

Deinstitutionalisation of individuals with disabilities in Lebanon

Literature Review - June 2023

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About Disability Under Siege

The Disability Under Siege Network+ Project is a co-created programme bringing together a community of researchers, educational practitioners, advocacy organisations and disability led groups in the UK and Middle East. It will contribute to research efforts by providing intellectual and logistical resources that local practitioners need to transform education provision for children with disabilities in conflict-affected countries.

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1.1 Abstract

This literature review provides an overview of the deinstitutionalization of people with disabilities in the globe and Lebanon. It explores the historical context, current situation, challenges, and potential benefits associated with transitioning from institutional care to community-based support for individuals with disabilities. The review highlights the importance of promoting inclusive policies and practices that empower individuals with disabilities, enhance their quality of life, and foster social inclusion. The findings contribute to the existing body of knowledge and inform future research and policy initiatives aimed at advancing the deinstitutionalization process in Lebanon.

1.2 Historical Context of Deinstitutionalization in the globe

Attitudes towards individuals with disabilities have undergone significant transformations throughout history, profoundly influencing their inclusion in mainstream society. Traditionally, people with disabilities were often placed in specialized institutions, effectively segregating them from the rest of society. These individuals relied heavily on welfare facilities like rehabilitation centers, special schools, and welfare units, which further contributed to their exclusion and isolation from mainstream society (Shapiro, 1993; ESCWA & Centre for Lebanese Studies 2019; Shuayb, 2020).

The categorization of disability and its impact on the integration or isolation of individuals with disabilities in society has been shaped by various disability models and definitions proposed by different stakeholders, including community members, service providers, policymakers, and people with disabilities themselves. Riggan and Maki (2004) emphasize the importance of these definitions in determining eligibility for programs and services. Kaplan (1998) introduces the concept of the "moral model of disability," which associates disability with a moral failing, engendering feelings of guilt and shame within the family unit of the person with a disability. This model has contributed to the segregation and isolation of people with disabilities, impeding their integration into society and denying them access to education, employment, and public services. According to Swain and French (2000), the moral or "tragedy model" of disability permeates media representations, language, cultural beliefs, research, policy, and professional practice. It views disability as a personal problem resulting from impairment rather than acknowledging the failure of society to provide accessible facilities and services. However, it is important to note that people with disabilities themselves



often recognize disability as a significant aspect of their identity, challenging the assumption that they must conform to a "normal" standard (Swain & French, 2000).

The "medical model" of disability, as described by Kaplan (1998), perceives disability as a defect or illness that requires medical intervention for a cure. In contrast, the "rehabilitation model" is an extension of the medical model, considering disability as a deficiency that can be rectified through rehabilitation or professional assistance (Pfeiffer, 1998). The rehabilitation model gained prominence after World War II, primarily due to the increased number of disabled veterans in need of rehabilitation to reintegrate into society. The "social model" of disability, developed by British activists in the 1970s under the Union of the Physically Impaired Against Segregation (UPIAS), emphasizes that people with disabilities are excluded and segregated from their communities due to societal attitudes that perceive their impairments as barriers to integration. The social model recognizes that individuals with disabilities may have impairments limiting their mobility, vision, hearing, or communication, but it asserts that access to education, employment, and public services should not be denied if the specific needs of individuals are considered in the design of the built environment (UPIAS as cited in Shuayb, 2020).

Scholars such as Finkelstein (1980, 1981), Barnes (1991), and Oliver (1990, 1996) argue that disability is a consequence of societal policies and organizational structures that have established hospitals, care services, and specialized institutions, resulting in the social exclusion and segregation of people with disabilities. These policies have hindered their access to mainstream education, healthcare services, and employment opportunities, leading to a form of social oppression (Shuayb, 2020). Prior to the disability rights movement that emerged in the 1960s, the prevailing approach in many Western countries was the medical model, which limited the interaction of individuals with disabilities with society and the environment by emphasizing their impairments (Shapiro, 1993; ESCWA & Centre for Lebanese Studies, 2019; Shuayb, 2020).

The Industrial Revolution in Britain during the 18th and 19th centuries brought about significant societal changes, including mass migration to cities and the emergence of social pressures. These factors ultimately led to the establishment of the Poor Laws in 1834 and the construction of purpose-built institutions known as 'asylums' to accommodate individuals with mental health difficulties, who were commonly referred to as 'idiots' or 'lunatics' at that time (Wickham, 2006). Campbell and Oliver (1996) point out that in 19th century Britain and many



other Western societies, individuals with disabilities were perceived as inadequate and incapable of participating or functioning in mainstream society alongside their non-disabled counterparts.

The development of segregated institutions persisted into the early 20th century, although the rationale behind relocating individuals to these institutions underwent a transformation. Between the two World Wars, legislation was enacted to promote the segregation of people with disabilities, particularly those with learning disabilities and mental health conditions, from mainstream society. These laws facilitated the construction of special schools for children with learning disabilities, thus reinforcing segregation and isolation. In the 1930s, the introduction of IQ testing further perpetuated this segregation, as individuals scoring low marks on the test were labeled as 'mentally defective' and were even prohibited from attending special schools (Jarret, 2012).

Hutchison (2002) notes that in Scotland during the 19th century, individuals with disabilities were considered different and were consequently treated as "others," contributing to the growth and expansion of institutionalization. As a result, individuals with mental and sensory impairments were placed in specialized institutions, effectively excluding them from family structures and the local community.

