

Convention on the Rights of Persons with Disabilities

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Committee on the Rights of Persons with Disabilities

Guidelines on identifying and addressing disability-based violence*

I. Disability-based violence¹

1. Disability-based violence includes any act, omission, law, policy, custom, practice or social system that results in, or is likely to result in, physical, psychological, sexual, economic, social or bodily or mental harm to persons with disabilities on the basis of disability alone or in combination with other grounds. Disability-based violence may take interpersonal or structural forms, such as coercion in mental health, and may amount to torture or cruel, inhuman or degrading treatment. It may consist of a single act, repeated practices or conditions of deprivation or exclusion.

2. Disability-based violence represents a form of disability-based discrimination that violates the dignity and integrity of the person. Structural forms of discrimination normalize or exacerbate disability-based violence, including harmful practices against women and girls with disabilities.² Disability-based violence is rooted in unequal power relations between persons with disabilities and others. Disability-based violence remains undocumented and underreported although represents a common experience amongst persons with disabilities, in their daily life experiences.³ Violence may start in childhood or when the person acquires an impairment or is perceived to have one and persists throughout life.

3. Disability-based violence encompasses violence perpetrated, facilitated, condoned or legitimised by State authorities, private actors, including service providers or social systems. Some forms of disability-based violence include regimes of institutionalization, forced treatment, psychiatric violence and coercion in mental healthcare and support related violence and harassment, neglect of children with disabilities,⁴ and harmful practices against women and girls with disabilities.⁵

4. Disability-based violence often results in direct or indirect harm for persons with disabilities. It can occur with the intent to commit such violence through deliberate actions or can be the result of harm stemming from social inequalities embedded in discriminatory laws, policies or practices, with or without such intent.⁶

5. **States parties should:**

* Adopted by the Committee at its thirty-fifth session (12–27 August 2026).

¹ This document addresses disability-based violence and its reading may trigger posttraumatic stress. Please consider seeking support for preventing potential impact.

² CRPD/C/GC/6, para. 18 and CRPD/C/GC/3 paras. 17 and 29.

³ Committee's [Survey on Disability-based Violence](#) (2025).

⁴ CRC/C/GC/13, paras. 4, 20 and 21.

⁵ Committee on the Elimination of Discrimination Against Women, [Recommendations and Guidance, September 2022](#), and CRPD/C/GC/3, paras. 36–37.

⁶ CRPD/C/20/3, para. 80.

(a) Recognize and end disability-based violence and eliminate its root causes, including ableism, societal prejudices, and unequal power relations. These duties cannot be deferred by reference to progressive realisation or resource constraints;

(b) Ensure that persons with disabilities are closely consulted and actively involved in all public decision-making processes relating to identifying, addressing and combating disability-based violence;

(c) Collect information on disability-based violence, including violence in institutions, ensuring that data collection is disaggregated by disability and other factors. Data collection should allow identifying patterns of disability-based violence and its root causes and inform policymaking to address it.

II. Purpose and process of these guidelines

6. The document provides guidance to duty-bearers on how to identify, address and end disability-based violence, in line with their obligations under the Convention. The guidelines address violence affecting persons with disabilities, its causes, forms, and barriers in pursuing effective access to justice.

7. The guidelines draw up on 162 Committee's concluding observations its General comments, its Guidelines on liberty and security of the person⁷ and on Deinstitutionalization, including during emergencies⁸ alongside its views on individual communications, and recommendations on inquiry procedures.

8. The process included a [survey on Disability-based violence](#), a technical consultation with stakeholders, and a public call for written submissions.

9. The survey on disability-based violence was available in accessible formats. There were 767 responses describing violence experienced by respondents, their relatives or peers.

10. States parties, National Human Rights Institutions, independent monitoring bodies, regional bodies, research centres, organizations of persons with disabilities, including organizations of survivors of psychiatry, and other civil society organizations provided input.

III. Complex manifestations of disability-based violence

11. Disability-based violence has multidimensional causes and occurs in different contexts

A. Legislation, policies and practices perpetuating violence

12. Legislation, policies and practices, including of customary nature are still anchored in the medical model, protectionist and paternalistic approaches to disability often resulting and justify disability-based violence.⁹ They usually retain discriminatory systems, including guardianship, coercion and exclusion.

13. Guardianship intensifies disability-based violence. Legislation, policies and practices authorizing institutionalization, involuntary committal and forced treatment, forced medication based on actual or perceived impairment, particularly in relation to mental health, which are incompatible with articles 12, 14, 15, 16 and 17 of the Convention also lead to disability-based violence.¹⁰ In such contexts, violence is often purported as care, treatment, protection, discipline or risk management.

⁷ CRPD Bi-annual report (A/72/55, Annex).

⁸ CRPD/C/5.

⁹ CRPD/C/GC/6, para. 3.

¹⁰ CRPD/C/GC/1, para. 42.

14. States parties should ensure that legislation, public policies and practices are anchored on the human rights model of disability and:

(a) Review and reform legislation and policies and repeal those regimes that perpetuate disability-based discrimination, and ensure protection of persons with disabilities against violence and violations of personal integrity, including torture and ill treatment;

(b) End practices that perpetuate detention, forced institutionalisation, forced treatment or other coercive measures on the basis of disability, and repeal or suspend the discriminatory laws, policies, contracts and administrative arrangements that sustain them;

(c) Ensure that anti-discrimination legislation, equality policies and strategies include measures to address all forms of violence against persons with disabilities, including on intersectional grounds in private and public spheres of life.

B. Ableism, stereotypes and prejudices

15. Disability-based violence usually stems from and is justified by ableism and related stigma and stereotypes, the medical model of disability, and the portrayal of persons with disabilities as dangerous to themselves or others.¹¹

16. Ableism, which assumes living a life of value is only possible with certain standards of body or mind, leads to prejudice and violence against persons with disabilities labelling them as incapable, dependent, dangerous, burdensome, or in need of control.¹² Ableism exacerbates discrimination through coercion, overprotection, abuse and neglect against persons with disabilities who are considered not in conformity with expectations of appearance, healthiness, behaviour, decision-making or social participation. The social marking of persons with disabilities further reinforces stereotypes and contributes to the normalization and justification of violence.

17. Superstitions considering impairment as a curse, punishment or karma often lead to killings, abuse, gross neglect, lifelong exclusion from the community and isolation of persons with disabilities, including children with disabilities, persons with psychosocial disabilities and women with hearing impairments.¹³

18. Paternalist and protectionist approaches in society justify and make disability-based violence harder to report or challenging, especially where the person depends on the decision maker, family member, guardian or caregiver for support, housing, communication, survival or access to services.

19. Recalling the Committee's General comment No. 6 (2018), the Committee recommends that States parties ensure inclusive equality and:

(a) Combat ableism, disability stigma, stereotypes, prejudices and practices that create power imbalances and perpetuate discrimination and disability-based violence, together with other intersecting forms of stereotypes, including gender-based discrimination, through policy reforms, training of public officials and service providers, inclusive education, and disability inclusive media guidance;

(b) Eradicate practices of control over the lives of persons with disabilities, including in support interactions;

(c) Ensure that persons with disabilities, including persons with intellectual and persons with psychosocial disabilities, access accessible and age-appropriate information and skills-based education, tailored to their requirements, to recognize

¹¹ A/HRC/43/41, paras. 9, 10, 11.

¹² CRPD/C/GC/8, para. 7.

¹³ CRPD/C/HTI/CO/1, para. 18.

violence, abuse, and exploitation, including forms presented as care, protection or support.

(d) Ensure persons with disabilities are empowered, including through training and strengthening of self-advocacy structures to recognize unsafe situations, understand their rights, identify trusted persons and support services, communicate concerns and seek help through accessible and confidential reporting mechanisms;

(e) Raise awareness and promote accountability of public and private actors for practices that normalize disability-based violence.

C. Violence manifests in multiple contexts

20. Disability-based violence may occur in public or private spheres, or online. The risk and impact of violence against persons with disabilities is exacerbated by social, economic, and cultural factors particularly in contexts where persons with disabilities are isolated or segregated from the community, or where they are marginalized.

