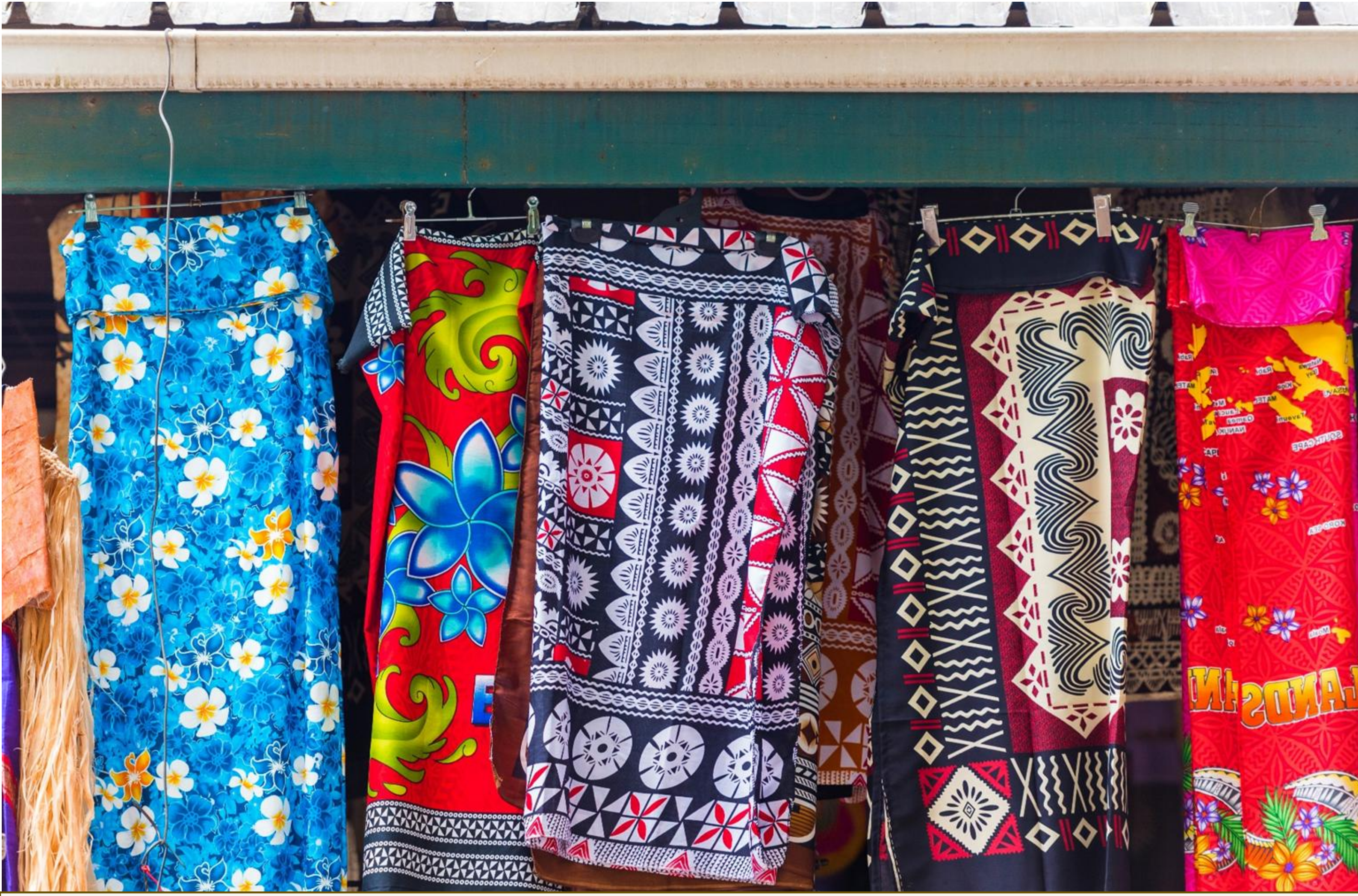


SUMMARY OF FINDINGS

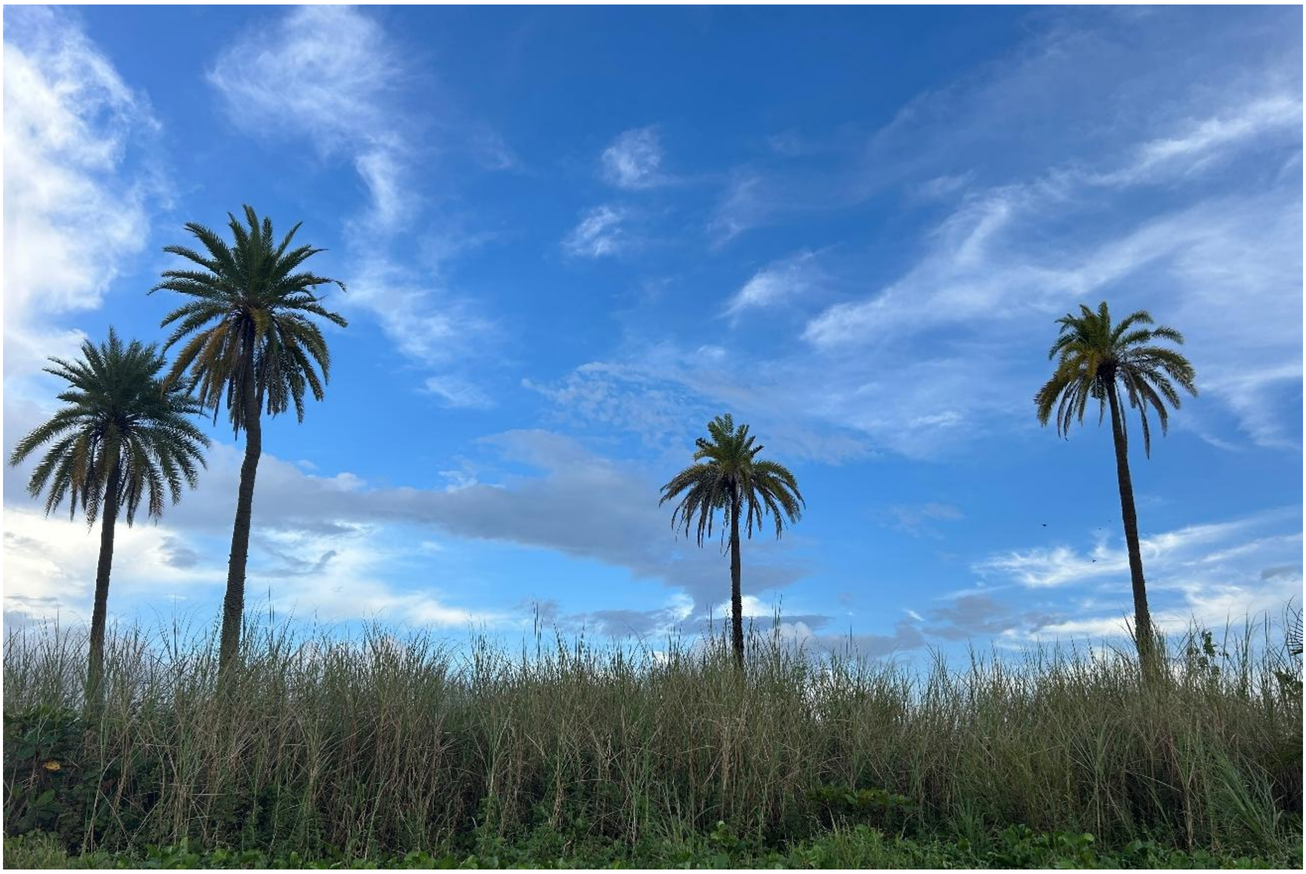
Enablers and barriers to community participation for people with psychosocial disabilities in Fiji

Researchers: Sera Osborne, Aleisha Carroll, Alexandra Devine, Odille Chang, Sally Cobb, Kartika Goundar

Contents

Abbreviations

Acronym	Description
CA	Crimes Act 2009
CPA	Criminal Procedure Act 2009
FNU	Fiji National University
MHA	Mental Health Act 2010
OPD	Organisation of People with Disabilities
PSA	Psychiatric Survivors Association of Fiji
RPD Act	Rights of Persons with Disabilities Act 2018
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities



Credit: CBM Australia. Image of palm trees in Nadi, Fiji.

Acknowledgments

The research team would like to acknowledge and thank all the interviewees and organisations of people with disabilities in Fiji for taking part in this research. This publication was made possible through funding support from CBM Australia. The views expressed in the publication are the authors alone and are not necessarily the views of CBM Australia.

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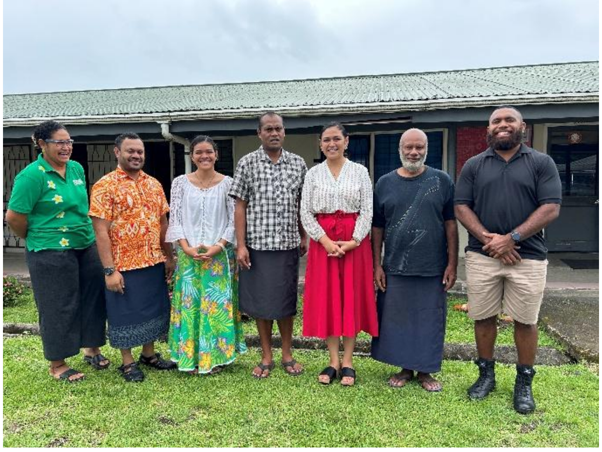

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About the research partners

Psychiatric Survivors Association of Fiji (PSA) is the organisation representing people with psychosocial disabilities in Fiji. PSA's mission is to improve the lives of people with psychosocial disabilities through self-help, peer support, advocacy, community education, and policy engagement.

CBM Australia (research funding agency) is a Christian international development organisation dedicated to improving the lives of people with disabilities living in poverty. CBM focuses on breaking the cycle of poverty and disability, through inclusive, rights-based approaches.

Fiji National University (FNU) Is a leading public education institution in the Pacific region. The College of Medicine, Nursing and Health Sciences is one of FNU's flagship colleges. It offers a comprehensive suite of programs in medicine, public health, nursing, and other health disciplines. The college fosters research and innovation, contributing to healthcare improvements in the region.

University of Melbourne (**UoM)** is one of Australia's most prestigious public research universities. Sitting within the Melbourne School of Population and Global Health, the Disability and Health Unit aims to work in partnership with people with disabilities and their representative organisations to improve the health of people with disabilities through rigorous research and knowledge exchange.

Executive Summary

Background

Community participation is a fundamental right under the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which Fiji has ratified in 2017. Yet, in many contexts, people with psychosocial disabilities are known to experience barriers in attaining this right.

Fiji is committed to ensuring all people with disabilities are equitably included in their communities, enabling positive connections and a sense of belonging. To do so requires a greater understanding of factors that influence the inclusion and participation of people with psychosocial disabilities within their communities.

This study aimed to contribute to this understanding by exploring the experiences, enablers, and barriers to community inclusion and participation of people with psychosocial disabilities in Fiji.

Methodology

Study objectives:

- Assess the rights of people with psychosocial disabilities within Fiji's legal and policy frameworks.
- Gather lived experiences of people with disabilities, their families and caregivers on community participation and inclusion.
- Understand stakeholder perspectives on barriers and enablers to inclusion and provide insights and recommendations to guide inclusive policy, program and service development.

Desk-based review: The study began in 2024 with a desk-based review of literature and policy documents. This included an analysis of Fiji's legal and policy framework and a mapping of available services relevant to people with psychosocial disabilities.

In-country qualitative data collection: Data was collected between January and May 2025 through semi-structured interviews and Talanoa group discussions in the Central, Western and Northern Divisions, and a small number of online sessions. Sites were selected to ensure geographic diversity and representation of urban and rural communities.

Key Findings

Perspectives on inclusion

- Respondents perceived the concept of their community inclusion as being a valued and accepted person and not defined by their disability, actively supported by their family and community, and included in decision making with freedom from stigma and discrimination.

Experiences of exclusion

- Whilst respondents pointed to some examples of community inclusion, most had experienced or observed exclusion on the basis of their disability. Exclusion was prominent across all domains of community participation.

Factors influencing community inclusion and participation

- Negative attitudes towards people with mental health issues and psychosocial disability are shaped by misconceptions about capacity to contribute, make decisions, and perceived dangerousness. These perceptions are reinforced by incapacity laws.

- Stigma and discrimination are reinforced by legacies of institutional practices, with people attending the mental health institution being labelled and contributing to perceptions of danger, incapacity and deviance, leading to social exclusion and marginalisation.

- Negative stereotypes are perpetuated by media, community attitudes, and policy and legal frameworks, which portray people with psychosocial disabilities as unpredictable or incapable, limiting their opportunities for participation.

- Stigma creates a cycle of exclusion, where individuals are denied support and inclusion, further entrenching distress, isolation and barriers to recovery. Emotional impacts of exclusion are long-lasting and can be life-threatening (contributing to suicidal ideation).

- People with psychosocial disabilities are expending extra effort and energy in proving their worth and capabilities to others.

- Barriers to mainstream services compound exclusion, such as in health (including sexual and reproductive health), justice and social protection.

- Conversely, when participants felt they had been included, accepted and valued this had a positive impact on their mental health and wellbeing, and community participation.

