. We understand that as an institutional culture. (India)

Restraints can be physical restraints, as well as chemical restraints (i.e., medications), and isolation of individuals or groups from the outside world.

Usually, the person is under lock and key, and there are gatekeeper mechanisms. So, somebody will always be controlling who the person is meeting, who the person is talking to, when they eat and sleep, and whether the person is able to step out, should the person be kept inside. (India)

And often all these institutions involve others making decisions on behalf of the person with disability; substituted decision making is a key feature of institutionalized settings.

What I mean by deinstitutionalization is not about closing buildings – its about our dignity, freedom and choice. If we live in our home for example, our home could be an institution as well if we don't have our rights, freedom - being controlled. For me, it's not about places. As long as we don't have dignity or enjoy our basic rights such as choice and freedom, it is institutionalization. (Indonesia)

Conversely, **deinstitutionalization** was defined as the restoration of choice, control and fundamental freedoms through transformation of the systems and structures that reinforce institutionalization.

Deinstitutionalization means... get the people a safe space in...their own community to live as a dignified person...For those in an institution, it is like you are in a jail. But if you're in the community. You have your space, you have your friends, you have circle of networks...So, what we want... is persons with disability to be in that environment... We don't want, like, somebody to decide on everything for us. (Sri Lanka)

In some circumstances, OPDs come to discussions about deinstitutionalization not realizing they are in fact working on DI processes. They might be delivering awareness raising of rights, providing crisis support, and building peer networks, but think that DI is only about removing psychiatric institutions. After engaging in the CoP, there was a quick realization that everything they are doing relates to, and is in service of promoting DI.

Like one way people interpret Guidelines – there shouldn't be any hostel and no hospitals...how it can be misinterpreted. [When] we are talking about DI – no one should be forced to live somewhere against their will. If they want to stay in a hostel or stay in a hospital, someone's liberty shouldn't be taken away – it's not about no 'institution'. It's about freedom of choice. (Nepal)

However, this requires careful qualification as it also carries risks if interpreted too loosely. In many contexts, hospitals, hostels, and similar congregated arrangements are routinely framed as the only viable response or solution, especially in the absence of adequate community-based supports. A CRPD-aligned understanding of choice remarks that choice is only meaningful when persons with disabilities are presented with access to a range of community-based alternatives, can exercise legal capacity, make their own decisions, and are free from coercion and confinement. Where these conditions are absent, the language of 'choice' risks concealing forms of institutionalization rather than challenging them.

1.2 Driven by lived experience of institutionalization

Several respondents identified that they and/or their staff, along with their members, have formed their understanding through their own lived experience of institutionalization:

All of us are people with lived experience. We've been institutionalized ourselves. (India)

Experiences and challenges shared amongst OPD constituents included those around having 'invisible' disabilities, being 'mad', experiencing rights infringements such as removal of legal capacity, liberty and freedom of movement, social exclusion, and experiences of violence, torture, and inhumane treatments. Members self-identified as persons with psychosocial disabilities as well as other disabilities such as neurodivergence, autism, and learning difficulties.

2 Drivers of institutionalization

The Guidelines, and the CRPD, clearly state that under no circumstances can a person be placed in an institution or be subjected to deprivation of liberty; nevertheless, the reality of widespread institutionalization reflects the fact that this is indeed still commonly practiced and 'justified' by families, service providers and the States. OPDs explored and identified many interrelated 'reasons' sitting behind the use of institutional approaches. An overview of these includes the following:

- Treatment, often packaged as care, is offered in an institutional setting that cannot be sourced elsewhere in the person's context.
- Institutionalization considered necessary as 'preventive detention' or to 'observe them' for medical purposes.
- There are economic factors challenging the family's ability to provide the needed and necessary disability support.
- Misconceptions about the capacity of persons with psychosocial disabilities and prevailing stereotypes or prejudice around psychosocial disabilities, including that such individuals are 'aggressive', are 'troublemakers', and that they might 'not have the mental capacity to live independently in the community'.
- Communities taking a 'protective' or charitable approach to persons with psychosocial disabilities. OPDs frequently observe social welfare organizations picking up wandering and unhoused people ('to clean up the streets') and institutionalizing them.
- Families send persons with psychosocial disabilities to institutions because they do not believe that persons with psychosocial disabilities are open to dialogue when they are distressed, or open to communication during any emergency (or distress) situation.
- Persons with psychosocial disabilities are often treated or framed as a 'burden' to the families and caregivers and this, combined with scarce supports available for families to provide a support role, means that institutionalization seems like an 'easy way out' or the 'only solution'.

Respondents explored some themes around the drivers of institutionalization more deeply, as follows.

The cycle of repeated confinement

Respondents described how families, and health and social care systems resort to institutionalization during moments of acute distress or heightened support needs, and how this leads to a revolving-door pattern of institutional placements. OPDs observe that families and caregivers institutionalize individuals during periods of intense distress, self-harm, or perceived danger or risk to others, with decisions driven by medicalized notions of treatment and observation. Medical framing of crisis means that institutionalization is associated with scenarios such as stopping medication, refusal to eat or sleep as dictated by others, or escalation of 'severe symptoms', reinforcing a 'cure-oriented' approach rather than rights-based support.¹ Once admitted, individuals often cycle through multiple institutions –

¹CHRUSP, & TCI. (2025). Understanding of crisis and crisis support from the perspective of users and survivors of psychiatry and organization of persons with psychosocial disabilities (OPDs). <https://tci-global.org/wp-content/uploads/2026/01/Understanding-of-Crisis-and-Crisis-Support-CHRUSP-TCI.pdf>

psychiatric wards, mental hospitals, ‘beggar’s’ homes, and shelters – creating a pattern of perpetual confinement rather than facilitating community inclusion. Even when discharge from one institution occurs, lack of community-based supports result in transfer to other institutional settings.

So once a person goes into an institution, it's like they have fallen into a black hole, and they are unable to get out...they might come out but then they will [return]. This keeps happening over and over again. [Or] the person is pushed from one institution to another...first they will be locked at home. If that doesn't work, they will send them to the psychiatric ward of a general hospital. If that doesn't work, put them in a mental hospital. Mental Hospitals feel the present pressure to deinstitutionalize so they release the person from there. The person is put in a beggar's home, they will be discharged...put into a shelter home, so the person just keeps moving from one institution to the other. (India)

Respondents described cycles of repeated confinement that extends beyond acute and long-term psychiatric wards to family settings, psychiatric rehabilitation homes, and other residential mental health rehabilitation facilities. Some rehabilitation homes are intended to function as less restrictive, transitional homes to assist persons with psychosocial disabilities in developing daily living skills and independent community life. However, in the absence of adequate community-based supports, such as community housing, peer support, personal assistance, supported decision making, family support, employment supports, and crisis support, people with psychosocial disabilities find themselves trapped in a cycle of institutionalization. In Taiwan, financial and organizational incentives compound this issue. The National Health Insurance system does not impose maximum inpatient stay limits but increasing co-payment rates by length of stay interact with hospital management practices to produce indirect pressures for transfer or discharge.

Residents may leave the hospital in form but remain without sustainable, self-chosen community support...Without effective links to housing, peer support, supported decision-making, personal assistance, employment, and daily living support, psychiatric rehabilitation homes may become quasi-institutional settings within the cycle of repeated confinement. (Taiwan)

Poverty-driven institutionalization and systemic gaps in social protection

Respondents described how poverty, economic insecurity and inadequate support systems push persons with psychosocial disabilities towards institutions. Families unable to afford support (and associated opportunity costs) or services often resort to institutionalizing relatives, with poverty cited as a primary driver in contexts like Indonesia and Nepal. Governments establish institutions as shelters providing basic needs, while private institutions – sometimes under religious treatment banners – emerge to profit from demand, often outside regulatory oversight.

Respondents also highlighted how social protection and insurance systems frequently fail to support community living. Existing social insurance schemes do not cover non-medical supports while criminalization of suicidality and restrictive health insurance policies further limit access to support. For some individuals, family-based support is not a safe option especially in cases of family violence or abuse, yet they find few safe accommodation options—reinforcing institutionalization as the default solution. There are also several barriers to work, including where applicants must prove that they are ‘fit to work’. So again, the solution is to send the person in the institution and usually medical treatments are the only solutions offered, if any.

Structural barriers to independent living, and the role of inaccessible environments

Housing insecurity is associated with recurring institutionalization of persons with psychosocial disabilities. Families and individuals resort to institutions when housing and disability supports are unavailable, often following family breakdown or crisis situations. Despite CRPD adoption, housing schemes rarely integrate universal design or reasonable accommodation, and accessibility is narrowly interpreted as physical infrastructure, neglecting psychosocial and cognitive needs.² Also, housing is often conditional upon medical or treatment compliance, which further makes housing inaccessible for persons with psychosocial disabilities.³

In most contexts in the region, the predominant understanding of ‘care’ is custodial rather than supportive, leading to development of halfway homes, boarding houses, and rehabilitation centres instead of community-based solutions. OPDs advocate that transforming systems requires shifting to a support paradigm that prioritises personal assistance, peer support, and community services alongside accessible housing and transportation.⁴

² TCI. (2025). Call for Inputs for the thematic study on the rights of persons with disabilities and disability-inclusive infrastructure, including transport and housing.