The establishment of the British National Health Service in 1946 and the adoption of the medical model resulted in the use of the term "mentally handicapped" and the replacement of special institutions and schools with hospitals. Attitudes towards people with mental health difficulties and physical disabilities shifted from viewing them as "dangerous or degenerate" to recognizing their need for treatment, albeit still considering them a burden on public resources (Shuayb, 2020). However, individuals with intellectual and learning disabilities continued to face segregation and isolation, often receiving inadequate care. In 1920, the Education Act mandated that local authorities be responsible for providing education to blind and deaf children (Jarret, 2012). Individuals with learning disabilities remained segregated and isolated, and the quality of care provided to them was extremely poor (Shuayb, 2020). The Education Act of 1920 sought to promote special education for children with disabilities, with local authorities being obligated to provide education for blind and deaf children (Jarret, 2012). These circumstances prompted many individuals with disabilities to advocate for equal rights, emphasizing their right to choose and opportunity in accessing education, employment, transportation, and public and private services. Recognizing that special institutions posed a



significant barrier to the inclusion of individuals with disabilities in mainstream society, the disability rights movement, which originated in the United States, has brought about a shift in attitudes towards promoting inclusion and improving access to education, employment, and services. The disability rights movement emerged in response to the barriers imposed by special institutions on the inclusion of individuals with disabilities in mainstream society. In the 1960s and 1970s, Americans with disabilities brought to public attention the conditions within institutions and the inhumane treatment they experienced (Racino, 2020). This revelation led to the deinstitutionalisation movement, which aimed to transition individuals from institutions to community settings (Shapiro, 1993).

According to Greenblatt et al (1983) the concept of deinstitutionalization" emerged to move away from confining individuals with mental disorders in large psychiatric institutions. The deinstitutionalization of people with disabilities, including those with mental health conditions, in the USA, the UK, and Europe began in the late 18th and early 19th centuries. Prior to this period, individuals with disabilities were often confined to large institutions such as asylums, workhouses, or poorhouses, where they faced neglect, abuse, and isolation. (Racino, 2020). The deinstitutionalization movement aimed to establish community-based mental healthcare and drug treatment services as alternatives, with the goal of facilitating social integration for people with mental disorders. This movement gained prominence initially in Western European countries, North America, Australia, and New Zealand (Chow et al., 2013). The underlying principle was to provide treatment and rehabilitation for individuals with mental disorders near their communities, while minimizing stigmatized environments and restrictions on individuals with mental disorders personal freedoms.

Thornicroft et al. (2011) put forth a set of principles that are essential for effectively addressing the needs of individuals with mental conditions in an inclusive manner. These principles encompass ensuring the accessibility and acceptability of services, recognizing and building upon the goals and strengths of people with mental illnesses, establishing a comprehensive network of supports and resources, and prioritizing evidence-based services aligned with the principles of recovery. Adhering to these principles is crucial for mental health services to effectively meet the needs of individuals, promote their recovery, and enhance their overall well-being (Thornicroft et al., 2011).

In addition to the mental health context, the independent living movement led by disability activists aimed to shift away from institutional settings and promote accessible services. This



movement sought to address architectural and transportation barriers that hindered individuals with disabilities from enjoying equal opportunities in society (Shuayb, 2020, Shuayb, in press). Independent living centers and units were established globally, emphasizing the significance of designing accessible buildings and integrating people with disabilities into mainstream society to ensure equal opportunities and remove barriers in the built environment (Goldsmith, 1997; Steinfeld & Maisel, 2012).

The social model of disability has transformed the understanding of disability by shifting the focus from the individual to society. It rejects the notion that disability stems from personal misfortune or the fault of the individual with a disability. Instead, it argues that disability emerges from society's failure to create an enabling environment, leading to the marginalization of specific groups within society (Finkelstein, 1981; 1996, 2007; Barnes, 1991; Oliver, 1991, 1996). Consequently, society bears the responsibility of establishing inclusive environments that facilitate the full participation of individuals with disabilities. By integrating the principles of inclusive mental health care, the objectives of the independent living movement, and the principles of the social model of disability, it becomes evident that promoting accessible services, removing barriers, and fostering inclusivity are integral components in addressing the needs and rights of individuals with mental health conditions and disabilities (Finkelstein, 1981,2007; Barnes, 1991; Oliver, 1991, 1996, Thornicroft et al., 2013).

In the United States, the deinstitutionalization movement gained momentum in the mid-20th century, driven by the encounters of many people with disabilities who were isolated and confined in institutions or stayed at their own residence without being able to be included in mainstream services. According to Butler(2000), deinstitutionalization of people with mental disabilities began around the 1950s, and 1960s but Congress addressed the rights of the people with disabilities by endorsing the Developmentally Disabled Assistance and Bill of Rights Act⁷ and Section 504 of the Rehabilitation Act of 1973 which prevented recipients of federal funds, including government agencies, from denying people with disabilities the opportunity to participate in a program or activity on the basis of that disability. Another reason that paved the road towards the deinstitutionalization of people with disabilities was the discrimination and exclusion that hindered many students with disabilities from gaining access to higher educational institutions. Universities like the University of California at Berkeley lacked special programs for students with disabilities and lacked wheelchair-accessible accommodations (Goldsmith, 2001; Nielson, 2012). Ed Roberts, a prominent



disability right activist and a key figure in the independent living movement, played a pivotal role in shaping the movement for deinstitutionalization (Goldsmith, 1998).