- Peer-to-peer support was transformative for participants in this study, providing safe places and relationships for learning, empowerment and mutual benefit.

- Almost all respondents indicated that better understanding and acceptance of and accounting for their disability would significantly improve their wellbeing, including their mental health.

Policy and practice considerations

Governments and development partners

- Harmonise legislative and policy frameworks with the CRPD, including repealing the Mental Health Act of 2010, and removing discriminatory language and provisions from the Criminal Procedures Act and Crimes Act. Strengthen mental health protection and promotion in relevant public health legislation and policy.

- Include OPDs and incorporate the lived experience of psychosocial disabilities into design, implementation and monitoring and evaluation of all social and health care systems.

- Expand disability support systems, including social protection schemes, to account for the specific disability needs and experiences of people with mental health issues and psychosocial disabilities.

- Shift away from institutional approaches; investing in research and development of community-based, culturally-sensitive, rights-oriented models of supports and services for people with psychosocial disabilities and their families. Include a wide range of services and supports: personal assistance, crisis support, respite support, help with self-care, and support for parenting and family life, recognising the important role that family and communities play in providing disability supports.

- Build knowledge and understanding of the rights of people with psychosocial disabilities and mental health issues into capacity building initiatives at all levels of governance (village leaders, faith-based leaders, district authorities, and government officials). Promote supported decision making; replacing substituted decision-making mechanisms.

Service providers and civil society organisations (including organisations of and for people with disabilities)

- Engage in monitoring and reporting efforts on Fiji's implementation of the CRPD including as it relates to people with psychosocial disabilities (e.g. through shadow reporting). Advocate for the alignment of laws and policies with the CRPD, with particular attention to legal capacity, supported decision-making, and freedom from torture and inhumane treatment.

- Ensure affordability, accessibility and quality of services for people with psychosocial disabilities across all regions, shifting from institutional approaches to community-based rights-oriented services.

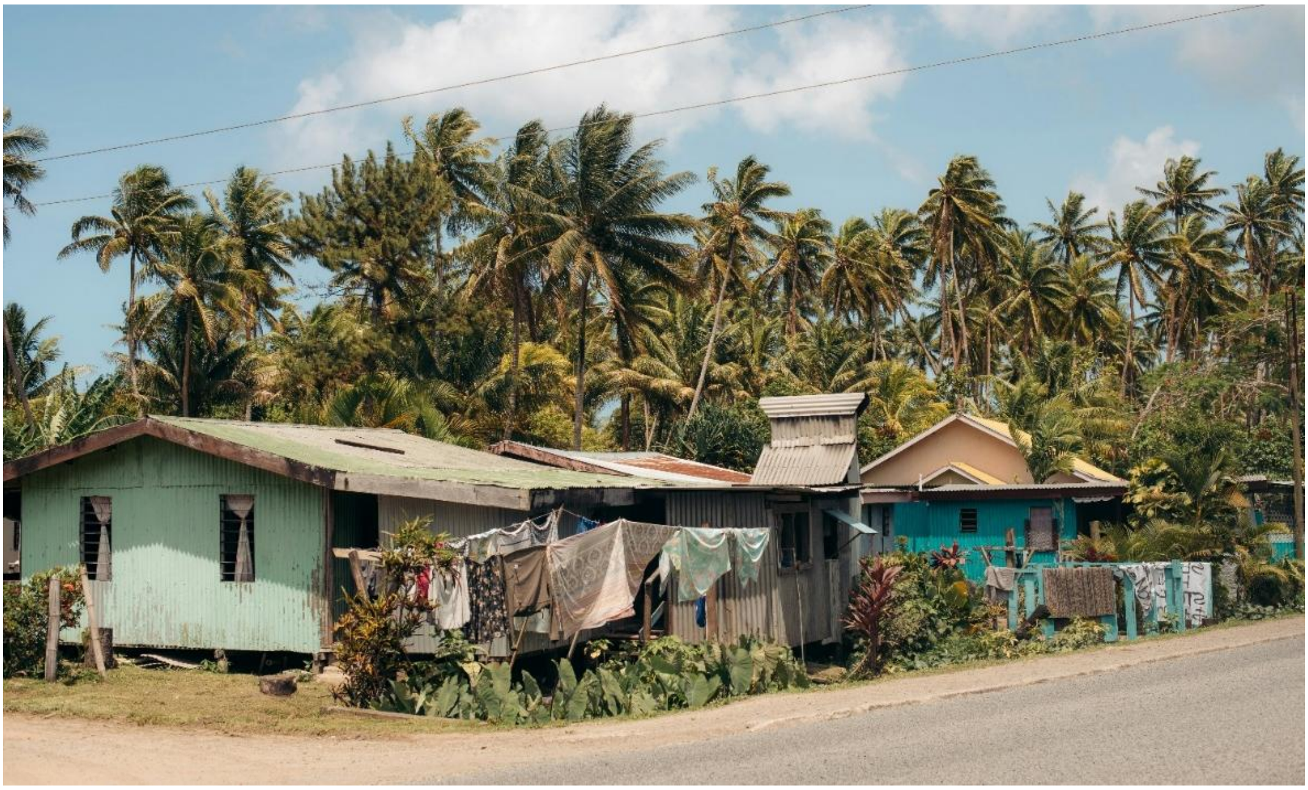
- Raise awareness and build family and community understanding of disability rights, culturally sensitive mental health and support; include people with psychosocial disabilities in training for communities.

- Continue to strengthen and expand peer-to-peer support approaches (e.g., networks, groups, and 1-1 support) and extend OPD branches into regional areas.

- Continue to develop approaches to supported decision making within families and communities (such as circles of support, etc.) and explore community-based support models like ‘community-watch zones’ to build local safety nets and inclusive support structures.

Families and individuals with psychosocial disabilities

- Acknowledge psychosocial disability as a form of disability with valid support needs – just like physical or sensory disabilities. Seek information on how to provide rights-based, empowering care and support.
- Know your rights – understanding the CRPD and national laws can help you advocate for yourself and others. Use your voice to challenge stigma – sharing your story can shift attitudes and inspire others.
- Recognise that stigma is external, not internal (you needn’t be defined by a diagnosis or label). Practice expressing your needs and preferences (e.g., for support, space, participation, etc.)
- Understand the diversity of experiences within psychosocial disability and that each journey is unique.
- Participating in a community group, a household decision, or a local event can build momentum – it’s ok to start small. Explore peer support opportunities – connecting with others who have similar experiences can reduce isolation and build confidence.



Credit: Nik Schmidt on Unsplash. Image of residential street, Fiji.

Introduction

The United Nations Convention on the Rights of Persons with Disabilities (CRPD or Convention) recognises disability as an evolving concept and arising from the interaction between individual impairments and societal barriers that hinder their full and effective participation on an equal basis with others, and promotes a shift toward rights-based approaches – particularly recognising psychosocial disabilities. Community participation is a fundamental right enshrined in the CRPD to which Fiji has ratified The CRPD frames disability as the result of interactions between individuals' impairments and societal barriers that hinder full and effective participation in society on an equal basis with others. This rights-based approach marked a shift away from biomedical models, particularly in the recognition of psychosocial disability – a term endorsed during the CRPD negotiations to reflect this paradigm change. Barriers to participation for people with disabilities are rooted in societal and environmental factors such as inaccessible infrastructure, transport, and prevailing attitudes. Individual factors – like health, poverty and social support – also play a role, alongside systemic exclusion from education, employment and disability-specific supports.

The CRPD emphasises full inclusion in all aspects of life – social, political, recreational and public. It defines participation as engagement in community-based activities chosen by individuals with disabilities that occur in community settings, and foster interaction with others, including those without disabilities. To promote inclusion and dismantle barriers, it is essential to understand how people with disabilities experience both obstacles and enablers to participation.

Globally, the marginalisation of people with psychosocial disabilities is well documented. Stigma and discrimination – often stemming from varied conceptualisations of disability and mental health – are exacerbated by the absence of community-based, rights-oriented services and supports. Institutional approaches, driven by stigma and lack of alternatives, continue to reinforce exclusion. However, a global shift toward deinstitutionalisation of people with psychosocial disabilities is underway, advocating for community-based supports aligned with human rights principles. This transition is associated with improved empowerment, inclusion and service quality. Understanding community and societal-level factors is therefore critical to designing effective supports that enable participation. The Sustainable Development Goals (SDGs), the Fiji National Development Plan, and the 2050 Strategy for the Blue Pacific Continent all make reference to leaving no-one behind. Despite this regional and global momentum, there is limited evidence from the Pacific Islands on the barriers and enablers to participation of people with psychosocial disabilities, to guide inclusive sustainable development. There are few studies that use a CRPD perspective, and even fewer studies that centre the voices of people with psychosocial disabilities and their families.

This research addresses that gap by exploring the experiences of people with psychosocial disabilities and their families and support persons in Fiji. It aims to understand the barriers and enablers to community participation and generate insights to inform inclusive policies and programs. This study aims to address this gap by exploring the experiences, enablers and barriers to community inclusion and participation of people with psychosocial disabilities in Fiji.

Study aims and objectives

The overarching aim of the study is to foreground the voices of people with psychosocial disabilities to identify and promote key pathways to improved community participation. The specific objectives are to:

- Explore the rights of people with psychosocial disabilities as articulated within Fiji's legal and policy framework.
- Understand the perspectives and experiences of people with disabilities, their families, and caregivers regarding community participation and inclusion through interviews and focus groups discussions.
- Explore the perspectives of key government stakeholders (such as policy makers and service providers) and non-government organisations (e.g., Organisations of People with Disabilities (OPDs) and community organisations) on the barriers and facilitators to inclusion of people with psychosocial disabilities in the community and generate insights and recommendations to inform the development of more inclusive policies, programs and services for people with psychosocial disabilities at the local and national levels.

Methods

Situating the team

The project team comprises a multidisciplinary group of university researchers working alongside lead researchers from disability advocacy and development agencies in Fiji and Australia. All members of the research team have a shared commitment to significantly improving the situation of people with psychosocial disabilities and mental health issues. The lead in-country researcher is a woman with psychosocial disability living in Fiji and staff member of the Psychiatric Survivors Association. When the lead researcher has personal experience with the topic being explored, the questions asked and the conclusions drawn are more likely to reflect what interviewees care about and intend to communicate[1]. The importance of lived experience in research is in line with the CRPD 'nothing about us without us.' In addition, previous authors have highlighted the potential for greater interviewee comfort with disclosure when being interviewed by another with shared experience[2].

Desk-based review

The desk-based review analysed available literature contributing to the understanding of psychosocial disabilities in Fiji, as well as exploring the rights of people with psychosocial disabilities as articulated within Fiji's legal and policy framework. A desk-

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[1] Happell, B & Roper, C. (2007). Consumer Participation in Mental Health Research: Articulating a Model to Guide Practice. *Australasian Psychiatry* 15 (3): 237–241. https://doi.org/10.1080/10398560701320113

[2] Croft, B, Ostrow, L, Italia, L, Camp-Bernard, A & Jacobs, J. (2016). Peer Interviewers in Mental Health Services Research. *The Journal of Mental Health Training, Education and Practice* 11 (4): 234–243. https://doi.org/10.1108/JMHTEP-02-2016-0012

based mapping of available services relevant to people with psychosocial disabilities in Fiji was also conducted.

Given Fiji's ratification of the CRPD in 2017, the legislative review was undertaken to assess the alignment of key Fijian laws with the CRPD, particularly in relation to the rights of persons with psychosocial disabilities. The review focused on laws that impact institutionalisation, deinstitutionalisation and access to justice. The approach involved a targeted analysis of five core pieces of legislation – the 2013 Constitution of Fiji, the Rights of Persons with Disabilities Act 2018, the Mental Health Act 2010, the Criminal Procedure Act 2009, and the Crimes Act 2009. Each law was examined for its recognition of international obligations, its conceptualisation of disability, anti-discrimination provisions, and its treatment of rights such as legal capacity, liberty, informed consent, and freedom from torture or degrading treatment. The review prioritised the CRPD's rights-based and social model of disability and drew on guidance from the CRPD Committee to identify gaps, inconsistencies and opportunities for reform.

In-country qualitative data collection

Qualitative data collection was conducted between January and May 2025. Qualitative data was collected using semi-structured interviews and Talanoa group discussions. The in-country data collection was mainly conducted in Suva, Lautoka, Raki Raki and Labasa, as well as a small number of online interviews. These sites were selected in consultation with PSA in consideration of available resources, geographical diversity of the research locations, and with the aim of ensuring representation of people with psychosocial disabilities in urban and rural communities.

Research participants were purposively recruited through the networks of PSA. All efforts were made to recruit a representative sample in relation to gender and age and geographical location. Data collection involved:

- Key Informant Interviews with key stakeholders including government representatives and OPDs.
- In-depth interviews and group discussions and with carers of people with psychosocial disabilities.
- In-depth interviews and group discussions with people with psychosocial disabilities.

Sampling

Purposive sampling was used. Potential in depth interview and group discussion participants needed to self-identify as having a psychosocial disability or as a carer of a person with psychosocial disabilities. Information about the study was communicated via email, text message and phone calls using PSA's established networks and meetings. Interested individuals were invited to attend a preliminary meeting and presented with information on the study. Key informants were contacted via email and invited to participate. All individuals participating in the study provided informed consent.