<https://tci-global.org/wp-content/uploads/2025/09/TCI-Submission-on-Housing-and-Transportation.pdf>

³ TCI. (2021). Access to Community Services for People with Disabilities following De-Institutionalization [Video recording]. https://www.youtube.com/watch?v=SunkKYyMJ9k&list=PLTZaELcJTT613lghITz5vv1jBqkX_8JTS&index=1

⁴ TCI. (2023). ‘Support’ as ‘Care’: A/HRC/52/52 (advanced unedited version) report from the OHCHR: A response from TCI. <https://tci-global.org/wp-content/uploads/2023/06/Final-Support-versus-care-TCI-response-to-A-HRC-52-52.pdf>

3 Approaches and strategies taken for deinstitutionalization

Organizations are engaging in deinstitutionalization through many different ways, and their priorities will vary depending upon their organizational capacity and contextual factors. This section explores the main strategies and approaches raised in this study, being the **analysing drivers of institutionalization**, the **many aspects of building inclusive community-based support systems**, and creating **enabling policy and legal frameworks**. **Reflexive approaches** such as responding to intersecting and compounding discrimination, strategic framing, and recognising the uneven progress of deinstitutionalization across different countries are also noted. Respondents described the importance of all of these approaches and strategies, prioritized as most appropriate through strategic and contextualized approaches, in engaging with deinstitutionalization processes.

*Pulls together in the big ecosystem of what deinstitutionalization means, different OPDs latch on to different parts of that, and it all works together.
(Indonesia)*

3.1 Analyzing and combating drivers for institutionalization

OPDs are looking carefully at the reasons for institutionalization in their contexts and using this information to guide targeted actions. OPDs' engagement with the attitudes and belief systems that underpin discrimination against persons with psychosocial disabilities, including institutionalization, has been informed by ongoing analysis, reflections and evidence gathered at multiple levels of societies. Examples include the "Forgotten People" alternative report (2020) submitted for the 13th Pre-sessional Working Group of the CRPD Committee⁵ and the Psychiatric Survivors Association research on "Enablers and Barriers to Community Participation of People with Psychosocial Disabilities in Fiji (2023)".⁶

⁵ Perhimpunan Jiwa Sehat (The Association of Indonesian Mental Health) (2020). Forgotten people, alternative report on the situation of people with psychosocial disabilities in indonesia. Report can be accessed at https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCRPD%2fICO%2fIDN%2f41150&Lang=en

⁶ Psychiatric Survivors Association of Fiji and CBM Australia (2023) Understanding enablers and barriers to community participation for people with psychosocial disabilities in Fiji. Accessible at: <https://www.cbm.org.au/resource/understanding-barriers-and-enablers-to-community-participation-for-people-with-psychosocial-disabilities-in-fiji>

3.2 Strengthening inclusive community-based support systems

The Guidelines emphasise a critical pathway to achieving DI is providing and strengthening community-based, person-centred support systems as alternatives to institutional care. OPDs shared examples of their organizations' work on a range of projects and initiatives that involve providing such alternative community support options to institutionalization and removing barriers to community participation and inclusion. Drawing on long-term engagement with its member organizations and in line with The Guidelines, TCI Global has generated a model of community inclusion which sets out key domains of actions needed to overcome marginalization and subsequent institutionalization of persons with psychosocial disabilities. See Figure 1 for the community inclusion domain indicators.



Figure 1: Domains of community inclusion indicator tool (CII-T)

Similarly, this study found that strengthening community-based support systems involves many activities that organizations engaging in deinstitutionalization undertake in combination – including mobilizing community support systems, addressing negative attitudes, peer-to-peer support services, economic and housing assistance, family education and support, and individual advocacy support. This section explores each of these.

3.2.1 Mobilizing community support systems

Community support systems refer to the wider network of relational, collective and humane exchanges and processes that enable persons with disabilities to live with dignity, belonging and support in everyday life, including peer support, neighbourhood support, befriending, support for exercising legal capacity, conflict resolution, community negotiation to prevent institutionalization etc. They are distinct from support services in that they are rooted in humane exchanges, social networks and collective forms of trust, care, and belonging within families, neighbourhoods, and communities.

Community support services refer to disability-related and individualized supports that enable persons with disabilities to live in the community, such as social protection schemes, disability cards, personal assistance, and other forms of practical support linked to daily living and participation.

Respondents described a range of interventions to mobilize community support systems for persons with psychosocial disabilities: *“We’re just targeting this particular community and seeing if somebody picks it up, then it will be great, and that will allow us to do the work in this way”* and drawing on personal experiences of their recovery and inclusion journey: *“I was given a diagnosis of schizophrenia, first and then bipolar disorder... The only reason I’ve come to this place of well-being is because of community support.”* (India)

‘Circles of Support’ and ‘Community Watch Zones’ are approaches to community-based inclusive development (CBID) being piloted in Fiji that involves providing intensive support interventions in a village setting. It includes a combination of actions, which aim to mobilize support systems for persons with psychosocial disabilities, such as education on rights of persons with disabilities, working with village leaders and health workers to establish referral mechanisms to services, identification of ‘inclusion champions’ who can provide practical supports to persons with psychosocial disabilities and their families, and facilitating supported decision making processes at the household and community level (e.g. personal and domestic care activities, social protection, health, and reporting of abuse to the justice system).

So, we [OPD] try to follow individuals with the project. Documenting. We are now strongly doing cooperation with the human rights commission. Sensitizing the mindset and documenting stories and presenting [to] the duty bearers...changing the system rather than changing the individual. Huge challenge is the mindset in the communities. (Nepal)

One thing that we think about the issue is it’s an injustice – for persons with psychosocial disability - this is a systemic justice issue. So, when the DI Guidelines came out, we were just saying – what can we do – so let’s make a safe space first. Try to strengthen our community first and see what we can do from there. Our support is for making the safe space and be heard and we have some kind of activity-based training... (Indonesia)

3.2.2 Addressing perceptions and negative attitudes towards persons with psychosocial disabilities

Common across all OPD engagement are efforts to change the mindset, stereotypes and perceptions of disability. The persistent medical model and charity model approach to psychosocial disabilities and associated discriminatory legal regimes associated with institutionalization, has seen persons with psychosocial disabilities treated as merely patients, persons with mental illness, or those of “unsound mind” rather than as rights-holders.⁷



There was a man who had mental health issues because he had been tortured during the civil war. He was in [institution] he was kept in a cage, [which led to] stigma that he is dangerous to others. When he went home, people were scared of him – a woman saw him and she broke her leg running away from him and blamed him for it. The family had to pay big money and the man was punished. (Nepal)



From my experience, because...they don't understand psychosocial disability. They don't have that mentality to help or support, but rather, they would start judging the person, and try and discuss why the person has it, blaming the mother for having an affair, blaming the parents for doing this, doing witchcraft. And for persons with psychosocial disability, it's very rare to see or to have that unwritten rule and agreement that we need to help this family. No, that does not happen in the village. (Fiji)



Case example – Sri Lanka

Members of Nidahas Chinthana Sansadaya – Consumer Action Forum (NCS-CAF) with psychosocial disabilities were trained in how to develop short action dramas, based on their life stories followed by field rehearsals. Performances have been held for audiences of persons with psychosocial disabilities, their family members, health professionals, policy makers, policy implementers, media, police, development professionals, public, entrepreneurs etc. Besides the community level programs at schools,

⁷ Davar, B. (2022). The Discriminatory Standards of Constructing ‘Patienthood’ of the ‘Mentally Ill’ within Public Health (Repost). #WhatWENeed.

https://whatweneed.tci-global.org/wp-content/uploads/2022/11/The-Discriminatory-Standards-of-Constructing-%E2%80%98Patienthood-of-the-%E2%80%98Mentally-Ill-within-Public-Health_for-WhatWENeed.pdf



community halls and temples, they perform at trade fairs, special educational workshops organized by Ministry of Health, Police Department, Hospitals, Business Development Service Providers, etc. Persons with psychosocial disabilities could stand for their rights and advocate for their peers (labelled as crazy and unsound minds), as effective leaders, wounded healers, and consumer advocates in the sector of mental health promotion and education. They as performers/actors, in a dramatized discussion forum (Forum Theatre) could effectively advocate for their rights, and depict the strong influence of the family and social environment on the persons health and wellbeing. Evaluation of the outcomes of the activities demonstrated that viewers had an increased sense of personal responsibility for the societal exclusion of persons with psychosocial disabilities.⁸



Some OPDs have developed their own awareness raising campaigns and training packages, aligned with the local and cultural contexts of their communities and using arts and play for wellbeing and healing.⁹ Others are using the World Health Organization QualityRights Training package to sensitize others about how to respect and uphold rights of persons with psychosocial disabilities.

