Organization: Transforming Communities for Inclusion (TCI Global)
Contribution to the draft Guidelines on disability-based violence

TCI *is a global, membership-based organization of persons with psychosocial disabilities (OPD) with 28 members from 21 countries. TCI forecasts a future in which all human rights and full freedoms of persons with psychosocial disabilities are realized and we are guided by the extraordinary vision of the CRPD.*

We commend the Committee's efforts to give visibility to this crucial issue for persons with disabilities, particularly persons with psychosocial disabilities. We also recognize the considerable effort involved in collating and analyzing the responses and producing the draft Guidelines given all constraints. We appreciate the Committee's commitment to engaging persons with psychosocial disabilities and their representative organizations in the process, including by inviting OPDs to provide initial comments on the draft, participate during in-person consultation and respond to the current call for inputs. TCI also appreciates being a part of this important process and has already highlighted several issues of relevance to our constituency, including psychiatric violence, exclusion from climate change and humanitarian contexts, concerns around care agenda, institutionalization, coercion and the denial of legal capacity. We are now submitting further comments and feedback based on consultation with our members. TCI remains available to support the Committee in the next steps of this process, drawing on the rich knowledge, experience and expertise of our strong and diverse membership.

Feedback on the Consultation Process and Methodology

As a suggestion for the process, we would point out that the process of asking for survey responses and basing the Guidelines on those responses is not robust enough. This may inadvertently lead to many forms of violence or different constituencies (such as autistic or neurodivergent communities) being left out due to not being recorded through the survey, or individuals not being able to fill up the survey on time or accessibility issues with online portal. We would highly recommend if this process could add additional component of research, evidence collection from different sectors, utilize different modalities for submitting inputs and conduct policy and legal consultations.

As a forward-looking suggestion, subsequent drafts should also be open for public consultation, so that the Guidelines are grounded not only in survivor's experiences but also in their leadership. We respectfully suggest that the Committee consider publishing an updated draft at its upcoming 35th session and holding a wider and more inclusive consultation before its 36th session.

The collection of responses through a survey for a critical and sensitive topic like this was experienced as harmful by some peers. The questions required people to revisit their worst moments or traumatic experiences, and some peers needed support after completing the survey or accessing it. The lack of accessible, trauma informed support mechanisms available along with the survey was therefore concerning. For future processes, clear information, more accessible formats for inputs, options to pause, and appropriate peer or psychosocial support before, during and after participation should be made available.

Feedback on conceptual clarity and implementation gaps

In their current form, the Guidelines can be at best utilized as a public awareness tool to give visibility to the issue of disability-based violence, or a pedagogical tool. However, it needs stronger normative definitions and more mandatory requirements for the States to be used as a tool for strategic litigation and to hold States accountable.

The concept of disability-based violence should be broad enough to include structural, systemic, institutional, psychiatric, relational and epistemic forms of violence, while remaining sufficiently precise to support legal, policy, monitoring, accountability and reparation measures.

The Guidelines tends to use structural, systemic and systematic discrimination interchangeably, which may not be helpful, and create barriers for persons with disabilities, if they wish to use these for their advocacy in their regions. The Guidelines will benefit from conceptual clarity to be added to these terms, especially when they are being used for the first time, and then to use them uniformly throughout the text.

The Guidelines do not yet adequately reflect gender diversity. While they rightly give attention to violence experienced by women and girls with disabilities, they should also recognize that transgender, non-binary and other gender-diverse persons with disabilities may face distinct forms of violence, including pathologization, denial of identity, coercive treatment and heightened risks in institutions and detention settings. A stronger intersectional approach is needed so that these experiences are not overlooked or treated as the same.

The Guidelines should more explicitly reflect Global South realities, including contexts where independent monitoring systems are weak or absent, private and informal institutions are unregulated, community-based supports and services are under-resourced, and persons with psychosocial disabilities remain outside effective protection systems. Without such recognition, implementation may be limited to contexts that already have stronger monitoring and accountability infrastructure.

In their current form, the recommendations are not sufficiently concrete for implementation or accountability. They risk reading as a general request to implement the Convention rather than as practical guidance to States parties. The recommendations should include clearer obligations-based language, concrete measures, examples of legislative and policy approaches, timelines, monitoring responsibilities, and guidance for implementation by States, OPDs, monitoring bodies, justice actors and service providers.

The Guidelines strongly address the legal, policy and institutional dimensions of disability-based violence, but they should more clearly analyze violence as an exercise of power within relationships. Unequal relationships with family members, professionals, support providers, guardians, police and institutional staff can produce control, dependency, surveillance, intimidation, withdrawal of support and fear of retaliation. These relational dynamics may themselves constitute violence and enable more visible forms of coercion and abuse.