Limitations

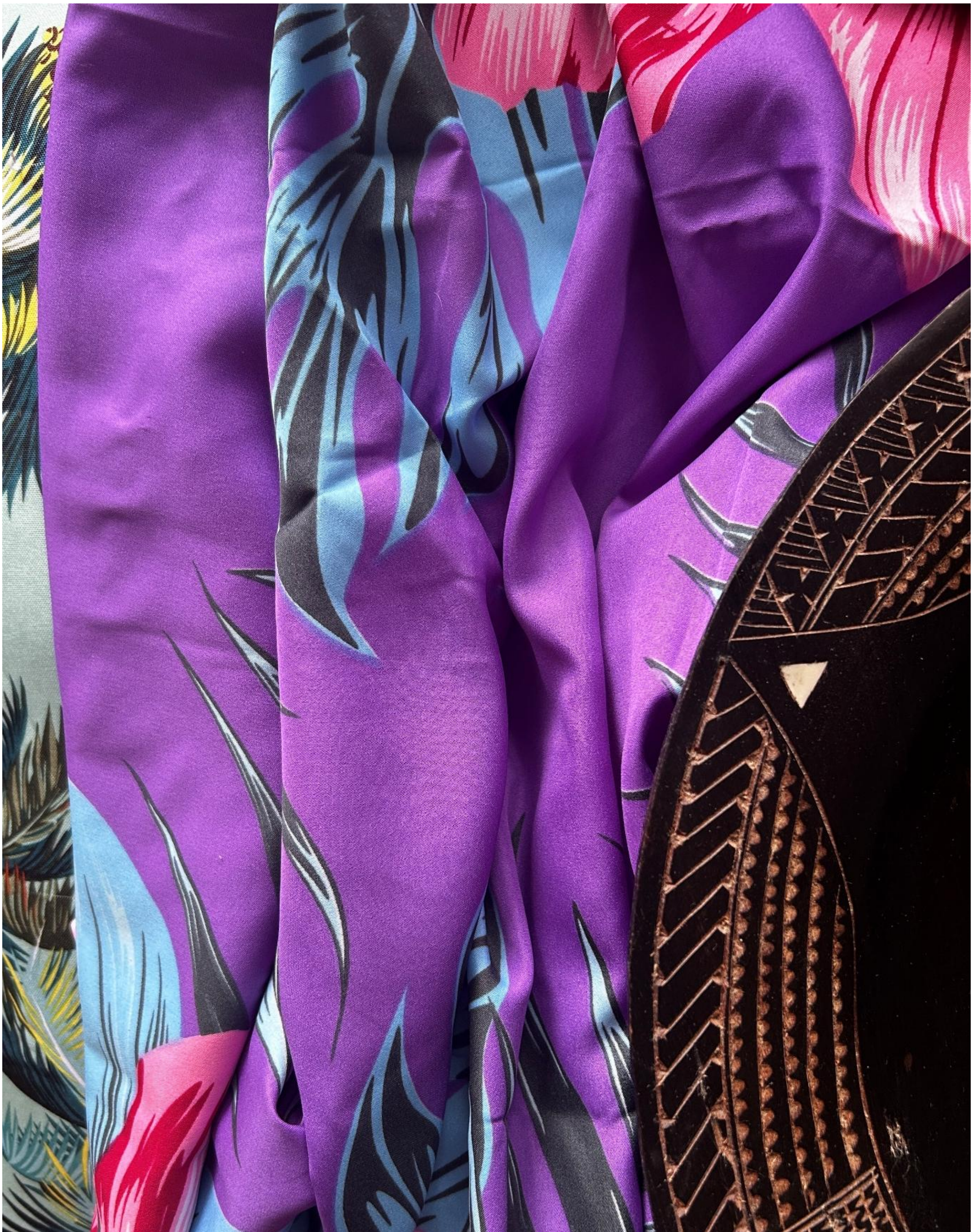
Scope: whilst the project explored barriers to community participation using a qualitative approach, it did not examine statistics on people with psychosocial disabilities. The legislative review was targeted at three key laws and their interactions with the Constitution but did not provide a comprehensive review of all laws and policies pertaining to people with psychosocial disabilities.

Representativity: Fiji is geographically and demographically diverse, and there is great diversity amongst people with psychosocial disabilities. This meant that the study could not be representative of the whole country with the resources available for this study.

Sample design: the study did not include children with psychosocial disabilities as all participants were at least 18 years of age. The study also did not collect information on other types of disabilities that respondents might have had.

Ethics: Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee (2024-30138-55826-3) and the Fiji National Research Ethics Review Committee (ID: 104.24) prior to the commencement of data collection.

Copyright: CBM Australia. Image of open coconut on sand, Fiji



Credit: CBM Australia. Image of fabric and wood engravings.

Findings

Legislative review

Key findings

This review reveals that while some legislation, like the Rights of Persons with Disabilities Act, reflects a rights-based approach aligned with the CRPD, others – particularly the Mental Health Act, Criminal Procedures Act, and Crimes Act – retain medicalised and discriminatory frameworks that may perpetuate institutionalisation, stigma and exclusion. These legal provisions can directly restrict an individual's ability to live independently, make decisions, access justice and engage in social, economic, and civic life. By highlighting inconsistencies, gaps and opportunities for reform, the review provides critical insights into how Fiji's legal system either facilitates or hinders the full and equal participation of people with psychosocial disabilities in their communities.

1.1 Constitution of the Republic of Fiji 2013

The constitution is the supreme law of Fiji and includes provisions relevant to the rights of people with disabilities. It recognises disability as including mental and psychological conditions but uses stigmatising language such as 'unsound mind.' While the Bill of Rights prohibits discrimination on the basis of disability, it allows Parliament to pass discriminatory laws if deemed 'necessary,' a term that is undefined in the Constitution. The Constitution also permits deprivation of liberty on medical grounds and restricts voting rights for individuals declared of 'unsound mind.' Although it references international law, including the CRPD, it lacks explicit recognition of the right of people with disabilities to live independently and be included in the community.

1.2 Rights of Persons with Disabilities Act 2018

The Rights of Persons with Disabilities Act largely aligns with the CRPD and in this way can be considered an enabling framework for community participation for people with psychosocial disabilities. It adopts a rights-based definition of disability and references in particular the right to live independently and be included in the community (s38), the right to legal capacity (s32), the right to free and informed consent including in relation to health (s44) and medical or scientific experimentation (s36), and right to liberty and security of person (s34). With regards to the right to live independently and be included in the community, s38 legislates this right as recognised in CRPD Article 19. This means that, under Fiji law, as with the CRPD, people with disabilities have the right to live independently and be included in the community – whoever they are and wherever they live – as well as have their basic needs satisfied. This includes access to support services including personal assistance of choice, being enabled to make decisions, to put their choices into action and to be part of community. The Act does not currently recognise the higher standard of immediate realisation in relation to some rights within the CRPD, namely civil and political rights.

Aspects of the Act which could be further strengthened include that it retains medicalised language applied such as ‘abnormality’ (s2), and ‘suffer’ (s27)). The Act also doesn’t distinguish between progressive realisation of rights (economic, social, and cultural rights) and immediate realisation of rights (civil and political rights), which may delay the immediate realisation of civil and political rights. The Act references the Mental Health Act, which undermines its rights-based approach. Procedural accommodations and access to justice are mentioned, but their practical implementation requires further investigation. The Act would benefit from stronger protections for women with disabilities.

1.3 Mental Health Act 2010

Significantly, the Mental Health Act was developed prior to Fiji’s 2017 ratification of the CRPD, and prior to the introduction of the Bill of Rights established within Fiji’s Constitution in 2013. Despite the Rights of Persons with Disabilities Act establishing the right to equal legal capacity, the Mental Health Act allows for substituted decision making for people who meet the definition of “mental incapacity” and doesn’t guarantee supported decision making. In this way, the Act fails to distinguish adequately between mental capacity and legal capacity. This is contrary to CRPD Committee guidance that there is a strong **distinction between mental and legal capacity** and one’s mental capacity is no grounds for denying the right to legal capacity. To do so would amount to discrimination on the basis of disability or impairment.[3] Whilst the Mental Health Act purports to protect the rights of people with disabilities it also lacks a rights-based definition of disability, using potentially stigmatising language.

In addition to substituted decision-making, the Act allows for involuntary detention and treatments without consent, including electroconvulsive therapy, psychosurgery and sterilisation. The Act also permits detention beyond prison terms for people with psychosocial disabilities charged with crimes. A range of sections in the Mental Health Act also contravene the property rights of people with disabilities by limiting the capacity of individuals to deal with property on the grounds of impairment or disability. Although it includes review mechanisms and ethical standards, these are undermined by broad exceptions to both these mechanisms and to the requirement of consent. The Mental Health Act in this regard is highly medicalised and inconsistent with the CRPD. Having since ratified the CRPD, Fiji is obliged to review, abolish and / or amend the Mental Health Act to ensure legal harmonisation with the CRPD.

1.4 Criminal Procedure Act 2009

The Criminal Procedure Act outlines the powers and procedures to be applied for apprehension of offenders and the conducting of criminal trials. The Act governs criminal procedures and includes provisions referencing mental capacity. Like the Mental Health Act, it conflates mental and legal capacity, allowing courts to deny legal capacity based on mental state. The Act does not provide for accommodations to support the individual’s understanding of proceedings such that they are able to exercise their right to enter a plea. Rather the focus is on the individual ‘cannot be

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[3] CRPD Committee General Comment No.1 (2014) on equal recognition before the law (CRPD/C/GC/1) (https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Download.aspx?symbolno=CRPD/C/GC/1&Lang=en)

made to understand' (s108 Procedure when accused does not understand proceedings). This is contrary to requirements that the individual be provided with the necessary accommodations and support required to exercise legal capacity with full effect given to their will and preferences.[4]

The Act authorises detention in mental health facilities without consent and lacks provisions for supported decision-making or procedural accommodations. The President can order that a person remain 'under supervision in any place as the President thinks fit (s108(4)(a)) for an undefined period. Language used in the Act reinforces stigma (e.g., 'insanity', 'insane' and 'unsoundness of mind') and there is no explicit anti-discrimination clause. While The Criminal Procedure Act allows for regulations to align with international treaties, including the CRPD, these have not been adequately implemented.

1.5 Crimes Act 2009

The Crimes Act codifies criminal responsibility and includes numerous references to mental impairment and illness. It lacks a rights-based definition of disability and uses stigmatising terms such as 'mental subnormality' and 'abnormality of mind'. The Act provides a defence of diminished responsibility and allows surgical operations without requiring consent, which may violate CRPD standards. There is no anti-discrimination provision, and the Act does not recognise the right to live independently or legal capacity. Further research is needed to assess the application of its provisions in institution-based health and social care settings – specifically whether people with psychosocial disabilities are being afforded their rights under this Act. For a full report of the findings from the legislative review please contact the authors.

Service mapping

A service mapping exercise revealed limited formal and dedicated services and supports for people with psychosocial disabilities in Fiji. PSA is the primary provider of peer-to-peer support groups, livelihood seed grants and training on the rights of people with psychosocial disabilities. PSA has also been trialling a community-based inclusive development model ("community watch zones")[5]. This community development approach involves intensive awareness activities and identification of inclusion champions within a specific village or community. These champions are then provided additional training and referral pathways to provide a support system around people with disabilities living in the community. Beyond this, there are several mainstream health and social support programs which were mentioned by respondents in the qualitative data collection phase (as described in the next section of this report). These included:

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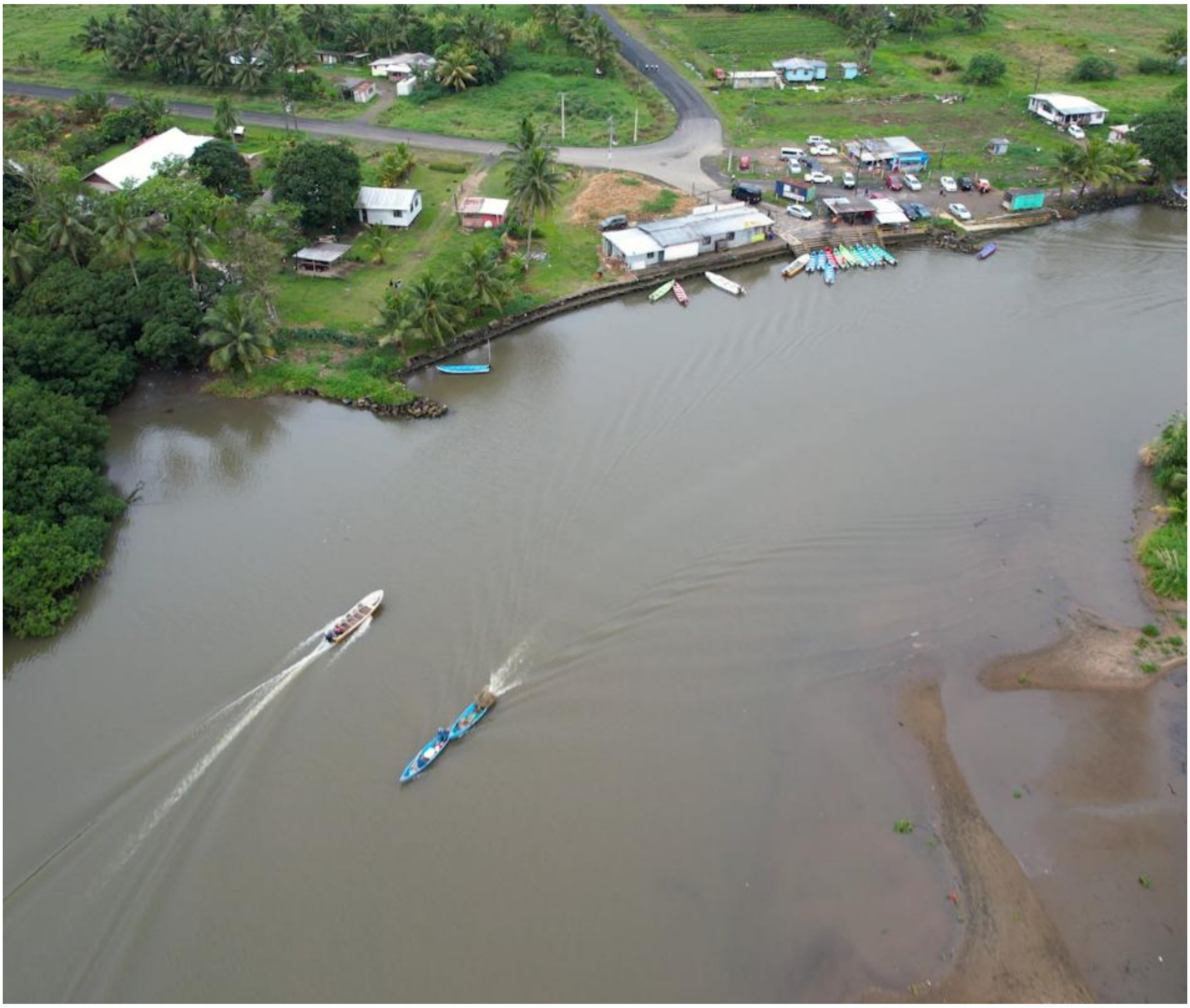
[4] Committee on the Rights of Persons with Disabilities. *Guidelines on deinstitutionalization, including in emergencies* (CRPD/C/5)(10 October 2022), para 55.

[5] Pacific Disability Forum (2025) *Community-based inclusive development in the Pacific*. Accessed at: https://pacificdisability.org/wp-content/uploads/2025/06/Community-Based-Development-in-the-Pacific.pdf

- St Giles hospital (the tertiary mental health facility based in Suva) and Stress Wards located in Labasa, Lautoka and CWM hospitals. St Giles, in addition to medical treatment, provides some counselling and group activities.
- Community health services may have staff trained in mental health treatment provision.
- Lifeline Fiji provides crisis counselling support services.
- Empower Pacific provides general counselling services, including a 24/7 hotline phone service.
- Other counselling, GBV and shelter support are provided by the Fiji Women's Crisis Centre.



Copyright: Room 3 Photography. Image of fiji waterway.

Qualitative findings

3.1 Participants

Forty-one people participated in the study and 26 of these were people with psychosocial disabilities and nine family members and support persons. Ages ranged from 24 to 65 years. Twenty identified as women and 21 as men. Participants lived in Central division, Western Division, and Northern Divisions. Respondents participated in either a Talanoa group discussion or an in-depth interview. An additional four respondents participated as key informants, and these were representatives of OPDs and government officials.

3.2 Key findings

The findings from this study reveal a complex but consistent picture of how people with psychosocial disabilities in Fiji experience community participation, exclusion, and support. Respondents described both the aspirations and realities of inclusion, highlighting the central importance of dignity, equality and meaningful engagement in community life. At the same time, they reported pervasive social, economic and institutional barriers – ranging from stigma and discriminatory attitudes to limited access to services and restrictive legislation – that undermine their rights and wellbeing. The following sections present these findings in detail, outlining participants perspectives on inclusion, their lived experiences of exclusion, and the underlying factors shaping these dynamics, and their views on the changes needed to realise full participation.

3.2.1 Perspectives on community participation

Across respondent groups, community participation was viewed as a fundamental right grounded in dignity, respect and active engagement in community life.

Key findings

Respondents perceived the concept of community inclusion as:

- being valued and accepted as a person and not defined by their disability,
- actively supported by their family and community to reach their potential,
- being free from stigma and discrimination, and upholding their right to participate in their community, including in decision making and in meaningful roles, on an equal basis with others without disability.

Equality and valuing the person

All respondent groups in this study strongly associated community inclusion with being valued by the community as a person first. This included being accepted for who they are, irrespective of one's mental health condition or disability and not being defined by their diagnosis. One respondent with disability shared:

> **“It doesn’t matter who, but we shouldn’t be looked at differently. Look at us and treat us equally.”**

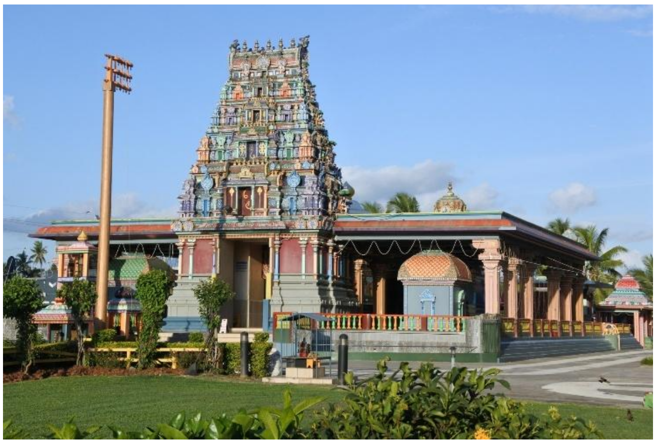
Most respondents described community inclusion as freedom from stigma and discriminatory attitudes. Participants emphasised that community inclusion meant being treated with dignity, respect and being supported by families and communities.

> **“It's making sure that everyone is living…in the Community setting and enjoying living in that community. Without in any form of Stigma or discrimination…irrespective of gender age. Religion.” – Key informant**

Another key theme was active participation in community life. This included mention of sports, religious activities, traditional activities such as weaving, and community meetings. Respondents emphasised that inclusion was not just about being present but being actively involved in activities to the same extent as others.

Supportive families and environment

An inclusive community would welcome individuals into social spaces, with families and community groups (such as faith-based organisations and women’s organisations) extending support and ensuring people are not stigmatised. One stakeholder noted that inclusion should involve support from various community actors – faith-based organisations, women’s and men’s groups – underscoring the importance of collective responsibility. Inclusion was seen as possible when individuals felt supported and empowered.



Siva Subramaniya temple in Nadi, Fiji.
Credit: Chameleonseye from Getty Images Pro.

> **“We live in the village,**
> **[community inclusion means] they will love her, care about her, include her and help her.” – Carer/Support person**

> **“…they should be accepted…They should be provided with the support from family members, from faith-based organisations within that community, from women's group, from men's group…they shouldn't see us, or stigmatize us because we have a mental health problem or we're diagnosed with a mental illness.” – Key informant**

These accounts align clearly with how community participation is enshrined in the CRPD, affirming the right of all people with disabilities to live independently and be included in the community, with equal access to necessary services and supports to do so. Inclusion, in this context, means more than physical presence – it involves meaningful engagement in community life, including social, cultural, political and economic activities. Community participation is viewed in the CRPD, as it is in respondents’ accounts, as the mechanism through which inclusion is realised. It reflects the ability of individuals to choose, access, and engage in activities alongside others without disabilities.

3.2.2 Experiences of community participation

While a small number of participants with psychosocial disabilities reported feeling included in their community, occurrences of inclusion varied by family, community and individual circumstances, with most people with psychosocial disability reporting feeling excluded from community participation to some extent. This included people with psychosocial disabilities being treated unfairly, disrespectfully and with prejudice.

Key findings

- Almost all people with psychosocial disabilities in the study had experienced barriers to community participation on the basis of their disability/mental health issue.
- Many participants had experienced discrimination regarding decision making or having their voices heard.
- Participants shared many incidents of abuse, violence and neglect occurring in communities towards people with psychosocial disabilities. Violation of rights within mental health services was also described.

Socio-economic exclusion

Family members reported that they observed their own family members or others being excluded from community life, including being left out of meetings, events, and decision-making. Carers observed that when people with psychosocial disabilities were invited it was often only to perform tasks, not to contribute meaningfully, pointing to a broader issue of tokenism.

> **“Some families they include their family members, but other families they just disregard them, like their opinions are not valued.” – Carer/Support person**
>
> **“I do take part in community health work in the village (Cakacaka vaka koro), this involvement maintains the village cleanliness. And I continue to engage myself because this is one way, I be part of the community work.” – Person with disabilities**
>
> **“They are hardly included in the community activities…if there is a meeting and they are not included. Or they are not even invited to come into the area. And their voice are not heard…For functions, some family members bring them in just for them to work.” – Carer/Support person**

Even within the disability community there were examples shared of people with psychosocial disabilities being excluded from social and advocacy activities. Some reported that they were not invited to participate in social activities and others observed their peers being assigned menial tasks during events instead of being given the opportunity to lead or voice their opinions. One stakeholder reflected that if people with psychosocial disabilities are unsure if they have support, they will go along with what's being offered as a role, but if they feel they have support people behind them, they will advocate for themselves for the tasks they should have.

Respondents with psychosocial disabilities described feeling differentiated and left out, particularly by community leaders and decision-makers.

> **"We still struggle with how our leaders confront people like us…Sometimes they differentiate us and makes us feel left out." – Person with disabilities**

A few respondents highlighted intersecting identities and the compounding of exclusion for women with psychosocial disabilities, particularly single mothers, and people living in housing complexes for disadvantaged groups, sex workers, as well as unhoused people.

Exclusion from community life included people with psychosocial disabilities often being excluded from traditional and religious activities. Exclusion from employment and livelihood opportunities was common, often linked to stigma and lack of support.

> **"He was being pushed away from home…they won't provide, because he wasn't working…then he turned to working on the streets." – Person without disabilities**

Participants reported barriers to accessing health, including sexual and reproductive health, social protection and disability services.

> **"The hospital system does not accommodate people with psychosocial disabilities…Because of the stress of waiting and being looked at by others…he became mentally unwell." – Carer/Support person**

Civil and political exclusion

Participants described being denied participation in traditional leadership and political processes. This results in loss of the right to vote, exclusion from traditional leadership and community decision-making roles, and denial of the right to make personal, legal or financial decisions.

> **"As a person with psychosocial disability, one of the barriers for me is the function of the Vanua.[6] I feel left out…It was only to the 'rightful people' with a 'rightful mind' to go and participate. As soon as they saw me, they kind of gave this vibe to me that you are not welcome here. So, I go and stand next to the window and I listened…So, I can get what information they're saying." – Person with disabilities**

One key informant described instances of good practice and championing of the rights of people with psychosocial disabilities within government. Policies changed to enable them to open bank accounts, and some officials routinely go to PSA on decisions that affect their constituents. However, where there is disagreement between a family and

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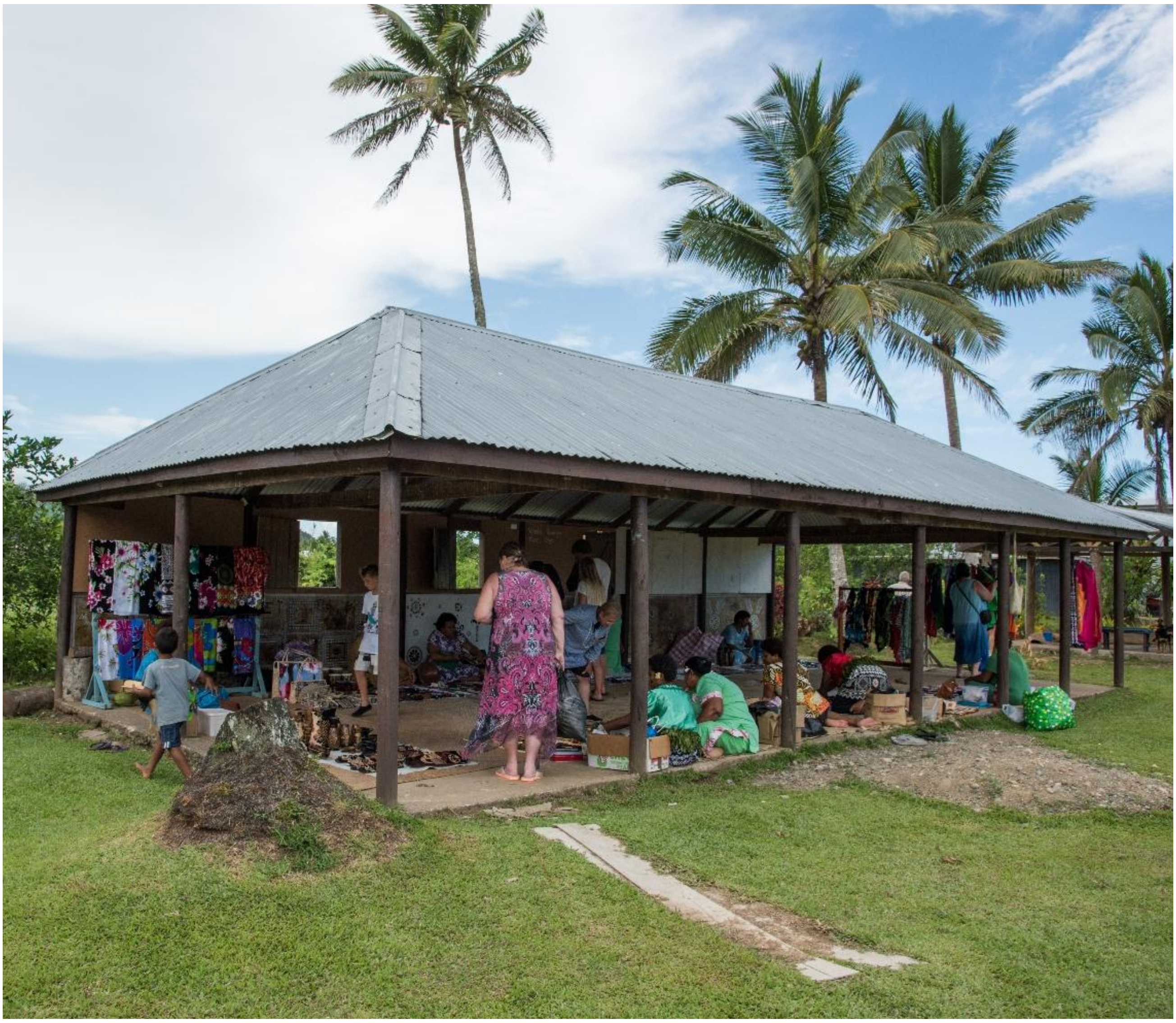
[6] "Vanua" in Fiji refers to land, home, or village, and is a central concept in the iTaukei culture, particularly in relation to land ownership and traditional beliefs.

their member with disability, usual practice was to allow the family to make the decision.