Roberts, who himself had significant disabilities resulting from polio, sued the University of California at Berkeley and was eventually admitted in 1962 but had to reside at the health center on the edge of the campus (Goldsmith, 1998). In 1972, Roberts founded the Center for Independent Living (CIL) in Berkeley, California, which was the first organization of its kind to provide support and resources for people with disabilities to live independently (Nielson, 2012). The CIL aimed to empower individuals with disabilities to take control of their lives and advocate for their rights, and its model of independent living became a catalyst for the disability rights movement across the United States (Nielson, 2012).

Roberts was an advocate for deinstitutionalization, believing that it perpetuated dependency and denied individuals with disabilities their right to autonomy and full participation in society. His advocacy efforts and leadership influenced federal legislation aimed at promoting the rights and inclusion of people with disabilities (Fleischer & Zames, 2001, 2005; Barnartt & Scotch, 2001; Shapiro, 1993; Goldsmith, 1998). The Rehabilitation Act of 1973, influenced by Roberts's work, is considered a significant achievement of the disability rights movement in the USA (Shapiro, 1993). Sections of the Act, such as 501, 503, and 502, prohibited employment discrimination, required the removal of architectural and transportation barriers, and facilitated accessibility into buildings and alterations (Goldsmith, 1998; Berger & Wilbers, 2021). Additionally, the endorsement of "The Community Mental Health Centers Act of 1963" by President John F. Kennedy marked a significant turning point in the shift from institutions to deinstitutionalization in the USA, aiming to establish community-based mental health centers and reduce reliance on large institutions (Shorter, 2000).

The Rehabilitation Act of 1973 served as a foundational legislation for subsequent disability rights laws, notably the Americans with Disabilities Act (ADA) of 1990. However, the implementation of deinstitutionalization following the ADA was flawed, as community resources and support systems were insufficiently developed to accommodate the release of individuals from institutions. This resulted in unintended consequences such as homelessness and involvement in the criminal justice system (Batavia & Schriener, 2001).

While the ADA of 1990 expanded the protection against discrimination for individuals with mental disabilities, allowing them to be integrated into society and have access to community centers that catered to their specific needs, the lack of funding for treatment in home or



community care settings was deemed insufficient by the United States Court of Appeals. As a result, many states were exempted from providing such treatment, citing an undue burden (Rocheffort 1997, Butler, 2000).

Rubenstein (1996) highlights the positive impact of the ADA on individuals with disabilities, particularly in terms of employment, accessibility, and housing provisions that facilitated their transition from institutions to accessible housing or community residence halls. Title II of the Disability Discrimination Act (DDA) of 1990 explicitly prohibited the exclusion, denial of benefits, or discrimination against qualified individuals with disabilities by public entities (Butler, 2000). This regulation played a crucial role in ending the isolation, segregation, and discrimination prevalent in institutionalization.

The passage of the ADA imposed responsibilities on state and federal courts to determine the right of individuals with mental disabilities to live within the community or in the "least restrictive environment." However, the ADA's coverage under the 1990 law was limited, primarily focusing on extending and shaping services rather than encompassing a larger percentage of individuals with mental disabilities (Butler, 2000). The flaws in the ADA, particularly in terms of the extent to which the costs of providing community-based treatment should influence a state's placement of individuals with mental disabilities, hindered many individuals from accessing community-based treatment (Yohanna, 2013). Additionally, the deference given to states in determining which individuals qualified for community-based treatment limited the number of individuals with mental disabilities receiving appropriate care. To address these flaws in the ADA of 1990, stakeholders and policymakers have called for Congressional clarification regarding the broad scope of integration under the ADA. This clarification aims to resolve the current cost dilemma faced by courts and ensure that individuals with various mental disabilities are entitled to a range of treatment options (Butler, 2000). In 2008, the ADA, 1990 was amended to expand the definition of disability so it covers broad coverage of individuals to the maximum extent permitted by the terms of the ADA and generally shall not require extensive analysis. According to the US Equal Employment Opportunity Commission (2011), the law amendment makes important changes to the definition of the term "disability" by rejecting the holdings in several Supreme Court decisions and portions of EEOC's ADA regulations. The effect of these changes is to make it easier for an individual seeking protection under the ADA to establish that they have disabilities within the meaning of the ADA. According to Daly (2010) the ADA 2008 amendment addressed the flaws that disability-rights advocates experienced in four Supreme Court decisions issued from



1999 to 2002, which narrowly interpreted the ADA in favor of employers. Moreover, the ADA amendment law played a role in improving the integration of people with mental conditions into the workplace (Daly,2010).

The movement from mental health hospitals to community-based service provision in the United Kingdom began in the period from the 1930s to the mid-1950s. This shift was driven by several factors, including the increasing number of individuals with mental health conditions in mental health hospitals (BiLiR, 2018). The development of medical treatments and the introduction of psychiatry necessitated the residence of many people with mental disabilities in these hospitals to receive proper and adequate treatment (BiLiR, 2018; Grob, 1991,1994).

Additionally, changes in rural families due to internal migration, wars, and industrialization contributed to the need for professional treatment and care outside of families. Mental health hospitals served as suitable places to meet the basic needs of individuals with mental disabilities during this initial period (Bennett & Morris, 1992).

