TCI Submission

Call for Inputs for the thematic study on the rights of persons with disabilities and disability-inclusive infrastructure, including transport and housing

Co-submitters (TCI members): Autism Inclusiveness Direct Action (AIDA) (Malaysia), Taiwan Mad Alliance (Taiwan), Consumer Action Forum (Sri-Lanka), Psychosocial Disability Rights Network (Pakistan), Mental Health Support Group (Maldives), Liberation (UK), Porque (Japan), and Ya_All: The Youth Network (India)

We warmly welcome the initiative of the OHCHR to invite persons with psychosocial disabilities and their representative organizations to contribute to this crucial topic. Addressing disability-inclusive infrastructure, particularly housing and transportation, is essential to realizing the rights enshrined in the CRPD. We commend the Committee for recognizing the structural barriers faced by our constituency and for opening space to document them at the international level.

About TCI Global: Transforming Communities for Inclusion (TCI) is a global organization of persons with psychosocial disabilities. TCI forecasts a future in which all human rights and full freedoms of persons with psychosocial disabilities are realized. We are guided by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and are the largest representative voice of persons with psychosocial disabilities, having members from 19 countries and networks in 50 countries globally. We define 'psychosocial disabilities' inclusively: persons who identify as with psychosocial disabilities, users and survivors of psychiatry, persons with intersectional, neuro-diverse identities which includes autistic persons, persons attributed a 'mental illness', persons deemed to be of 'unsound mind', etc.

<u>Executive Summary</u>

Access to safe, affordable, accessible, and dignified housing and transportation are essential preconditions for independent living and community inclusion of persons with psychosocial disabilities. Yet, despite years since the adoption of CRPD, systemic barriers persist, Persons with psychosocial disabilities remain excluded from accessible and affordable homes in our own communities, and continue to face multiple barriers in accessing transportation on an equal basis with others. We are still constrained within the stronghold of medicalized frameworks and discriminatory legal regimes, treated as merely *patients, persons with mental illness,* or those of *"unsound mind"* rather than as rights-holders. In this submission, we outline the structural barriers

in law, policy, and practice across housing and transportation, drawing on evidence from TCI member countries, and we provide recommendations aligned to the UN Convention on the Rights of Persons with Disabilities.

Methodology

This submission is prepared by Transforming Communities for Inclusion in collaboration with its full members. The call for inputs was shared with members, and inputs from several TCI member countries were collected. Recognizing the diverse realities and intersectionalities of our members, inputs from women, youth, intersectional identities, and older persons have been incorporated inclusively. The submission has been prepared in partnership with Autism Inclusiveness Direct Action Group (AIDA), Malaysia, and Taiwan Mad Alliance, of Taiwan, considering the findings and reports received from Pakistan, Malaysia, Taiwan, Sri Lanka, India, UK, Maldives, and Japan.

Section 1 – Legal and Policy Frameworks

1. What national, regional or local policies exist in your country to promote accessible transport and housing for persons with disabilities?

2. How do these frameworks align with obligations under the Convention on the Rights of Persons with Disabilities?

3. How are these integrated in the design and implementation of comprehensive care and support systems-related infrastructure?

Across TCI's membership, laws and policies on accessibility in housing and transport exist in countries such as Malaysia and the Maldives, but their design and implementation remain incomplete. Frameworks in Sri Lanka, United Kingdom, Japan, Maldives and Malaysia carry the language of disability rights, yet when examined through the lens of psychosocial disability, they falter. Accessibility is almost always reduced to physical features of the built environment. Ramps, lifts and tactile paving are mandated, while sensory environments, predictability, communication and legal personhood are ignored. Persons with psychosocial disabilities are excluded either through restrictive definitions of disability or by laws that legitimize guardianship and institutionalization.
Persons with psychosocial disabilities are discriminated and excluded as they are seen as persons with 'mental illnesses', persons who are mental patients, persons of 'unsound mind', 'mad' persons, etc. This poses intractable attitudinal, legal, social, economic, cultural and program barriers to access opportunities, take risks, make their own decisions, have their will and preference respected, or enjoy all fundamental human rights for living independently and on an equal basis with others.[1]

Furthermore, we as persons with psychosocial disabilities are frequently shackled legally, by incapacity laws, such as mental health laws and a wide variety of civil laws, through 'civil commitment procedures' (e.g. through Vagrancy law). We are stripped off our personhood and our right to identity, further exacerbated through guardianship and conservatorship laws. We are seen as 'non-persons', who do not have any rights in society. We are seen as non-persons, and not as persons who can live in the mainstream communities by providing support systems, inclusive community services and reasonable accommodations. The impact of being civil dead-on lives of persons with psychosocial disabilities is total disqualification from decision making process, community living, family life, work and employment, education, etc.[2]

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[1] A/HRC/37/56 (Report of the Special Rapporteur on the rights of persons with disabilities)
[2] TCI. (2023). *Contribution to the call for submission from the Committee on the Rights of Persons with*

These laws and policies for e.g. mental health laws, guardianship laws and mental health policies in several TCI member countries further disqualify us to access housing and transportation as we are committed against our will to mental institutions, asylums, rehab centers, nursing homes, social care institutions, half way homes, de-addiction centers, group homes, shelters, camps and other a variety of institutions. The laws and policies promote building more and new institutions rather than investing in community living, accessible housing and transportation. Institutions are seen as best fit for us.