⁸NCS-CAF. (2024). *Theatre of the Oppressed” Forum Theatre as a Tool to Change Community Attitudes towards Inclusion of Persons with Psychosocial Disabilities. #WhatWENeed.* <https://whatweneed.tci-global.org/wp-content/uploads/2023/12/NCS-CAF-Forum-Theatre-Blog.pdf>

⁹Davar, B., Sharma-Dhamorikar, R., & Nair, K. (2023). *Transforming Communities for Inclusion: Examples of practice [A Photo Story].* <https://whatweneed.tci-global.org/wp-content/uploads/2023/11/Photo-Story.pdf>

We do two kinds of work. One of them is in the communities directly – we have psychosocial wellbeing programs for the community...help them create safe spaces where they can talk to each other... (India)

We provide human rights training for government officials and professional workers. At present, four [OPD] members have taught courses at the Legal Aid Foundation, focusing on matters that require attention during involuntary placement. In addition, with support from the Ministry of Labor, we are compiling a handbook on workplace reasonable accommodation for persons with psychosocial disabilities. (Taiwan)

3.2.3 Provision of peer-to-peer support

All OPD members of the CoP delivered peer to peer support¹⁰ as part of their approach to community-based support options. CoP respondents pointed to the unique experiences of disempowerment and oppression experienced by persons with psychosocial disabilities and that they are best placed to provide peer support to each other. Support was associated with empowerment in identity as a person with disability, sharing of knowledge and learning - particularly in relation to navigating health and social care systems, avoiding forced detention and treatment - as well as crisis support and joint advocacy.

We live in the bubble of humiliation and discrimination and stigma and we cannot really talk about this openly [unlike other types of disabilities]. That's why peer support within the OPDs of psychosocial disability is very important... because our disability is still up to now is like a secret In the society...Peer support should be conducted by persons with psychosocial disabilities by themselves, it's not like there is the people telling us what to do, but really a space, space among ourselves. It's very, very important. (Indonesia)

OPDs described peer support as providing safe spaces for the constituents to learn, share, and work together without fear. Several OPDs described developing their skills in peer support, for example through Intentional Peer Support courses for psychosocial disability communities and professional workers, and to developing teaching materials better contextualized to the local setting.

¹⁰Peer support originated from the psychiatric survivors movement and civil rights movement as a response to psychiatric abuse and oppression in the United States in the 1970s. Peer support grew out of a need for transitional support following deinstitutionalization that was based on shared experiences rather than a hierarchical 'professional-client' model.

Case example - Indonesia

Indonesia Revolution and Education for Social Inclusion (REMISI) is an organization representing persons with psychosocial disabilities focusing on monitoring and implementing the rights of persons with psychosocial disabilities in Indonesia. They take a rights-based approach to deinstitutionalization; prioritizing autonomy, peer support, and trauma-informed care. They convene peer support groups for persons with psychosocial disabilities, providing spaces for healing, restoring dignity and strengthening collective movement among persons with psychosocial disabilities living in the community. REMISI is also developing community-based alternatives to institutionalization through this peer support group program. The peer support group has developed a strategy to avoid institutionalization and support rapid discharge from psychiatric hospitals. In several peer support sessions, the group has developed an advance directive tool for crisis situations based on the 5Ps:

Places – safe locations to go during a crisis

People – comfortable and trusted individuals to contact

Psychosocial supports – types of support needed during a crisis

Preference for supports – individual preferences for care and communication

Plans and preparedness – anticipatory steps prepared in advance

REMISI has also developed a Pocket Book for young people which sets out their rights as persons with psychosocial disabilities. By doing so, REMISI is supporting young people to make informed decisions, indirectly strengthening the capacity of communities to resist institutionalization.



3.2.4 Economic and housing assistance

OPDs are often stepping in to provide emergency shelter informally or through funded projects, highlighting gaps in States provision of accommodation that respects the will and preference of individuals with psychosocial disabilities. Respondents described their organizations as providing peer groups and individuals with psychosocial disabilities with livelihood stimulus funds, building skills such as in farming, crafts and entrepreneurship, and facilitating access to government grants for start-ups.

Despite the UN Guidelines on Deinstitutionalization stating that survivors of institutionalization should have access to reparations and community support systems, this is rarely implemented. For persons with psychosocial disabilities being discharged from institutional settings, OPDs in the Asia-Pacific region are stepping in to provide practical assistance such as connection to families, social protection mechanisms, legal aid, livelihood opportunities, and provision of “care packs” including toiletries, clothes, etc. as most people have had their personal belongings removed during institutionalization in the absence of State provisions.

What we do is try to strengthen the position of the person with psychosocial disabilities themselves, so they are not really ‘down’ in terms of power relationship. So we kind of like trying to strengthen their position, while trying to communicate the problem with their family. (Indonesia)

Case example – India

Bapu Trust for Research on Mind and Discourse is a non-government organization founded by persons with psychosocial disabilities. Bapu Trust provides housing support to persons with psychosocial disabilities, facilitated through a combination of community-based efforts and linkages with existing government schemes. The team works to connect individuals with public



housing and local municipal programs, while also mobilizing support for immediate needs through sponsorships for home repairs and basic infrastructure. In several cases, rent subsidies or informal waivers were negotiated with landlords, local leaders, and community groups to ensure continued housing. The team also engages with immediate and extended families to negotiate safe and supportive shelter arrangements, and facilitate access to electricity and gas connections through small donations from local community members, or in-kind contributions. Bapu Trust also enables direct cash transfers in certain situations- grounded in the belief that individuals should have the dignity and autonomy to make their own housing-related choices, based on what they need most. Peer support plays a significant role- individuals often choose to live together and share housing costs, creating not only affordability but also a sense of mutual support and belonging.



3.2.5 Family education and support

OPDs described several family-level factors that reinforced institutionalization which they sought to address. Families that did not receive any support or held stigmatizing views around psychosocial disability would see their family members as a “burden” and were likely to send them to an institution due to associated poverty and/or a sense of hopelessness about the capacities of persons with psychosocial disabilities. Consequently, OPDs frequently provided support to persons with psychosocial disabilities and their families to access social protection mechanisms such as disability allowances and eligible health insurance as well as education with the aim of shifting the mindset of families.

Because most of the family, they see persons with psychosocial disability as having no future at all, like their life has ended...like a dead end, nothing else you can do. You just keep on living without any purpose in life. So putting you in the institution is okay, because what else? you do not have anything left in your life. So we are trying to communicate that becoming a person with psychosocial disabilities doesn't mean that they stop there. And giving hope, hope is very important. (Indonesia)

Case example – India¹¹

The Seher program, implemented by Bapu Trust for Research on Mind and Discourse, was founded by persons with psychosocial disabilities and stands as a key model within OPD-led community practice. At its core, Seher approaches institutionalization not as a single event, but as a continuum requiring intervention at three critical points: preventing entry into institutions, responding to imminent risk of institutionalization, and enabling deinstitutionalization – supporting individuals to leave institutions and sustain life outside in open communities.

Nadeem is a 32-year-old person with a psychosocial disability with high support needs came into the program with experiences of suicidal thoughts, severe paranoia, and overwhelming fear of being harmed by others. He had withdrawn, refusing to step out of this home and lived with deep shame and guilt, and memory gaps. In conversations, Nadeem recalled a time when he was doing well, followed by an incident involving friends after which everything changed. He remembers losing consciousness and later, being found lying on the road without clothes. Following this, his family admitted him to a general hospital where he received electroconvulsive therapy and high doses of psychiatric medication. It was at this stage that he came in contact with Seher. The response was multi-layered and deeply relational:



¹¹ LaCroix, K., Dixit, S., Nair, K., & Davar, B. (2021). CIRCLE OF CARE. FOOTSTEPS Mental Health and Well Being, (113). <https://res.cloudinary.com/tearfund/image/fetch/https://learn.tearfund.org/-/media/learn/resources/footsteps/pdfs/footsteps-111-120/2021-tearfund-footsteps-113-redacted-en1-en.pdf>

What was done:

- **Holistic assessment:** The team undertook a comprehensive understanding of Nadeem's context – mapping his needs and existing supports across family, neighbourhood, and community systems, to identify pathways for sustained care.
- **Trauma-informed interventions:** The focus was on enabling safety and recovery – reducing distressing thoughts and fears, supporting Nadeem to reconnect with his body, establish personal boundaries, and identify spaces of safety in the home and in the community.
- **Community and peer support:** A network of peers, including individuals with lived experience and people known to Nadeem, was activated. Through intentional befriending, this created an accessible, trusted circle of care and support – people he could reach out to at any time, within close physical and emotional proximity.
- **Family engagement and Open Dialogue processes:** At multiple points when the family considered re-institutionalization, the program intervened through structured dialogue. The work focussed on building the family's capacity to respond to crisis without resorting to institutional practices – offering practical strategies, enabling them to develop supportive and constructive psychosocial response skills, engaging in shared reflection, and consistent encouragement that alternatives were both possible and effective.
- **Collaborative care with health systems:** The program engaged with psychiatrists to address the debilitating side effects of medication, which had significantly limited Nadeem's daily functioning. Through sustained advocacy, his medication was gradually adjusted and complemented with alternative approaches including body-based practices, and traditional healing methods of his choice. This integrated recovery plan reduced his dependency on medication without triggering a relapse and significantly decreased repeated hospital admissions.

All interventions were carried out in a collaborative, consultative, and participatory manner, with Nadeem leading the processes at every step, guided by his will and preferences and evolving sense of what felt safe and meaningful to him.

3.2.6 Individual advocacy

OPDs described providing individual-level advocacy, alongside legal and policy advocacy for their constituents.

For example, individual advocacy for persons with psychosocial disability facing discrimination in the workplace and education settings (e.g. being fired for having a psychosocial disability or being excluded from university if they exceed the limits of study milestones due to being unwell) as well as for people who are being forcibly detained in an institution (e.g. linking to legal representation and taking cases to the supreme court to have individuals released).