In 1948, the National Health Service (NHS) was established in the UK, which brought people with intellectual disabilities who were receiving services in mental health hospitals and medical institutions under the control of the NHS. The NHS provided medical care services for individuals with intellectual disabilities, and the provision of services for individuals with mental disabilities became based on the principle of shared responsibilities between the local authority and the NHS (Stalker & Hunter, 1999). Local authorities were given social responsibilities through the expansion of social services, providing residential places for individuals with intellectual and mental disabilities, and offering daycare and social work. These efforts played a significant role in the deinstitutionalization of mental healthcare provision in the UK (BiLiR, 2018). Housing for people with mental disabilities, addressed by the National Health Service and Community Care Act in 1990, represented a significant step towards deinstitutionalization. Health and social services, voluntary organizations, and housing associations constructed many specialized supported housing and hospital hostels. Private service provision also increased its role in housing and caring for long-term individuals with mental conditions, with patients being referred to as the 'new long stays' in these 'virtual asylums,' while their medical treatment was maintained by private institutions (Killaspy, 2006). The term "virtual asylums" has sparked debates among policy makers and disability activists about whether this process represents a form of institutionalization trend in the UK (Curtis



et al., 2009; Priebe et al., 2005; Priebe et al., 2016; Thomas et al., 2011; Thornicroft et al., 2013).

The establishment of community-based services can be traced back to the years 1954 and 1957, with nurses assuming strict control over psychiatrists. During this period, nurses mainly visited patients' homes and families. However, the need for community mental health nursing increased with the changing roles of local services in the 1970s. Although these services contributed to reducing the number of mental health hospitals in the UK, they were not completely closed, and community mental healthcare centers were established as transitional institutions between mental health hospitals and patients (BiLiR, 2018). Deinstitutionalization aimed to transition individuals with disabilities out of large institutions and into community-based settings that provide individualized support and opportunities for inclusion. According to Bagenstos (2009), deinstitutionalization was not about simply closing institutions; it was also about developing community-based alternatives that would allow people with disabilities to live meaningful lives in the community.

In 1995, the Disability Discrimination Act (DDA) was enacted to prohibit discrimination against people with disabilities. This act covered people with physical or mental disabilities and aimed to facilitate their access to mainstream services, thereby promoting the transition from institutions to community-based services. The DDA was replaced by the Equality Act 2010, which came into force in October 2010. The Equality Act unified discrimination legislation, including the Race Relations Act, the Disability Discrimination Act, and the Sex Discrimination Act, under one law. It expanded the definition of disability and protected individuals from discrimination based on nine characteristics, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. The Equality Act 2010 continued to include people with physical, cognitive, and mental health disabilities, ensuring their rights to access mainstream services and promoting their full integration and inclusion in society (Shuayb, 2020).

In the process of deinstitutionalization, both the United States of America and the United Kingdom have taken significant steps. However, on a global scale, the United Nations played a crucial role in promoting deinstitutionalization by introducing the Convention on the Rights of Persons with Disabilities (CRPD) in 2006 (ESCWA & Centre for Lebanese Studies, 2019; Shuayb, 2020). Since its coming into force in 2008, the CRPD has been widely accepted and ratified by numerous countries worldwide, including the United Kingdom and Lebanon, the



latter of which ratified it in February 2023. The CRPD adopts the social model of disability and the philosophy of independent living, aiming to legislate the removal of barriers, including institutional confinement (Shuayb, in press; Jouni & Al-Hroub, 2023).

Article 19 of the CRPD, titled "Living independently" and "being included in the community," highlights the equal right of all persons with disabilities to live in the community and make choices on an equal basis with others. Article 19 of the CRPD is influenced by various movements and critiques, including the disability rights movement, the anti-psychiatry movement, the movement of mental health service users, critiques of institutional life, and the approach of 'normalization' (Ratzka, 1996; Evans, 2002; Mansell et al., 2007; Mladenov, & Petri., 2020; Beresford, 2012; Duffy, 2010; Duffy, Waters, & Glasby, 2010). While Article 19 of the CRPD emphasizes the importance of closing residential institutions for people with disabilities and replacing them with community-based services, many scholars argue that in actual policies and practice, deinstitutionalization has often been reduced to the dismantling of large settings or the replacement of large institutions with smaller ones located in the community (Mladenov, 2021.; Duffy, 2011).

1.3 De-institutionalization of people with disabilities in Lebanon

The findings from the literature review in the USA and England emphasize the importance of moving beyond the closure of institutions and instead focusing on the development of comprehensive community support systems to facilitate independent living and inclusion for individuals with disabilities. Simply closing institutions is not sufficient; it is essential to ensure the availability of adequate resources, services, and support networks to facilitate a successful transition from institutional care to community-based settings. Furthermore, a critical evaluation of existing policies and practices is necessary to identify and address potential shortcomings and challenges associated with the deinstitutionalization process.

While the deinstitutionalization movement has made significant progress in countries such as the USA and the United Kingdom, as well as through international instruments like the CRPD, Lebanon has faced specific challenges that have hindered its transition from institutional settings to community-based services. These challenges have contributed to the limitations experienced in the deinstitutionalization process in Lebanon.

Lebanon's history has been marked by a series of challenges and adverse circumstances that have profoundly affected the integration of individuals with disabilities into society. Events



such as wars and other conflicts have led to a significant number of casualties and an increased incidence of disabilities, accompanied by extensive damage and destruction to the country's infrastructure (Shuayb & Doueiry, 2021). The political instability experienced in Lebanon has also had repercussions on the mental health of its population. According to Blanchet et al. (2016), the prevalence of mental health conditions has reached an estimated 30% of the total population. Additionally, the consequences of war-related exposure have contributed to higher rates of mental health conditions, highlighting the inadequate capacity of existing mental health services to meet the growing demands (Amawi et al., 2014).