TCI also appreciates that the Committee is developing Guidelines on disability-based violence and both Guidelines on intersectional discrimination. Given the close relationship between these two processes, we suggest that the two documents should cross-reference and reinforce each other, while maintaining conceptual clarity between discrimination and violence. This is important to avoid confusion in implementation, advocacy and accountability. While intersectional discrimination may create the conditions for violence, enable impunity, or itself amount to violence in certain circumstances, not every discriminatory act will necessarily meet the threshold of violence. The Guidelines should therefore clarify the relationship between intersectional discrimination, disability-based violence, abuse and ill-treatment, and ensure that both documents provide coherent and mutually reinforcing guidance to States parties, OPDs, monitoring bodies and justice actors. We have also provided the same comment on the other set of guidelines.

Specific comments on the Guidelines text:

Comment on paragraph 1: We would recommend covering and expanding on the definition of disability-based violence in paragraph 1 itself. This would ensure there is legal clarity and political direction at the outset of the Guidelines.

- The definition should explicitly name psychiatric violence in the form of involuntary committal, forced treatment, physical or chemical restraints, formal or informal guardianship, substitute decision making, coercion, paternalism and institutionalization in the definition. Without a clear definition in paragraph 1, States and institutions may exploit ambiguity to exclude psychiatric violence from the scope of the Guidelines.
- Disability-based violence should explicitly include violence based on perceived disability. This includes persons perceived as having psychosocial disabilities, persons labelled as having mental disorders, illness or 'unsound mind', and persons labelled as drug users, where violence is linked to such perception or labelling.

Comment on paragraph 14: The conceptualization of disability-based violence should clarify whether 'acts or omissions that result in harm of suffering' also includes state's own failures to provide necessary support or reasonable accommodation or to prevent, investigate and respond to violence. Although we understand that this has been also covered under section D (Obligations related to non-State actors), however such definitions and clarifications are needed at the beginning of the Guidelines to avoid any ambiguity. Additionally, as this is the foundational section/s of the Guidelines, it is important to enlist at least some key 'societal value systems and ideologies' that enable and perpetuate such violence.

Consider the following edits (in yellow): Acts or omissions, including failure by State Parties to provide necessary support or reasonable accommodation or prevent, investigate or respond to violence, that cause, enable or perpetuate harm or suffering….. Disability-based violence occurs in private and in public dimensions of life, with or without individual intent, where harm is inherent in societal structures or social practices, and it is perpetuated because of societal value systems or ideologies such as ableism, sanism, eugenics, medical model of disability and other intersecting systems of oppression…

Comment on paragraph 16: It is extremely important to add psychiatric violence in the list of types of violence expanded under this paragraph.

Comment on paragraph 19: The stated paragraph mentions disability-based violence as an everyday experience for persons with disabilities but follows up with explaining the life course experience of violence. This paragraph can be strengthened by elaborating on what forms of everyday discrimination such as being excluded, not believed, labelled, monitored, controlled etc. can themselves be forms of violence when they cause harm, fear, deprivation or loss of

autonomy. In other cases, they may create conditions in which violence can be enabled, promoted or perpetuated. It will also be pertinent here to make a distinction that not every act of discrimination is a form of violence in itself, and a threshold could be defined to do this.

Consider adding or revising the following: Everyday discriminatory practices such as social exclusion, diagnostic labelling, loss of credibility, surveillance, family rejection, employment and housing discrimination, and chronic fear of intervention may themselves constitute disability-based violence where, individually or cumulatively, they cause or foreseeably result in physical, psychological, sexual, economic, relational or epistemic harm, coercion, deprivation, fear or loss of autonomy. Other discriminatory practices may not themselves amount to violence but may create dependency, isolation and impunity that enable violence to occur.

Comment on paragraph 20: Along with ableism, sanism should be clearly named, as it is a specific ideological framework that makes suspension of rights for persons with psychosocial disabilities appear legitimate. In addition to that, stereotypes related to incapacity, inability, dangerousness, being violent or risky dictate attitudes, practices and policies against persons with psychosocial disabilities.

Consider adding the following text after the last sentence. For persons with psychosocial disabilities, sanism, medical model of disability and stereotypes related to dangerousness, incapacity, inability, violent or risky justify abuse, neglect, rights violation and violence.

Comment on paragraph 21: This paragraph should mention how eugenics thinking influences or shapes medical or therapeutic approaches. Additionally, multiple medical treatments are based on 'normalization' or 'rehabilitation' and this should also be addressed as disability-based violence, as they start from the assumption that there is something 'abnormal' to be fixed within minds and bodies of persons with disabilities.