Case example - Indonesia

Eko (pseudonym) shared his personal journey as a young man with psychosocial disability who was freed from dire conditions within an institution by the Indonesian Mental Health Association (national OPD representing persons with psychosocial disabilities) (IMHA). At the age of 19, Eko was kidnapped in the night and taken to a privately owned institution after neighbours complained to authorities that he was shouting in the night. Eko experienced severe neglect and abuse during his two-year confinement. The turning point in his life came with IMHA visiting the institution with government officials as part of the Open the Gates project which aims to support implementation of the National Roadmap for Deinstitutionalization. IMHA, with support from Ministry officials, secured his release through a lengthy court process. They provided him with critical medical care for back and skin conditions he acquired while chained in unsanitary conditions in the institution. He was also treated for glaucoma that had developed undetected while detained. Beyond physical recovery, IMHA facilitated Eko to return to society by helping him pursue his interest in education and enrolling in university. Their collaboration with an organization that supports people with vision impairment supported Eko to regain independence and start education. Eko expressed deep gratitude to IMHA and he now dreams of studying international relations.¹²



3.3 Creating an enabling policy and legislative environment

Respondents described engaging in policy and legislative reform which has resulted in positive improvements in rights-based frameworks. For example, getting confinement and isolation defined in law as a breach of fundamental freedoms for persons with disabilities both in the community and in institutions. OPDs working in contexts where government authority is decentralized have worked at the national level on key pieces of legislation, and were increasingly working at the district and

¹² Adapted from CBM Global (2024) Evaluation of the Open the Gates Project (unpublished).

provincial levels in efforts to engage duty bearers around community support services and to address institutionalization at the local level.

Respondents identified Article 14 and Article 19 of the CRPD as critical priorities in advocacy efforts. Article 14, which addresses liberty and security of the person, requires immediate realization by States Parties as it relates to civil and political rights. In contrast, Article 19, which focuses on living independently and being included in the community, allows for progressive realization over time. One respondent explained how this distinction shaped their advocacy strategy: rather than beginning with calls to abolish institutions entirely, they prioritized actions that would end the deprivation of liberty within existing institutions. This included advocating for measures such as “opening up” institutions to allow freedom of movement in and out. As the respondent put it: *“our obligation is to stop the deprivation of liberty itself. That confinement based on disability must end. Let’s make the institution no longer a prison”* (Indonesia).

Similarly, in Taiwan the OPD worked hard to bring restrictions on liberty and communication in psychiatric wards to the attention of the Legislative Yuan and national human rights monitoring mechanisms. This enabled matters (like access to mobile phones while hospitalized) that were often treated as matters of internal ward management to be re-understood within the framework of liberty, personal security, and communication rights.

Respondents also frequently mentioned targeting alternative local rights frameworks outside of the traditional health frameworks and focussing on inclusion in broader mainstream services (rather than expending energy on trying to transform the health system – which has historically seen little change despite long-term efforts).



We have helped prompt the Legislative Yuan to begin re-examining the definition of disability, and institutional discussion has gradually moved toward recognizing assessment approaches that take fluctuating functional impairments into account. This is particularly important for persons with psychosocial disabilities, because the current system has long tended to rely on more fixed, stable, and quantifiable functional limitations as its benchmark... it may become possible to reduce the exclusion of some people from support systems (Taiwan)



Case example - Indonesia

Open the Gates is a project co-implemented by Indonesian Mental Health Association, a women-led OPD representing persons with psychosocial disabilities in Indonesia and supported by CBM Australia and CBM Indonesia with funding from the Australian Government. The project has given IMHA a platform to continue their central role as experts on issues affecting persons with psychosocial disabilities, in particular shaping effective policies and programs to progress deinstitutionalization in Indonesia. The key achievement of the project has been bringing attention to the gendered violence and abuse in institution-based settings. This builds off earlier advocacy work supported by the Disability Rights Fund and works alongside the broader feminist movement's advocacy to strengthen protections for women and girls. IMHA were successful in influencing a landmark law on Sexual Violence (2022) to include sexual violence not covered in existing laws and frequently arising in institution-based settings such as forced contraception, forced sterilization, and sexual exploitation (Article 4) and to recognise violence that occurs in social rehabilitation centres (not just in homes). IMHA is working with the P5HAM (national working group on deinstitutionalization) to create guidance for implementation of the law for people detained in rehabilitation centres whilst advocating for a transition to community-based supports and services that protect the rights of women with psychosocial disabilities.



3.3.1 Generating evidence

OPD representatives described the importance of generating evidence to support their policy and advocacy. This included collecting and synthesizing information from the grassroots level to present to duty bearers. Evidence included research and data on the current situation (for example what is happening inside institutions and in communities) as well as examples of “what works” in addressing exclusion and protecting rights in their context.

I think the best...advocacy is two things...our advocacy is based on what the community needs. The voice of communities is very important as the base of our advocacy. The second is evidence, including research. If you want to have a strong advocacy, you have to have a legitimization to talk on behalf of the community and also back up your advocacy with evidence. (Indonesia)

It is the evidence behind our advocacy messages that we have been missing. Research will help us to have a stronger message to the government. (Fiji)

Case example - Fiji

The Psychiatric Survivors Association (PSA), established in 2004, is the National organization of persons with psychosocial disabilities in Fiji and the oldest of its kind in the Pacific Island Countries. PSA, with support from CBM Australia and DFAT's Partnership for a Healthy Region fund, played a central role in enabling its members to engage meaningfully during the 2024-2025 review of Fiji's Mental Health Act. PSA used evidence generated through structured participation, lived experience documentation, and rights-based analysis to inform and influence legislative reform processes related to deinstitutionalization. By building the capacity of members to articulate experiences in CRPD-aligned terms, PSA strengthened the evidentiary basis of its advocacy, demonstrating how OPD-led evidence can challenge institutional assumptions and support systemic change. Members were supported to understand the Mental Health Act, interpret legal language, connect lived experience to specific legislative provisions, and develop rights-based advocacy messages grounded in CRPD principles. This preparation included tailored workshops and a mock consultation session, enabling participants to build confidence and engage on equal footing with legal and institutional actors. PSA also emphasised the systematic provision of reasonable accommodations, peer support, and trauma-informed facilitation. These measures helped address long-standing barriers faced by persons with psychosocial disabilities in policy processes. This example highlights how progress towards deinstitutionalization often begins not only with changes in law or services, but with transforming who is recognised as legitimate participants in shaping those reforms.¹³

¹³Psychiatric Survivor's Association. (2025). Ensuring Meaningful Participation of Persons With Psychosocial Disabilities in the Mental Health Act Review. #WhatWENeed.
<https://whatweneed.in/wp-content/uploads/2025/12/PSA-Blog-Submission-WWN-2025.pdf>

3.3.2 Movement building

Some OPDs, like the Psychiatric Survivors Association of Fiji, had their origins in the psychiatric survivors' movement, born from the civil rights movement in the USA in the 1970s as a revolt against abuse and neglect within psychiatric services.¹⁴ The World Network of Users and Survivors of Psychiatry (WNUSP) actively participated in the drafting process that produced the CRPD in 2006. In 2012, a network of persons with psychosocial disabilities and their organizations emerged in Asia (Transforming Communities for Inclusion Asia), seeking to provide a platform for the specific issues faced by Global South members. This network spread to the Pacific Islands and ultimately registered as a global organization in 2022 (TCI Global) whilst maintaining connections to WNUSP. The movement of persons with psychosocial disabilities has been steadily growing, with representation in 21 countries in TCI Global's membership. TCI Global is an active voice at the Conference of State Parties to the CRPD, and includes deinstitutionalization, community inclusion and OPD member support within its core mandate.¹⁵

At the local level, one respondent described the development of their OPD as grounded in a shared recognition that their recovery was shaped by social determinants. Movement building was associated with ongoing collective discussion and action as members came to understand that individual recovery could not be realised without changes to surrounding social and institutional conditions:

As discussion and collective action gradually unfolded, we came to understand more and more clearly that if the surrounding social and institutional conditions were not changed, individual recovery could not truly be realised. Based on this understanding we began to collect more partners and resources. (Taiwan)

OPDs representing persons with psychosocial disabilities continue to face barriers to being included in the wider disability movement in many contexts. OPDs reflected both on the challenges in being accepted into the cross-disability movement as well as the importance of the cross-disability movement for advancing the rights of persons with psychosocial disabilities.¹⁶

¹⁴ TCI. (2021). *Self-advocating for rights, one poem at a time: Experiences of archiving Luke Taveta's poems by Psychiatric Survivors' Association with the help of TCI DPO support grant.* <https://tci-global.org/wp-content/uploads/2023/04/Interview-Report-of-PSA-on-the-DPO-Support-Grant.pdf>

¹⁵ <https://tci-global.org/our-origins/>

¹⁶ TCI. (2018). *Bali Declaration [Declaration]*. <https://tci-global.org/wp-content/uploads/2022/12/Bali-Declaration-English.pdf>

So I think the first [thing] they got to invite them, get to know them and knowing that [we] also face disability - because of stigma that we face is not only from the non-disabled community, but also within the community of other disabilities...So like it or not, we have to go through this phase, but we need to encourage them, to involve them in in the cross disability activities (Indonesia).