21. Violence occurs in environments of everyday life in urban, rural and remote areas, institutional settings,¹⁴ sheltered workshops, places of detention, migration facilities, - internally displacement camps, emergency shelters during humanitarian emergencies and armed conflicts. It also manifests at homes, workplace, public spaces like streets, parks, transportation stations, grocery stores, public or private schools and other educational settings in all levels of education, health care facilities, family settings, and digital space.

22. **States parties should:**

(a) **Adopt a comprehensive approach to eliminate disability-based violence, regardless the place, situation or context where violence manifests;**

(b) **Ensure independent monitoring compliant with the Convention as a mean to identify, prevent and addressing violence against persons with disabilities, in all settings;**

(c) **Ensure that independent complaints mechanisms are available also to persons still in institutions and are not replaced by internal complaint mechanisms.**

23. Persons with disabilities may experience various forms of violence, including on intersectional grounds. Violence consists of a variety of forms and degrees of intensity.

D. Structural or systemic disability-based violence

24. Structural or systemic violence describes a form of violence where laws, policies, and practices cause harm to persons with disabilities. This dimension can be the result of structural and intersectional discrimination embedded in legislation, policies, or practices, grounded in ableism, paternalism, segregation, control, coercion, exclusion or denial of autonomy. Lack of inclusion, support, participation and equal recognition before the law perpetuate violence.

E. Grave or systematic disability-based violence

25. Disability-based violence may amount to grave or systematic violations of the Convention. Grave violations of the Convention include those violations likely to cause substantial harm, including further segregation, isolation or impoverishment, assessed by reference to scale, prevalence, nature and impact, including any permanent or irreparable consequences for the enjoyment of rights. Systematic violence relates to the recurrence, regularity, and continuous and/or organized nature of acts; the improbability of their random occurrence, and diversity of acts of violence. **Legislation, policies and practices which violate the rights of persons with disabilities are often the basis of systematic forms of disability-**

¹⁴ CRPD/C/GC/5 para. 16; CRPD/C/5, paras. 14 and 15.

based violence. Structural patterns of disability-based discrimination often led to systematic disability-based violence.¹⁵

26. The following paragraphs describe the impact of disability-based violence reported to or recorded by the Committee.

F. Disability-based violence amplified by intersectional discrimination

27. The risk of violence increases when disability intersects with other factors such as, race, colour, sex, gender, gender identity or expression, sexual orientation, sex characteristics, language, religion or belief, political or other opinion, national, ethnic, Indigenous or social origin, descent, caste, property, birth, age, socioeconomic status, health status, migration, refugee, asylum-seeking or statelessness status, marital, maternity or parental status, deprivation of liberty, institutionalization, rural, remote or maritime location, and other status. **Persons with disabilities at a higher risk of violence due to intersectional discrimination, include:**

Persons under guardianship

28. Persons with disabilities under guardianship or other substitute decision-making regimes are often subjected to involuntary committal and non-consensual and/or forced treatment, including forced psychiatric interventions, sometimes lifelong. Economic exploitation and control experienced by persons with disabilities also relate to guardianship and inherent power imbalances. Persons with disabilities under guardianship often lack access to effective remedies and justice and are exposed to violence by law enforcement officers.

Survivors of psychiatry

29. Persons who have been diagnosed and treated by the mental health system against their will or without their free and informed consent, or who are perceived by others as ‘mad’ or ‘mentally ill’, face a heightened risk of recurring psychiatric violence and other disability-based violence, discrimination and exclusion, in all areas of life, including, in education, health, work, housing, family relationships, participation, and opportunities for advancement.

Women and girls

30. Women and girls with disabilities experience violence at the intersection of gender and disability-based discrimination.¹⁶ This violence is rooted in the intersection of ableism, patriarchal systems, gender and disability stereotypes and the denial of autonomy, bodily integrity and legal capacity.

31. Gender and disability-based discrimination maintain women and girls with disabilities in subordinate positions compared with others in family, household or the community¹⁷ heightening risks of violence.

32. Intimate partners, relatives and other persons in positions of trust, service providers and authorities can perpetuate gender and disability-based violence.

Denial of sexual and reproductive rights

33. Women and girls with disabilities not only face similar barriers to exercising their sexual and reproductive rights as other women, but also unique barriers and abuses due to the intersection of gender and disability and pervasive stigma and stereotypes. Violations of women’s sexual and reproductive rights may amount to torture or cruel, inhuman or degrading treatment.¹⁸

¹⁵ CRPD/C/MEX/IR/1, para. 33; CRPD/C/HUN/IR/1, para. 108; CRPD/C/20/3, para. 80; CRPD/C/15/4 para. 113.

¹⁶ CEDAW/C/GC/35, paras. 9, 10, 12

¹⁷ [CRPD/C/GC/3](#), paras. 17 (e) and 29.

¹⁸ CEDAW/C/GC/35, paras. 16, 17, 18.

34. The lack of comprehensive sexuality education, including for young girls with disabilities, women with intellectual and with psychosocial disabilities is conducive to disability and gender-based violence.

35. Guardianship aggravates reproductive coercion against women and girls with disabilities, including control of reproductive decisions and access to healthcare. Risks of violence heighten when access to sexual and reproductive information is mediated by family members, who may exercise control over their reproductive choices.

36. Women and girls with disabilities who have experienced sexual violence risk rejection and revictimization if they report it.

Non-consensual or forced sterilization, abortion and contraception

37. Gender and disability-based violence include non-consensual or forced sterilization, non-consensual or forced abortion, non-consensual or forced contraception, female genital mutilation, and forced marriage; as well as the denial of accessible contraception, post-rape care, emergency contraception, HIV post-exposure prophylaxis and maternal health care, and abortion/post-abortion care.

38. Non-consensual or forced sterilization is a normalised practice experienced by girls and young women with disabilities once they reach puberty. It is imposed on men and boys too. Forced sterilization and forced abortion¹⁹ of women with psychosocial disabilities and with intellectual disabilities following institutionalization is a common cause of long-term harm.²⁰

39. Forced abortion is rooted in ableist, patriarchal and eugenic assumptions about disability, reproduction and parenting, and are part of a pattern of reproductive control, assuming that women with disabilities are unfit for motherhood, and parenting, or should be discouraged from reproducing.

40. This violence also includes practices for controlling menstruation, sexuality or development, particularly hormonal treatments to inhibit growth or puberty of girls and young women with intensive support needs, including when imposed without their free and informed consent.²¹

Physical, sexual, psychological, and economic violence

41. Women and girls with disabilities also experience violence in the form of physical, sexual and intimate partner violence, emotional abuse, financial exploitation, isolation, verbal attacks, humiliation, intimidation, femicides, threats of violence, and abandonment.

42. Girls with disabilities experience sexual violence in early childhood and throughout adolescence and adulthood, as they are often perceived as vulnerable, fragile, dependent, unlikely to be believed and defenceless because of impairment.

43. **Forced medication is a common form of violence against persons with disabilities.** Physical violence against women with disabilities is multifaceted; for example, oblige intake of psychiatric medication to access to food. Physical attacks against women with albinism marginalize them due to the loss of work capability and employment opportunities.

44. **Economic violence** against women with disabilities is often aggravated by factors, such as age and migration. guardians and third parties often control, divert and withheld social security payments to which women with disabilities are entitled.

45. Women and girls with disabilities face heightened risks of, trafficking, forced marriage, displacement and deprivation of services in the community.

46. Gender and disability stereotypes prevent access to justice and effective remedies as women and girls with disabilities are **not considered credible by law enforcement officers.**

¹⁹ CRPD/C/AUS/CO/2-3; CRPD/C/BGD/CO/1.

²⁰ CRPD/C/MEX/IR/1, paras. 14 and 22.

²¹ A/72/133 paras. 29 to 33.