Access to justice is critical to being able to participate in community. Challenges raised by respondents is supported by other research findings from Fiji that women with disabilities are typically encouraged by police to use reconciliation instead of continuing with their claim. Women with psychosocial disabilities may not be believed by police or the cases had not been closed when they reported experiences of GBV. Participants described systemic barriers to justice, including disbelief and lack of support.

> **"We see crimes like rape not being reported for women with psychosocial disabilities. They see them as hopeless so their rights are not [upheld] and access to justice is not respected." – Key informant**



Credit: EAGiven. Image of a community market.

Credit: Donyanedomam. Image of house and palm trees in rural area.

3.2.3 Underlying factors influencing experiences

Negative attitudes towards people with psychosocial disabilities are driven by misconceptions about their capacity to make decisions and contribute, and perceived dangerousness. Stereotypes are reinforced by institutional legacies, media portrayals and policy frameworks, producing cycles of exclusion that limit access to mainstream services, deepen isolation and can have long-term, and even life-threatening, emotional impacts. By contrast, inclusion, acceptance and peer-to-peer support are consistently reported as transformative, improving wellbeing and community participation as further described below.

Key findings

- Negative attitudes to people with mental health issues and psychosocial disabilities are shaped by misconceptions about their capacity, and is reinforced by institutional legacies, with labels like “St Giles patient” contributing to perceptions of danger, incapacity and deviance.
- Negative stereotypes are perpetuated by media, community attitudes and policy and legal frameworks, which portray people with psychosocial disabilities as unpredictable or incapable, limiting their opportunities for participation.
- People with psychosocial disabilities are expending extra effort and energy in proving their worth and capabilities to others.

Conceptualisation and understanding of disability

Factors inhibiting participation were frequently attributed to different understandings of disability present in communities and households. Key informants reported that responses to changes in emotional and psychological status or wellbeing, or behaviours outside what is considered the ‘norm’ were shaped by varied belief systems present in communities, commonly associated with spiritual wrongdoing (e.g., that elders doing past wrongs and families carrying curses had led to these behaviours), or faith-based and mental illness (biomedical) paradigms. Respondents perceived a lack of understanding of mental health, impairments, and associated disability as being a key underlying factor leading to perpetuation of stigma and prejudice.

> **“Most of the communities…are not even aware about psychosocial disability.” – Person with disabilities**
>
> **“I believe it’s the lack of knowledge that our family members have…they do not know how to work with a person that lives with psychosocial disability.” – Person with disabilities**

The relative ‘invisibility’ of psychosocial disability compared with other types of disabilities meant that whilst there was increasing awareness of disability inclusion and improved practices towards acceptance of people with disabilities more generally in Fiji, this acceptance had not yet been extended to people with psychosocial disabilities. In this respect, respondents reported that many communities were not aware of psychosocial disability and mental health conditions through the lens of disability frameworks, and this meant that there was little demand to uphold rights or duty bearers with a sense of responsibility to uphold their rights as other people with disabilities. Most respondents reported a lack of understanding amongst communities of psychosocial disabilities as a key barrier to community inclusion and participation. In addition, respondents noted frequent confusion between intellectual disability and psychosocial disability, and little understanding of the diversity of experiences within psychosocial disability.

> **"I think that's a problem... The Turang Ni koro[7] is not educated with... I wish the Turaga Ni koros have a gathering so they can be educated about psychosocial disability." – Person with disabilities**

> **"I believe it's the lack of knowledge that our family members have because with us, with psychosocial, it's mainly a disability that most people do not understand how to deal with... I strongly believe that that's something that makes a community not so to be inclusive… because they do not know how to work in here with a person that lives with psychosocial disability… most of the communities they are not even aware about the psychosocial disability, the different type." – Person with disabilities**

Negative and discriminatory attitudes and behaviours

Respondents perceived these behaviours as stemming from stereotypes, biases and assumptions about psychosocial disabilities. People with psychosocial disabilities and their families described dehumanising treatment which included having their voices or choices ignored, having others (family, community, media) speaking about them as if they're a problem or burden, and/or not recognising their dignity or worth as a person. Many respondents noted that once a person is labelled as a person with psychosocial disability, having a mental health diagnosis, 'crazy' or a 'St Giles patient' were associated with assumptions about incapacity and this was shown in behaviours such as not giving someone a chance to participate, making decisions for them without asking, and assuming they don't understand or can't contribute. 'St Giles' – the psychiatric institution – serves as a commonly used shorthand label for people with psychosocial disabilities and was associated with stigma, reinforcing exclusion based on history of institutionalisation. One respondent described the label as being worse than the experience of feeling ill:

> **"Most of the persons who come back from St Giles, they are label. That labelling is what is more dangerous to our members than the sick." – Carer/Support person**

Carers/support persons also described their family members as being misperceived as dangerous or unpredictable. These stereotypes were seen to contribute to the social narrative that invalidates their personhood, reducing them to their diagnosis (rather than recognising their full humanity) and limiting opportunities for people with psychosocial disability to participate.

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[7] "Turang ni koro" in Fiji refers to the village headman, a traditional and administrative leader of a village (the "koro").

> **“Mum hardly participate in anything to do because of the disability, because they think that she will just lash out at people, but its usually in the game at home and around the neighbourhood that makes her like that…they hardly get included because people are scared that they will put those around them in danger, but that’s hardly the case. So for mum, she would love to participate in those things...” – Carer/Support person**

Both key informants and people with disabilities highlighted that media reporting on people with psychosocial disabilities and mental health conditions was biased and had a role in reinforcing negative perceptions. They described the media’s tendency to overreport on crimes committed by a person perceived to have a mental health issue, that criminals were often wrongly referred to as having mental health issues, whilst there was limited reporting of abuses, violations of rights or neglect of people with psychosocial disabilities, which is considered to be prevalent in communities.

Discrimination is rooted in negative attitudes, stereotypes and stigma, which shape how people with psychosocial disabilities are perceived and treated. These discriminatory beliefs influence policy and service design (e.g., institutional approaches and lack of community-based supports), leading to exclusion from decision making, leadership and civic life, and are reinforced by media, community norms and institutional practices.[8] Discrimination was both a driver of exclusion and a consequence in this study; respondents reporting discrimination across multiple domains – families, communities, government and health services – indicating systemic rather than isolated issues.

> **“Discrimination, despite the fact that some of my family members are aware of my disability I still go through this with others that don’t understand my disability.” – Person with a disability**

Emotional toll of exclusion

The emotional toll of exclusion and lack of recognition in public and household spaces was frequently mentioned by both people with disabilities and carers. Differential treatment by key community people reinforced a sense of social invisibility, and being left out of decision making and general activities was associated with feelings of isolation and diminished self-worth. One respondent reported that the stigma and related exclusion they experienced, “Makes me feel angry, I want to punch them in the face”. Most respondents highlighted how exclusion is internalised, affecting how people with psychosocial disabilities perceive their place in the community, and contributing to reduced motivation to disclose their disability and also to participate in community activities. Discrimination also manifested as a consequence of exclusion, reinforcing emotional distress, isolation and reduced self-worth. One carer reported that “If you don't handle them with the right attitude…if there’s no other option, then suicide.” Participants described how being treated unfairly or dehumanised led to avoidance of disclosure of disability, withdrawal from community life and emotional trauma, and in some cases, suicidal ideation:

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[8] World Health Organisation (2022) *Global report on health equity for persons with disabilities. Global report on health equity for persons with disabilities*. Geneva. Licence: CC BY-NC-SA 3.0 IGO.

> **“And to be not included, it really hurts me emotionally ... And this thing happens, a stigma. And I don't know how my niece's friends knew. When I came home one day, they were calling me, and they were saying, they were saying those type of things. And to be not included, it just worsens your sickness. And I cannot, I don't know how to find a way to cope with it.” – Person with disabilities**

> **“Netball ... it’s been a long time I used to play netball and couldn’t play basketball but currently stays at home. I only stopped because of stigma and I don’t feel like going anymore.” – Person with disabilities**

The long-term emotional impact of discrimination and impact on social relationships was also evident, with one participant explaining:

> **“Every time you see that person, you feel that same emotion. Even if they are talking to you in a nice way, you still have that same reaction, what they made you feel. Even though you would forget that moment that they said the exact words, but the feeling... It's there.” – Person with disabilities**

Credit: Donyanedomam. Image of a house in rural area.

Policy and legislative context

People with psychosocial disabilities related exclusion from political processes to perceptions of incapacity and 'an unsound mind.' This points to the impact of outdated policy and legal frameworks that conflate mental capacity at a point in time with legal capacity and consequential removal of legal personhood. These laws and policies depict people with psychosocial disabilities as 'disordered' and lacking capacity to make decisions that influences community and government attitudes towards people with psychosocial disabilities.

> **"The Mental Health Act…is more a medical-based approach law than a rights-based approach." – Key informant**

> **"Even in our workplace, that is something we are still fighting to actually break down…Whenever we bring [inclusion in decision making] up, so it's always about unsound mind, it keeps the argument …falling back to the medical term: 'Are you sure they fit to actually make decisions for themselves.'" – Key informant**

History of institutionalisation

St Giles Hospital was established in Fiji in 1884 and at the time of its founding, it was an institution located next to the prison and named the 'Lunatic Asylum', initially serving mainly British expatriates. St Giles Hospital remains the main point of contact today and was described by respondents as the "only place to go" for those seeking assistance with their psychosocial disability and mental health. Some respondents associated the conditions and treatment within the hospital with rights violations, such as isolation, and the current mental health system guided by the Mental Health Act as being rooted in a medical model rather than a rights-based one:

> **"When we talk about how the Mental Health Act …It's more a medical based approach law than a rights-based approach…"– Key informant**

> **"It's a prison cell…[they] have said it's worse than a prison…And they are being put behind metal doors that are so thick there's no light in the room and it's just concrete in there. No proper ventilation. And to some extent they are put in there without any clothing because they are being thought that they will use their clothing to hurt themselves… When you are being isolated … I'm not allowed in there even when I give food..." – Carer/Support person**

Globally, institutional settings are associated with inhumane practices.[9] Responses in this study aligned with this experience of institutionalisation – reporting a lack of person-centred support and crude practices:

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[9] United Nations (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. A/HRC/35/21

> **“I didn’t want to let them admit me into St Giles because I had heard from other members that it has not improved. They still do things like using a hosepipe to wash down women who are menstruating and everyone with different severity of issues are lumped in together. I’m afraid it will make me more sick if I go in there.” – Person with disabilities**

Another key informant also described institutional approaches such as physical restraints being used in community settings:

> **“We've gone into a home and they've actually- the worst-case scenario was tied to a bed. The other was…had a rope around his waist and the rope could only go as far as the door to their home.” – Key informant**

These accounts highlight how institutional environments may dehumanise people with psychosocial disabilities, potentially reinforcing fear and societal stigma, and presenting a barrier to accessing mental health services rather than enabling recovery, inclusion and participation. Historical institutional approaches have also meant there has been less focus on development of community-based supports and services that focus on preserving dignity and autonomy and individual support needs.

Several respondents reported a lack of availability of supports and services in communities leading to ongoing exclusion. One respondent linked exclusion as a factor contributing to individual’s return to institutional settings:

> **“Because as soon as they come to their home, some persons with some serious illness there, you know, they might not stay at home for long, they will end up again [at St Giles] because of the stigma status.” – Carer/Support person**

Punitive context and stigma

The legacy of institutional approaches, particularly the dominance of St Giles Hospital, has contributed to a widespread association between psychosocial disability and danger, incapacity or deviance. The label ‘St Giles patient’ is used pejoratively in communities as shorthand for someone who is unpredictable or incapable.

