## **OUTCOME OF REGIONAL CONSULTATION FOR ASIA PACIFIC**

**BACKGROUND**

On 12 May 2021, the Committee held the online regional consultation for Asia Pacific. There were 90 participants in total: 24 speakers and 52 observers, as well as five Committee members, nine personal assistants and members of the Secretariat. The Committee received 39 written submissions and three videos.

The following countries and territories were represented: American Samoa; Australia; Bangladesh; China; the Cook Islands; the Federated States of Micronesia; Fiji; Guam; India; Indonesia; Japan; Kiribati; Laos; Malaysia; Mongolia; Myanmar; Nauru; Nepal; New Caledonia; New Zealand; Niue; Pakistan; Palau; Papua New Guinea; the Philippines; Republic of Korea; Republic of the Marshall Islands; Samoa; Singapore; the Solomon Islands; Sri Lanka; Tahiti; Thailand; Timor-Leste; Tonga; Tuvalu; Vanuatu; Vietnam; and Wallis/Futuna.

**1. THEMATIC CONCERNS IN THE REGION**

The following is a summary of the concerns raised by participants:

1. Equality and non-discrimination

- Discrimination in law and practice persists, for example in laws denying or restricting legal capacity of persons with disabilities, particularly persons with intellectual disabilities. In some cases, new mental health legislation continues perpetuating institutionalization.

- Social stigma or negative stereotypes, humiliation, discriminatory and negative attitudes towards persons with disabilities by government officers and by society in general persist, such as in the misconceptions that persons with psychosocial disabilities need to be treated as patients or that they are potential criminals.

- Persistence of the medical model to disability, involuntary admission, no psychosocial support in the community; no access to health services, or employment support.

- High reliance and dependency of persons with disabilities on their family members or relatives, in the absence of social protection or support to live independently.

-Discrimination, including the lack of reasonable accommodation in access to employment, health services, access to justice, transportation and communications.

2. Different forms of institutionalization and pathways to institutionalization

- Several pathways to institutionalization including: mental health legislation providing for institutionalization on the basis of disability, alternative care mainly provided in the form of residential care;

- Budget allocation: funding and maintenance of psychiatric hospitals continues, “how much is enough until we can start preparing people to move out from institutions?” Corruption in institutions.

- There is a lack of independent living schemes, limited or inexistent support services; no availability of personal assistants. Families of persons with disabilities and communities are “charged with the care” of persons with disabilities. This often leads to families leaving their family member with disabilities in institutions or in unregulated care homes, where families pay high costs.

- Many people still live in public and private institutions: neglected, abandoned, invisible, and forgotten in institutions until they die; isolated for many years and secluded in life-long residential facilities, including psychosocial facilities; chronic institutionalization and repeated admissions; trans-institutionalization: moving people from large to small group homes or from detention centres to psychiatric facilities.

- Residential facilities limit control. In small groups homes, persons with disabilities lack or have limited control about their lives.

- Indefinite detention in prison of persons with disabilities is arbitrary. Evidence of worsening situation for persons with disabilities in detention settings: in numbers and in the deterioration of conditions for persons with disabilities put under indefinite detention; overcrowding, poor sanitary conditions. Lack of appropriate mechanisms to detect and address situations of violence in settings with institutional characteristics: torture and ill-treatment in institutions; isolation, restriction of movement, shackling.

-Individualized support does not follow the person- one speaker’s testimony was that she had support during the compulsory education years, only to see that support cease or diminish once she became an adult and moved into work.

3. Barriers in implementing States parties’ obligations under article 19

3.1. Legislation, public policies, and practices:

-Persistent confusion about what deinstitutionalization entails and about the institutional nature of facilities where people are living (all different types of institutions e.g., social care homes and hospitals).

- Lack of implementation of existing legislation.

- Government officials and staff working with/for persons with disabilities do not understand the rights of persons with disabilities. Lack of respect for persons with disabilities, civil society efforts are not respected.

- Lack of political will and absence of measures to facilitate the full enjoyment by persons with disabilities of independent living. States have developed principles but these are not implemented.