The United Kingdom's Equality Act 2010 illustrates the limits of formal protection.[3] Recognition depends on proving that difficulties are "substantial" and "long-term," erasing many forms of discrimination. Section 14 on intersectional discrimination has never been brought into force, and in England Section 1 on the socio-economic duty is dormant, and Equality Impact Assessments are not legally required. In addition, the Act is undermined by current and planned mental health and mental capacity laws which maintain not only involuntary hospitalization and forced treatment, but community treatment orders which institutionalize people in community settings. A law that appears comprehensive therefore fails those most in need of protection.

In Sri Lanka, housing grants and allowances exist, but post-disaster housing policies have channeled resources into institutional facilities rather than community-based homes. Transport frameworks reference accessibility but overlook essential psychosocial dimensions such as reliable information, calm environments and trained staff.

In Malaysia, rights are recognized in the Persons with Disabilities Act 2008, yet the law is not enforceable[4]. The Mental Health Act 2001 and Contracts Act 1950 restrict legal agencies, and the Destitute Persons Act 1977 has been used to detain nearly 8,000 people between 2021 and 2025, with some referred to long-stay psychiatric hospitals[5,6]. At the same time, agencies such as Urbanize under the Ministry of Housing and Local Government have piloted inclusive city design projects, from calm rooms to sensory spaces, but these remain isolated.

Japan has adopted the Barrier-Free Act and the Act for Eliminating Discrimination against Persons with Disabilities. Yet psychosocial accessibility is absent from their scope. Deinstitutionalization exists in rhetoric but not in practice, leaving individuals with limited housing options and inaccessible transport.

In Latin America, members note that housing frameworks often exclude psychosocial disability by omission, with laws oriented towards physical design but rarely linked to legal capacity or equal recognition. In African contexts, governments continue to tie housing programs to custodial models, sometimes under post-disaster or humanitarian schemes, and national laws on accessibility often fail to include psychosocial disability altogether.

Across all regions, the pattern is consistent: substitute decision-making remains legal, custodial institutions continue to receive investment, accessibility is defined in physical terms, psychosocial

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Disabilities on the Day of General Discussion (DGD) Article 11 of CRPD.
https://tci-global.org/wp-content/uploads/2023/07/TCI-Global_Submission-for-General-Comment-on-Article-11-CRPD.pdf

[3] https://www.gov.uk/guidance/equality-act-2010-guidance

[4] https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2022/11/Malaysia-Pwd-Act-2008.pdf

[5] https://www.moh.gov.my/index.php/database_stores/attach_download/317/29

[6] https://www.rcrc-resilience-southeastasia.org/wp-content/uploads/2017/12/Contracts-Act-1950.pdf

accessibility remains invisible, and participation is tokenistic. The gap between CRPD guarantees and reality remains wide. In Taiwan, Article 15 of the Civil Code still stipulates that a person under guardianship has no legal capacity; therefore, juridical acts such as entering into contracts for the purchase or lease of housing, purchasing airline tickets, or other major transactions are, in principle, void. A person placed under assistance is regarded as having only partial capacity; for "important juridical acts," including housing contracts, the consent of the assistant is required, otherwise the act may be annulled. From the example of Taiwan, it can be seen that due to the failure to comply with Article 12 of the CRPD on equal recognition before the law, persons with psychosocial disabilities are also denied the equality required by Article 5 in accessing housing and transport. This directly risks undermining the freedom of movement under Article 26 and the right to an adequate standard of living under Article 28.

Members—including in Taiwan—report that housing and transport laws often fail to define refusal of reasonable accommodation as discrimination, leaving people with psychosocial disabilities without redress. States should codify this as discrimination and establish complaint, conciliation, and sanction mechanisms with clear guidance for consistent enforcement.

In practice, most policies fall short of meeting obligations under the Convention on the Rights of Persons with Disabilities (CRPD). Article 9 (Accessibility) and Article 19 (Living independently and being included in the community) are routinely overlooked when it comes to persons with psychosocial disabilities. Many legal frameworks continue to uphold guardianship laws and mental health legislation that deny legal capacity, which directly contradicts CRPD Articles 12 and 19.

TCI members have consistently reported that the principle of "accessibility" is narrowly interpreted as ramps, elevators, or physical infrastructure, while psychosocial and cognitive accessibility is almost entirely absent. Housing schemes rarely integrate universal design or provide reasonable accommodation. Transport laws may exist, but their implementation remains fragmented, and monitoring mechanisms are weak or non-existent. This creates a situation where states claim compliance with CRPD on paper but fail to deliver substantive equality in practice.

In many countries, what is understood as care results in institutionalization in halfway homes, special education boarding schools and rehabilitation centres, rather than enabling community inclusion through services and supports. Instead of fostering autonomy and inclusion, we note amongst our members that current policies and investments incentivize and strengthen the medical model of disability. Comprehensive care and support systems must be reimagined to build stronger communities, accessible and inclusive housing, and transport as part of a holistic framework that prioritizes personal assistance, peer support and community services.[7]

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Section 2 - Accessible transport

4. What measures have been taken to ensure the accessibility of different modes of transport

[7] TCI Global. (n.d.). *'Support' as 'Care': A/HRC/52/52 (advanced unedited version) report from the OHCHR: A response from TCI.* https://tci-global.org/wp-content/uploads/2023/06/Final-Support-versus-care-TCI-response-to-A-HRC-52-52.pdf

(urban, rural, long-distance, maritime, air, railway, bus)?