> **“Most of the persons who come back from St Giles…that labelling is what is more dangerous…than the sickness.” – Carer/Support person**

This labelling contributes to a cycle of exclusion, where individuals are denied opportunities for participation and support, reinforcing their marginalisation and distress. Stigma is reinforced by media, community attitudes and systemic discrimination.

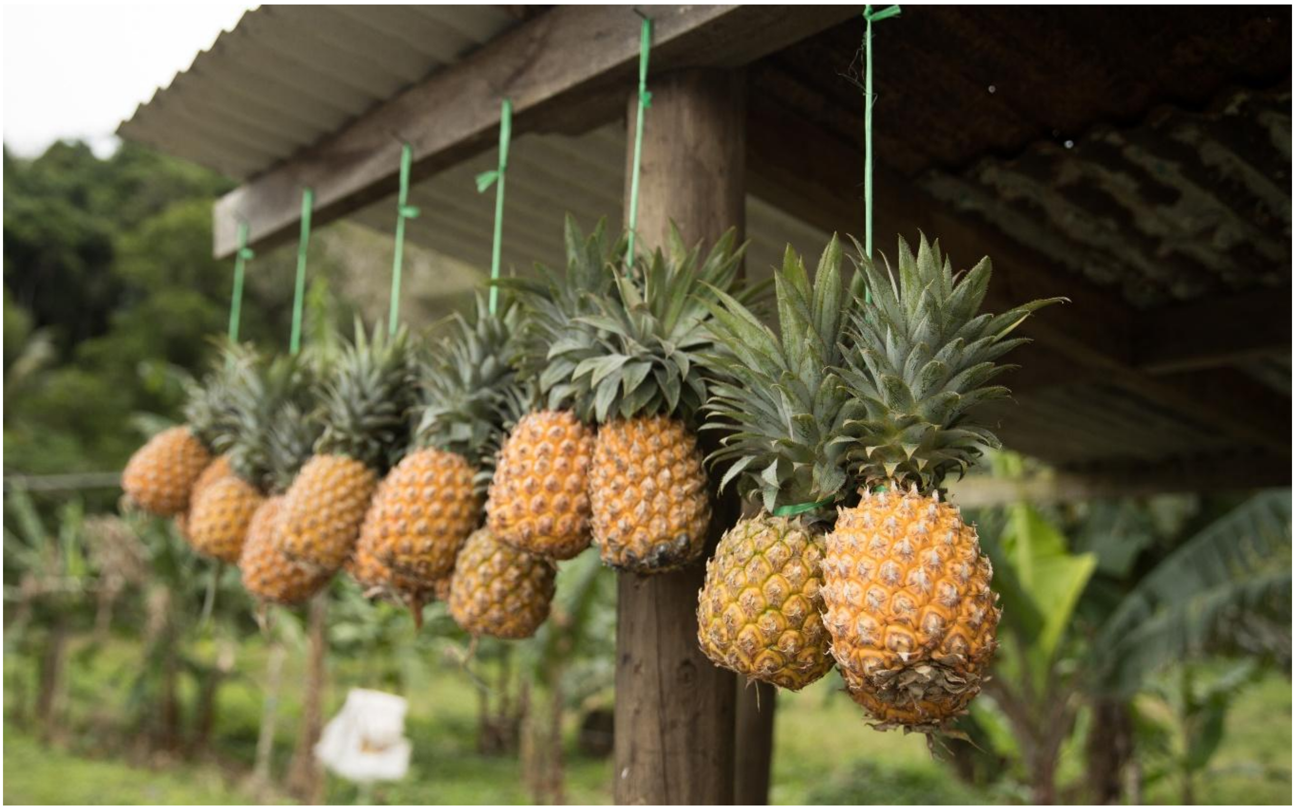
Abuse, neglect and violation of rights

Consequences of devaluing and dehumanising people with psychosocial disabilities extended beyond exclusion from activities to incidents of abuse and neglect. Respondents described personally experiencing or observing abuses against people with psychosocial disabilities including physical, sexual, emotional and financial abuse. Incidents of neglect included not being provided needed supports, not being given/having limitations on access to food within the household, insecurity of housing, and failure to protect individuals from harm or support reporting of harm.

> **"I think for me when I became sick … well, sometimes [family] lock the door for me to sleep outside. When I came to know about PSA, and when I saw the work, [PSA does] about awareness. ... I think we are really stigmatised. For me personally, I had no family support. Sometimes I would beg around Suva City and then the police took me to St Giles and I tried my best to recover." – Person with disabilities**

Working hard to gain recognition and respect

Several respondents described the need to 'prove oneself' in order to gain recognition and respect – reflecting a common coping strategy ('high-effort coping') among marginalised individuals who feel compelled to work harder to be seen and valued.[10] This dynamic was illustrated by a supporter who had observed a woman with psychosocial disabilities being excluded from traditional weaving activities in her village, despite her capability. In response, the woman actively challenged community perceptions by engaging in visible, productive activities. Her decision to start a small business was not only an act of resilience and agency, but also a form of self-advocacy – an effort to demonstrate her value and assert her right to belong. While such efforts can be empowering, they also come at a potential cost. The emotional and physical toll of constantly needing to prove one's worth can be significant – especially when the episodic nature of a person's disability limits their ability to meet these demands consistently.



Credit: Kolbz. Image of pineapples hanging in market stall

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[10] Bronder EC, Speight SL, Witherspoon KM, & Thomas AJ (2014). John Henryism, depression, and perceived social support in Black women. Journal of Black Psychology, 40(2), 115–137. 10.1177/0095798412474466

Access to mainstream services

Respondents described service providers holding negative attitudes towards people with psychosocial disabilities, even those working within mental health services. A lack of confidentiality associated with admission information, limited understanding and provision of disability supports and reasonable accommodations were also noted. Services raised in discussions included mental health, sexual and reproductive health, social protection, and justice. Respondents identified lack of knowledge and understanding hindering access to a range of services, which could in turn maintain or compound exclusion.

> **"The hospital system does not accommodate people with psychosocial disabilities… Because of the stress of waiting and being looked at by others. When members try to voice their anxiety, it is denied…fainted in front of the receptionist – only got attention then. Because of that they had to stay in the hospital for more days for his mental health, 4-5 days which means that his family has to struggle and come to pay." – Carer/Support person**

The need to provide a medical certificate (costing upwards of $50) and challenges in assessment processes for psychosocial disabilities was identified as a prohibitor of access to disability benefits and entitlements. Several respondents identified gaps in data collection on people with psychosocial disabilities.

Tertiary education was noted as a good practice example by one respondent, whereby there was targeted inclusion of people with psychosocial disabilities to participate.

> **"Fiji National University has opened up a place for those with psychosocial impairment, to go and study, and that is a big plus ..." – Carer/Support person**

OPDs play a significant role as a conduit to basic services, as well as providing direct services including gender-based violence response, temporary housing and other crisis support. This was reported in the context of people with disabilities being hesitant to approach services directly due to anticipation of barriers and OPDs being a safe place to request support.

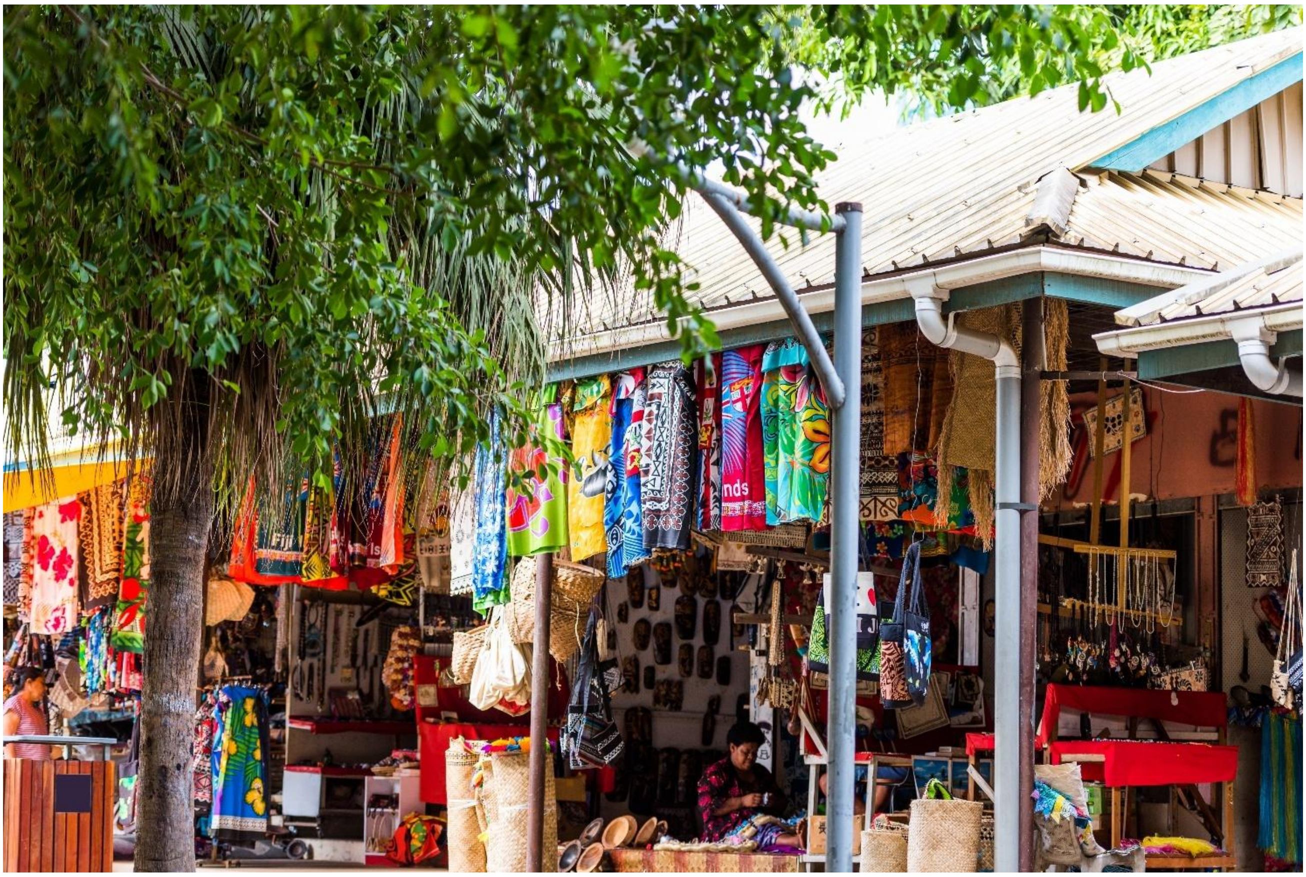
Economic contribution and belonging

Several respondents linked the ability to work with greater acceptance from family and community. While employment was seen as both a pathway to and a result of inclusion, the framing of inclusion as dependent on productivity may point to the conditional nature of that acceptance – suggesting that a person's worth and belonging may be tied to their economic contribution. One participant shared:

> **"When I started working here at [organisation]…now they are saying, oh, at least you are working now, bringing some money home, those type of things, contributing to the food bills and all those things. So.. Now they are talking to me, now they don't lock the door for me to stay outside." – Man with disability, Central division**

> **"He has a brush cutting business and he's interacted with neighbors around and they have been very helpful to him in allowing him to come and cut their grass and he's been very encouraged by that. And we encourage him also that that is a great opportunity for him. He can showcase his talents and the neighbors are very amazed at what he can do." – Carer, Central division**

This account highlights a tension between how inclusion can be transactional, with acceptance contingent on meeting certain expectations-such as earning an income or contributing materially to the household. While employment can foster dignity, independence and social connection, framing inclusion around productivity risks reinforcing exclusion for those unable to work due to the nature of their disability or other barriers.



Credit: Gerald Grotelueschen. Image of handy craft market

Inclusion as a catalyst for improved mental health

Participants described inclusion as a powerful contributor to emotional wellbeing and recovery. Feeling accepted and supported by families and communities was associated with increased happiness and a sense of normalcy or belonging. One woman with psychosocial disability shared that being able to use social coping techniques for mental health without fear of discrimination was an important impact for her:

> **"The more I talk about it the more I feel better." – Person with disabilities**

This is aligned with research in other contexts that found that perceived support and facilitation of different coping styles in families can be a protective factor for depression and anxiety.[11] Another participant reflected on the transformative potential of inclusion:

> **"Some say you can't change the past, but you can change the future. So, if I was included and…if my family at home understood me, I would be very happy and it would help me recover. I think my emotional well-being and everything will be good. I'll feel that, I'll just feel like I'm just another normal person...If I was included." – Person with disabilities**

Community participation and inclusion are mutually reinforcing

Family members and support persons also observed that inclusive environments enabled individuals with psychosocial disabilities to express and demonstrate their unique talents and skills, which in turn promoted inclusion. This highlights the broader value of inclusion – not only for individuals, but for communities that benefit from the diverse contributions of all members.