LGBTIQ+ persons

47. Non-binary, transgender, intersex, lesbian, gay, bisexual, queer and gender-diverse persons with disabilities also experience gender and disability-based violence. They are often subjected to medicalization, forced treatment, and institutionalization. Diverse gender identity has been sometimes identified as an impairment, exacerbating intersectional violence.

Children

48. Children with disabilities are often exposed to aggravated forms of disability-based violence on account of the intersection of disability and other factors, including gender, socioeconomic status, ethnic or migrant situation.²² They often face abandonment, family separation, forced treatment, institutionalization, physical, sexual, psychological violence or neglect. Children with intellectual disabilities and children with psychosocial disabilities are at heightened risk of violence in institutions.

49. In some communities, children with disabilities are also subject to infanticide. Reported situations include abandonment, gross neglect, homicide, abuse and lifelong exclusion in the community. Children with albinism are often secluded at home and prevented to attend school out of fear of violence.

50. Children and adolescents with disabilities experience higher rates of bullying in school. This includes physical aggression, theft, intimidation, and cyberbullying by other students. They are more likely to experience physical, psychological, sexual, and technology-based violence. Girls with disabilities face heightened risks of violence, including corporal punishment, the use of restraints and seclusion.²³

Older persons

51. Older persons with disabilities have been exposed to neglect and abandonment, including in institutions. Disability stigma frequently results in the, abandonment and abuse against older women with disabilities and against persons with psychosocial disabilities. Older women with disabilities face intersecting forms of violence.²⁴ Economic dependency due to disability, gender roles, age and other factors heightens the risks of abuse and institutionalization.²⁵

Autistic persons

52. Autistic children are often subjected to bullying, seclusion and restraint in schools, false cures and treatments such as extreme diets, chelation or bleach, coercive behavioural treatments to “normalise” behaviour, neglect, filicide and other types of violence. Autistic adults are harassed also on account of perceived deviation from gender and heterosexist norms. Autistic women can be perceived as masculine or queer for wearing clothing to manage sensory sensitivities. This violence includes threats, verbal violence, and infantilization. The misunderstandings and lack of support for autistic persons increase their risk to violence and institutionalization.

Indigenous and Afro-descendant persons

53. Indigenous and Afro-descendant persons with disabilities are exposed to increased risks of violence, including in prisons due to prolonged solitary confinement and limited access to justice.²⁶ Indigenous women with disabilities can experience sexual violence, including marital rape, and rape and sexual abuse in institutions.

²² European Union Agency for Fundamental Rights. [Violence against children with disabilities: legislation, policies and programmes in the EU \(2015\)](#).

²³ CRPD/C/GC/4, para. 51.

²⁴ CEDAW/C/GC/27, para. 13.

²⁵ (A/74/186), para. 36.

²⁶ CRPD/C/PER/CO/2-3, para. 26; [CRPD/C/AUS/CO/2-3](#)

Internally displaced, migrant, stateless, asylum seekers and refugee persons

54. Disability-based violence may trigger forced displacement and, migration, trafficking, may be a ground of persecution in refugee situations. Internally displaced persons, refugees, asylum seekers, migrants, and stateless persons with disabilities face heightened risks of disability-based violence and gender-based violence, psychological violence exploitation, arbitrary detention, institutionalization, trafficking and disappearances. Persons with disabilities when seeking asylum are exposed to intersectional discrimination, structural exclusion and limited accessibility to information, support, and disability-responsive measures. Failure to implement deinstitutionalization exacerbate risks of violence during emergencies.²⁷

Persons with disabilities in poverty

55. Poverty creates and perpetuates conditions for disability-based violence through exclusion, stigma, isolation, and harassment. Poverty and social exclusion, including in rural and remote areas increase dependency and risks of violence, including trafficking. Institutionalization is often used against persons with disabilities living in extreme poverty or homelessness instead of being provided with support and accessible services in the community.²⁸

56. **States parties should:**

(a) **Recognize violence experienced by women and girls with disabilities as both disability-based violence and gender-based violence;**

(b) **Acknowledge the amplified impact of intersectional discrimination on disability-based violence and identify, combat and eliminate ableism, patriarchal systems, sexism, ageism, sanism, cissexism, audism, racism underpinning disability-based violence against persons with disabilities holding several identities;**

(c) **Combat disability-based discrimination, including by ensuring that legislation and policies address intersectional discrimination and violence;**

(d) **Adopt robust research and disaggregated data collection systems, on intersecting forms of violence against persons with disabilities that inform public decision-making.**

G. Patterns of disability-based violence

Psychiatric violence

57. Psychiatric violence is a form of disability-based and structural violence driven by the powers conferred on mental health professionals, including psychiatrists to exercise confinement, segregation and non-consensual interventions. It is rooted in medical model and therapeutic approaches towards persons with disabilities that conceive psychiatric treatment as one of the main responses for persons with psychosocial disabilities.

58. Psychiatric violence encompasses violent acts, omissions or patterns of conduct perpetrated, authorized or legitimized under laws, policies, practices, pertaining to mental health systems. Acts of psychiatric violence violate the rights to equal recognition before the law, liberty and security of the person, and personal integrity, and obligations under article 15 of the Convention and may amount to torture and cruel, inhuman or degrading treatment.

59. It emerges from ableism and sanism and it results from the pathologization of forms of distress, consciousness, emotional expression, children's development (whether ordinary or divergent), life cycle events, behaviour or decision-making portrayed as 'mental health disorders' or 'unsound mind'. It is rooted in society's intolerance of madness/intense emotional distress and unusual perceptions. Such intolerance leads to psychiatric violence when it takes the form of a medical and therapeutic approach to 'correcting' or 'treating'

²⁷ A/HRC/57/22; CRPD/C/UKR/CO/2-3; CRPD/C/IRQ/CO/1; CRPD/C/TUR/CO/1; CRPD/C/DJI/CO/1.

²⁸ (A/HRC/56/61/Add.3, para. 26).

psychosocial diversity through medical interventions imposed whether or not the person consents. Therapeutic need, medical necessity, and 'best interest' constitute prevalent grounds often used to override the rights, will and preference of adults with disabilities or justify coercion.

60. Psychiatric violence manifests itself in widespread use of coercion, including forced treatment, forced medication, and forced institutionalization. It includes the physical acts of detaining someone against their will in a mental health setting, the use of physical, mechanical and chemical restraints, or forcing someone to take mind-altering drugs or undergo electroshock. It also encompasses seclusion, forced abortion, sterilization or contraception, and physical and sexual assaults, and poor living conditions in institutions

61. The perception of dangerousness and the use of coercion in individual crises increases harm. When community-based support, including non-medical options, lack or are underdeveloped, psychiatric violence is reinforced.

62. Psychiatric violence is usually carried out by the staff of institutions or outpatient mental health services, acting under the authority of psychiatrists, the latter provided in mental health legislation, medical emergency exceptions in health legislation, criminal justice laws or guardianship laws.

63. By turning private thoughts and behaviour into objects for medical observation and assessment, psychiatric violence places individuals in an inferior position not only to psychiatrists and mental health staff, but also in community, reinforcing ableism and sanism.

64. The reliance on psychiatry and mental health services, couple with the lack of supports respectful of individual autonomy deprives persons experiencing crisis, intense distress or unusual perceptions of needed support and relegates them instead to repeated cycles of violence.

65. **States parties should:**

(a) **Eliminate coercion in law and in practice, including by prohibiting legal authorization to non-consensual and forced intervention and ending nonconsensual interventions, and provide emergency assistance to leave places where these practices occur, as well as effective remedies redress and reparation;**

(b) **Ensure supported decision-making and respect for autonomy, will and preference of persons with disabilities related to their psychosocial wellbeing;**

(c) **Combat disability stigma and stereotypes related to situations of crisis or heightened distress, avoiding medicalization and pathologization; Ensure that support in those situations is available outside of mental health institutional frameworks, and respect person's choice.**

(d) **Adopt alternatives to coercion that are community-based and include trusted supporters chosen by the person, peer support networks, advance planning tools, communication assistance, and decision support circles;**

(e) **Provide training for service providers to deliver support in line with Convention.**

Institutionalization and disability-based violence

66. Institutionalization on the basis of disability is a discriminatory practice²⁹ and a form of disability-based violence. It includes placement in a facility including for temporary 'care or treatment,' preventive detention, or observation. By limiting autonomy and contact with the outside world, institutionalization increases the risk of disability-based violence.