Consider the following edits: Likewise, eugenics thinking shapes and influences medical and therapeutic approaches towards persons with disabilities heighten disability-based violence. ~~Prevalent concepts, such as T~~therapeutic need, medical necessity, and 'best interest' as well as treatments that are aimed at 'normalizing' or 'rehabilitation' are grounds that prompt disability-based coercive measures..

Comment on paragraph 24: The Guidelines must utilize this opportunity to strengthen the connection with the Convention Against Torture (CAT), by expressly recognizing that certain forms of disability-based violence, including psychiatric violence, may amount to torture or other cruel, inhuman or degrading treatment. Failure to recognize and investigate such practices within the anti-torture framework may weaken accountability. Moreover, the Guidelines should consciously attempt to clarify relationship between violence, abuse and

ill-treatment to keep the conceptual clarity and retain its normative and analytical significance.

Comment on section B (Social systems underpinning disability-based violence): This section does not adequately name or analyze the broader social systems and ideologies that produce and legitimate disability-based violence. We would strongly encourage this section to distinguish social systems from settings and types of violence to explain how these systems interact to create, normalize and conceal disability-based violence.

Comment on paragraph 26: While we appreciate that paragraph on denial of legal capacity addresses forced sterilization as a form of violence perpetrated against women and girls with disabilities, we would suggest expanding the scope of the harms of substituted decision making among various aspects of life. Denial of decision-making affects where we choose to live, who we live with, who we marry, if we want children, or if we can have custody of our children, how we manage our finances or property, which service we access, what we eat or wear or want to go etc. This would give a clear and broad picture of the consequences of denying legal capacity to persons with disabilities.

If forced sterilization has been mentioned here with a rationale, we would suggest expanding the scope to violation of all reproductive choices and bodily autonomy and refer to eugenics thinking and paternalism as the social system underpinning such practices. The healthcare sections elaborate on these, and that should be central to the Guidelines. Additionally, it should also recognize that disability discrimination intersects with patriarchy, heteronormativity and pathologization of transgender persons, including through diagnosis of gender dysphoria, barriers to abortion, cis-sexism etc.

Comment on paragraph 27: Institutionalization is a form of disability-based violence, and has been named as such in paragraph 28. However, in paragraph 27, it refers to institutions as the location where the violence occurs. The Guidelines should avoid this inconsistency in framing and ensure that institutionalization is first and foremost identified as a form of disability based violence, while also recognizing the additional forms of violence that occurs in institutional settings.

Consider the following edits: Disability-based violence occurs in the context of public and private services and settings. ~~, such as institutions.~~

Comment on paragraph 28: In the context of service providers, the Guidelines should explicitly state that these can be public or private, profit or non-profit, and that they should be held responsible for a) running institutions and b) for all forms of disability-based violence occurring within them. Also, for this name the social system of sanism, medical model of disability and psychiatric dominance.

Consider the following edit: Service providers, including public and private actors operating institutions for profit or non-profit can be held responsible for running institutions and for ~~incur in responsibility because of the~~ concomitant forms of disability-based violence commonly affecting persons with disabilities...

Comment on paragraph 32 (a): We will recommend adding the following to the first sentence:

(a)Tolerance and normalization of disability-based violence in legislation, policies, and practices purportedly for the purposes of care, treatment, risk management and protection…

Comment on paragraph 32 (i): We will recommend adding the following to the first sentence:

Lack of close consultation, active involvement and leadership of persons with disabilities in public decision-making…

Comment on paragraph 32: We would also recommend an additional point under prevalent factors that enable disability-based violence. The Guidelines should mention about deliberate ignorance or devaluation of survivor's led knowledge that is either made invisible or placed lower than professionals or medical knowledge.

Consider the following addition as point (p): Deliberate ignorance and devaluation of survivor led knowledge that is key to developing alternatives to coercive practices. Certain forms of knowledge are placed above others, such as professional or medical knowledge, and such epistemic injustice allows harmful practices to continue, contributes to impunity and sustains disability-based violence.

Comment on paragraph 36: The paragraph mentions 'overmedication' however we would recommend removing the term. In its current formulation, overmedication tends to imply that some level of medication is acceptable, which in turn validates the medical model. The preferable term here is forced medication.

Please consider the following edits: Persons living in institutions may be subjected to neglect, isolation, coercion, forced medication, ~~overmedication~~, verbal and emotional abuse…

Comment on paragraph 37: This paragraph states important facts when it comes to sexual violence reported by persons with disabilities within institutions. However, the Guidelines should clarify that power imbalance, restraints, surveillance etc. are also in themselves forms of disability-based violence, not just causes of the same. Additionally, levels of dependency indirectly treat 'dependency' as a characteristic of persons with disabilities, whereas institutionalization itself creates situation of forced dependency that enables disability-based violence.