- Lack of clarity of roles at the different levels of government (national, local); incoherence implementation of deinstitutionalization between central and local governments and bodies;

- Lack of sufficient data on the situation of persons with disabilities.

3. Article 11 CRPD and links to institutionalization

- Heightened vulnerability due to Covid-19. Covid-19 hit persons with disabilities in institutions hard with a huge Covid-19 infection rate among persons who are institutionalized. Many persons with disabilities who have tested positive for Covid-19 are in critical condition and many more lost their lives.

- Reliable information about Covid-19 deaths is still unknown or information is hidden.

- During Covid-19, persons with disabilities in institutions were at greater risk of infections since there was no access to social distancing measures. People with disabilities were not allowed to leave group homes. They were already isolated from families and experienced further isolation due to the pandemic.

- More social barriers due to Covid-19 meant difficulties in getting food, medicines, etc. Persons with disabilities have financial hardship. There have been some (insufficient) efforts to provide support to people exposed to COVID-19. Insufficient accessible information about COVID-19 prevention and protection measures.

- Covid-19 increased inequalities: there were more challenges to get basic services, especially for people with disabilities living in remote areas. The situation is devastating: climate change, economic crisis, Covid-19.

- Support services are almost inexistent in some areas.

- People with leprosy more vulnerable during the pandemic. Lockdown put more strain on families to care for persons with leprosy.

4. Intersectional areas of discrimination

- Specific groups of persons with disabilities are subjected to intersecting forms of stigma, discrimination and inequality, including: women and girls with disabilities; persons with intellectual disabilities; persons with psychosocial disabilities; indigenous persons with disabilities; persons with disabilities in remote locations, older persons with disabilities; children with disabilities; persons affected by leprosy; persons with disabilities who are homeless.

- Women with disabilities are discriminated against on the grounds of gender and disability, or other possible grounds. Laws and policies on disability or institutionalization neglect aspects related to women and girls with disabilities. At the same time, disability is not always considered in gender-related legislative and policy frameworks. Women and girls with disabilities  face barriers in most areas of life and are subjected to structural and institutional forms of gender-based violence, including forced sterilisation, forced abortion, forced contraception, denial of legal capacity, forced treatment, and restrictive practices.

**2**. **KEY RECOMMENDATIONS FROM THE REGION**

Participants identified the following recommendations to be considered in the development of the Committee’s guidelines on deinstitutionalization:

* **Effective implementation of deinstitutionalization**:

-Review and reform legislation and adopt measures, including time-bound strategies, policies and action plans, to end institutionalization and to prohibit all forms of institutionalization. Article 19 should be recognised explicitly in Constitutions and legislations. States parties should commit to deinstitutionalization.

-Mainstream the right of persons with disabilities to live independently and to be included in the community in legislation and all policies and activities of the government;

-Set clear timeframe for deinstitutionalization (such as by 2024). Address problems caused by institutionalization simultaneously.

-Clarify that the involvement of the whole government structure is crucial for deinstitutionalization. Need the coherent implementation of deinstitutionalization between central and local governments and bodies. Deinstitutionalization should not be left to the Ministry of Health or Social Welfare Department only. Identify and define roles at the different levels of government (national, local) and ensure the coherent implementation of deinstitutionalization between central and local governments and bodies.

-Establish a monitoring mechanism to assess progress by all levels of government, particularly local governments;

-Ensure access of all persons with disabilities to individualized support, through a rights-based approach, which includes disability allowances and ensure access on an equal basis with others to: housing allowances; unemployment allowances; personal assistance; access to health care and well-being services; training programmes and skills development vocational training; social protection schemes.

-Reallocation of budgets. Ensure sufficient budget allocation and human resources for individualized support services and strengthen community support networks and community-based services. Discontinue funding of psychiatric facilities. Ensure moratoriums on any new placements in institutions and take measures to break funding cycles, channelling funds into alternatives to institutions. Invest in strengthening social protection schemes, including provisions to cover disability-related expenses, and in community support services to ensure living independently. State needs to invest in public housing programmes. Services need to reach persons with disabilities in remote locations.