67. Failure to ensure access to community-based support services, including personal assistance, accessible communication and other community services, including affordable

²⁹ CRPD/C/5, para. 6.

and accessible housing, accessible transport and inclusive education, perpetuates institutionalization and its harmful effects.³⁰

68. Intersectional discrimination aggravates institutionalization and violence.

(a) Women and girls with disabilities in institutions are often exposed to forced nakedness, abusive body searches, sexual abuse, coercion and violations of sexual and reproductive autonomy;

(b) Older persons with disabilities, in institutions are often subjected to forced medication, restraints, isolation, abandonment and neglect;

(c) Persons living in rural, and remote areas are at risk of institutionalization in the absence of support and available accessible services in the community;

(d) Residential and/or special education separate children with disabilities from other learners, their families and the community.

Instances of torture and ill treatment in institutions

69. Power imbalance in personal interactions and “a culture of compliance” are common in institutions.

70. Institutionalization has resulted in systematic neglect, coercion and dehumanization for persons with disabilities.³¹ Women with disabilities, are in a situation of subordination to male caregivers. Persons with psychosocial disabilities, persons with intellectual disabilities, persons with cognitive disabilities, older persons, LGBTIQ+ and Afro-Descendant persons are at a heightened risk of short and long-term institutionalization and ill treatment in institutions.

71. Paternalistic and coercive practices justified as ‘care’, coupled with the denial of bodily autonomy, subject persons with disabilities in institutions to degrading treatment and a complete loss of privacy. Practices, including forced nakedness heighten risks of rape and sexual abuse.

72. violence in institutions include neglect, physical assaults, sexual violence, killings, coercion, heavy sedation, forced administration of mind-altering drugs, restraints, and solitary confinement, verbal and emotional abuse.

73. Private service providers, running institutions may bear responsibility for disability-based violence, which often becomes normalized.

74. Violence becomes a pattern in the absence of monitoring and accountability. Persons with disabilities victims of violence in institutions are often unable to file complaints to independent oversight/judicial bodies.³² This is mainly due to the control exercised over them.

75. State Parties should end institutionalization and carry out deinstitutionalization strategies for persons with disabilities, and:

(a) **Develop programmes that enhance awareness of rights, facilitate the recognition of abusive conduct, and promote early access to support and protection services;**

(b) **Ensure confidential, independent and accessible reporting mechanisms for violence in institutions, immediate protection from retaliation, access to sexual and reproductive health care, psychosocial support, legal aid and survivor-centred investigations;**

³⁰ CRPD/C/HUN/IR/1, para.101.

³¹ CRPD/C/34/D/78/2020, paras. 9.1 to 9.6 and 10.

³² European Union Agency for Fundamental Rights, 2025 “Places of care=places of safety? Violence against persons with disabilities in institutions”. See page. 15.

(c) **Conduct investigations into allegations of violence, including gender-based violence, torture and ill treatment in institutions, establishing responsibilities for acts of private providers;**

(d) **Provide persons with disabilities with effective remedies, which are accessible, timely, and capable of ending violations, including effective reparation for the harm caused by disability-based violence, including restitution, compensation, habilitation and rehabilitation, satisfaction and guarantees of non-repetition.**

Violence in the context of family separation and institutionalization

76. Legislation in many countries still provide for separation of children with disabilities from their parents based on disability, which constitutes a serious interference with family life. Placement in institutions is often justified for the purpose of providing care or protection. When adults with disabilities report abuse, adult protective services institutionalize them as alleging their protection, rather than relocating the abuser.

77. The removal of children from family on the basis of disability stereotypes, assumptions of parental incapacity or the absence of disability-related support is a form of disability-based violence. Family separation is conducive to developmental delays and exacerbation of impairments, trauma, and isolation, of children with disabilities.

78. Some communities stigmatize parents of children with intellectual disabilities deemed to be “evil spirits”, “snakes”, or “possessed” due to the sins of the parents, especially mothers. Social stigma stems from having a child outside of marriage or not following customary practices. Mothers of children with disabilities are pressured to kill their children. Those who refuse may face extreme hardship, reputational damage and the exclusion of their children from the community, including from childcare and education, and harmful effects on physical and mental health of the mothers.

79. **The Committee recalls article 23 (4) of the Convention and its Guidelines on deinstitutionalization, including in emergencies (2022) according to which disability can never justify the removal of children from parental care. States parties should:**

(a) **Prohibit separation on the basis of impairment, including under as allegations of being a victim of gender-based violence or poverty. Addressing violence against women with disabilities should prioritize safety and the provision of accessible support to the parent and child;**

(b) **Speed up the adoption of measures of individualized and community-based support to parents with disabilities and parents of children with disabilities, including those living in rural, remote or maritime areas.**

Forms of disability-based violence amounting to torture or cruel, inhuman or degrading treatment

80. The Committee has identified forms of disability-based violence that are inconsistent with article 15 of the Convention, namely **involuntary detention, involuntary treatment, seclusion and the use of physical, chemical and mechanical restraints** in medical facilities.³³ The use of solitary confinement, such as isolation rooms³⁴ and degrading living conditions affecting persons with disabilities in institutions³⁵ may also constitute torture or other ill-treatment. The lack of effective prosecution of the suspected perpetrators of crimes against persons with disabilities causes revictimization and a violation of obligations under article 15.³⁶

81. Repeated acts of violence and abuse during custody, indefinite detention on the basis of disability,³⁷ the denial of reasonable accommodation and accessibility in detention

³³ A/72/55, Annex, para. 12;

³⁴ CRPD/C/HUN/CO/2-3, paras. 31, 33

³⁵ CRPD/C/BGR/CO/1, paras. 25, 35 and 37;

³⁶ CRPD/C/18/D/22/2014, para. 8.6

³⁷ CRPD/C/16/D/7/2012, para.8.9 and 8.10.

settings³⁸, deprivation of food, medication, communication or mobility aids, and the use of solitary confinement and/or physical restraints in prisons, and refugee or immigrant detention centres also violate the prohibition of torture.

82. **Non-consensual administration of mind-altering drugs such as neuroleptics, or mind-altering procedures such as electroshock and psychosurgery, often cause irreversible harm and entail discriminatory attempts to control an individual's personality, behaviour and choices, violating the prohibition against torture and ill treatment.**³⁹

83. **The Committee recommends that States parties:**

(a) **Recognize forms of disability-based violence amounting to torture and/or ill-treatment and extend the implementation of anti-torture frameworks to them;**

(b) **Ensure that mechanisms for the prevention of torture include persons with disabilities in performing monitoring functions;**

(c) **Ensure investigation, prosecution and sanction of perpetrators of torture and ill treatment against persons with disabilities.**

Denial of free and informed consent and biomedical practices

84. Surgeries on intersex children and other biomedical practices, including treatments on the AT4 receptor, CRISPR gene-editing-like tools, may be carried out in the absence of free and informed consent of the person concerned. The Committee has regretted the lack of legal and policy frameworks to ensure the free and informed consent of persons with disabilities in relation to scientific treatments and experimentation,⁴⁰ and irreversible medical interventions on intersex children.⁴¹

85. **States parties should repeal legislation allowing for substituted decision-making, and ensure free, and informed consent and supported decision-making s prior to any medical or scientific procedure. They should combat discriminatory or ableist and harmful practices in the context of medical and scientific procedures, research and experimentation, including through awareness among the scientific community, medical profession, and service providers.**

Coercive behavioural-control or modification practices

86. Practices including forms of Applied Behaviour Analysis and other behaviour-modification programmes, contingent electric shock administered through skin-shock devices, and aversive use of restraint and seclusion constitute disability-based violence and are incompatible with the prohibition of torture. Experimental non-consensual treatments being used in autistic persons respond to ableist perceptions that disability is the 'worst outcome', ignoring the risks for severe health side effects. Disability-based violence also includes treatments aimed at suppressing autistic or neurodivergent identities, psychosocial diversity, gender identity, sexual orientation, and practices presented as religious interventions involving confinement, beating, restraint, deprivation of food or water, forced ingestion, exorcism, intimidation or other forms of coercion.

