Revista Ponto de Vista Jurídico

doi.org/10.33362/juridico.v14i2.3966

Legal capacity and the prohibition of forced interventions under the Brazilian Inclusion Law

Capacidade civil e a proibição de intervenções forçadas na Lei Brasileira de Inclusão

Luana Adriano Araújo[1]

Recebido em: 19/11/2025
Aceito em: 14/12/2025

ABSTRACT: This article examines the persistence of forced interventions in the Brazilian legal framework a decade after the enactment of the Brazilian Inclusion Law (Lei Brasileira de Inclusão – LBI), which aimed at harmonizing national legislation with the Convention on the Rights of Persons with Disabilities (CRPD). Although the LBI formally abolished disability-based civil incapacity, limited guardianship to patrimonial affairs, and prohibited non-consensual medical and institutional interventions, coercive practices remain prevalent in areas such as reproductive regulation and psychiatric treatment. The first section examines the shift from discernment-based incapacity to the recognition of legal capacity, highlighting unresolved tensions between legal capacity and competence to consent. The second section refers to the LBI's prohibition of forced interventions, in contract to ongoing forms of coercion. It concludes that the transformative potential of the LBI and the CRPD depends on the dismantling of said coercive practices.

Keywords: Legal capacity. Disability rights. Forced interventions.

RESUMO: Este artigo analisa a manutenção de intervenções forçadas no ordenamento jurídico brasileiro uma década após a promulgação da Lei Brasileira de Inclusão (LBI), que buscou harmonizar a legislação nacional com a Convenção sobre os Direitos das Pessoas com Deficiência (CDPD). Embora a LBI tenha formalmente abolido a incapacidade civil baseada na deficiência, restringindo a curatela a assuntos patrimoniais e proibido intervenções médicas e institucionais sem consentimento, práticas coercitivas continuam recorrentes em áreas como o controle reprodutivo e o tratamento psiquiátrico. A primeira seção examina a transição da incapacidade baseada na categoria "discernimento" para o reconhecimento da capacidade legal, destacando tensões não resolvidas entre capacidade jurídica e competência para consentir. A segunda seção trata da proibição legal de intervenções forçadas, contrastando-a com formas de coerção ainda em curso. Conclui-se que o potencial transformador da LBI e da CDPD depende da eliminação de tais práticas coercitivas.

Palavras-chave: Capacidade legal. Direitos das Pessoas com Deficiência. Intervenções Forçadas.

---

[1] Doutora em Direito (UFRJ). Universidade Federal do Rio de Janeiro. ORCID: https://orcid.org/0000-0002-6761-837X. E-mail: luana.adriano88@gmail.com.

INTRODUCTION

The approval of Law nº 13.146/2015, the Brazilian Inclusion Law (Lei Brasileira de Inclusão – LBI) marked one of the most ambitious legal attempts in the Global South to harmonize domestic legislation with the transformative content of the Convention on the Rights of Persons with Disabilities (CRPD). By reforming status-based civil incapacity and affirming full legal capacity for persons with disabilities on an equal basis with others, the LBI provided for a paradigmatic shift towards supported decision-making and autonomy-centered disability rights. In line with this orientation, the LBI also expressly prohibited forced or non-consensual interventions, reinforcing the requirement for prior, free, and informed consent for any treatment, hospitalization, procedure, or scientific research. Yet, ten years later, the implementation of this perspective is still at odds with persistent legal, clinical, and administrative practices that maintain substituted decision-making schemes that rely on paternalistic rationales. Therefore, despite the LBI's clear prohibition of disability-based restrictions to civil capacity, coercive practices – including involuntary hospitalization, forced sterilization, and compulsory therapeutic programs – continue to be normalized and oftentimes judicially authorized.

This article examines the state of forced intervention a decade after the enactment of the LBI, arguing that the endurance of coercive practices reveals the persistence of a epistemic and institutional framework that equates disability with impaired autonomy, risk, or dangerousness. These practices show how the civil capacity reform performed in Brazil remains vulnerable to medicalized governance and ableist assumptions that structure clinical protocols and administrative regulation. In response to that, the article proposes a reinterpretation of the LBI that takes prohibition of forced interventions not as peripheral or minimum safeguard, but as a necessary condition for the effective realization of full recognition of equal capacity. In the first part, I trace the shift from the discernment-based regime of civil incapacity to the autonomy-centered framework introduced by the LBI, clarifying how guardianship is limited to patrimonial acts and problematizing the residual space of health-related decision-making. I also explore the remaining tension between legal capacity and competence to consent, arguing that biopsychosocial assessment tools and supported decision-making can be mobilized to operationalize a complex, non-coercive model of decision-making in healthcare. Secondly, I will focus on the terrain of forced interventions in Brazil – specifically in the areas of forced sterilization and compulsory therapeutic programs, showing that recent legislative and policy developments reveal a worrisome resurgence of coercive practices.