-Individualized budgets for persons with disabilities should enable them to have access to public housing, health care, social protection, etc. on an equal basis with others. States should cover any significant extra-cost related to disability. Barriers to public housing, welfare, educational or health care allowances have to be eliminated.

-Develop referral mechanisms to support people with disabilities living in remote locations.

-Conduct capacity building for all State officials on deinstitutionalization. Clarify concepts of deinstitutionalization (refurbishing institutions or group homes is not deinstitutionalization).

-Organize awareness raising campaigns to eliminate negative stereotypes and the stigmatization of persons with disabilities in society. Mobilise for changing mind-sets in the community. Run public awareness to counteract stigma. Huge need to increase awareness of the equal rights and dignity of persons with disabilities.

-Take measures so that persons with disabilities enjoy equal recognition before the law, including by abolishing substituted decision-making regimes, such as guardianship, and by introducing supported decision-making regimes that respect the autonomy, will and preferences of persons with disabilities. Focus on autonomy rights and on restoring, respecting and supporting the exercise of legal capacity.

-Deinstitutionalization processes should be interlinked with the all articles of the Convention. It is about choice of persons with disabilities, but also about how lives are fulfilled.

-Increase measures to ensure that persons with disabilities are able to access general learning opportunities available during lockdowns, including vocational training, without discrimination and on an equal basis with others. This means developing accessible and innovative vocational training programmes, such as community-based programmes and accessible online platforms for persons with disabilities to maintain and develop skills and capacities.

-Emergency support should not be provided in institutions. There should be recovery facilities in the communities.

-Maintain an intersectional approach, including children, women, LGBTIQ communities, cultural and linguistically diverse communities; persons affected by leprosy; older persons, persons with dementia, persons who are homeless. Cross-cutting OPDs should also be included.

-Organizations of persons with disabilities, particularly of persons with psychosocial disabilities or with lived experience of institutionalization should be included in the development of mental health care and support initiatives. These initiatives should be community-based and promote peer support.

-Measures to ensure persons with disabilities regain control need to be developed: must take control over their own lives back from service providers. Art. 19 includes an aspect of participation in the community and citizenship.

-Support for independent living has to be available throughout the life cycle.

* Consultations with persons with disabilities through their representative organizations

-Ensure the effective participation of persons with disabilities in the design, implementation and review of deinstitutionalization;

-Support the direct engagement of persons with disabilities to participate in such processes;

-Develop and use accessible communication formats for mass media and public information. Persons with disabilities need to have accessible information, and information and communications technology about services and support schemes available.

-Include persons with disabilities in decision-making processes. Recovery efforts need to take into account the views of persons with disabilities

Ensure the meaningful participation of persons with disabilities in any initiative.

* **Actions at the regional or international levels**

- Include deinstitutionalization in international development cooperation programmes and funds.

- Link deinstitutionalization in all actions and measures to implement the 2030 Agenda and the Sustainable Development Goals. The rights of persons with disabilities need to be mainstreamed in all international cooperation efforts.

- Establish an international platform for good practices on deinstitutionalization to facilitate the sharing of experiences for effective implementation by national governments.

- International pressure is needed. The deadline for meeting deinstitutionalization objectives is 2024.

- Civil society and the international community should use other relevant treaties in the system, such as the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment when advocating for deinstitutionalization.

- Connect with the regional Human Rights Commissioners, for instance the ASEAN Human Rights Commissioner and advocate for the implementation of deinstitutionalization within the ASEAN disability forum – enabling Master plan 2025 (blueprint for implementing CRPD at the regional level).

-Connect with other initiatives stemming from the United Nations system, such as the OHCHR Policy Guidelines for Inclusive Development Goals or the Human Rights Indicators to help governments understand qualitative/quantitative measurements.

* **Good practices**

Peer-led community support programmes including supported decision-making and income generating opportunities through self-employment.

Rights-based individualized support.

Home visit care for living independently, at a schedule/ frequency decided by the individual.

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