Excessive use of force against persons with disabilities by law enforcement officials

87. Persons with disabilities, particularly young persons with disabilities, have been subjected to disproportionate use of force due to disability, in cases when distress, noncompliance or communication barriers related to impairment are assumed as a threat or disrespectful behaviour during law enforcement operations. These operations have often resulted in unlawful killings.⁴²

³⁸ A/72/55, Annex, para. 18.

³⁹ A/63/175, paras. 40, 47 and A/HRC/43/49, para. 37.

⁴⁰ CRPD/C/CRI/CO/1, para.31.

⁴¹ CRPD/C/DEU/CO/2-3; CRPD/C/AUS/CO/2-3, para. 34 (b)

⁴² CRPD/C/ISR/CO/1, paras. 21 and 22

88. Arbitrary use of force includes instances where persons with disabilities are committed by the police to psychiatric facilities, in response to individual crisis, and instances of police responding to so-called 'wellness checks' requested by service providers or family members. These incidents often involve disproportional use of force, including resulting in death.

89. The intersection of disability with poverty, homelessness or racial/ethnic minority status represents a high level of risk for police brutality and extrajudicial killings. Persons with disabilities in street situations or living in precarious circumstances, and rural areas, are exposed to systemic abuse, arbitrary detention, institutionalization, and violence, including from authorities and private actors acting under their tolerance, due to perceived or actual impairment coupled with drug-dependency.⁴³ Disability stigma and criminalisation of drug consumption increase detention, lead to the loss of community networks and heighten risks of disappearance and trafficking for persons with disabilities.⁴⁴

90. Persons with disabilities in detention face disparities in access to healthcare, lack of reasonable accommodation, and disability-related support. They also have difficulty maintaining their psychosocial wellbeing when incarcerated. Women with disabilities are also subjected to dismissive bullying or other degrading treatment by law, enforcement staff.

91. **States parties should prevent the excessive use of force, investigate and bring perpetrators to justice and ensure that persons with disabilities have access to justice and effective remedies, including for persons in rural areas. States parties should prevent arbitrary detention of homeless persons with disabilities. Individual crisis should be addressed without coercion, in a non-medical manner.** States parties should train law enforcement officials in de-escalating all potential situations of violence, raising awareness about the rights of persons with disabilities and the diverse types of distress and trauma reactions.

Disability-based violence and discrimination in the justice sector

92. Persisting barriers to access to justice for persons with disabilities can trigger and perpetuate disability-based violence.

93. Barriers include the lack of procedural and reasonable accommodations, biases and normalization of violence among the law enforcement officers, the lack of awareness of persons with disabilities about their rights, retraumatizing experiences throughout the justice system, the fear of reprisals, the lack of acknowledgment of disability-based violence and procedural, economic and legal obstacles for participation of persons with disabilities in judicial procedures.

94. **States parties should combat stigma and barriers to access to justice for persons with disabilities and ensure appropriate investigation, prosecution and sanction of perpetrators. States parties should eliminate provisions denying legal standing for persons with disabilities based on disability, combat stigmatization and discriminatory practices in the justice system and introduce support mechanisms for victims throughout judicial procedures.**

Denial of support

95. The denial of disability-related support, including personal assistance, communication support, mobility aids, assistive devices, reasonable accommodation, may constitute forms of disability-based violence and coercive control that can be manifested in home but also in public places or in the context of services.

Abusive support interactions

96. Disability-based violence frequently arises from unequal power relations between persons with disabilities and those who provide support, care, or services. Violence does not arise from the need for support itself, but from support arrangements organised around

⁴³ A/HRC/56/61/Add.3, paras. 10, 26.

⁴⁴ CRPD/C/MEX/IR/1, paras. 15, 16. CRPD/C/MEX/IR/CRP/R.1, paras. 71, 73, 107.

dependency, control, substitute decision-making or institutional responses rather than the person's rights, will and preference.

97. These power imbalances are often reinforced by discriminatory legal and policy frameworks, and the absence of accessible, individualised and community-based support. Social exclusion and segregated settings may further increase dependency by limiting opportunities for persons with disabilities to exercise choice and control over their lives and participate in the community on an equal basis with others.

98. Providing support exclusively within the family/household can lead to violence when situations of crisis or heightened distress cannot be well-managed or when family supporters experience stress, which could lead to violence or neglect.

99. **States parties should address the structural conditions that concentrate power over the lives of persons with disabilities. They should ensure access to rights-based, individualised and community-based support systems that promote autonomy, self-determination and inclusion in the community. States should ensure capacity-building opportunities for family supporters, support workers, and service providers on the provision of support in compliance with the Convention.**

Disability-based violence in situations of risk

100. Disability-based violence is often exacerbated in situations of risk, including climate-related disasters, armed conflicts and occupation, health and humanitarian emergencies.⁴⁵ The lack of measures to ensure the protection and safety of persons with disabilities in situations of risk, including inaccessible emergency preparedness, evacuation systems, communication and humanitarian responses are conducive to disability-based violence and should be addressed as root causes of such violence.

101. Violence in these contexts include extrajudicial executions; indiscriminate attacks against civilian infrastructure predominantly used by persons with disabilities, including community-based rehabilitation centers; non-inclusive and inaccessible emergency preparedness and response; deprivation of bare essentials; arbitrary detention; barriers due to the lack of accessible early warnings, roads and the loss of mobility aids, devices and assistive technologies.⁴⁶ Persons with disabilities in rural and remote areas have faced exacerbated violence based on disability and geographical location.

102. Climate related disasters and slow onset climate events, including extreme heat, floods, storms, droughts may intensify disability-based violence where persons with disabilities are excluded from emergency preparedness, evacuation, early warning, climate resilient infrastructure, adaptation measures, and rebuilding efforts.⁴⁷

103. **States parties should ensure that:**

(a) **Their legislation, policies and strategies related to disaster risk reduction, emergency preparedness crisis management, humanitarian response, recovery, including readaptation, and reconstruction incorporate disability-inclusive measures, including to address disability-based violence;**

(b) **Persons with disabilities are closely consulted and actively involved in all decision-making related to risk;**

(c) **Resources for humanitarian action, recovery, readaptation, peacebuilding and reconstruction target persons with disabilities and include and guarantee the continuity of accessible support and referral services, including victim-support for survivors of disability-based violence, and taking into account intersecting forms of discrimination;**

(d) **Persons with disabilities should have access to justice and effective remedies for the violence faced during situations of risk.**

⁴⁵ A/HRC/61/CRP.1; CRPD/C/33/2, Annex IV.; CRPD/C/27/2; CRPD/C/CYP/CO/1.

⁴⁶ A/HRC/57/22; CRPD/C/33/2, Annex IV.; CRPD/C/27/2; CRPD/C/COL/CO/1.

⁴⁷ CRPD/C/TUV/CO/1; CRPD/C/PLW/CO/1; CRPD/C/MDV/CO/1; CRPD/C/CAN/CO/2-3.

Disability-based violence and international crimes

104. Some forms of disability-based violence could be considered as aggravating factors of crimes against humanity and war crimes. Disability has been recognized by international tribunals as an aggravating factor in determining sentencing for the commission of international crimes⁴⁸. Persons with disabilities have often been subjected to forms of violence because of being unable to flee attacks due to disability. This violence has included targeted killings, torture, mutilation, burning of homes and arson attacks, arbitrary detention, forced displacement, persecution on discriminatory grounds, rape and other forms of sexual violence, illegal and forced conscription, which may amount to international crimes.⁴⁹

105. **State parties participating in the process to elaborate a United Nations Convention on the Prevention and Punishment of Crimes against Humanity⁵⁰ should incorporate measures to address persons with disabilities and to ensure the accessible and effective participation of persons with disabilities and their representative organizations in the negotiation process.**

H. Physical, psychological, sexual, domestic, economic, forms of violence and violence in the digital environment

106. **Disability-based violence includes** physical, psychological, sexual, domestic, economic violence, violence in the digital environment or facilitated by technology and **involuntary medical or psychiatric interventions including the threats of such harm.** These forms of violence are often interconnected, and harm is inflicted in more than one form. This violence often remains hidden, underreported, thereby limiting access to protection, justice and effective remedies.