LEGAL CAPACITY, DISABILITY AND HEALTH-RELATED DECISION-MAKING

The topic of legal capacity was one of the most controversial in the drafting process of the CRPD (Francis, 2021; Degener, De Castro, 2022; Pyaneandee, 2018; Series; Nilsson, 2017; Arstein-Kerslake, Flynn, 2017). The approved text of CRPD's article 12 extols the importance of promoting the individual autonomy of the person with disability, which undeniably comprises the freedom to make their own choices. The article thus provides that persons with disabilities shall be recognized to enjoy legal capacity on an equal basis with others in all spheres of life (§2), with appropriate measures taken to provide the support they need for the effective exercise of legal capacity (§3), combined with the adoption of safeguards to ensure respect for their rights, wills, and preferences (§4). It further establishes that such measures must be proportionate and adjusted to personal circumstances on a case-by-case basis, applied for the shortest possible period, and subject to regular review (§4). With the coming of national reports as a fulfillment of Parties' obligations to the United Nations (Art. 35), the Committee on the Rights of Persons with Disabilities noted that there was a collective misunderstanding in the interpretation of the scope of article 12, this being the reason why the first general comment produced by this entity was related to this article. While General Comment nº 1/2014 came to life, the final discussions on the drafting of the LBI – Brazilian Inclusion Law – were happening in Brazil. This temporal concomitance had the effect of supporting the progressive reforms the law promoted on the Civil Capacities System in the Civil Code (CC). According to what was then written in the CC, were listed as absolutely incapable of exercising personally the acts of civil legal life (i) those under sixteen years of age; (ii) those who, due to infirmity or mental disability, do not have the necessary discernment to perform such acts; and (iii) those who, even for a temporary cause, are unable to express their will (art. 3). At that time, the category of those relatively incapable of certain acts or regarding the manner of exercising them fell upon (i) those over sixteen and under eighteen; (ii) habitual drunks, drug addicts, and those whose discernment is reduced by mental disability; (iii) persons with special needs, without complete mental development; (iv) prodigals. This recognition of incapacity comes on the heels of an inadequate equalization between legal incapacity and vulnerability. Not for another reason, it was said that:

> The institute of incapacities was imagined and built on a morally high reason, which is the protection of those who are carriers of a legally appreciable disability. The intention of the law was to offer protection to people suffering from incapacity, considering the diversity of personal conditions of those who are incapable and the greater or lesser depth of the reduction in discernment, graduating the form of protection (Pereira, 2002, p. 170). [highlights inserted]

A still unsolved mystery of the original CC wording is the meaning of "discernment" – let alone "reduced discernment" or "absent discernment". This expression appears for the first time in the CC of 2002, substituting the deemed to be discriminatory expressions of the CC of 1916. The latter qualified people with mental or intellectual disability as the ones who have "insanities of all kinds", thus preventing them from practicing acts of civil life due to their incapacity. The CC/2002 maintained the idea that disability generates incapacity, but now the apparently neutral and vague term "discernment" was used to measure when such an incapacity should be total or partial. From this legislation on, a new qualifying classification of capacity is established, namely "discernment", reiterated in other precepts of CC/2002, such as in article 282 (inability to appear as a witness of those who do not have discernment); article 1.548 (nullity of marriage contracted with a "mentally ill person lacking the necessary discernment"); article 1.767 (subjection to guardianship of those lacking the necessary discernment); and article 1.860 (impediment to the right to make a will for those lacking "full discernment"). It is important to highlight that even if we were to adhere to a medical, individualized model of disability, there is no such epistemological category of "discernment" in either the fields of psychology or psychiatry. Its use centralized the decisional authority over legal capacity in the hands of judges and court-appointed experts, the latter using a variety of assessment tools whose credibility could not be guaranteed, allowing for wide interpretative discretion. Although vague, its use was then celebrated because it implied leaving in the past discriminatory assumptions related to terms such as "madness" and "insanity". The CC/2002 created a category vague enough to allow for equalization between a disability (mental, intellectual and psychosocial) and a civil incapacity, without it seeming that the approach is status-based (because it supposedly would be based in discernment, not diagnosis). As stated by Adriano Araújo:

> [U]navoidable discourses - and the more they are unavoidable the more simplifying they become - on legal capacity have proven so effective in perpetuating the marginalization of disabilities through prayerfully repeated slogans such as: "capacity is the measure of personality" or "discernment is the measure of the quality of will" or even "to have discernment is to have the capacity to understand and to exercise will". Although this discourse of truth seems more sophisticated than the previous idea of attributing absolute incapacity to the "insane of all kinds", "discernment," "personality," "will," "to will," and "to understand" do not lose their semantic complexity because the law decides to cement the millennial discussions about their meanings. Even so, it is almost a ritual of the constitutional/contemporary Brazilian private law scholar to ostracize the former "insanity of all kinds", declaring that on the other hand "discernment" was a category that was clear, clean, and moreover purged of prejudices. Therefore, the CC/1916 often needs to die once again, whenever a defense of the CC/2002's discernment is raised against the changes proposed by Law No. 13,146/2015 (called the "Brazilian Inclusion Law" - LBI) (Adriano Araújo, 2022, p. 1283).