Respondents reflected on their efforts and learning from strengthening the movement of persons with psychosocial disabilities within and outside of the disability movement. Many of their members, due to marginalization within other movements, have not had access to the same training and education as others in movements, such as persons with disabilities or women, so there is a lot of ‘catch up’ work to be done.

We have to strengthen the new OPD - how to do that first is to increase their confidence. How to increase their confidence is to make them 1,000% sure that they have rights. So training on human rights and on CRPD is a great way to boost the confidence that they are not at fault...they are not a burden to society, that it's...also the barriers... So when they sit together with other cross disability organization, this other cross disability organization will see that...she's smart. She knows what's this talking about, and then they gain respect. (Indonesia)

Deep impact on us has been our closer collaboration with a cross-disability organization—the Taiwan Independent Living Alliance. This collaboration has enabled us to see more clearly that deinstitutionalization is not only an issue for persons with psychosocial disabilities themselves, but a shared issue closely connected to the broader fields of independent living, support services, and legal reform for persons with disabilities. By entering into this kind of cross-disability dialogue, we have felt even more deeply that, if deinstitutionalization is to be genuinely advanced, discussion cannot remain confined within the psychiatric system. (Taiwan)

OPDs have sought engagement through civil society networks with feminist movements and other human rights movements as entry points to influencing key pieces of legislation affecting the lives of persons with psychosocial disabilities. Many OPDs have forged relationships with human rights bodies in their country

and where they exist, ministries responsible for human rights and law, and social justice have provided an effective entry point for creating momentum and commitments to deinstitutionalization.¹⁷ Respondents described efforts to mainstream the psychosocial disability perspectives in areas such as climate, human rights, and women's issues, and progress where they have engaged movements outside of the disability groups by reframing rights violations from their perspective.



When we talk about the women's organization, we reframe that from the perspective of women. And when we talk to the human rights group, we reframe that from the perspective and the language that they understand. So instead of institutionalization we can name it the 'application of liberty', because we use the term that they can easily grasp. Human rights groups...they have strong legitimacy. So by reframing institutionalization, not only from the disability perspective, but also from the human rights perspective, like it or not, the government must see institutionalization as the violation of human rights. (Indonesia)



People in the government have shown interest... They were very interested in what we had to say about psychosocial disability...The Ministry of Social Justice and Empowerment... they were the ones who were interested. (India)



Some OPDs are seeking to support youth with psychosocial disabilities and within this, engage with the wider youth human rights movement.¹⁸



One barrier amongst youth is that DI is 'boring' and they don't seem interested. We need to be able to engage youth in a fun way so they can connect with the issue. It needs to be in plain language, accessible. Supported decision making and human rights – much more relevant to them in their daily life. Need to make sure the issue is reachable. Have looked at games-based approaches to explaining CPRD for persons with psychosocial disabilities for youth. We 'gossip' about the human rights system in Indonesia. (Indonesia)



¹⁷ <https://whatweneed.in/iris-award-2022/>

¹⁸ REMISI. (2024). Submission by Remisi. #WhatWeNeed.

<https://whatweneed.in/wp-content/uploads/2025/01/Remisi-WhatWeNeed-Campaign-2024.pdf>

One respondent described the contribution that consultations on the Guidelines on Deinstitutionalization as an important catalyst for international movement building.



At least since the regional consultations on the Guidelines on Deinstitutionalization began in 2021, and the subsequent public call for written submissions in 2022, persons with psychosocial disabilities, survivors/users, mad people, and others working on related issues from different countries have gradually found in this field a sense of belonging and a space for advocacy. As a result, dense and rich exchanges of knowledge and experience have emerged in recent years, gradually forming a kind of transnational collective identity. (Taiwan)



One OPD noted that compromise is often an unavoidable aspect of strategic cross-movement collaboration. For example, access to communication devices was considered by the OPD as essential to counter the social isolation produced by institutionalization, enabling inpatients to maintain external support, preserve evidence, and activate remedies, particularly in situations involving restraint, seclusion, and coercive interventions. During legislative advocacy, however, other NGOs were more willing to recognize a degree of professional discretion for medical institutions assessing patient's conditions, managing perceived risk and maintaining ward order. Consequently, during the Mental Health Act amendment process, the OPD joined a broader reform coalition to advance a civil society draft grounded in the principles of “openness as the norm, restriction as the exception”, proposing that inpatients should generally enjoy freedom of communication and access to legal counsel and visitation rights, with any restriction permitted only in exceptional circumstances and could not be justified solely by abstract references to a person's condition and generalized claims of medical necessity or ward order.

Case example - India

Through its Compassion and Resilience Leadership Program and community initiative Project RoRe in Madhya Pradesh, India, The Red Door works with young



people from historically marginalized communities to challenge dominant bio-medical approaches to mental health. The program equips participants to critically engage with the structural drivers of distress – including patriarchy, caste, and exclusionary social norms – through a rights-based, CRPD-informed lens. Participants are supported to establish peer-led psychosocial support spaces within their communities. These ‘pockets of resistance’ provide non-hierarchical emotional support, foster collective wellbeing practices, and create opportunities for critical reflection and social justice learning. Through these spaces, community members have co-designed locally relevant tools, such as an emotional first aid toolkit grounded in cultural and contextual realities. By strengthening peer leadership and community-based responses, the initiative supports attitudinal change toward psychosocial diversity and builds alternatives to institutionalization and medicalization of distress, positioning participants as advocates for more inclusive and rights-based mental health support systems.



3.4 Reflexive and contextual approaches

3.4.1 Responding to intersecting and compounding disadvantage

Respondents identified the specific situation of women and girls with disabilities along with discrimination faced at the intersection of disability and gender, acknowledging the multiple barriers faced by people of diverse gender and sexual orientations and sex characteristics. Some OPDs grew out of the shared experiences of intersecting identities:



At the beginning, a group of people who had all experienced psychic injury in the course of their lives came together, because they were simultaneously confronting dominant gender norms and other forms of social oppression. Our work has two main dimensions. On the one hand, we hope to build a space where persons with psychosocial disabilities can support one another, think together, and speak collectively. On the other hand, we combine a CRPD human rights perspective with queer critique to engage in policy advocacy, legal reform participation, international human rights mechanisms, and public communication. (Taiwan)



The queer community is so pathologized. So many of the people that we work with from the community are given diagnosis of schizoaffective disorder, borderline personality disorder...There's gender, there's caste, there's class-based inequalities... (India)



Advancing deinstitutionalization during conflict presents significant challenges for OPDs. Conflict situations often lead to increased institutionalization as States and humanitarian actors resort to segregated facilities under the guise of safety or care. At the same time, common arising issues such as criminalization of marginalized groups – including persons with psychosocial disabilities, people who attempt suicide or self-harm, sex workers, and people from LGBTQIA+ communities – creates an environment of fear and repression. This makes it difficult for OPDs to convene, organize, and advocate for rights-based reforms.

Several OPDs are working closely with, and in some cases advocating to, feminist and LGBTQIA+ and sexual and reproductive health and rights movements to position deinstitutionalization as central to their respective agendas. Persons with disabilities are often presumed 'asexual', 'hypersexual' and mistakenly seen as lacking the capacity to make decisions about sexual autonomy, intimate relationships, and reproduction. This control exists not only in social attitudes, but also systematic use of forced contraception and forced sterilization of women and girls within institutions and other health services. In addition, persons with psychosocial disabilities in psychiatric wards or social rehabilitation centres may be placed in seclusion rooms, injected with sedatives, or physically restrained after being deemed to have engaged in 'inappropriate sexual behaviour' such as homosexual relationships. Sexuality and intimacy are thus often treated as matters of risk management and behavioural control, rather than as part of legal capacity, bodily autonomy, and equal participation. For these reasons, OPDs advocated that sexual autonomy cannot be separated from legal capacity, liberty, and deinstitutionalization. Deinstitutionalization is not only about leaving hospitals or institutions. It must also dismantle institutional control over disabled people's bodies, intimate relationships, and sexual choices. OPDs are advocating that *"sexual rights need deinstitutionalization, and that deinstitutionalization must include sexual rights"* (Taiwan).



Restrictions on movements, surveillance, and threats to personal security in conflict situations further limit opportunities for collective action and policy dialogue. It is also often prohibitively difficult for OPDs operating in conflict zones to receive government or donor funds. As a result of all of these factors, efforts to dismantle coercive systems and promote community-based alternatives are severely constrained, underscoring the need for international solidarity and flexible strategies that protect informal networks and OPDs while sustaining advocacy for inclusive, rights-based support services.

3.4.2 Strategic framing and contextualized approaches

A large aspect of deinstitutionalization work is advocacy and sensitization, for example with government and policy makers, as well as with others such as hospital staff and service providers as well as family members and peers. Respondents recognise the term ‘deinstitutionalization’ but often avoid using it explicitly in advocacy and policy dialogue, opting instead for language like ‘community inclusion’ to make advocacy more palatable. This reflects a nuanced approach to messaging in contexts where there are barriers to government engagement on deinstitutionalization.