Physical violence, including restraints

107. **Survey's respondents reported physical assaults and beatings, threats, confinement in closets, toilettes and/or other places of isolation, use of physical restraints, coercion and electroshocks against persons with disabilities. They also reported attempts of strangulation, having been dragged by their hair and having been tied up. Other forms of violence reported include threats with knives, having a person's head struck against a wall, preventing persons with disabilities from screaming or complaining during acts of violence.**

108. Children with disabilities are often exposed to corporal punishment and use of physical and chemical restraints in school settings. Children with intellectual disabilities and children with psychosocial disabilities are at a higher risk of corporal punishment because of disability stigma, misunderstanding of disability-related behaviours, and intolerance. Medication on children with disabilities may be used as restraint and more generally as behaviour control through dampening.

Assaults and killings against persons with albinism

109. Persons with albinism have been subjected to crimes that affect them exclusively.⁵¹ These attacks include physical and psychological assaults, maiming, killings and trafficking in body parts to be used in witchcraft-related practices. This is because of stigma and myths associating their physical appearance with supernatural powers. These attacks remain in impunity due to the lack of investigation and prosecution of perpetrators and lack of preventive or protective measures for survivors.⁵²

⁴⁸ ICC. Rules of Procedure and Evidence. Rule 145.

⁴⁹ [A/HRC/61/XX](#); A/HRC/61/CRP.1.

⁵⁰ A/RES/79/122 (2024).

⁵¹ CRPD/C/22/D/24/2014, paras. 2.1; CRPD/C/20/D/23/2014; CRPD/C/18/D/22/2014.

⁵² CRPD/C/18/D/22/2014, para. 8.6; CRPD/C/20/D/23/2014, para. 8.7; CRPD/C/22/D/24/2014, para. 8.6

Hate Crimes

110. Persons with disabilities have experienced violent crime, injury, and assault at much higher rates than other persons.⁵³ Intersectional discrimination on grounds of religion and ethnicity increases risks of hate motivated crimes. Legal frameworks of several States parties address hate-motivated crimes including disability as a protected characteristic.⁵⁴ Sheltered workshops and other segregated environments can be more unsafe and increase the risk of disability hate crimes.

Psychological violence and abuse

111. Persons with disabilities may experience emotional abuse, humiliation, and psychological harassment and violence. Relatives, intimate partners, and caregivers can incur in psychological violence using derogatory language, insults, pejorative remarks, blaming for requiring support or disclosing sensitive personal information. Psychological violence includes disdain in personal interactions, mockery of impairment, exclusion from social life, underestimation and humiliation. Online interactions on social media may prompt psychological abuse, for instance when encouraging suicide.

112. Overt non-consensual administration of psychiatric medications and institutionalization or threat of institutionalization represent forms of interrelated physical and psychological violence. Verbal abuse, invalidation, and mistreatment in healthcare settings constitute forms of psychological violence.

113. Bullying exercised by co-workers at the workplace and denial of reasonable accommodation to employees, and customers with disabilities were reported. Persons with disabilities can be subjected to scrutiny and surveillance in the workplace, including from supervisors and resulting from policies encouraging co-workers to report suspected impairment.

Hate speech

114. Disability-related hate speech reinforces discrimination against persons with disabilities. Hate speech includes denigrating, making intimidating statements, issuing threats of violence, and spreading harmful narratives about persons with disabilities as a group.

115. Hate speech occurs in the community and online. It also occurs in statements by high rank officials, and in news and mass media. persons with disabilities avoid certain locations and activities to protect themselves from victimization. Hate speech restricts participation in public life, averts human rights advocacy, increases fear and isolation, and discourages reporting of violence.

116. Portrayals of persons with disabilities as perpetrators of welfare fraud that emerge during periods of austerity intensify their risk of being subjected to hate crimes.⁵⁵ State parties should combat negative and discriminatory stereotypes against persons with disabilities in public and the media, and address complaints about hate crime by persons with disabilities.⁵⁶

Gaslighting

117. Gaslighting as a form of psychological violence against persons with disabilities, including children with disabilities occurs when abusive practices are denied, dismissed as trivial, and tolerated with impunity. Victims' trauma and fears and complaints are silenced by discrediting them as an unreliable witness.

⁵³ CRPD/C/GBR/CO/1, para. 38; CRPD/C/AUT/CO/2-3; CRPD/C/NLD/CO/1; CRPD/C/EUR/CO/2-3.

⁵⁴ For example legislation in Belgium, Chile, Costa Rica, Greece, Norway, Spain, South Africa.

⁵⁵ CRPD/C/15/4, paras. 79, 85, 91, 109, 114; CRPD/C/GBR/FUIR/1, para. 74, 81.

⁵⁶ CRPD/C/15/4, para. 114 (h).

Sexual violence

118. Persons with disabilities are disproportionately affected by sexual violence, including abuse, rape, coercion, sexual harassment, and infringements of their bodily integrity, privacy, dignity and personal autonomy. Sexual violence is one of the most silenced and unaddressed forms of violence.

119. Risks of sexual violence are heightened in institutions. Sexual violence is often compounded by physical and psychological aggression affecting children and women with disabilities, at work, public transport or in the street.⁵⁷ Persons with disabilities subjected to sexual violence are exposed to extreme traumatization, control and abuse.

120. Sexual violence committed against persons with disabilities in institutions usually unfolds other forms of disability-based violence, such as psychiatric violence, isolation and forced abortion, used to hide rape and other forms of sexual abuse against women and girls with disabilities.

121. Sexual violence may result from manipulation of emotions by and intimate partner.

122. Discrimination in work and employment may result in violence and harassment against persons with disabilities, including sexual harassment, particularly against women with disabilities, young persons and gender-nonconforming persons with disabilities. Barriers to access individual remedies in cases of harassment is common.

Home and family violence

123. Disability-based violence often occurs in private settings and remains hidden and unaddressed. Socioeconomic deprivation in family can lead to resentment and acts of aggression against family members with disabilities.

124. Persons with disabilities experiencing violence at home face heightened barriers to reporting abuse, being recognised as credible victims or witnesses, escaping abusive relationships, and accessing support and recovery.⁵⁸

125. Persons with disabilities may experience intimate partner violence through coercive control, threats of institutionalization, isolation, abandonment, sabotage of support arrangements, outing or threats of outing, and barriers to reporting or accessing support.

126. Women with disabilities are often intimidated by partners, including threats to kill or hurt them, or to leave them for a non-disabled partner. Many women with disabilities are subject to extreme physical violence including repeated rape and sexual assault.

127. Men with disabilities may face physical abuse, psychological abuse, coercive control, financial exploitation, neglect and disability-specific abuse linked to dependence on partners for support. Men with disabilities who experience intimate partner violence may face compounded barriers linked to disbelief, stigma surrounding male victimization, dominant norms of masculinity, dependency recognition, reporting and access to support services.

Coercive family control over the sexuality of women and girls with disabilities

128. Women with disabilities are often denied sexual agency and presumed incapable of consent, while sexual violence against them is often underreported, dismissed or disbelieved. This is due to a convergence of patriarchy and ableism that uniquely affects them. In some communities, families attempt to prevent sexual assault against women with disabilities by depriving them of autonomy over their own bodies and, sexual self-determination. Some families believe that their daughters with disabilities can be protected from sexual abuse by limiting their movements outside the home, forbidding them from attending school, or permitting distance education only. Access to information about sexuality is also restricted so as not to encourage sexual behaviour or as a way of preventing sexual abuse by third parties.