It was reported by several TCI member countries that measures to ensure accessible transportation remain fragmented, inconsistent, and largely focused on assistive technology and physical accessibility for persons with mobility impairments. Over the past decade of time, policies and practices have also been changed a lot for persons with visual impairments, and hearing impairments, by investing massively in assistive devices and making transportation services accessible. Unfortunately, persons with psychosocial disabilities remain largely excluded from these practices.

Various countries have used universal designs to develop national level accessibility codes/guidelines for making transportation accessible. Governments have made efforts but have left out people with psychosocial disabilities from these consultations. Also in several member countries, there are umbrella OPDs (cross disability organizations), who are leading these initiatives in collaboration with states and donors, but they leave out OPDs of persons with psychosocial disabilities, recognizing them as people who only need mental health services and not an accessible environment.
Some governments have been working with OPDs to facilitate persons with disabilities through concessions, allowances and special discounts for accessing transportation. Due to identity issues and lack of access to disability identity cards, persons with psychosocial disabilities are left out from accessing transportation services.

In Sri Lanka, low-floor buses have been introduced, but railway stations and rolling stock lack basic features, airports do not guarantee consistent accommodations, and inland waterways have no accessibility standards. Parliamentary discussions in 2025 acknowledged these gaps but enforcement remains weak.

In Pakistan persons with psychosocial disabilities are identified as persons having an unsound mind, and are not recognized in the disability movement, as persons with disabilities. Persons with unsound minds are legally restricted to enjoy an equal life as others. Hence, persons with psychosocial disabilities in Pakistan and several other countries who were historically colonized have to hide their identity to access transportation services, and are not able to access quality transportation services, making it almost impossible, as the designed services do not cater to the needs/reasonable accommodation of persons with psychosocial disabilities.

In the United Kingdom, operators are legally obliged to provide adjustments such as ramps and lifts, and schemes like the Freedom Pass expand access. Yet nearly 90% of disabled people report barriers ranging from inaccessible stations to harassment, showing the gulf between statutory rights and lived experience.

Japan has invested in lifts and low-floor buses, yet persons with psychosocial disabilities avoid trains due to overstimulation, noise and complexity. These factors are invisible in official monitoring.

Malaysia has expanded physical accessibility in urban rail and bus networks, introduced tactile paving and lifts, and rolled out the OKU SMILE Pass in 2024 granting free fares. Airports piloted calm rooms, but these cater mainly to children and families, not adults with hidden disabilities. Rural mobility has received little attention, and accommodations for persons with psychosocial disabilities remain limited to private or porter assistance.

In Kenya, community-led cooperatives have adapted paratransit services to rural areas, providing vital though small-scale alternatives where state provision is absent. These initiatives demonstrate

that accessible mobility beyond cities is possible when local communities lead[8]. In Bogota, subsidized transport passes for persons with psychosocial disabilities have enabled access to education, work and civic life, illustrating how policy shifts grounded in OPD advocacy can produce tangible change[9].

Members also shared that public transport remains overcrowded, unsafe, and stigmatizing for persons with psychosocial disabilities, who often face harassment, discrimination, or outright refusal of service due to several reasons. Specifically In rural areas, the situation is even more dire: transport is scarce, informal, and rarely regulated. Persons with psychosocial disabilities are often unable to travel to schools, workplaces, or healthcare facilities, leading to social and economic isolation. Members from African contexts noted that in many rural regions, the lack of paved roads or reliable bus services effectively excludes persons with disabilities from community life altogether.

Air and railway travel also pose barriers. Members from Sri Lanka, and Pakistan highlighted that airlines and railway companies often require disability certificates for travelling in airlines and railways, which mostly persons with psychosocial disabilities do not have access to. Such discriminatory practices reinforce stereotypes of incapacity and deny equal access to mobility. Maritime transport is similarly inaccessible, with no reasonable accommodations or accessible communication for persons with psychosocial disabilities.

5. Are point-to-point and demand-responsive transport services (e.g., accessible taxis, paratransit) available? If so, what has been their impact?

Point-to-point and demand-responsive services are still absent in many low income countries, and are limited to developing and developed countries. In some countries, pilot initiatives such as accessible taxi fleets or subsidized paratransit services have been introduced through public private partnerships and also solely by private companies, but these primarily address the issue of physical accessibility only. Even those available services are priced far beyond the means of most persons with disabilities. The impact of such services has therefore been marginal, reaching only a small fraction of the population.

Where they exist, these services are prohibitively expensive for everyone. Persons with psychosocial disabilities are mostly living in poverty, confined to institutions and muddled in asylums for decades, financially controlled by their own family members or other guardians, have no access to disability related social protection, no access to employment or livelihood opportunities, leaving them to live in poverty. Members shared that they have been dependent on their families, communities, peers, friends, for accessing transportation and for their personal mobility.

Some members did report that governments, in certain contexts, provide near-full subsidies, enabling persons with psychosocial disabilities to access these services. However, as the example of Taiwan's paratransit system illustrates, more than 63% of trips are for medical purposes, indicating that service structures remain centered on healthcare while neglecting broader social inclusion.