Discussions on deinstitutionalization are often difficult to initiate because psychosocial disability is still largely understood through charity and medical models, with limited awareness of human rights frameworks. In many contexts in the Global South, there is a lack of community-based alternatives for OPDs to point to and families remain the primary support system. Hence, abrupt closure of institutions, without building rights-based supports in the community, risks shifting responsibility onto families without providing adequate support and services needed to uphold rights in practice. Whilst respondents value The Guidelines as a political commitment and internal reference, some viewed the call for immediate closure of institutions as difficult to operationalize in contexts such as the Global South where community-based supports remain weak or underdeveloped, as compared to Global North with more established service models. Respondents pointed to responsible approaches that seek to prevent new institutions being developed, prevent new admissions to institutional settings, and demonstrate examples of what community inclusion can look like.



We work and talk in different ways – instead of DI we talk about community inclusion...The translation [of deinstitutionalization] is something not well known [here]. We talk about the need of the community for inclusion... The social model and human rights approach is still a long way to go. The segregation – and send that person a long way and live and die there ... is part of the charity model. In developed countries – the community system is there. [Here] if a person needs – everything is by family member, there is no government system. So it is all by the family member. Its too much for the family member – if they have high support needs. (Nepal)



One respondent articulated a holistic approach to reform, emphasising that key issues - including peer support, independent living, legal capacity, coercive interventions, restraint and seclusion, freedom of communication within psychiatric wards, community-based support and deinstitutionalization – were framed as mutually reinforcing aspects of the broader system that shapes the experiences and rights of persons with psychosocial disabilities.

For us, these are not separate issues. We have always believed that only by simultaneously advancing the political and public participation of persons with psychosocial disabilities can these questions be meaningfully discussed and transformed. I believe that “deinstitutionalization” provides a conceptual framework that helps bring together what may otherwise appear to be scattered actions and lines of thought in the founding and operation of [OPD], including peer support, personal assistance, supported decision-making, involuntary admission, restraint and seclusion, and access to justice. (Taiwan)

For Taiwan, it is not a member of the United Nations but nevertheless has developed a domestic review mechanism, in line with the CRPD. International experts are periodically invited to Taiwan to conduct treaty reviews and OPDs have made use of this mechanism to raise issues. Through shadow reports, questions submitted to review committees, and follow up local advocacy, they have compelled government agencies to disclose data that would otherwise be difficult to obtain (e.g. statistics on personal assistance use, peer support provision, and number of people deprived of legal capacity).

3.4.3 Recognizing uneven progress and policy commitment

There is significant variance across contexts in terms of progress towards deinstitutionalization, and this influences OPDs’ priorities for engagement. For example, in countries such as Sri Lanka and Indonesia, deinstitutionalization is explicitly stated in national policy frameworks but is yet to be fully realised at the local levels. Other countries remain reliant on institutional models for health, social care and education, with some policy frameworks even reinforcing these approaches rather than moving toward community-based alternatives. While certain countries have attempted decentralization of mental health services to regional or district levels, these efforts often lack a human rights perspective, and also, should not be conflated with deinstitutionalization. If not done in a CRPD compliant way, decentralization can be used to reproduce medicalized and coercive responses at a more local level, without shifting power, resources, or decision making toward rights-based, community-led supports. It may also extend the clinical gaze and mechanisms of control closer to people’s homes and everyday lives, including through community treatment orders and other forms of outpatient surveillance.¹⁹ As such,

¹⁹ TCI Global. (2025). *Response to the four questions raised by the UN Secretary-General (OHCHR) in the letter to the UK Permanent Representative in Geneva, dated 23 June 2025* [Submission to CRPD Committee]. <https://tci-global.org/wp-content/uploads/2025/09/TCI-Submission-to-the-Committee-In-response-to-CRPD-2025.pdf>

decentralization should not be assumed to be rights-based in itself. If pursued, it must be designed to strengthen community support systems, autonomy, and non-coercive forms of support, rather than simply expanding the identification, monitoring medication compliance, and treatment of ‘patients’ at community level.



Because as long as the resources and institutional design of community support continue to be organized mainly along psychiatric system lines, community support is likely to become a mere extension of psychiatric care rather than support centred on disability rights and community living. For this reason, we are more inclined to address it under the framework of the Social and Family Affairs Administration and the People with Disabilities Rights Protection Act. (Taiwan)



Case example – Sri Lanka

Over 20 years the number of long-term residents at the mental institution reduced from 2,500 to 93, indicating significant systemic change. From the perspectives of persons with psychosocial disabilities, some of the factors triggering this change included the recognizing lack of resources as a key barrier to people returning to their community. Another factor was having champions in government, for example, the government official at the time refused to approve the NGO registration for BasicNeeds unless action was taken to support long-term residents from Angoda Mental Hospital (presently referred to as National Institute of Mental Health) to return to the community. This prompted BasicNeeds-Sri Lanka, led by a person with psychosocial disabilities to design the horticulture therapy project in consultation with 100 long-term residents with psychosocial disabilities. This Horticulture Therapy project was initiated in 2002 in collaboration with the Ministry of Health, and Volunteer Services Organization and became a cornerstone of deinstitutionalization, enabling economic empowerment and reintegration. Parallel to this work was its Community Mental Health and Development programme that focused on social inclusion, which was designed and implemented with persons with psychosocial disabilities, family members, community leaders, and mental health and mainstream service providers. Its outcome was the formation of the Consumer Action Forum (CAF) which was an important avenue for channeling voices of and providing peer support to persons with psychosocial disabilities at the community level. Today the Nidahas Chinthana Sansadaya – Consumer Action Forum (NCS-CAF) is a strong network that collaborates with the cross-disability movement to include persons with psychosocial disabilities; provide livelihood support to its network members, and advocate for mobilization of disability-inclusive community support systems.

“We are now more into community preparation...while the government is moving to the deinstitutionalization structure, we should be more...developing systems and ways for the people to come and live in the community. And also preventing [institutionalization]. So those are the two things that we are concentrating on.” (CAF)

3.4.4 Responding to past and future emergencies

Past wars, natural disasters and armed conflict have produced displacement and collective trauma, creating historically complex challenges for deinstitutionalization. Under Article 11 of the CRPD, States have an immediate obligation to protect persons who remain in institutions from danger, deprivation, violence, abuse and inhuman or degrading treatment during emergencies. At the same time, Article 19 of the CRPD and the Guidelines, states that emergency protection must not become a justification for building, renovating, reconstructing, investing in, or refilling institutions. The recent COVID-19 pandemic brought greater attention to the poor conditions within institutions as high rates of infection and related mortality grew whilst at the same time hospitals imposed extended isolation measures. Similarly, during natural disasters the integrity of ageing building infrastructure may be exposed, can create pressure and result in responses such as investment in refurbishing or rebuilding. Established in 1957 in post-war Taiwan, Yuli hospital housed persons with psychosocial disabilities – many of whom were veterans or referred by military, legal, and security institutions – often resulting in long-term separation from families and communities. For those without social support, institutionalization became prolonged and permanent. OPDs described the central tension around deinstitutionalization in emergencies lies in responding to urgent risks while preventing crisis governance from re-entrenching institutionalization. This also requires emergency preparedness plans that enable people to evacuate, access shelter, maintain support networks, and receive chosen supports in the community, rather than being directed into institutional settings.

4 Key challenges for OPDs in progressing deinstitutionalization

4.1 Ethical and political dilemma of participation and strategic decision making

Respondents highlighted the tension between focussing on long-term systemic change and responding to the immediate needs of individuals currently institutionalized and residing in life-threatening conditions. OPDs face difficult decisions about where to allocate limited resources, balancing advocacy for systemic change with urgent humanitarian concerns. Advocates expressed personal vulnerability and fear, questioning whether focussing on long-term advocacy without immediate benefit for those currently institutionalized felt exploitative.

I'm still a bit scared about DI because I was institutionalized. Sometimes when I talk about it too much and I'm not giving direct benefit to people in the institutions, maybe I'm exploiting the issues. It's very important – but the advocacy to do the change - maybe I don't get that much change. I'm preventing people from being institutionalized. But what about the people in the institutions... (Indonesia)

Taiwan Mad Alliance (TMA), established in 2019, is the only organization representing persons with psychosocial disabilities in Taiwan. Recent legal reforms addressing involuntary hospitalization introduced new procedural mechanisms, including legal aid, procedural guardians, case monitoring by public-interest organizations. These measures aimed to strengthen rights protections and ensure that individuals subject to involuntary processes were not rendered voiceless. While recognising the potential value of these safeguards, TMA identified a significant ethical and political dilemma regarding participation in their implementation. Engagement – particularly in roles such as assessors or monitors – was understood to require entering institutional systems that continue to be based on coercive intervention. TMA expressed concern that participation could legitimise involuntary hospitalization practices, while non-participation risked the exclusion of rights-based and CRPD-aligned perspectives and reduced protections for affected individuals. Rather than framing this as a binary choice between participation and resistance, TMA described the situation as a “grey zone” requiring ongoing ethical judgement. Participation was seen as potentially enabling limited harm reduction and



opening procedural space within an otherwise coercive system, while also carrying the risk of reinforcing its legitimacy:

“The question is not simply whether or not to participate, but rather this: within a system that still takes coercive intervention as its premise, would entering it amount to complicity, or might it still become a practice of reducing harm in a limited way and opening up procedural space?” (TMA)

This example illustrates how institutional reforms affecting persons with psychosocial disabilities often combine expanded procedural safeguards with new techniques of governance and control. For OPDs, such reforms complicate advocacy strategies and challenge simplified frameworks based solely on participation or refusal. This experience highlights that deinstitutionalization and resistance to coercion require ongoing, reflexive engagement with ethical tensions.