⁵⁷ CRPD/C/MWI/CO/1-2, para. 33;

⁵⁸ [CRPD/C/NIC/CO/1-3](#), para. 28.

Violence in health care services

129. Alongside attitudinal and physical barriers to access healthcare services, persons with disabilities can experience violence in medical settings, for instance when they are deprived of their assistive devices. Institutionalization, disability stereotypes, substitute decision-making, and lack of measures to ensure free and informed consent create conditions that increase the risk of violence and abuse in healthcare settings.

Discrimination in medical triage practices and end of life care

130. Implicit and explicit bias causes physicians to make decisions about how to allocate scarce medical treatments in a way that disadvantages persons with disabilities. This includes denial of organ transplantation and deprioritization of persons with intellectual disabilities with, chronic weakness or advanced age, from ventilator support and critical care during emergencies.⁵⁹

131. Distribution of medical resources is often guided by measures such as sequential organ failure assessment (SOFA) scores, which inappropriately deprioritizes nonverbal patients, quality adjusted life years (QALYs) and disability adjusted life years (DALYs), which devalue persons with disabilities' lives.

132. In some cases, medical practitioners have excluded persons with psychosocial disabilities from treatment such as chemotherapy for cancer, based on they do not comply with prescribed psychiatric medication, so they are deemed no to comply with cancer treatment as well.

133. Assisted dying regimes expanded to include persons with "mental illness" or where 'natural death is not reasonably foreseeable' reproduce ableist assumptions that disability involves intolerable suffering or a life of lesser value.⁶⁰ Assisted dying laws and practices may result in 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.

Diagnostic overshadowing

134. Diagnostic overshadowing describes the practice of wrongly attributing a patient's signs and symptoms to an assumed pre-existing disability or condition, rather than to the actual cause of disease. Persons with psychosocial disabilities and persons living with multiple chemical sensitivity reported instances of inappropriate psychiatric referral and institutional violence.

Ignoring health complaints

135. Some complaints are ignored because they are treated as delusional or because of adverse effects of psychiatric medications. Complaints are often mistrusted or ignored because of the motivation of medical professionals to control the individual's distress, personality or behaviour through psychiatric medications.

Violence facilitated by technology

136. Technology-facilitated violence includes online abuse and is exacerbated by ableism in technology, including Artificial Intelligence tools. Persons with disabilities are exposed to ableist algorithms, digital gaslighting, abuse of credential by guardians, banking and payment card fraud, higher rates of consumer fraud, doxing, spyware, and surveillance cameras at home. Technologies are used to do digital monitoring, risk profiling, sharing of personal data without consent with the purpose of controlling persons with disabilities. Lack of accessibility to webpages, and digital platforms for submitting complaints, prevents accessing redress.

⁵⁹ CRPD/C/FRA/CO/1.

⁶⁰ CRPD/C/CAN/CO/2-3.

137. Insufficient protection mechanisms have been reported against sharenting and the exploitation of children with disabilities on social media, with the usage of their image during difficult moments for monetization in the name of “awareness”.

138. Cyber-harassment targets persons with disabilities online, and includes using deception, such as pretending to be a person with disabilities, to draw in their targets and to torment them once they have access. Persons with disabilities are also bullied online to cause emotional distress to them and their family members. Cyber-harassment remains unaddressed as it occurs in virtual space beyond the jurisdiction of national enforcement mechanisms.

139. Technology-facilitated violence includes threats of sexual violence, image-based abuse, coercive control by partners or guardians, monitoring of movements, doxing, outing, and abuse of inaccessible reporting systems.

Economic violence, trafficking and exploitation

140. Economic exploitation often affects children with disabilities and includes instances of trafficking through begging,⁶¹ Persons with disabilities also have heightened risks of organ trafficking, slavery and servitude, being used as drug couriers, and being exposed to abduction and forced labour in farms and institutions.⁶²

141. Social stigma and objectification of persons with short stature exposes them to public humiliation, unwanted physical contact, non-consensual photography, harassment in public spaces, entertainment-based exploitation and persistent stereotyping that undermines their dignity, autonomy and equal participation in society.

142. Persons with disabilities are denied control over their own financial affairs due to guardianship or other substitute decision-making regimes. They are often deprived of the access and management of their disability pensions and social benefits, including cash transfers.

143. Economic violence manifests in financial dependence and lack of access to income. Persons with disabilities can be mistreated when claiming their pensions or denied benefits, which increases risk of poverty and institutionalization. Persons with disabilities who have been denied disability benefits can be obliged to accept an unwanted ‘treatment relationship’ with a psychiatrist to certify eligibility for such a pension.

144. Persons with disabilities, in some cases, are derived to institutions because of lack of access to income and poverty. In some cases, they have been forced to pay for involuntary institutionalization. Institutionalization often perpetuates economic deprivation and dependency. Some institutions deny income or access to social benefits to persons with disabilities or consume a large share of a person monthly disability pension, leaving a minuscule amount for personal expenses, which deprives persons with disabilities of financial autonomy.

145. Segregated employment, including sheltered workshops isolate and expose persons with disabilities to economic exploitation, and discrimination in remuneration, social protection, career advancement, and informal employment.⁶³ Some legislations allow the dismissal from employment of persons with actual or perceived psychosocial disabilities, on the basis of the discriminatory use of ‘danger to self or others’ that results in stereotyping against persons with disabilities.

IV. Recommendations

146. Disability-based violence is a violation of the rights of persons with disabilities. However, it is neither unavoidable nor irremediable. It can be recognized, prevented and eliminated. Disability-based violence is never justified as a form of protection, care or support.

⁶¹ CRPD/C/DOM/CO/2-3, para. 29; CRPD/C/BFA/CO/1, para. 32; CRPD/C/THA/CO/1, para. 33;

⁶² CRPD/C/PRY/CO/1, para. 43; CRPD/C/AZE/CO/2-3, para. 37; CRPD/C/MNG/CO/2-3, para. 33.

⁶³ CRPD/C/GC/8, paras. 13, 14, 15.

147. All recommendations herein should be implemented in close consultation and with the active involvement of persons with disabilities through their representative organizations, including organizations of survivors of violence.

(a) End disability-based violence

148. States Parties should:

(a) End all forms of disability-based violence, including those amounting to torture or ill treatment and discrimination and take measures to eradicate harmful social practices, and stereotypes that perpetuate, disability-based violence. Heightened attention is required in relation to violence in the digital space and facilitated by AI and new technologies.

(b) Redress the harm suffered by victims and survivors of disability-based violence and ensure accountability for perpetrators;

(c) Address the root causes of disability-based violence in legislation, policies and practices, including by:

(i) Periodically reviewing and revising their legislative, administrative, and policy frameworks to identify and eliminate structural barriers that perpetuate disability-based violence, including laws and practices based on substitute decision-making;

(ii) Establishing supported decision-making systems based on the autonomy, will and preference of persons with disabilities;

(iii) Repealing legislation allowing for coercive measures, including institutionalization, involuntary committal, and forced treatment, based on a mental incapacity determination, and/or criteria such as “danger to the person concerned or to others” or “need for care and treatment,” under “medical emergency” criteria, or as a purportedly “least restrictive alternative” and prohibit the use of non-consensual or forced treatments;

(iv) Ensuring that response to situations of crisis or heightened distress exclude resort to coercive measures.

(d) Develop support for persons with disabilities compatible with the Convention and based on the will, preferences and choice of persons with disabilities. States parties should, ensure decent work for support workers, and support for family members with care roles, build capacity of family supporters, support workers and community-based support service providers to deliver support in line to the Convention.

(b) Combat and eliminate heightened and intersectional forms of disability-based violence

149. Gender-based violence and disability-based violence aggravate risks of violence against women and girls with disabilities and gender diverse and non-binary persons with disabilities, including those who are lesbian, gay, bisexual, transgender, intersex and queer. Intersectional forms of disability-based violence are yet to be recognized and addressed in policies for the prevention of violence, including those aimed at eliminating gender-based violence.