6. What training is provided to transport personnel to ensure accessible, dignified service?

Training for transport personnel remains minimal and inconsistent, and rarely involves persons with

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[8] Improving paratransit service: Lessons from inter-city matatu cooperatives in Kenya https://trid.trb.org/View/1437018

[9] Increased ridership and improved affordability: Transforming public transport subsidies in developing contexts https://www.sciencedirect.com/science/article/pii/S0739885924000878

psychosocial disabilities, leaving little understanding of our realities and needs. Reports from South Asia and Africa show that transport staff often refuse entry to people perceived as “mentally ill,” treat them with suspicion or hostility, and in some cases forcibly remove them from buses or trains. In Taiwan, such discrimination is reflected in the widespread “surveil–refuse–report” mechanism: control centers identify passengers deemed “mentally abnormal” via CCTV and dispatch staff to follow them; once “abnormal behavior” is judged, service is denied and MRT or local police are notified. Framed as safety, these appearance- and behavior-based procedures and trainings amount to differential treatment and restrictions on liberty, violating CRPD Article 5 (equality and non-discrimination) and Article 9 (accessibility).

Accordingly, UN human rights mechanisms, civil society, and national governments must ensure that organizations of persons with psychosocial disabilities (DPOs), with adequate resources, lead or co-design comprehensive rights-based training programs. Core components should include reasonable accommodation, respectful communication, and scenario-based conflict response exercises, all grounded in lived experience, to replace current neglectful or exclusionary practices and ensure transport services are genuinely accessible with dignity.

7. What indicators or monitoring mechanisms are used to assess the accessibility and inclusiveness of transport systems?

Monitoring mechanisms for transport accessibility are weak or nonexistent in most countries. Where indicators exist, they are limited to counting ramps or elevators, without evaluating whether services are actually inclusive and unstable for persons with psychosocial disabilities. Members reported that official accessibility audits often exclude OPDs of persons with psychosocial disabilities from the processes, leading to reports that present an inflated picture of compliance while lived realities remain unchanged.

For example, in several South Asian contexts, government reports claimed progress in transport accessibility based on infrastructure upgrades, while persons with psychosocial disabilities continued to face barriers such as denial of service, lack of accessible information, and absence of reasonable accommodations. Similarly, in African countries, monitoring frameworks do not disaggregate data by type of disability, masking the exclusion of those with invisible disabilities such as psychosocial or cognitive impairments.

The UK’s monitoring systems have not corrected persistent failings. Japan counts accessible stations but not user experience. Malaysia focuses on infrastructure numbers, without indicators on dignity, predictability or psychosocial inclusion.

Across all regions, physical accessibility has advanced but there has been not debate on what could be psychosocial accessibility that needs to be incorporated while designing infrastructure. Urban systems are more developed than rural or long-distance services, demand-responsive transport is fragmented, training is inconsistent, and monitoring captures outputs rather than outcomes. The result is that States can claim progress while persons with psychosocial disabilities continue to face barriers in mobility and autonomy.

To align with CRPD obligations, monitoring mechanisms must be participatory, rights-based, and include disaggregated data collection. OPDs must be directly involved in setting indicators, conducting audits, and ensuring accountability.

Section 3 - Accessible and Inclusive Housing

8. What actions have been taken to increase the availability and accessibility of housing for persons with disabilities?

Persons with psychosocial disabilities are denied the right to access inclusive and accessible housing. They are mostly confined to social care institutions in the name of care and homes such as, group homes, half-way homes, rehabilitation homes, homes in the name of care and independent living, leaving persons with psychosocial disabilities isolated and confined from mainstream community.

Since the 20 years of the CRPD there have been very few efforts from the states to promote community living and promote deinstitutionalization practices. Despite lack of support from states and donors, TCI members across the global south have been working in their grassroots communities to promote housing opportunities within mainstream for persons with psychosocial disabilities by running different community inclusion and community support programs. As persons with psychosocial disabilities lack support from states and CSOs, these efforts have been limited to some grassroots communities based on the support organized by local OPDs of persons with psychosocial disabilities.

TCI has been promoting community inclusion and community support programs of its members by providing platforms for advocacy and referencing them at national, regional and global policy spaces. TCI also contributed to the co-development of the deinstitutionalization guidelines that refers to inclusive housing in mainstream communities for persons with disabilities zillion times, and also has a full section on accessible housing for guiding states parties to promote community living for persons with disabilities, including those living with psychosocial disabilities.[10]

Members from Sri Lanka highlighted that post-disaster housing schemes typically channel resources into institutional facilities, such as “rehabilitation homes” or group care centers, rather than providing individualized housing solutions. We have mostly heard this from our members in several countries including Sri Lanka that reconstruction funds after floods and tsunamis have been used to refurbish or expand psychiatric institutions, reinforcing segregation. Members from Kenya reported that poverty and lack of social protection schemes mean that many persons with psychosocial disabilities remain homeless or dependent on families in precarious living conditions.

Involuntary hospitalization not only removes people from their housing and social networks; in some jurisdictions, records of such admissions are entered into judicial or administrative files, indirectly affecting rental credit screening. In practice, landlords often invoke “safety” or “neighborhood concerns”—or other unrelated reasons—to pressure tenants into “voluntarily” ending leases. During hospitalization, restricted external contact makes lease termination more likely, while personal belongings may be treated as “encroachment” and cleared, and in some cases even considered criminal trespass (as reported by members in Taiwan). In East Asian cultural contexts, there have also been cases where a person with a history of involuntary hospitalization died by suicide, and landlords—claiming the property had become a “stigmatized house”—filed civil suits against bereaved families for devaluation and prevailed. These dynamics demonstrate how coercive measures severely erode the right to housing, the right to independent living, and the right to community inclusion of persons with psychosocial disabilities.