4.2 Chronic underinvestment in rights-based and culturally sensitive support options

The dominance of biomedical and charity-informed responses to persons with psychosocial disabilities continues to be a major barrier to development of community-based alternative options.

In the last 5-6 years government had the idea that no one should be on the street – all should have clothes and shelter. The government is putting money [with a] charity perspective. There are 10,000 people there now and they are also saying that 90% have a mental health problem...So we did assessment – now some [people have been] in there 5 years. [We are] wanting to help them to find family – they are disconnected from family and community. Very important issues for us to tackle – after years they lose their memories and are disconnected from their route. They are forced to live in the institution. (Nepal).

Governments showing minimal commitment to addressing the rights and needs of persons with psychosocial disabilities has resulted in chronic underinvestment in many contexts. Countries in the Global South continue to spend less than 1% of health budgets on mental health, much of this going to medical treatment without addressing the social determinants and contexts of health.²⁰ This is in line with the common misassumption that funding for persons with psychosocial disabilities should come through mental health programming and budgets, whereas the CoP's financing Call to Action paper makes clear that the funding streams around psychosocial disability and deinstitutionalization need to be a cross-sectoral budget area distinct from and additional to general health.²¹ OPDs and their members are observing the chronic underinvestment in community support options and are advocating for funds to be diverted to provision of disability support services.

When I started working in this area I went to the hospital – people coming and taking medication but lack of community follow-up and psychoeducation. After a few months they relapse... The problem is still the issues are being managed by the health system. The mindset is 'like treating like antibiotics'. So we are in the sensitising [phase]. In the community some are helping and documenting [good practices]. When we have some evidence of it working – social services, families - we want to document more of these in coming days to take to the duty bearer. (Nepal)

Governments could provide funding to enable existing peer communities in the community to use resources autonomously and flexibly in a peer-run manner. This also means that it is necessary to develop systems of assessment and support different from those applied to professional helpers, so that mutual aid work is no longer disciplined through management, documentation, and performance-oriented logics, but is instead genuinely recognised as relational labour, ethical practice, and community infrastructure. (Taiwan)

²⁰ World Health Organization (2023) Deinstitutionalization of people with mental health conditions in the WHO South-East Asia Region. New Delhi: World Health Organization, Regional Office for South-East Asia; 2023. Licence: CC BY-NC-SA 3.0 IGO.

²¹ Transforming Communities for Inclusion Global (2025) Call to action: financing deinstitutionalization in the Global South. Available at: <https://tci-global.org/wp-content/uploads/2025/08/Call-of-Action-CoP-on-DI.pdf>

Market trends driven by the interests of pharmaceutical companies and institutions powered by private interests (*“some of the private institutions are owned by social welfare officials”* noted one respondent) challenges efforts to promote understanding of the disability support needs of persons with psychosocial disabilities and supporting community-based options that are sensitive to local support systems and cultural ways of knowing, well being and doing. This is compounded by ableist and neoliberal structures that dictate who is ‘normal’ and systems of thinking which define who is of value and ‘deserving’ of investment.²²

The whole mental asylum and psychiatry, all of that was pretty colonial in nature...Neoliberalism has made it imperative for everybody to be a certain kind of way, to be a certain kind of productive. We’re fighting against a lot of things. (India)

4.3 Persistent reinforcement of institutionalization in legislative frameworks

OPDs recognized that whilst gains are critical, legislative and policy change takes considerable time, continual pressure, and flexibility and resources to utilize opportunities as and when they arise. Hard won progress can quickly be undone by changing of the guard in government transitions. Several OPDs have engaged in policy advocacy aimed at repealing or preventing the introduction of Mental Health Acts that create exceptions to legal capacity laws with limited success. These exceptions allow the removal of decision-making rights for persons with psychosocial disabilities, intellectual and cognitive disabilities and permit practices such as forced treatment, substituted decision making and involuntary detention.

During the review/development of the mental health policy, there was consultation with us but the things we suggested were not taken up. There was a lawyer assigned by the government and they didn’t get OPDs involved. The Mental health act [MHA] ... we hope that the MHA won’t be approved. We see that the MHAs are primarily to protect the rights of service providers rather than persons with psychosocial disabilities. So, we have focussed our energies on getting persons with psychosocial disabilities included in mainstream services. We are also using the Protection of Victims of Crime and Witnesses Act as an avenue for raising cases of abuse of persons with psychosocial disabilities. (Sri Lanka)

²² Davar, B., & Carroll, A. (2024). Transforming lives: Deinstitutionalization for people with disabilities. #WhatWENeed. <https://whatweneed.tci-global.org/wp-content/uploads/2025/01/Disability-2030-Essay-Deinstitutionalisation.pdf>

Even where discriminatory mental health laws have been removed, they have seen exceptions to legal capacity being inserted into other health laws. For example, Indonesia previously had a standalone mental health law (2014), but in 2023 the government enacted Law 17 on Health, consolidating various health-related laws into a single legal framework. This reform was carried out using the Omnibus Law method, aimed at streamlining and integrating health legislation.

At first people were happy that the Mental Health Law had been removed, but it was replaced with a small chapter in the health law that still enables forced treatment, forced admission, and guardianship. This small chapter is still extremely effective in violating our rights. In addition, the decision making around treatment is not person-centred – rather it is family and health professional-centred. There is also a mental incapacity clause in the criminal justice framework too. Specific regulations for supported decision making are needed. (Indonesia)

A key barrier to systemic reform and policy alignment is persistent power imbalances between health professionals and OPDs. Despite the evidence behind a range of psychosocial interventions and community support options, organizations have faced significant backlash when trying to offer alternatives to provision of medical treatment in improving health and wellbeing of communities or trying to take a role in decision making about issues that affect them.

Even if they're looking at lived experience advisors, they'll only take compliant lived experience advisors who say things like, 'Oh, these meds have been life-saving'... We weren't allowed to talk... I raised my hand so many times... There was so much gatekeeping... it's the psychiatrist that everybody turns to when it's about mental health... (India)

4.4 Navigating skill gaps in support systems

OPDs pointed to capacity challenges in building skilled OPD staff and peer support networks for DI efforts. Respondents emphasised the complexity and resource intensity of preparing peer supporters to meet diverse needs in contexts with limited professional psychosocial support services. Social workers, psychologists, and counsellors are in short supply, leaving peers and family members as the primary support providers. Peer supports need extensive knowledge of human rights, CRPD, national mental health mechanisms, and basic counselling skills, alongside sensitivity to issues such as gender-based violence and HIV to enable facilitation of safe spaces.

While many individuals valued OPDs and peer support, few are willing or able (within their current resources) to take on the demanding role due to the significant time, energy, and emotional investment required.

Many people would love to come to have those supports but don't want to do it [themselves] ... Its very exhausting - they have to know human rights and the CRPD, the Indonesian mechanism for mental health, how to be a good listener and how to do the basic counselling. The issue of HIV and sensitivities [are another layer]. Have to make sure it's a safe space for everyone. (Indonesia)

4.5 Maintaining resilience under resource constraints and systemic neglect

Respondents described the compounded challenges of advocating for psychosocial disability rights in contexts where political will and investment are lacking. OPD staff face overwhelming demands from members as well as donors at times, while grappling with personal experiences of institutionalization, making the work deeply personal and emotionally taxing: *"Because its very personal – I have lived with the experience of institutionalization. (Indonesia)"* Sustainable funding and mutual support among OPD members are essential for maintaining health and wellbeing at the advocacy and service provision frontline. The importance of regional solidarity and confidence building was raised by several respondents. Initiatives like TCI Global's plenary meetings were noted as vital for fostering confidence, prioritising actions, and creating a sense of collective strengthen amid an overwhelming landscape of urgent needs.²³ Some OPDs also reflected that the scale and immediacy of advocacy demands on their time have constrained their ability to advance organizational development processes and to undertake systemic evaluation of their work to assess impact.

We have not yet truly established a stable and continuous method capable of assessing whether our work has in fact been helpful to people. On the one hand, this reflects the limitations of organizational scale, resources, and staffing; on the other hand, it also shows that in the past we have acted more often in response to immediate needs in advocacy, legal reform, capacity-building, and crisis response, and have had less room to look back and more fully sort out which efforts actually produced impact, how that impact was formed, and where things did not work as expected. (Taiwan)

²³ <https://whatweneed.in/tci-plenary-on-community-inclusion/>

4.6 Harnessing funding for deinstitutionalization

In a shrinking aid space and global trends shifting against hard won wins in equity and inclusion, OPDs identified that getting funding to support their deinstitutionalization work is increasingly challenging. Whilst they had seen some improvements in donor trust in OPDs being able to set and implement their own agenda, enabling dedicated resourcing towards DI, other donors have tagged funding in line with their own priorities. This has meant that OPDs are forced to shoe-horn efforts around DI into donor-shaped program funding opportunities.

We have no funds. Honestly, right now we're in a space where we have no funds. The last three, four months, we haven't had a salary... We've tried to get funding, we've written countless proposals... but we were rejected... We've never had any core funding, it's always been project-based. (India)

The tendency of donors to favour project funding and 'activities' and infrastructure has undervalued the importance of more 'human aspects' to the work and OPDs frequently identified the need for more untagged core funding so they can build and retain their staff.