Consider the following edits: This violence is enabled by conditions created through institutionalization itself, including ~~are enabled caused by levels of~~ forced dependency, power imbalances..

Comment on paragraph 39: Criminalization and overrepresentation of persons with psychosocial disabilities is covered here. We would further recommend that psychiatric wards in prisons should be named here as well because they show how criminalization and psychiatric coercion overlap, exposing persons with psychosocial disabilities to segregation, forced treatment and other forms of disability-based violence.

Consider the following addition after the last sentence: This includes psychiatric wards and units within prisons, where persons with psychosocial disabilities may experience segregation, forced treatment, restraint, seclusion and other forms of disability-based violence.

Comment on paragraph 61: This section talks about disability-based violence being driven by conceptions of disability as a curse and covers mainly intellectual disabilities. We confirm that these superstitions influence and shape the lives of persons with psychosocial disabilities as well, where we are branded as 'witches', 'curse from God', 'possessed by evil spirits', 'paying our sins from previous lives', 'lacking faith or values', 'immoral or source of shame for family' etc. It is therefore important to explicitly add persons with psychosocial disabilities in this section.

Comment on paragraph 71: This paragraph should further talk about private institutions for drug rehabilitation, and how their unregulated nature obscures prevalence and monitoring of disability-based violence.

Consider the following addition after last sentence: Private 'drug rehabilitation or deaddiction' centres remain unregulated, informal or unregistered hence obscuring the forms and prevalence of disability-based violence occurring within these institutions, along with impeding monitoring, investigating and accountability processes.

Comment on paragraph 77: Along with expanding on denial of sexual and reproductive healthcare services, one significant point is around denying general healthcare to persons with psychosocial disabilities. Even if an individual approaches healthcare settings for a general body checkup, they are usually referred to the psychiatric department owing to their medical history or labelling as 'mental patients'. This is in violation of Article 25 of the CRPD, and we would recommend adding this to the section M (Violence and abuse in health care services and settings).

Comment on paragraph 81: It is important to note along with health professionals, families or care givers also take decisions related to reproductive choice of girls and women with disabilities, and practice substituted decision making.

Comment on paragraphs 85, 86 (Discrimination in medical triage practices and end of life care): We would strongly recommend adding the issues around assisted dying regimes being discussed globally, and their extremely problematic expansion to include persons with 'mental illness' or cases where 'natural death is not reasonably foreseeable'. Such regimes reproduce ableist assumptions that disability involves intolerable suffering or a life of lesser value and hence, uses a false language of 'choice' over focusing on inadequate housing, income, healthcare, supports as the causes for exclusion and discrimination. The Committee itself also raised serious concerns through concluding observations on periodic reports of Canada (CRPD/C/CAN/CO/2-3) and also sent a request pursuant to article 36, paragraph 1 to the government of France asking for clarity on its upcoming assisted dying bill (CRPD/2025/JA/ro).

Consider the following addition as a separate point: Assisted dying laws and practices constitute or enable disability-based violence where disability is treated as a basis for ending life, particularly when persons with disabilities lack access to adequate income, housing, healthcare, personal assistance and community-based support.

Comment on paragraph 112: The text of this paragraph underplays violence that happens within community services, and implies that all community settings are by default, safe. Community based relationships can also be coercive, controlling, compliance-focused or based on substitute decision-making, and community location alone does not guarantee rights respecting support (for example community treatment orders are an example of coercive community-based services; also, families keeping persons with disabilities locked up is another example of disability-based violence in homes and communities).

Consider the following edit: State parties should also ensure that community-based services (in-home, residential, community located) do not reproduce institutional forms of control. Disability-based violence may occur in community-based services where support relationships remain coercive, surveillance based, compliance focused, controlling, or based on substitute decision making.

Comment on paragraph 108: Recovery is framed too narrowly in this section and can also sound patronizing if its limited to rehabilitation and reintegration. The scope of recovery should be expanded to include reconnection with community, restoration of identity and decision making etc.

Consider the following edits: Replace 'including through adopting positive measures towards full inclusion in the community, and measures for ensuring recovery, rehabilitation and social

reintegration in cases of violence' with 'including through healing from trauma and coercion, reconnection with community, cultivating peer and mutual support, rebuilding identity, and restoration of decision making and removal of barriers to full inclusion and belonging in the community.'