According to El-Khoury, Haidar, and Charara (2020), mental health services in Lebanon face significant challenges, particularly at the primary care level and in the provision of care for severe psychiatric disorders. These challenges are attributed to factors such as political instability, chronic underfunding, and pervasive stigma, which have collectively perpetuated a traditional model of mental healthcare characterized by private clinics affiliated with inpatient and long-stay psychiatric units. These circumstances have led to the underserving of mental health needs within the population. Various studies have shed light on the prevalence of mental health conditions among Lebanese individuals. Karam et al. (2008) found that at least 25% of the Lebanese population has experienced a mental health condition at some point during their lifetime. This highlights the significant burden of mental health issues faced by individuals in Lebanon and underscores the pressing need for improved access to comprehensive and effective mental health services.

During the period of Ottoman rule, Lebanon witnessed the implementation of Law Number I on 1/1/1900, which addressed the legal status of individuals with mental health conditions and intellectual disabilities. This law employed derogatory terms such as "the idiot" and "the insane" to describe these individuals, leading to the establishment of mental health hospitals and institutions (Kerbage, 2014). Despite historical developments, Khoury and Daouk (2017) highlighted that Lebanon's legal framework for protecting the rights of people with mental health conditions is primarily based on the Welfare Act and the Protection and Treatment of Mentally Ill Patients (Legislative Decree no. 72-9/9/1983). However, Nizar Saghieh et al. (2009) argued that this decree does not align with the UN Convention on the Rights of Persons with Disabilities (CRPD) that aim to prevent discrimination against individuals with mental health conditions and individuals with disabilities. Consequently, psychiatric institutions continue to exist without efficient legislation regulating involuntary admissions, safeguarding patient rights,



and promoting outpatient mental healthcare as an alternative to hospitalization and institutionalization (Kerbage, 2017).

According to Chahine and Chemali (2009), Lebanon currently has three dedicated mental hospitals. The largest among them provides acute and long-term care for patients of all ages with mental health conditions, including psychiatric illnesses and individuals with intellectual disabilities, offering over 1200 beds. Additionally, the World Health Organization (2015) reported that Lebanon has five active mental health hospitals, eight community-based psychiatric units in general hospitals, 42 outpatient mental health facilities, five day-treatment facilities, seven community residential facilities, and 30 inpatient mental health beds in forensic facilities. However, there is a scarcity of multidisciplinary mental health teams, with such collaboration primarily found in the context of working with children with learning disabilities. Moreover, there is a lack of community mental health services focused on mental health promotion and prevention (Alameddine et al., 2015).

In 2014, the Ministry of Public Health (MoPH) in Lebanon, along with the World Health Organization (WHO), the United Nations International Children's Emergency Fund (UNICEF), and the International Medical Corps (IMC), initiated the National Mental Health Program (NMHP) with the aim of reforming mental health care and involving universities and scientific societies (Kerbage, 2017; Ministry of Public Health, 2015). Subsequently, in 2015, a national mental health strategy for the period 2015-2020 was launched. The strategy aimed to establish a sustainable mental health system that ensures access to high-quality mental health services, employing a cost-effective, evidence-based, and multidisciplinary approach. It emphasized community involvement, continuum of care, human rights, and cultural relevance (Ministry of Public Health, 2015; Kerbage, 2017).

The national mental health strategy in Lebanon aimed to promote community-based mental health care and address the shortcomings in mental health legislation. However, this strategy has been subject to criticism for its reliance on the medical model of mental health, which focuses primarily on diagnosis and treatment (Moghnie & Marranconi, 2017). Scholars argue that a more comprehensive approach is needed, one that takes into account the social and environmental factors that influence mental health. In response to these critiques, Kerbage (2017) highlights the efforts of lawyers within the Legal Agenda to propose a revised draft of the mental health legislation. The goal was to align the legislation with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), particularly emphasizing Article



19 of the convention, which emphasizes the rights of individuals with disabilities to live independently and be included in their communities. The revised draft was adopted by the National Mental Health Program at the Ministry of Public Health. However, it is worth noting that since its adoption, there has been a lack of public discourse on the progress of the draft law. The absence of updates and discussions regarding the implementation of the revised legislation raises concerns about the commitment to advancing the rights and inclusion of individuals with mental health conditions in Lebanon (Kerbage, 2017).

Globally, the institutionalization of children and adults with disabilities has been recognized as a significant barrier to the realization of their rights. The practice of placing individuals with disabilities in residential institutions prevents their independence and inclusion within their communities, thus impeding the principles outlined in Article 19 of the CRPD (ESCWA & CLS, 2019). Despite the various initiatives and legislation drafts aimed at promoting inclusion in Lebanon, individuals with disabilities, including those with physical and mental disabilities, still face significant barriers to full participation in mainstream services. The establishment of institutions for people with disabilities in Lebanon has been influenced by dominant models such as the charity and tragedy model of disability, as well as the medical model of disability, both of which have a welfare-based approach (Handicap International, 2012). According to Kingston (2013), the welfare provision system in Lebanon, which individuals with disabilities heavily rely on, can be characterized as an "informal security/insecurity regime." This system reflects the limited involvement of the Lebanese state in social policy, tracing its origins back to the late Ottoman and French mandate periods. During the Ottoman era, social welfare activities were primarily carried out by local charities, religious foundations, and foreign missionaries, with minimal state involvement. The French mandate period witnessed some establishment of social infrastructure, such as schools, hospitals, and public health facilities, but these efforts were not based on a rights-based social contract between the state and society. Instead, they were temporary measures to appease demands for independence, leading to the subsidization of private social welfare institutions connected to clan and community networks. This informal security/insecurity regime had subordinating effects on marginalized social groups, including individuals with disabilities (Kingston, 2013).