We want to make, if we see that it is very important to have a training, but we do not have a budget for that. We can always lobby, like ministries, agencies, whatever, for them to let us borrow their facilities so it reduces the cost of places. But it is a bit difficult because, like what I said before, most of the donors, they put emphasis on the cost of the activity, but not the human values... the success of this kind of work is based on the dedicated staff to really put their heart on this work. (Indonesia)

A group of approximately 30 children and a few adults are sitting in a large circle on a lush green grassy field. They are all looking towards the center of the circle. In the background, there is a large, forested hill under a clear blue sky. A soccer goal is visible in the distance on the left. The overall scene is bright and sunny.

Insights and Opportunities

Deinstitutionalization is not simply about closing institutions – it is about creating inclusive, rights-based systems that enable persons with disabilities to live and thrive in their communities. This section highlights practical strategies and opportunities identified by CoP members for OPDs, States Parties, and development partners to drive systemic change. It emphasises the importance of reframing the narrative towards building community support systems, fostering cross-movement alliances, and investing in evidence-based advocacy. By strengthening partnerships, piloting scalable models, and embedding DI within broader development agendas, stakeholders can collectively dismantle discriminatory structures and promote autonomy, dignity, and social inclusion. These insights provide a roadmap for collaborative action that aligns with international human rights standards and responds to the urgent need for sustainable and community-driven alternatives.

For OPDs

- Undertake analysis to inform strategic communication for deinstitutionalization. Consider framing deinstitutionalization as building inclusive community support systems, not just closing institutions.
- Strengthen cross-movement alliances to ensure psychosocial disability perspectives are included in broader disability, human rights, social justice and feminist, and sexual and reproductive rights and health movements.
- Invest in documentation of lived experiences and practice-based examples of community-based alternatives to strengthen advocacy.
- Develop practice frameworks for peer supporters, including intentional peer support, human rights, trauma-informed approaches, and crisis response skills.
- Work with local governance structures to pilot community support models and demonstrate scalable alternatives.

The narrative should be around developing community support systems. Giving options to the duty bearers (not confronting) and...working with the decentralised government and creating more resources in the communities. So people can be connected with families and taken care with support from the government. (Nepal)

For State Parties

- Embed deinstitutionalization into national development agendas beyond mental health policy, including housing, social protection, justice, and education.
- Ensure OPDs have a central role in designing, implementing, and monitoring DI processes.
- Repeal laws enabling removal of legal capacity, substituted decision-making and involuntary detention; enact supported decision-making frameworks.
- Redirect budgets from institutions to community-based supports such as personal assistance, peer support, housing, and crisis response.
- Fund programming that builds community support services such as personal assistance, crisis support, mobility support, in-home support, supported decision making, trauma-informed services, intentional peer support, etc.
- Recognise institutions as sites of rights violations and establish mechanisms for redress and compensation.

For development partners

- Provide core, flexible, multi-year funding to OPDs to strengthen organizational resilience and leadership. This includes funding that allows OPDs to invest in strengthening their organizations such as building the capacity of staff, volunteers and allies in human rights and to undertake priority project activities.
- Create dedicated funding streams for deinstitutionalization efforts that are distinct from funding to support other programming and policy efforts regarding mental health.
- At all times, fund DI as a human rights and social inclusion agenda, not solely a health or medical issue.
- Fund systems-change initiatives, including legal advocacy and policy reform, and attitudinal change campaigns led by OPDs.
- Invest in intersectional and gender-responsive approaches to DI, addressing needs of women, children and youth, LGBTQIA+ persons and other marginalized groups.

- Invest in documentation efforts to support OPD's advocacy. Support OPD-led research and documentation of grassroots practices to build evidence for policy advocacy. Support documentation of lived experience, especially from women, girls, gender-diverse people, LGBTQIA+ people, youth, older persons, Indigenous persons, and other marginalized groups.
- Facilitate regional and national dialogues and convenings to promote movement-building and cross-sector collaboration.

Conclusion

This case study underscores the critical role of OPDs in advancing DI across the Asia-Pacific region. Despite systemic barriers, chronic underinvestment, and entrenched discriminatory practices, OPDs are driving transformative change through rights-based advocacy, community mobilization, and innovative support models. Their efforts demonstrate that DI is not merely about closing institutions but about creating inclusive systems that restore autonomy, dignity and choice. The findings highlight that sustainable progress requires coordinated action across stakeholders. States Parties must embed DI within broader development agendas, dismantle discriminatory legal frameworks, and redirect resources toward community-based support. Development partners have a vital role in providing flexible, long-term funding and supporting systems-change initiatives that prioritise human rights and social inclusion. OPDs need continued investment in capacity building, evidence generation, and movement strengthening to sustain advocacy and service delivery.²⁴

²⁴ TCI. (2018). Bali Declaration [Declaration].
<https://tci-global.org/wp-content/uploads/2022/12/Bali-Declaration-English.pdf>

Annex 1

Mapping of UN Guidelines on Deinstitutionalization, including in emergencies to themes presented in findings

This annex attempts to map key sections of the UN Guidelines on Deinstitutionalization, including in emergencies to the corresponding sections of the case study report. It illustrates how OPD-led practice documented in the report operationalizes and aligns with the normative standards set out in the Guidelines.

UN Guidelines on Deinstitutionalization, including in emergencies	Key focus of the Guidelines	Relevant section(s) of case study report	How the case study findings align with the Guidelines
I. Purpose and process	Right to live independently; participatory approach; prevention of institutionalization	Executive Summary; Introduction	The report adopts the Guidelines' rights-based framing of deinstitutionalization and positions OPDs as central actors in advancing Article 19 of the CRPD.
II. Duty of States Parties to end institutionalization	Institutionalization as discrimination, violence, and deprivation of liberty	Findings – Themes 1: Conceptualization of institutionalization Theme 2:	OPDs reject institutionalization as care or protection and document it as a systemic human rights violation across diverse settings.
III.A Understanding institutionalization	Institutionalization defined by control, coercion, and loss of autonomy rather than just physical structures/buildings	Findings – Theme 1: Conceptualization of institutionalization	OPDs define institutionalization through loss of choice, liberty, and control, regardless of whether it occurs in homes, hospitals, or shelters.

UN Guidelines on Deinstitutionalization, including in emergencies	Key focus of the Guidelines	Relevant section(s) of case study report	How the case study findings align with the Guidelines
III.B Deinstitutionalization processes	Deinstitutionalization as interconnected processes restoring autonomy and control; OPD leadership	Findings – Theme 3: Approaches and Strategies	The report documents layered OPD strategies rather than linear or facility-focused approaches to deinstitutionalization.
III.C Respect for will and preferences	Legal capacity; supported decision-making; genuine choice	Findings – Themes 3: Approaches and Strategies Theme 4: Key challenges for OPDs in progressing deinstitutionalization Case examples (Taiwan, Fiji)	OPDs prioritize supported decision-making and document ethical tensions in systems that remain coercive.
III.D & VI. Community-based support and networks	Peer support, community networks, personalized supports	Findings – Theme 3.2: Strengthening community-based support systems	OPD-led peer support, crisis response, and community mobilization illustrate practical community-based alternatives.
V. Enabling legal and policy frameworks	Repeal of coercive laws; legal capacity; access to justice	Findings – Theme 3.3; Creating an enabling policy and legislative environment Case examples (Fiji, Taiwan, Indonesia)	OPDs influence mental health, disability, and human rights legislation, embedding deinstitutionalization across legal systems.

UN Guidelines on Deinstitutionalization, including in emergencies	Key focus of the Guidelines	Relevant section(s) of case study report	How the case study findings align with the Guidelines
III.G Participation of persons with disabilities	Meaningful participation and OPD leadership at all stages	Methodology; Fiji case study; Movement-building section	Structured participation with reasonable accommodation demonstrates Articles 4(3) and 33 of the CRPD in practice.
IV. Intersectionality	Gender, sexuality, poverty, conflict, compounding discrimination	Findings – Theme 3.4: Reflexive and contextual approaches	OPDs address intersecting forms of discrimination shaping pathways into institutionalization.
VIII. Emergencies and conflict	Deinstitutionalization obligations during crises; heightened risk of institutionalization	Findings – Theme 3.4.1 Responding to compounding disadvantage	OPDs reinforce that emergencies do not justify segregation, detention, or suspension of rights.
X. Disaggregated data	Data and evidence to inform reform and prevent delay	Findings – Theme 3.3.1 Generating evidence	OPDs generate experience and practice-based evidence to strengthen advocacy and challenge institutional assumptions.

UN Guidelines on Deinstitutionalization, including in emergencies	Key focus of the Guidelines	Relevant section(s) of case study report	How the case study findings align with the Guidelines
XI. Monitoring of Deinstitutionalization processes	Independent monitoring, accountability, survivor participation	Findings – Themes 3.3.1: Generating evidence Theme 4.1: Ethical and political dilemma of participation and strategic decision making	OPDs engage in documentation, monitoring, and critical participation in review and oversight mechanisms.
XII. International cooperation	Alignment of international funding and networks with Deinstitutionalization	Community of Practice; Recommendations; Movement-building section	The CoP and transnational advocacy reflect Guidelines-aligned international cooperation that strengthens OPD leadership.



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