Malaysia provides an instructive example. A 1% quota in public housing has allocated close to 1,000 units, but schemes remain oriented towards physical disability. Universal design standards

[10] CRPD/C/5

reference ramps and lifts but not psychosocial requirements such as mediation with neighbors, predictable environments or tenancy security. At the same time, the Destitute Persons Act 1977 has been used to detain thousands, with media reports indicating referrals to psychiatric hospitals. Such practices place custodial models at the center of housing policy.

In the United Kingdom, accessible housing standards exist but remain limited, and supply falls far short of demand. People with psychosocial disabilities face the compounded risks of poverty, insecure tenancies and homelessness. Research indicates that 38% live in poverty, while homelessness is strongly correlated with mental health diagnoses.

In Japan, despite the Barrier-Free Act and anti-discrimination legislation, group homes promoted under community transition policies cannot meet demand, and psychosocial needs such as stable tenancy support or neighbor mediation remain absent.

In Colombia, building codes mandate some physical accessibility but rarely integrate psychosocial or cognitive design. In practice, persons with psychosocial disabilities face exclusion from housing authorities, who treat mental health as outside their mandate. In Kenya, members report that even where subsidies or grants exist, registries exclude psychosocial disability, cutting people off from assistance altogether.

Member from India shared that LGBTQI+ youth and older persons with psychosocial disabilities are at heightened risk of homelessness, and are often subject to systemic discrimination, family rejection, violence, and abuse. In India, the “Garima Greh” initiative was launched as a positive step to provide safe housing for transgender individuals. However, limited underfunding, delays in disbursing grants, and inadequate long-term planning have left many implementing organizations in debt and forced several shelters to close. This illustrates how promising policies, when not adequately resourced or monitored, can fail to deliver on their objectives and leave marginalized groups more vulnerable than before. Furthermore, in conflict-affected areas like Manipur, housing for marginalized groups remains inadequate. During COVID-19, no separate shelters were provided until civil society intervened, and in times of conflict, queer-trans individuals were placed in generic camps without regard for their safety or dignity. This reflects the persistent neglect of intersectional needs in emergency housing responses.

Housing policies must prioritize community-based, affordable, and accessible housing options that allow people to choose where and with whom they live, consistent with Article 19 of the CRPD, even during situations of humanitarian emergencies.

9. How are universal design, house adjustments and reasonable accommodation integrated into housing policies and building regulations?

In practice, specifically in Global South countries universal design is rarely integrated into housing policies or building codes. Where accessibility standards exist, they are limited to physical adaptations, to cater for the needs of persons with physical, visual and hearing disabilities. Some policies do consider the needs of intellectual and psychosocial disabilities, but remain very limited.
Members specifically from the global south reported that state parties have failed in reflecting community living, support systems, housing adjustments and reasonable accommodations for persons with psychosocial disabilities in national policies. In many contexts, psychosocial disability is not recognized as requiring accommodations at all. For example, in several South Asian countries, housing authorities assume that “mental health” is only a medical matter, and therefore do not consider inclusive housing as part of their mandate. We have also heard from our members that we have to prove that we are not harmful, are stable and non violent to have access to right to

housing[11]. Members observed that while building codes may mandate physical accessibility, there is little awareness of universal design as a holistic principle covering psychosocial support and inclusion.

10. Are there housing programmes or financial mechanisms (e.g., subsidies, grants) specifically supporting independent living for persons with disabilities?

Across many member countries, persons with psychosocial disabilities reported that very few housing programs or financial mechanisms are specifically designed to support independent living in line with Article 19 of the CRPD. Instead, financial resources are often channeled towards institutional models — such as modernizing mental health laws, and making services better for persons with psychosocial disabilities in psychiatric hospitals, "rehabilitation homes," social care institutions, and group homes — under the guise of housing or social protection.

The UN Guidelines on Deinstitutionalization, including in emergencies (CRPD/C/5) emphasize that measures such as renovating institutions, expanding beds, or replacing large institutions with smaller custodial models are not compliant with UNCRPD. Yet, members highlighted that disaster recovery and poverty alleviation funds are frequently misused in this way. For example, in South Asia, reconstruction programs after floods and tsunamis invested in modernized institutional facilities rather than community-based housing options. In African contexts, subsidies were provided for families or institutions to "care for" persons with psychosocial disabilities, but without direct entitlements to individuals themselves, thereby reinforcing dependency and segregation.

Few contexts provide direct financial support to persons with psychosocial disabilities for independent living. Members noted that where subsidies or grants exist, they are typically linked to family guardianship or custodial arrangements, stripping individuals of autonomy. Access to microcredit, mortgages, or rental subsidies is also denied due to legal incapacity frameworks, leaving many unable to secure housing independently.

At TCI, we have been advocating for redirecting funding and grants away from institutions – towards community support systems for independent living within mainstream communities. Community support can include and is not limited to formal or informal, peer support, neighborhood support, friends circles, circles of care/support groups, etc. We have also been advocating along with our members to address the issue of legal capacity where persons with psychosocial disabilities have direct access to housing allowances, subsidies, and grants, through which they can choose where and with whom to live.

<u>Section 4 – Participation and Governance</u>

11. How are persons with disabilities and their representative organizations involved in the planning, implementation, and evaluation of transport and housing policies?

Participation of persons with disabilities, particularly those with psychosocial disabilities, remains limited, tokenistic, or absent in most contexts. While many states report compliance with Article 4(3) of the CRPD — the obligation to closely consult and actively involve persons with disabilities in decision-making — in practice, consultation processes are either non-existent or limited to a select group of well-resourced disability organizations.