In response to global disability movements, Lebanese disability activists formed networks during times of war and in the postwar period to advocate for their inclusion in society and the establishment of a national policy domain with social policies (Kingston, 2013; Khawam, 2022). However, the framing of these policies did not primarily focus on rights-based



approaches and removing barriers to access mainstream services. Instead, the emphasis was placed on creating a service delivery system that provided technical aids and specialized services to meet the specific needs of individuals with disabilities. As a result, these aids were predominantly delivered through segregated care institutions rather than community-based services (Kingston, 2013; Kabbara, 2012).

The Civil War in Lebanon, which took place from the 1970s to 1990, had significant implications for the provision of support to individuals with disabilities. As a result of the war, medical and rehabilitation centers were established by militias and social-religious groups to assist the injured, including those who acquired disabilities during the conflict. These centers eventually evolved into service provider institutions known as "care institutions," which fostered segregation and contributed to the expansion of residential and specialized institution care, particularly in the 1990s when postwar funding surged (Khawam, 2022). Since the 1970s, numerous private disability institutions emerged in Lebanon and gained financial independence, operating autonomously from the state (Kabbara, 2012). This independence has posed considerable challenges in terms of coordination and regulation of their activities. Additionally, many of these institutions heavily relied on funding from Western donors and criticized the fragmented nature of Lebanon's social welfare regime. This fragmentation is characterized by a lack of legal and administrative clarity and coordination among the diverse institutions within the sector (Khawam, 2022).

Kabbara (2012) states that in the 1980s, organizations of people with disabilities (OPDs), such as the Lebanese Physically Handicapped Union (LPHU), the Youth Association of the Blind (YAB), and the National Association for the Rights of the Disabled (NARD), were established. These organizations distanced themselves from conventional charities, service-oriented institutions, and militia groups, shifting their focus toward rights-based activism and laying the groundwork for the nascent disability movement in Lebanon. During the Civil War, OPDs engaged in disruptive protests aimed at denouncing the manifestations of anti-war sentiment and violence, thereby increasing their visibility and influence (Kabbara, 2012). Although these activities did not explicitly demand full inclusion for individuals with disabilities, they effectively conveyed their concerns and raised awareness (Khawam, 2022).

Subsequently, the organizations of people with disabilities (OPDs) in Lebanon continued their activism, shifting their focus to lobbying efforts aimed at eliminating the exclusion of individuals with disabilities from society. In the early 1990s, a notable act of protest occurred when the



Lebanese Physically Handicapped Union (LPHU) demolished a newly constructed sidewalk in Beirut due to its lack of accessibility provisions, symbolizing a shift toward more assertive forms of protest by activist groups during the postwar era (Death, 2015). Moreover, these organizations advocated for policy reforms and campaigned for inclusive education and the establishment of community-based day care centers (Khawam, 2022; Jouni & Al-Hroub, 2023). Parent and self-advocacy groups, including the Lebanese Down Syndrome Association, the Lebanese Association for Self-Advocacy, and Friends of the Disabled Association, emerged as proponents of the inclusion of individuals with disabilities in community-based services (Khawam, 2022).

Despite the long history of the disability rights movement in Lebanon, which dates to the enactment of the "Handicapped Care Services Act" in 1973, the initial legislation failed to adequately address the full participation and integration of individuals with disabilities into society (Mansour, 2001). However, in recent years, the movement has gained momentum and visibility, largely driven by organizations led by individuals with disabilities and advocacy groups who possess firsthand experience of the limitations and challenges associated with institutionalized life (Kingston, 2013).

The transition from a charity-based approach to rights-based activism within the disability rights movement in Lebanon highlights a significant shift in perspective and priorities. This evolution reflects the growing demand for inclusive policies and services that prioritize the rights and inclusion of individuals with disabilities. However, several challenges impede the development and implementation of comprehensive disability policies in Lebanon. Financial constraints and the limited capacity of the Lebanese government to meet basic needs, such as providing technical aids to people with disabilities, have hindered the progress in developing comprehensive disability policies across various ministries (Kingston, 2013; shuayb & Doueir, 2023; Jouni & Al-Hroub, 2023). The government's ability to allocate resources for disability-related programs and services is constrained, which poses challenges for realizing the rights and meeting the diverse needs of individuals with disabilities. Furthermore, the political landscape in Lebanon presents another barrier to the advancement of disability rights. The political class has demonstrated a lack of interest in formulating national social policies and has instead used social distributions to further their own political agendas. This lack of commitment to formulating inclusive social policies undermines the efforts to promote the rights and inclusion of individuals with disabilities (Kabbara, 2012). Moreover, the presence of large social welfare and disability institutions, often affiliated with religious groups or political



parties, further complicates the disability policy landscape. These institutions leverage the sectarian dynamics inherent in the social policy framework to secure resources and maintain autonomy. This fragmentation within the disability sector hampers coordination, clarity, and the establishment of a comprehensive and integrated approach to disability policies (Kingston, 2013). Power struggles and internal conflicts over leadership and funding have characterized the movement over the years (Shuayb, in press; Khawam, 2022).

In 1992, the Ministry of Social Affairs and the Disabled was established in Lebanon with the aim of changing the perception of disability and the approaches taken in dealing with disabilities. This ministry was fully separated from the Ministry of Labor, and in 1993, a National Authority for the Affairs of the Disabled was established. A specialized committee was formed to draft a law on the rights of persons with disabilities. After extensive campaigning, lobbying, and pressure exerted on the Lebanese government, disability organizations, activists, and policymakers succeeded in having the disability Law 220/2000 endorsed in 2000 (Kingston, 2013; Shuayb & Doueiry, 2021; Shuayb, in press; Khawam, 2022). Despite the intentions of Law 220/2000 in Lebanon to promote the integration of individuals with disabilities into mainstream educational systems, the content of the law primarily aligns with the medical model of disability. This model emphasizes the establishment of specialized schools, rehabilitation centers, and institutions for people with disabilities, thereby perpetuating a segregated approach to education (Khawam, 2022; Shuayb & Doueiry, 2021).