Comment on paragraph 114: The reference to gender is too general and does not ensure that reparation responds to the specific gendered harms and consequences of disability-based violence. The Guidelines should therefore require gender-responsive, rather than gender-neutral, redress.

Consider the following addition after last sentence: Reparation should be gender-responsive and should address the specific gendered nature and consequences of disability-based violence, rather than applying gender-neutral forms of redress.

(i) **Comment on paragraph 121:** Along with describing close consultation with persons with disabilities, we would also recommend explicitly including leadership of survivors of disability-based violence in all stages of design, implementation, monitoring of laws, policies and practices.

Consider adding the following edit: States parties should undertake the following measures in close consultation and with the active involvement of persons with disabilities through their representative organizations, which must include leadership of survivors of disability-based violence in designing, implementing and monitoring prevention, protection, investigation, support, reparation and guarantees of non-repetition mechanisms.

(ii) **Comment on paragraph 121:** The Guidelines should clarify that it is not enough for States to adopt laws or policies that mention gender. States must also ensure that it understands its own obligations as gendered and intersectional and implement these laws. Training of all actors (justice, police, healthcare, government) should be done to ensure that they understand its implementation correctly. Training should also address the diverse ways in which survivors with disabilities may communicate, process and disclose experiences of violence. Survivors may provide non-linear accounts, require additional processing time, communicate more effectively in writing, experience shutdown, loss of speech or sensory overload, or display emotional responses that do not conform to expected assumptions about trauma. These differences should not be interpreted as inconsistency, lack of credibility, lack of cooperation or absence of harm.

Consider adding another point to 121: States parties should ensure mandatory and continuous training of judges, police, prosecutors, healthcare workers, social workers and service providers to recognize and address gendered and intersectional forms of disability-based violence. Such training should include the diverse ways in which survivors with disabilities

may communicate and disclose violence, and should ensure that non-linear accounts, additional processing time, written communication, shutdown, loss of speech, sensory overload or unexpected emotional responses are not treated as inconsistency, lack of credibility, lack of cooperation or absence of harm. Reporting and protection mechanisms should provide communication accommodations, sufficient time, sensory-accessible environments and alternative forms of communication based on the person's will and preferences.

(iii) **Comment on paragraph 121:** In its current form, the Guidelines does not describe how disability-based violence should be addressed across different areas of law. The Guidelines should explain whether disability-based violence should be addressed through civil law, criminal law, anti-discrimination law or a comprehensive legal approach.

Comment on paragraph 121 (c): Even if legislations guarantee legal capacity, it is not enough to prevent and eliminate disability-based violence because medical establishments or institutions use their own manuals and protocols that promote or normalize disability-based violence. Hence, it is important to amend or repeal all these Guidelines along with legal reforms.

Consider adding after last sentence: State parties should review, repeal or amend medical manuals, hospital protocols, medical and psychiatric guidelines and institutional procedures that authorize, normalize or enable disability-based violence.

Comment on paragraph 121 (e): The Guidelines does not sufficiently refer to or provide space for various survivor led alternatives and practices to eliminate, abolish coercive responses and provide rights-based support to persons with disabilities. If the subsequent draft is opened for public consultations, the Committee should invite examples of these practices and models that would enrich this discussion by providing real world, grassroot examples of survivor led work.

Consider adding after the last sentence: States parties should provide flexible resourcing and support survivor led and peer led alternatives, including peer support, peer respite, rights-based support during crisis situations, peer response systems, advance directives, and community based non-coercive supports, developed and led by persons with disabilities and their representative organizations.

Comment on paragraph 121 (l): Reparation should compensate past harm, but it should also transform the conditions that allowed the violence to occur. For TCI, we consider full implementation of Article 19 as a form of justice and essential to guarantee non-repetition because it provides conditions for prevention of institutionalization or coercive practices.

Consider adding as an addition point: Implementation of Article 19 should be recognized as a form of justice and a guarantee of non-repetition. The right to live independently and be included in the community, with rights based, individualized and peer led support, is essential to prevent recurrence of institutionalization, segregation, coercion and other forms of disability-based violence.

Consider adding additional points to conclusion:

- Collect, analyze and publish disaggregated data and conduct participatory research on disability-based violence, including violence in private homes, institutions, community services, healthcare settings, justice systems, schools, workplaces, homes or family units, digital spaces and other hidden or under-monitored settings. Data collection and research must be accessible, trauma-informed, survivor-led, and carried out with leadership of persons with disabilities and their representative organizations.

- State Parties must support OPD led political participation, rights education and community mobilization so that persons with disabilities, can recognize disability-based violence, claim their rights, use rights-based tools, and collectively work to prevent and stop disability-based violence in everyday life.