Members from South Asia and Africa reported that organizations of persons with psychosocial disabilities (OPDs) are routinely excluded from national disability councils, advisory boards, and

[11] TCI Webinar series on DI https://www.youtube.com/watch?v=h33kyHy2brY&t=1276s

housing or transport planning committees. Where invitations are extended, participation is symbolic, with decisions already predetermined.

Where inclusion occurs, it is undermined by inaccessible conditions. Meetings are announced at short notice, conducted in technical language, and fail to provide accommodations such as plain-language materials or peer support. This results in technical inclusion but practical exclusion.

The United Kingdom illustrates these dynamics. OPDs observe that professional groups and non-disabled charities dominate policy discussions. Structural conflicts of interest deepen mistrust: more than 10% of Members of Parliament in the House of Commons and approximately 6% in the House of Lords are private landlords, raising doubts about impartiality in housing policy.

Japan has expanded representation as OPDs in government councils, but housing and transport debates remain dominated by organizations of persons with physical disabilities. Civil society initiatives such as Porque's railway use survey provide valuable evidence, yet remain peripheral without institutionalized channels for input.

Members from Malaysia shared that representation of psychosocial disability in the National Council for Persons with Disabilities is very minimal. Only in 2025, after 17 years of its existence, was an autistic person elected—marking the first direct representation of someone with an identified psychosocial or neurodivergent disability[12]. Yet ministry consultations remain ad hoc, with no standing mechanisms to guarantee consistent engagement of psychosocial disability organizations.

In Taiwan .transport and housing governance, participation remains largely symbolic. The Ministry of Transportation's "Accessible Transport Promotion Task Force" has long involved the same members, Housing policy is institution-oriented, with reforms led by welfare providers rather than DPOs, sidelining independent living needs. Overall, consultation under Article 4 has been superficial, failing to ensure co-decision-making, thereby perpetuating medicalized and institutional approaches and falling short of Article 19 on the right to live in the community.

Evaluation processes display the most acute deficits. Monitoring is typically led by governments or consultants, with disability organizations restricted to validating findings rather than shaping them. Indicators focus on outputs of ramps, lifts, and tactile paving, while psychosocial barriers such as stigma, denial of service, and lack of accommodations are invisible. Official reports in South Asia claim accessibility gains that diverge from the daily realities of exclusion. African members note donor-driven evaluations measuring outputs rather than rights. Where psychosocial disability organizations have participated, they identified critical barriers such as harassment on transport and invisibility in housing schemes, but such opportunities remain rare and underfunded.

The prevailing pattern is clear: governance mechanisms on housing and transport exclude the voices of persons with psychosocial disabilities. Consultation is symbolic, evaluation detached from lived experience, and grassroots organizations left without resources to participate. Without systemic change, policies will continue to be designed and monitored without the knowledge of those most affected.

<u>Section 5- Data and Evaluation</u>

12. What data is collected on accessibility in transport and housing? Are these data disaggregated by disability and other factors?

[12] https://www.facebook.com/share/p/1BJBr1HPWB/

13. How is the impact of policies and practices on the participation of persons with disabilities evaluated?

For decades, persons with psychosocial disabilities have been fighting for their identity, right to live in mainstream communities rather than institutions, and right to legal capacity. They are known as under-represented groups, who also face exclusion while accessing disability movement spaces. Hence, there has not been much evidence available. States routinely present registries or infrastructure audits as evidence of progress, yet these datasets erase the experiences of persons with psychosocial disabilities.

In the United Kingdom, numerous transport and housing datasets exist—the National Travel Survey, Accessible Housing Registers, or Rail Data Marketplace—but they remain fragmented, inconsistent, and detached from lived realities. Japan counts accessible stations and new housing stock but does not disaggregate by disability type, gender or socio-economic status. Malaysia reports 756,681 registered persons with disabilities as of 2024, yet transport and housing data is reduced to infrastructure counts or cardholder numbers. Psychosocial accessibility is nowhere in these records. Even the Washington Group Questions are designed from the medical perspective, and count persons with disabilities through questions related to anxiety, depression or memory, instead of participation in communities and barriers faced. This practice entrenches undercounting and distorts national priorities, as budgets and service delivery are tethered to flawed figures.

Section 6 - Good practices

14. Please share examples of good practices, pilot initiatives or scalable programs in transport, particularly point-to-point transport and housing accessibility and adjustments.

15. What were the key factors for their success, and what lessons can be learned for replication or adaptation?

In the United Kingdom, Transport for All's campaign prevented the closure of rail ticket offices, building alliances not only with OPDs but with trade unions and parliamentarians as a move which would have had a serious impact not only on the ability of persons with disabilities to purchase tickets, but on access to necessary support at stations. In Japan, Porque's survey of railway users with psychosocial disabilities revealed how overstimulation—crowding, noise, lighting—deters people from using trains. Its recommendations for quiet spaces, staff training, and recognition of invisible disabilities have shifted policy debates.

Malaysia has piloted a range of initiatives, from the OKU SMILE Pass providing free urban transport, to Urbanize inclusive city design projects introducing calm and prayer rooms, to audits by SUHAKAM that prompted overdue safety reforms after transport fatalities. Civil society organizations such as MIASA have opened peer-led clubhouses and helplines, broadening support beyond hospitals. While fragmented, these efforts reflect a growing recognition that accessibility must extend beyond ramps to psychosocial inclusion.