> **"So at that time that officers in charge of our community, she always kept every tenant to always participate. Not to just stay home doing your usual thing. She wanted us to come out from our comfort zone, to try and participate with others so that we can understand each other, we can communicate and also to learn skills and new things from each other. Not just knowing what you know, but to expose your talent to others." – Person with disabilities**

Several supporters described the positive changes they had witnessed when appropriate supports were provided and deliberate efforts were made to include people. Participants frequently linked experiences of exclusion and inclusion with economic impacts. Reduced stigma and greater inclusion were associated with improved opportunities for employment and the ability to overcome poverty – for individuals and their families. Conversely, exclusion from family and housing often led to poverty, unstable or risky living conditions, and precarious income sources. One respondent shared how his peers had gone 'the extra mile' to support a team member with psychosocial disabilities:

> **"He was being pushed away from home…when he goes home, they won't provide, because he wasn't working, they won't have any meals for him or anything…but then he turned to working on the streets…We actually put in for food…we picked him up and took him home… After that...he never missed any training or anything, he would be the first person there. Like…that was the change we saw in him." – Person without disabilities**

Enabling participation through family, peer and community supports

Emerging research in the Pacific indicates that immediate families primarily provide care and disability-specific supports to people with disabilities, but a key barrier is lack

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[11] Roohafza HR, Afshar H, Keshteli AH, Mohammadi N, Feizi A, Taslimi M, Adibi P. What's the role of perceived social support and coping styles in depression and anxiety? J Res Med Sci. 2014 Oct;19(10):944-9. PMID: 25538777; PMCID: PMC4274570

of training or support for families to provide this important role.[12] This finding was supported by the current study whereby respondents most frequently described family members in the context of disability-specific support provision and empowerment.

> **"Those with psychosocial impairment, they feel that you know they are rejected, they distance themselves away….and they feel like they are unwanted. But as carers, we encourage them that they have the abilities, they have the capabilities to forge their way ahead in life…I've always been encouraging my son to show him that there's always life at the end of the tunnel..." – Carer/Support person**

However, respondents also highlighted incidences of community members providing supports as well as the important role that community members, including community-based groups, could have in provision of supports needed for equal community participation. One participant talked fondly of an officer without disability in a supported housing residence for disadvantaged groups:

> **"…I was elected to be a committee member. So that's the time that officers in charge of our community, she always kept every tenant to always participate. Not to just stay home doing your usual thing. She wanted us to come out from our comfort zone, to try and participate with others…" – Person with disabilities**

Peer support groups

Where there were peer-to-peer support networks in the community, participants described how their participation had improved through these interactions. Peer-to-peer networks and specifically PSA's support, were associated with provision of practical support (such as facilitating access to livelihood development and disability entitlements) and disability-specific-supports (such as accompaniment and empowerment) that enabled participation.

PSA was described as a "lifeline", offering emotional support, opportunities for engagement, and pathways out of poverty. PSA's primary approach is peer-to-peer support networks. Peer support was closely linked to emotional wellbeing and a sense of worth. The quote reflects how peer networks can counteract isolation and reinforce self-esteem in the context of prevailing exclusion.:

> **"When I come to PSA, I feel loved. I feel I'm part of something. I'm worthy." – Person with disabilities**

PSA was described metaphorically as "like a church", suggesting its deep personal significance and the comfort it provides. This theme underscores the importance of safe, affirming spaces where individuals feel seen, valued and supported. One participant emphasised the emotional and social value of both receiving and providing support within peer networks:

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[12] CBM-Nossal Partnership & Pacific Disability Forum (2025) *Understanding disability support services in the Pacific.* Unpublished.

> **“I'd love to share about PSA, an organisation that actually brought…out myself to where I am today. I’m sharing this because I actually got to help the youths in my community to take part in activities and sports and not be shy and helping them makes me feel happy and like I’m part of a family…Thank you so much PSA. I salute this organisation for the work they do, that has allowed me to do a lot of things and keep me moving forward to get out of poverty.” – Person with disabilities**

Engagement with peer support groups served as a motivator for social participation and personal growth. Participants described how regular interaction with peers encouraged them to stay active, pursue goals and contribute to their communities. Seeing familiar faces and being part of a collective effort helped individuals “move on in life,” demonstrating the positive ripple effects of inclusive peer environments for recovery and mental health. Stakeholders noted that they had observed that when people with psychosocial disabilities perceive they had support persons “behind them”, they were more likely to advocate for themselves and seek meaningful roles.

> **“He calls me almost every day, and he needs a bit of a pep talk, a soft talk, you know, but whenever he's angry…we have to counsel him in such a way, talk to him and divert that anger away from him and to some other topic…there are some situations whenever myself and him, we go through, I tell him some stories and then make him laugh on the phone. So that makes him happy.” – Carer/Support person**

Support needs

Families of people with disabilities and organisations providing services discussed the range of support needs for people with psychosocial disabilities. These included guiding and coaching through tasks/activities (self-care, domestic, and community); retraining, accompaniment[13] and gradual activity exposure; supported decision making; emotional assistance; and practical assistance with chores. Other supports noted included financial and transport assistance in the context of many people with psychosocial disabilities experiencing poverty.

Support persons in the workplace and a range of reasonable accommodations were also described to facilitate inclusion in meetings and the workplace including meals and travel assistance, extra time and repetition of new tasks, flexible working hours, simplifying complex information, providing information ahead of time before meetings, and open and light environmental spaces where people can move freely.

Emotional or relational supports were frequently mentioned and pointed to creating safe spaces where people with psychosocial disabilities can express their support needs:

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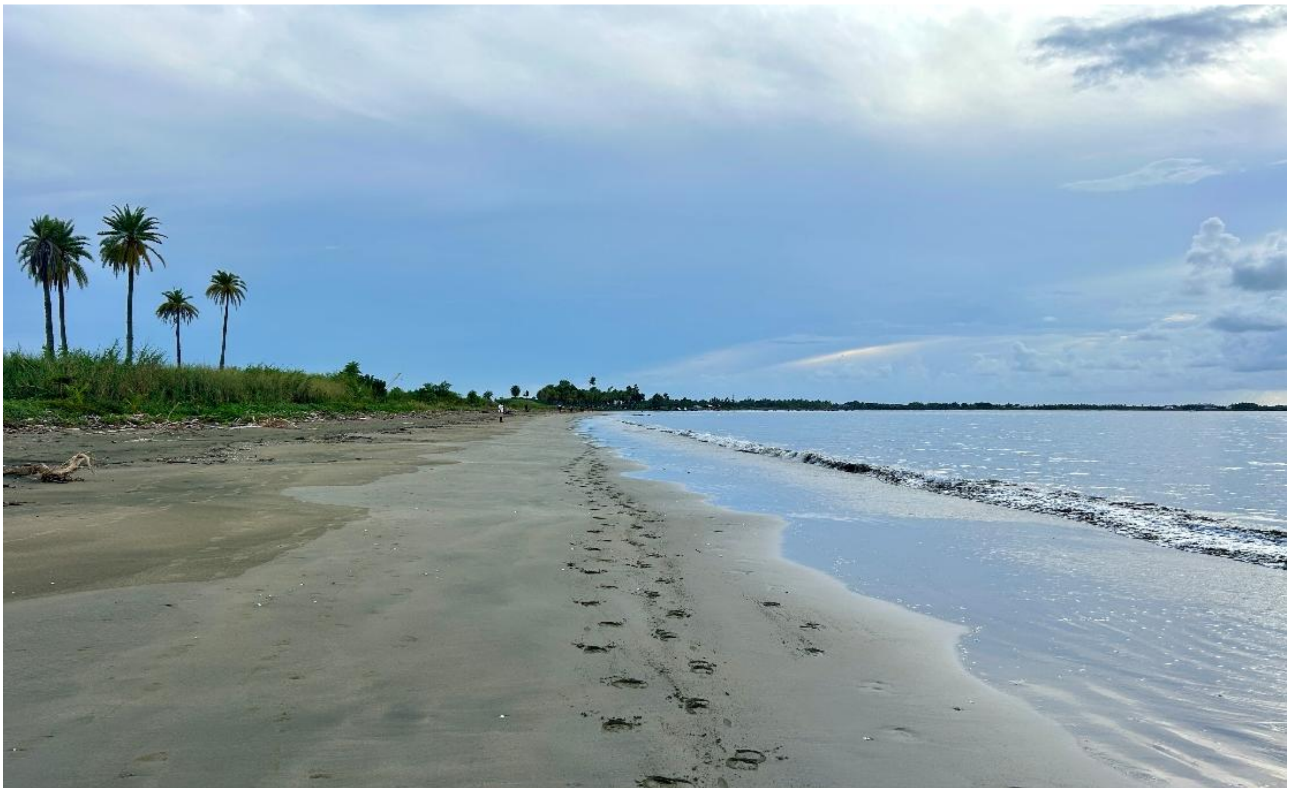
[13] In the context of disability support, “Accompaniment” means having a person who walks alongside and supports another, fostering a relationship of solidarity and empowerment. It may include providing assistance with daily tasks, navigating services, and promoting social inclusion, based on trust and respect for the individual’s autonomy and capabilities.

> **“Speaking gently and kindly…sitting with people and talking to them, having conversations, understanding them fully and help them meet their needs.” – Carer/Support person**
>
> **“…sometimes we would have customers who would want him to come like tomorrow and then when he wakes up in the morning, like he’s just not in the mood because of the disability and having a support person to go on his behalf would make things work and will not spoil his name to the clients.” – Key informant**

A small number of family members also raised access to appropriate medication and support to manage side effects. The additional costs of disability for people with psychosocial disabilities may be significant. Currently, people with psychosocial disabilities are eligible for the disability allowance (social protection mechanism) but costs for medicine, medical certification, transport to appointments, opportunity costs of support persons, and any additional disabilities is likely to exceed this allowance amount (currently $130 per month). However, where a person with psychosocial disabilities may have an episodic impairment, they may not meet the threshold for the disability allowance at the time of assessment. Reportedly, the family may be eligible to access the family welfare support mechanism at these times but the impact of this is yet to be understood.



Credit: CBM Australia. Image of beach in Nadi, Fiji.

3.2.4 Perspectives on what is needed to improve inclusion and participation

Participants identified a range of social, systemic, and economic changes required to strengthen community inclusion and participation of people with psychosocial disabilities. Their perspectives highlighted the need for legal reform, expanded supports, and greater community understanding to address persistent barriers and uphold rights.

Key findings

- Amend legislation setting the framework for rights-based mental health and social care services and supports and remove barriers to mainstream services, particularly justice, SRH, and social protection and economic empowerment.
- Increase availability and quality of supports for people with psychosocial disabilities, including strengthening of family support, expansion of peer support and mobilisation of community supports.
- Increase awareness raising and education on the rights of people with psychosocial disabilities and fore front the lived experience accounts of the impacts of inclusion and exclusion.

Advocacy agenda

Participants expressed a strong need for advocacy on their specific needs and rights as an impairment group. Disability discrimination, poverty, social exclusion and stigma were the most frequently mentioned issues affecting respondents' lives. Value, contribution and recognition for their talents and skills were also frequently mentioned alongside collective responsibility for provision of needed supports to be able to participate equally alongside others without disability. Media engagement and recognition beyond being a ‘St Giles case’ was another entry point mentioned. One respondent suggested that the hospital staff “should stand up” and address prejudicial media reporting on people with psychosocial disabilities and mental health issues. A key advocacy ask underpinning many of the respondents’ descriptions of barriers and enablers was to have other options for support outside the urban-based institutional approaches offered by St Giles Hospital. In addition, improving the access of people with psychosocial disabilities to mainstream health, education and social services. Advocacy to schools was specifically mentioned by one respondent – noting that education to the younger generations was key to changing community mindsets about psychosocial disability in the future.

Reform legislation and policy frameworks to align with the CRPD

Key informants promoted harmonisation of laws and policies that guide services and support provision to be aligned with the CRPD and the Rights of Persons with Disabilities Act. In particular, they emphasised the importance of meaningful inclusion of people with psychosocial disabilities in the design and implementation of policies and programs.

> **“First recommendation is you need to include our 4 OPDs in every government institution decision making process. From the inception to the implementation to the monitoring. What I find is most of the time the OPDs are invited at the end of that process. If there's a policy, it is already designed and then it's just taken to them to actually tick.” – Key informant**

Raise awareness and build community understanding

Key informants and participants with psychosocial disabilities frequently reported that where OPDs had done awareness raising and training on the rights and protections afforded to people with psychosocial disabilities under the CRPD and Fiji Law, they had seen improvements in their community inclusion as well as requests for further information on non-medicinal therapies and supports.

> **“After [OPD] did training for the community on inclusion, a woman with psychosocial disabilities sent us a message saying ‘thank you for this training – this is the first time ever that the community has asked me to come to the church or community meeting. I don’t feel alone anymore.’ Communities are not aware of people with disabilities rights and their responsibility to build up their members with psychosocial disabilities. After the training they are motivated to empower them.” – Key informant**

All respondents identified that community awareness and education activities should be undertaken, targeting families, community leaders and government officials to address understanding of psychosocial disability and mental health. Education was associated with teaching families and community members how to provide disability-specific supports and framing psychosocial disability as a disability rights issue. Together these were seen as necessary to shift attitudes and eliminate discrimination and violation of rights.

Transformation through lived experience accounts

Key to raising awareness was the transformative power of sharing lived experience stories in shifting community attitudes. Targeted awareness efforts that included lived experience had helped community members begin to see individuals with psychosocial disabilities as capable and non-threatening, illustrating how education and exposure can dismantle stigma and foster inclusion.