150. The Committee recommends that States parties:

(a) Adopt strategies to prevent and address disability-based violence on intersectional grounds;

(b) Ensure that legislation, policy and programmes for combating gender-based violence and discrimination recognize disability-based violence experienced by women and girls with disabilities and gender-diverse persons with disabilities, including violations of their sexual and reproductive health and rights;

(c) Adopt measures to enable women and girls with disabilities, to make autonomous decisions about their sexual and reproductive health and ensure that women have access to evidence-based and unbiased information. Women with

disabilities should be protected against forced abortion, contraception or sterilization against their will or without their informed consent. Women should neither be stigmatized for voluntarily undergoing abortion nor forced to undergo an abortion or sterilization against their will or without their informed consent;

(d) Exercise due diligence to prevent, protect, investigate, ensure accountability and effective remedies, including effective reparations for all forms of gender-based violence and disability-based violence against women and girls with disabilities, whether perpetrated by State actors, family members, intimate partners, caregivers, service providers, health professionals, private institutions or in the digital space;

(e) Provide comprehensive, accessible and non-discriminatory sexuality education to girls and young women with disabilities, both within and outside school. Parents and relatives need guidance on understanding the importance of sexuality education and respecting their children's right to express their views freely;

(f) Pay special attention to forms of disability-based violence against children with disabilities, including intentional killing and infanticide, and ensure accountability for perpetrators.

(c) Reinforcing independent monitoring and preventive mechanisms

151. Disability-based violence persists in the absence of or limited intervention of independent monitoring and preventative mechanisms of facilities and programmes for persons with disabilities.

152. **The Committee recommends that State parties:**

(a) Ensure the establishment of independent monitoring of all facilities and programmes, in line with the Convention as provided in articles 16 (3), and 33 (2), (3) and applicable general comments and guidelines adopted by the Committee;

(b) Ensure that National Preventive Mechanisms apply the Convention in examining disability-based detention, institutionalization, forced treatment, restraint, seclusion, denial of reasonable accommodation and other disability-specific forms of torture or ill-treatment. National Preventive Mechanisms should engage directly and confidentially with persons with disabilities, include relevant disability and survivor expertise within visiting teams, cooperate with representative organizations of persons with disabilities, and address laws and policies that authorize the practices observed;

(c) Ensure that independent monitoring mechanisms, including National Human Rights Institutions, other independent monitoring mechanisms and persons with disabilities and their civil society organizations, including survivors of institutionalization are allowed to conduct independent monitoring of all institutions where persons with disabilities still live, and to monitor deinstitutionalization processes;

(d) Ensure that monitoring findings, complaints and other credible indications of violence trigger immediate protective measures, preservation of evidence, independent investigation and, where appropriate, civil, administrative, disciplinary or criminal proceedings.

(d) Strengthen mechanisms for the protection and support for survivors of disability-based violence

153. The Committee observes with concern the lack of appropriate support, including recovery, rehabilitation, and social reintegration, available to persons with disabilities who have been exposed to disability-based violence; the unresolved trauma produced by this violence, and the limited access to information about protection against revictimization.

154. **States parties should:**

(a) Ensure the provision of gender- and age-responsive, disability inclusive, survivor-centred, culturally appropriate and trauma-informed support to survivors of disability-based violence. Such support and information should be provided in

accessible formats, including to persons still living in institutions taking into account the situation of persons with disabilities exposed to intersecting forms of discrimination. For persons in institutions, information and support should be available through confidential and independent channels outside the control of institutions or service providers;

(b) Ensure the availability of appropriate support throughout all stages of the process, from the detection of violence to the person's recovery. Support should enable persons with disabilities to access and understand relevant information, express their will and preferences, participate actively in decision-making processes, and avoid revictimization. Support measures must be provided in full respect of the person's autonomy and must not amount to substituted decision-making.

(e) Ensuring accountability and access to justice, including effective remedies

155. The overall lack of access to justice, redress and reparations for survivors of disability-based violence results from

(a) The denial of or restrictions to legal capacity deterring persons with disabilities to file complaints and be recognized as victims or witnesses in cases of disability-based violence;

(b) Challenges in reporting cases due to disability and gender-based discrimination, lack of credibility to the testimonies of persons with disabilities, isolation, in institutions or at home, the absence of reporting channels, especially in institutions and schools, and the lack of procedural and age-appropriate accommodation;

(c) The lack of support for survivors of disability-based violence to access to justice and additional distress when their cases are admitted and dealt with;

(d) The fear of retaliation and reprisals against persons with disabilities linked to dependency relationships, institutionalization and substitute decision-making regimes.

156. States parties should:

(a) Ensure that persons with disabilities access to justice on an equal basis with others, including effective remedies and effective reparation, including restitution, compensation, habilitation and rehabilitation, satisfaction and guarantees of non-repetition for the violations of their rights;

(b) Ensure that accountability for disability-based violence in care, support, health, residential and other services take into account not only the circumstances of individual perpetrator but also consider institutional and systemic factors that enabled, facilitated or concealed the violence;

(c) Ensure the immediate release of persons detained in mental health institutions and an end to non-consensual interventions, along with emergency assistance to leave places of arbitrary detention;

(d) Ensure that legal and justice responses are survivor-centred, trauma-informed, gender-and age responsive and disability-inclusive and address intersecting forms of discrimination heightening risks of violence;

(e) Provide accessible information and communication to all persons with disabilities seeking redress and ensure that communication differences associated with impairment are not treated as grounds for questioning the credibility, competence or reliability of a person reporting violence. Law enforcement authorities, prosecutors, courts and other justice actors should provide individualized communication support and appropriate procedural accommodations and should establish procedures for receiving, documenting and assessing evidence in ways that accommodate different forms of communication;

(f) Recognize and redress harm against survivors of institutionalization, forced treatment and any form of coercion in mental health services, including in cases where the infliction of such violence is still permitted in legislation, policies, and practices;

(g) Eliminate gender-based and disability-based discrimination impeding access to justice and ensure:

(i) Procedural accommodations, accessible communication, protection from retaliation, trauma-informed interviewing, privacy and confidentiality safeguards, and recognition of women and girls with disabilities as credible complainants, witnesses and rights holders, irrespective of guardianship status or perceived impairment;

(ii) Stereotypes about women with disabilities, sexuality, credibility, motherhood and capacity are explicitly addressed in police, prosecutorial and judicial training;

(iii) Cases of gender-based violence and disability-based violence are not mandatorily referred to mediation or conciliation, given the risk of coercion, revictimization and unequal power relations;

(h) Train law enforcement personnel about the dignity and rights of persons with disabilities, the credibility of accounts and testimonies of victims of disability-based violence and, appropriate case-management of reports and complaints;

(i) Establish and enforce guarantees of non-repetition, including the repeal of legislation, policies and practices which perpetuate disability-based violence, workforce vetting processes, and development of support services in the community, in line with the Committee's Guidelines on Deinstitutionalization, including in emergencies;

(j) Establish effective safeguards against any form of retaliation or adverse consequences, ensuring that survivors can exercise their right to effective judicial protection without fear of further harm.

V. Follow-up

157. The Committee invites States parties to report about implementation of these guidelines in their reports to the Committee and recommends that:

(a) States parties widely disseminate these guidelines;

(b) States parties conduct research about the complexity of disability-based violence, all its forms, trends, root-causes, prevalence, perpetrators and persons with disabilities affected. These data and findings shall inform policy design, implementation and monitoring;

(c) Independent monitoring mechanisms, including NHRIs, and national, regional and international mechanisms for the prevention of torture monitor measures to identify and address disability-based violence.

(d) Persons with disabilities and their representative organizations, are actively involved in monitoring

(e) The Global Disability Fund and United Nations agencies support implementation of these guidelines, including through their technical cooperation programmes;

(f) Humanitarian preparedness and response plans and comprehensive protection strategies include measures to identify and prevent risks of disability-based violence, and redress for survivors of violence in humanitarian contexts.