Common features underpin these successes: leadership by organizations of persons with disabilities, framing access as a right rather than charity, affordability, and community ownership. Their fragility is also telling: they succeed when embedded in law and policy, and falter when left as isolated pilots. The lesson is clear: accessibility in housing and transport must be legislated, financed as entitlement, and monitored with the participation of those whose lives depend on it.

Section 7 - Integration with care and support systems

16. How do policies and practices in transport and housing interact with or complement comprehensive care and support systems aimed at enabling independent living and community inclusion?

Housing and transport policies will only complement care and support systems when they are framed not as extensions of medicalized services, but as infrastructure for community inclusion—where "care" is reclaimed as solidarity and connection, and "support" is individualized, rights-based, and led by persons with disabilities themselves.

In the disability rights context, community inclusion has often been treated as an abstract value or aspiration, rather than as something practical to be systematically embedded into programs, policies, and community development. Many practitioners claim to be "inclusive," yet there is little shared understanding, evidence, or practice-based resources to demonstrate what inclusion truly looks like. Too often, medical professionals continue to equate inclusion with treatment or institutionalization, assuming these will "cure" a person and prepare them for the mainstream. Similarly, providing services is frequently mistaken for inclusion, though this represents only a partial step. Legal barriers that exclude persons with psychosocial disabilities are rarely acknowledged as central to inclusion, when in fact they are.

The CRPD expanded definition of inclusion by recognizing the right of all persons with disabilities to live independently and be included in the community (Article 19). This article makes clear that inclusion is not only about services, but about full and equal participation in everyday life. Persons with disabilities must have the right to choose where and with whom they live; institutions such as asylums, rehabilitation centers, or halfway homes cannot be considered genuine "residences." Services must be provided in and around communities including housing and transportation, ensuring access to both mainstream and disability-specific supports, reflecting the diversity of needs.

CRPD's General Comment No. 5 emphasizes that resources have historically been directed into institutions rather than into building community-based options. This has led to dependency, abandonment, and segregation. The UN Guidelines on Deinstitutionalization go further, calling for legal and policy reforms to dismantle institutional frameworks, alongside investments in accessible community services, peer-led supports, and inclusive systems.

In this way, community inclusion is not a vague aspiration but a concrete rights-based framework: it requires enabling legal environments, accessible mainstream and disability-specific services, and the strengthening of community support systems.

Through over a decade of work in the Asia-Pacific, supporting some of the largest community inclusion and psychosocial support programs in the Global South, specifically the Seher program of Bapu Trust in India[13], TCI has learned that the journey to genuine community inclusion requires a series of interconnected actions that must be backed by governments.

First, persons with psychosocial and multiple disabilities must have equal access to mainstream services such as health care, education, housing, skill development, food, and nutrition. Alongside this, governments must guarantee community-based supports including social protection schemes, pensions, disability identity cards, election and national IDs, personal assistance, and other entitlements that enable participation on an equal basis.

[13] Seher program of Bapu Trust https://baputrust.com/seher-inclusion-program/

Community inclusion also demands more than service transformation—it requires the dismantling of legal and institutional systems rooted in mental health and disability-based segregation. This means actively preventing and reversing institutionalization by tearing down the legal, financial, human resource, and physical infrastructures that sustain custodial cultures.

Equally critical is the removal of legal, social, and attitudinal barriers that obstruct community life. This includes repealing incapacity provisions, abolishing discriminatory mental health laws, prohibiting the bundling of socioeconomic benefits with medical compliance, and ending gatekeeping practices that deny decision-making rights.

At the same time, inclusion is sustained by the natural capacities of communities themselves. Families, neighborhoods, and collective networks provide care and support through trust, reciprocity, and negotiation. These community processes must be valued and protected, not interrupted by restrictive laws or coercive services.

Finally, governments must act as enablers—removing barriers, eliminating discriminatory practices, and redirecting resources away from institutions and toward systems that strengthen community life. Only through these fundamental shifts can persons with psychosocial disabilities enjoy uninterrupted lives of dignity, independence, and inclusion.

Concluding

The findings gathered from TCI members across regions reveal a striking contradiction. Housing and transport policies are presented as vehicles of inclusion, yet in practice they often function as instruments of segregation. Subsidies are diverted into rehabilitation homes, disaster relief is channeled to psychiatric institutions, and shuttle services are earmarked for custodial centers rather than accessible public networks. The result is that the very systems that should enable participation entrench dependency.

For persons with psychosocial disabilities, the consequences are visible in the data. Globally, between 30 and 40 percent of people experiencing homelessness who experience a psychosocial disability, and in some Western contexts the proportion rises to over 70 percent when combined with substance use diagnoses. In the United Kingdom, 82 percent of people experiencing homelessness carry a mental health diagnosis, while in Malaysia, nearly 8,000 people were detained under the Destitute Persons Act between 2021 and 2025, some referred to long-stay psychiatric hospitals such as Hospital Bahagia. These are not isolated figures but markers of systemic exclusion, showing how the absence of community-based housing and accessible transport feeds directly into cycles of poverty, institutionalization, and premature death.