Law 220/2000 specifically addresses the right of individuals with disabilities to equal educational opportunities in all types of educational institutions, including regular and special classes. Article 59 of the law ensures equal educational opportunities, while Article 60 prohibits discriminatory barriers in the admission process of educational institutions, regardless of their public or private nature (Al-Hroub, 2022; Jouni & Al-Hroub, 2023). Furthermore, educational institutions are required to provide necessary facilities and accommodations for entrance exams and academic assessments to cater to the needs of individuals with disabilities, as outlined in Law 220/2000. The exemption committee plays a vital role in considering applications from concerned parties, such as parents and educational institutions, based on comprehensive standards and procedural facilities. Schools, institutions, universities, and other educational establishments are also mandated to inform individuals with disabilities about the required documentation for registration, with priority given to grant applicants who hold disability cards. However, the implementation of Law 220/2000 to promote inclusion in mainstream educational systems has been limited. This is attributed to



the persistent existence of special care educational institutions and special schools, which contribute to the perpetuation of negative attitudes towards individuals with disabilities (Lakkis & Thomas, 2003; Jouni & Al-Hroub, 2023; Shuayb & Doueiry, 2023). The continued presence of segregated educational settings hinders the realization of inclusive education and reinforces the social exclusion of individuals with disabilities.

According to Wehbi (2007), although Law 220/2000 seeks to foster inclusive education and the integration of individuals with disabilities into mainstream settings, the government's financial support through the Ministry of Social Affairs continues to uphold special institutions, thereby perpetuating negative attitudes and the belief that individuals with disabilities are unable to thrive in regular classrooms. Numerous non-governmental organizations (NGOs) operate these specialized schools, relying on grants, donations, and funded projects, with partial funding provided by the Ministry of Social Affairs. These schools primarily offer primary special education and vocational training as an alternative to mainstream education, often serving as the residence for children with moderate to severe disabilities (Jouni & Al-Hroub, 2023). The absence of accessible schools poses an additional obstacle for students with disabilities, limiting their access to mainstream education. The government's failure to enforce the law in both public and private sectors marginalize individuals with disabilities, hindering their social interactions and impeding their access to education, employment, information, and services, thereby obstructing the process of deinstitutionalization (Jouni & Al-Hroub, 2023, Shuayb & Doueiry 2023).

The exclusion of children with learning disabilities from mainstream educational settings has been well-documented in the literature (Jouni & Al-Hroub, 2023). Private and public schools often lack the necessary resources, training, and support systems to adequately address the diverse learning requirements of these students. As a result, they are frequently redirected to alternative educational environments, such as NGO-specialized centers, which receive support from the Ministry of Social Welfare. Specialized schools and government-subsidized institutions become the primary educational options for children with learning disabilities. These institutions are designed to cater to the specific needs of students with diverse learning challenges. However, the limited availability of such institutions and the overwhelming demand for their services further compound the challenges faced by these children. Many children may remain underserved or experience delays in accessing appropriate educational placements. The lack of inclusivity in mainstream schools and the reliance on alternative educational settings place children with learning disabilities at a heightened risk of academic difficulties and



school dropout (Al-Hroub, 2022, Jouni & Al-Hroub, 2023). Without appropriate accommodations and tailored instructional approaches, these children may struggle to keep up with their peers, leading to poor academic performance and a potential disengagement from the educational system.

Although Article 61 of Law 220/2000 in Lebanon designates the Ministry of Education as responsible for funding specialized schools and their associated educational facilities, there remains a notable absence of a dedicated unit within the ministry to address the specific needs of students with disabilities, including interventions in sign language or Braille (Shuayb & Doueiry, 2023; Jouni & Al-Hroub, 2023). Instead, the Ministry of Social Affairs assumes the responsibility for specialized education and vocational rehabilitation institutes (Jouni & Al-Hroub, 2023). This situation is compounded by the fact that the current Minister of Social Welfare, Dr. Hector Hajjar, has previous experience working in NGOs like Caritas and Risala Assalam, both of which are specialized institutions for individuals with disabilities (The National News, 2021). This organizational structure poses challenges to the efforts of deinstitutionalization and the promotion of inclusive practices.

In 2012, the Center for Educational Research and Development (CERD) under the Ministry of Education and Higher Education (MEHE) introduced the National Educational Plan for Persons with Disabilities. While the plan was initially implemented as a pilot program in select areas across Lebanon, it did not extend to all public schools due to inadequate funding (Jouni & Al-Hroub, 2023). Consequently, the MEHE has made limited progress in the past five years in developing a comprehensive strategic plan for the educational integration of students with special educational needs (SEN), which is yet to be fully adopted and implemented (CERD, 2020).

In contrast, the Ministry of Education and Higher Education (MEHE) developed a comprehensive Five-Year General Education plan in 2021 with the objective of ensuring equitable access to high-quality education for all children in Lebanon while also strengthening the resilience of the public education system during crisis situations. The plan encompasses various levels of education, including basic education, secondary education, Technical and Vocational Education and Training (TVET), and higher education, with the aim of providing equitable and quality education to all children across the country (MEHE, 2021, p. 6). The plan also acknowledges the significance of fulfilling international commitments in the field of education and addressing vulnerabilities associated with disabilities and special education



needs (Jouni & Al-Hroub,2023). It emphasizes the promotion of inclusion for students at risk, specifically those with disabilities, to foster the development of responsible, active, innovative citizens and a skilled workforce (MEHE, 2021).