> **“There's a meeting in the village hall, and everyone is having lunch. They are made to sit outside the porch and eat there separately…But after the awareness raising this changed. because they finally changed the mindset that they are not aggressive people. They are just like us. They won't harm us. They won't hurt us. If we teach them, they will be able to do things.” – Key informant**

Visibility and personal connection with affected persons are common techniques for reducing stigma against people with psychosocial disabilities in other contexts. Respondents frequently identified the role of PSA providing education up until now and the need to scale these activities up to reach more communities.

Scale up community-based disability support systems

Mobilising and increasing the full range of community-based supports for people with psychosocial disabilities and their families was a key strategy identified by respondents. These supports should be of good quality and preserve the dignity and autonomy of people with psychosocial disabilities. PSA has been piloting the 'Community-watch zone' approach which includes intensive education, awareness and coaching support to a village community to mobilise natural supports and emerging champions and strengthen community referral pathways for health and justice support. Key informants noted initial results have been positive so far and pose an opportunity for further development and monitoring.

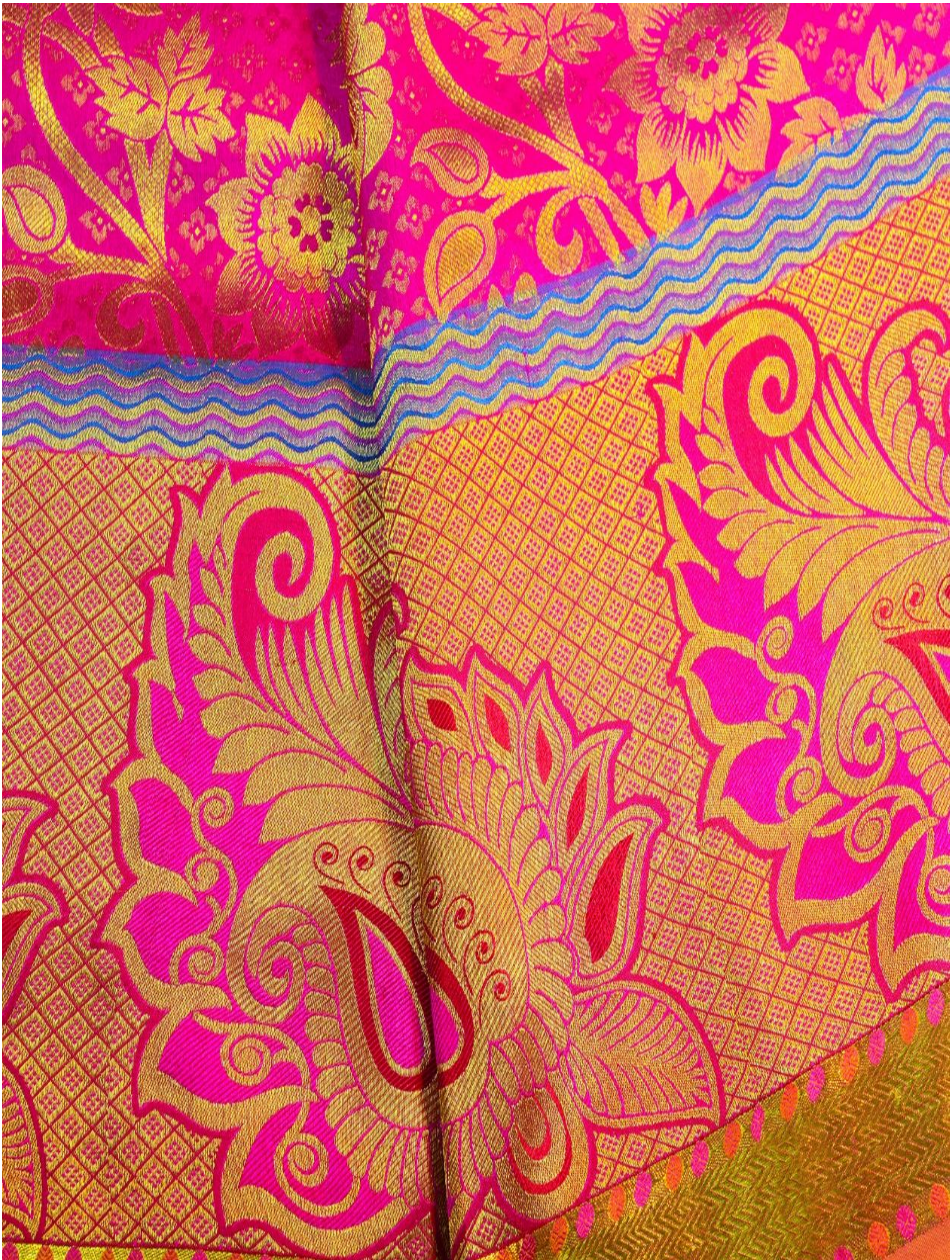
Decentralisation of OPDs to other divisions was also noted as a strategy to increase the visibility and supportive structures for people with psychosocial disabilities and their families. This was also noted in the context of strengthening the voices of people from different regions of Fiji and creating a channel to government.

There was a call to action from respondents to faith-based organisations, women's and youth groups, as well as village vanua to proactively address inclusion of people with psychosocial disabilities including provisions of disability-specific supports.

Improve access to mainstream services

Several respondents identified a range of strategies for addressing barriers to mainstream services. These included improving data collection on psychosocial disability, providing reasonable accommodations, and improving outreach to people with psychosocial disabilities, and addressing negative attitudes of service providers to people with psychosocial disabilities. Scaling up people with psychosocial disabilities' access to services centred on social protection, counselling via Empower Pacific, justice and sexual and reproductive health services.

Credit: Byakkaya. Image of woven roof.



Credit: CBM Australia. Image of sari fabric.

Policy and practice considerations

1. Government and development partners

- Harmonise legislative and policy frameworks with the CRPD, including repealing the Mental Health Act of 2010, and removing discriminatory language and provisions from the Criminal Procedures Act and Crimes Act. Strengthen mental health protection and promotion in relevant public health legislation and policy.

- Include OPDs and incorporate the lived experience of psychosocial disabilities into design, implementation and monitoring and evaluation of all social and health care systems.

- Expand disability support systems, including social protection schemes, to account for the specific disability needs and experiences of people with mental health issues and psychosocial disabilities.

- Shift away from institutional approaches; investing in research and development of community-based, culturally-sensitive, rights-oriented models of supports and services for people with psychosocial disabilities and their families. Include a wide range of services and supports: personal assistance, crisis support, respite support, help with self-care, and support for parenting and family life, recognising the important role that family and communities play in providing disability supports.

- Build knowledge and understanding of the rights of people with psychosocial disabilities and mental health issues into capacity building initiatives at all levels of governance (village leaders, faith-based leaders, district authorities, and government officials). Promote supported decision making; replacing substituted decision-making mechanisms.

2. Service providers

- Improve access to mainstream services, addressing barriers to health, social benefits, justice, and economic empowerment.

- Ensure affordability, accessibility, and quality of services for people with psychosocial disabilities across all regions, shifting from institutional approaches to community-based, rights-oriented services and integrating supported decision-making models.

- Raise awareness and build community understanding focused on disability rights, culturally sensitive mental health and emotional support, and inclusive practices to reduce stigma and promote empathy.

- Include a wide range of services and supports including personal assistance, crisis support, respite support, help with self-care, and support for parenting and family life.

3. Civil society organisations (including organisations of and for people with disabilities)

- Engage in monitoring and reporting efforts on Fiji’s implementation of the CRPD including as it relates to people with psychosocial disabilities (e.g. through shadow reporting). Advocate for the alignment of laws and policies with the CRPD, with particular attention to legal capacity, supported decision-making, and freedom from torture and inhumane treatment.

- Ensure affordability, accessibility and quality of services for people with psychosocial disabilities across all regions, shifting from institutional approaches to community-based rights-oriented services.

- Raise awareness and build family and community understanding of disability rights, culturally sensitive mental health and support; include people with psychosocial disabilities in training for communities.

- Continue to strengthen and expand peer-to-peer support approaches (e.g., networks, groups, and 1-1 support) and extend OPD branches into regional areas.

- Continue to develop approaches to supported decision making within families and communities (such as circles of support, etc.) and explore community-based support models like ‘community-watch zones’ to build local safety nets and inclusive support structures.

4. Families and individuals with psychosocial disabilities

- Acknowledge psychosocial disability as a form of disability with valid support needs and a diversity of experiences – just like physical or sensory disabilities – and that each person’s journey is unique.

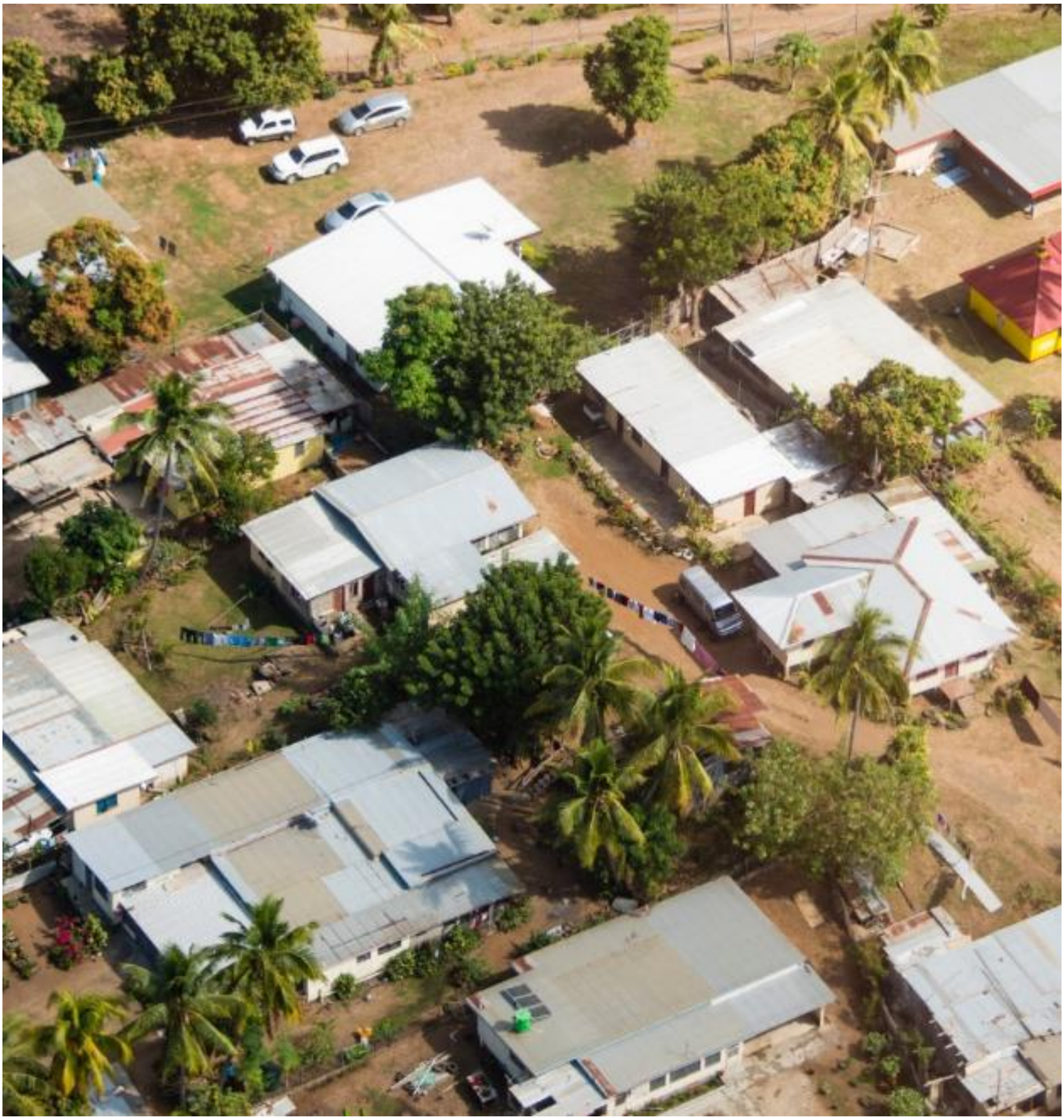
- Recognise that stigma is external, not internal (you needn’t be defined by a diagnosis or label).

- Families play a central role in enabling or limiting participation – ask if we are creating a supportive environment. Don’t be afraid to ask for support – support is a right, not a favour. Reflect on communication styles – are we listening with empathy, or making decisions on someone’s behalf?

- Seek support and training to better understand how to provide rights-based, empowering care and support. Explore peer support opportunities – connecting with others who have similar experiences can reduce isolation and build confidence.

- Identify trusted people in your community who can offer emotional or practical support (e.g., who can be your circle of support). Participating in a community group, a household decision, or a local event can build momentum – it's ok to start small.

- Know your rights – understanding the CRPD and national laws can help you advocate for yourself and others. Practice expressing your needs and preferences (e.g., for support, space, participation, etc.). Use your voice to challenge stigma – sharing your story can shift attitudes and inspire others.
- Consider prioritising emotional wellbeing – seek out spaces, tools and people that make you feel safe, valued and understood. Recognise that recovery is not linear and that's ok.



Credit: tobiasjo. A photo of a suburb in Nadi, Fiji

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