The evidence points to a way forward. Housing and transport must be understood not as neutral infrastructure but as integral to care and support systems that make independent living possible. This requires reform of discriminatory laws that strip people of their legal agency, recognition of psychosocial disability within housing and transport mandates, and enforceable legislation that makes access to these systems justiciable. It also requires a redefinition of accessibility. Success cannot be measured in lifts and ramps alone, but must consider predictability, dignity, safety, and the removal of psychosocial barriers. Training for transport personnel and urban planners must be mandatory and co-designed with organizations of persons with disabilities to ensure that hidden disabilities are addressed alongside visible ones.

Equally essential is the shift from symbolic to substantive participation. Organizations of persons

with psychosocial disabilities must be resourced and empowered to shape planning, implementation, and evaluation. Without their leadership, consultation risks being a hollow ritual and evaluation a paper exercise. Data systems too must be transformed, moving beyond registries and infrastructure counts to disaggregated, rights-based indicators that capture lived experience.

Good practices demonstrate what is possible. Subsidized transport passes in Latin America opened paths to work and education; grassroots advocacy in Sri Lanka prevented disaster funds from being used to expand psychiatric institutions; and in Malaysia, audits by SUHAKAM after transport fatalities forced long-overdue safety reforms. Each of these examples shows that when persons with psychosocial disabilities and their organizations lead, rights are made real. The challenge now is to embed these practices into law and national policy, so they are not isolated victories but structural guarantees.

The conclusion is unambiguous. Without systemic reform, housing and transport will remain part of the machinery of segregation. With reform, grounded in rights and designed with those most affected, they can become the very foundation of community inclusion. The recommendation is therefore simple but urgent: States must stop treating housing and transport as infrastructure alone and instead integrate them fully into the architecture of independent living. This means funding them as entitlements, legislating them as rights, and monitoring them through the voices of those whose autonomy and dignity are at stake. Only then will the promise of the CRPD be realized for persons with psychosocial disabilities.

Recommendations

First and foremost, all legal incapacity laws such as mental health laws, and guardianship laws must be abolished. Guardianship and incapacity regimes still prevent persons with psychosocial disabilities from signing tenancy agreements, accessing subsidies, concessions, social protection or even buying transport tickets in their own name. Persons with psychosocial disabilities should be recognized and identified, as persons with disabilities as defined by the CRPD, and not with identities which are most discriminated in society. In line with Article 12 of the CRPD and the Committee's jurisprudence, States should establish supported decision-making frameworks so that persons with psychosocial disabilities can exercise control over where they live and how they travel.

Equally important is the way public funds are directed. Evidence from TCI members shows that housing and other budgets are frequently used to renovate or expand custodial institutions, often under the guise of social housing or rehabilitation. This is in direct contradiction to Article 19 of the CRPD, General Comment No. 5, and the 2022 UN Guidelines on Deinstitutionalization, all of which advocate against investing in institutions or any segregated care facilities. States must therefore reinforce and allocate resources into accessible, affordable, and community-based housing options by ensuring persons with psychosocial disabilities have access to formal/informal support systems and services, including but not limited to, personal assistance, reasonable accommodation, and peer-led support services that make independent living possible. Any housing and reconstruction schemes must explicitly prohibit reinvestment in institutional beds, or modernizing mental health systems and instead prioritize inclusive housing that supports equal participation.

Public and private transport systems must be designed considering the accessibility needs of persons with psychosocial disabilities. The authorities must consider and monitor that persons with psychosocial disabilities are not discriminated, stigmatized, have dignity and autonomy while accessing services, and have access to all legitimate information. To comply with Article 9 of the CRPD, all indicators for psychosocial accessibility should be mainstreamed into transport audits and procurement processes, ensuring that buses, trains, ferries, and rural paratransit systems are

designed and operated in ways that respect the rights and dignity of persons with psychosocial disabilities.

Most importantly, the participation of persons with psychosocial disabilities and their representative organizations must be institutionalized in all housing and transport decision-making processes. In many countries, OPDs of persons with psychosocial disabilities don't exist, and in some countries, the OPD networks are still working with medical perspectives. States and CSOs working on Disability Inclusive Development must ensure that networks and OPDs of persons with psychosocial disabilities are established, strengthened with knowledge, and are included in designing services, procurement processes, accessibility audit exercises, and shaping policies for inclusive housing and transportation.

To promote independent living, financial mechanisms must be individualized and accessible to all persons with psychosocial disabilities. Subsidies, concessions, pensions, funds, and grants should not be tied to custodial settings or guardianship arrangements. Instead, states must ensure that persons with psychosocial disabilities have access to income generation opportunities, state benefits including social protection, housing and transportation allowances, disability related benefits etc. to support access to housing, transport passes, and other support systems and services, according to their own will and preferences.

Persons with psychosocial disabilities are not reflected in budgets, planning, and programs as they remain uncounted and unrecognized. Article 31 of the CRPD obliges state parties to ensure that all persons with disabilities are counted and are visible in national statistics, specifically while assessing statistics on housing and transportation. Governments must adapt tools that are inclusive and qualitative. Monitoring frameworks must track not only the number of accessible housing units or transport services, but also whether persons with psychosocial disabilities can use them without discrimination. Participatory audits with OPDs should be made a routine part of accountability systems.

Finally, frontline staff—whether in transport services, housing offices, or emergency response—play a decisive role in either enabling or denying access. Mandatory, recurring trainings, community awareness, and stakeholders sensitization are designed and delivered with OPDs; therefore, they should be built into the professional development of all relevant personnel. These trainings must be backed by complaint mechanisms that are accessible to persons with psychosocial disabilities and ensure redress when rights are violated.