However, it is crucial to examine whether the MEHE's plan will effectively contribute to the transition from special institutions to inclusive education, particularly in the current economic crisis. It is important to consider the specific steps and strategies that the ministry intends to implement to realize the objectives outlined in the plan and ensure the successful integration of students with disabilities into mainstream educational settings. Further investigation is necessary to evaluate the potential impact of the plan on the overall process of deinstitutionalization and to assess the feasibility and effectiveness of its implementation under the prevailing economic circumstances.

Furthermore, as part of the efforts to support individuals with disabilities in Lebanon, the Ministry of Social Affairs, in partnership with the European Union, UNICEF, and the International Labour Organization, introduced the National Disability Allowance (NDA) (UNICEF, 2023). The NDA is a social grant that aims to provide direct income support to persons with disabilities residing in the country. While the goal of the allowance is to include all persons with disabilities, the initial implementation of the program prioritizes youth between the ages of 18 and 28, supporting their transition to higher education or entry into the labor market. Currently, the program benefits approximately 20,000 individuals who possess a Personal Disability Card issued by the Ministry of Social Affairs' Rights and Access program. Eligible individuals receive a monthly allowance of US\$40 for a period of 12 months (UNICEF, 2023). However, there are calls from disability organizations to expand the program's parameters to include older people with disabilities.

On the other hand, despite Lebanon's initial signing of the Optional Protocol to the Convention on the Rights of Persons with Disabilities (CRPD) in 2007, the country faced challenges in implementing policies that promote the full inclusion of people with disabilities in mainstream services. This led to significant pressure from disability organizations and activists to urge the Lebanese government to ratify the CRPD. Finally, on March 29, 2022, the Lebanese Parliament issued a decree advising the government to proceed with the ratification of the CRPD and its Optional Protocol. Subsequently, on April 12, 2022, the Lebanese government approved the CRPD and its Optional Protocol (Presidency of the Council of Ministers, 2023). The ratification of the CRPD was officially published in the Official Gazette



of the State on February 9, 2023, imposing obligations on the Lebanese government to adhere to the provisions of the CRPD (Presidency of the Council of Ministers, 2023). Given the recent ratification of the Convention on the Rights of Persons with Disabilities (CRPD) by the Lebanese government, it is imperative to explore the necessary steps that should be taken to ensure effective collaboration between the government, relevant authorities, disability organizations, and non-governmental organizations. The purpose of this review is to align the law with the provisions outlined in the CRPD. Notably, special emphasis should be placed on Article 19, which emphasizes the right to independent living, and Article 24, which emphasizes the transition to community-based facilities, inclusive educational systems, and inclusive services that are essential to promote the full inclusion and participation of people with disabilities in society, in accordance with international standards and obligations.

1.4 Conclusion

In conclusion, while Lebanon has taken some steps towards the integration of people with disabilities in society, there are still significant challenges that hinder the process of deinstitutionalization and full inclusion. These challenges include the lack of accessibility in public spaces and transportation, discrimination in employment and education, and limited availability and accessibility of community-based services. The existing legislation, such as Law 220/2000, and the National Mental Health Program at the Ministry of Public Health have been criticized for perpetuating institutionalization rather than promoting community integration. Socioeconomic factors, such as poverty and unemployment, further contribute to the barriers faced by individuals with disabilities in accessing appropriate services and living independently.

Moving forward, conducting an in-depth investigation into the present situation in Lebanon becomes paramount, particularly within the context of the country's ongoing economic crisis. This inquiry seeks to conduct a comprehensive investigation into the roles played by local and international disability organizations, governmental bodies (specifically the Ministry of Education and the Ministry of Social Welfare), and policymakers in effectively addressing the rights and needs of individuals with disabilities. A critical aspect of this investigation entails a thorough analysis of the impact and implications of Ottoman Law Number 1 enacted on January 1, 1900, Legislative Decree no. 72-9/9/1983, the National Mental Health Program (NMHP), and Law 220/2000. Furthermore, it is vital to explore the influence of the National Disability Allowance (NDA) on facilitating the independent living of young individuals with disabilities and its potential contribution to deinstitutionalization efforts. Additionally,



examining and assessing the implementation of the Ministry of Education and Higher Education's (MEHE) comprehensive Five-Year General Education plan in 2021 is essential in identifying its potential for transitioning from special institutions to inclusive services. The primary objective of this investigation is to determine whether these laws and initiatives have impeded progress towards the deinstitutionalization of individuals with disabilities.

Furthermore, it is crucial to identify the various types of institutions and determine whether individuals with disabilities and those with mental health conditions are accommodated together or separately within these facilities. Moreover, understanding the range of services provided and the level of familiarity service providers possess regarding the needs of individuals with disabilities and mental health conditions is essential. Documenting the conditions experienced by individuals with disabilities residing in institutions and elucidating the barriers they encounter are critical steps in comprehending the limitations that hinder their integration into society. Additionally, it is imperative to explore how policymakers and the government intend to enact laws and regulations that align with the principles outlined in the Convention on the Rights of Persons with Disabilities (CRPD). Lebanon's ratification of the CRPD necessitates revising existing legislation to align it with the provisions of the convention. This process entails addressing the deficiencies found in current policies and devising comprehensive measures to support deinstitutionalization, community-based care, and the inclusive participation of people with disabilities in all facets of society.

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