The entry into force of the LBI changes this reference to "discernment". In fact, the assessment of civil capacity based on the modification made by art. 114 of the LBI points only to an objective criterion for the declaration of absolute civil incapacity, which is age: all those under sixteen years of age are deemed to absolutely lack civil capacity. On the other hand, relative civil incapacity is attributed to those older than sixteen and younger than eighteen; for habitual alcoholics and persons with drug dependence; for those who, for a temporary or permanent reason, cannot express their will; and for prodigals. The law thus determines the extinction of the declaration of civil incapacity based on the status of the disability, maintaining, however, the possibility that relative civil incapacity is recognized for those who are unable to express their will. Said modification was immediately challenged through Bill nº 757/2017, which sought to restore the category of discernment. This bill was justified on the notion that the LBI promoted disenfranchisement by recognizing full legal capacity regardless of disability. On the other hand, the Bill was also motivated by the need to harmonize the LBI with the new Code of Civil Procedure, which came into force three months after the LBI went into effect (Tartuce, 2017; Menezes, 2017). The most relevant point of the proposed amendment touches on the question of whether guardianship can interfere in the sphere of personal matters, including decisions related to bodily autonomy and exposure to intrusive or potentially coercive interventions. In this part, I hence will briefly discuss: the question of whether guardianship (curatela) can allow for interference in ward's personal and non-transferable rights under LBI; the idea of a biopsychosocial approach to disability and its possible connection with decision-making; and the relationship between supported decision-making (tomada de decisão apoiada) and healthcare interventions.

Before going into these topics, one caveat must be made. We cannot immediately rely on looking for the positions expressed by stakeholders during the drafting process of the law as an interpretative source. This is due to the legislative process that preceded the enactment of the LBI. In a tight summary[2], the idea of a separate law to establish the rights of people with disabilities goes back to Bill nº 3.638/2000, authored by Deputy Paulo Paim. The initiative of making a separate Statute to deal with disability issues was not so well accepted by the social movement of persons with disabilities. Some segments understood that disability is an intersectional agenda that should be considered in laws aimed at ensuring rights to all. In opposition to this perception, in 2007, in a message that submitted the text of the CRPD to the National Congress for consideration of approval with constitutional status, Deputy Eduardo Barbosa pointed out that:

> [A]lthough our country has a wide range of laws and regulatory decrees in favor of people with disabilities, these are not fully effective, either because many rights are found in decrees without coercive force, due to the lack of norms that impose sanctions on transgressors, either because the great proliferation of laws and decrees occurs in a disorderly and unsystematic way, making it difficult for the operator to apprehend and correctly apply the provisions (Brasil, 2008, p. 4).

Three years after the first unsuccessful proposition, in 2003, Paulo Paim, then a Senator, again proposed a bill to deal with the rights of people with disabilities: Bill 6/2003. Both projects proposed by the parliamentarian could not significantly advance in the legislative chambers until the year 2006. It was only that, along with the finalization of the CRPD text, that resistance from segments of the disability movement – who had previously argued that a specific statute on disability would be unnecessary and exclusionary – began to diminish. In this context, the second proposal, Senate Bill 6/2003, was approved in plenary and moved on to debate in the Chamber of Deputies, where it was rebranded as Bill nº 7.699/2006, the proposal that would later become the LBI. Dozens of other disability-related bills were appended to it, in parallel with the process of approving the CRPD with constitutional status. Due to the sheer size of the bill and the large number of appended proposals – which made the text practically intangible and extremely difficult to debate

---

[2] This summary is based on Rocha e Oliveira (2022); Braga (2021); Lanna Júnior (2010).

coherently – it came to be nicknamed as a "legal Frankenstein" (Adriano Araújo, 2022). Only in 2011 was the project revisited by the Joint Parliamentary Front for the Defense of the Rights of People with Disabilities and subsequently by a special Working Group of the Secretariat for Human Rights, tasked to debate the proposed text in accordance with the CRPD. It was within this Working Group that a substitute draft to the original bill was produced. Later, Congresswoman Mara Gabrilli introduced yet another comprehensive substitute text, incorporating both the Working Group's proposal and more than 313 amendments admitted to Bill 7699/2006. For this reason, it is difficult to directly assess the historical rationale behind each specific article of the LBI. For example, it is unclear why the original bill's explicit prohibition of forced institutionalization aimed at "correcting" disability (art. 15 of the initial proposal) was replaced with a softer provision that omitted reference to this prohibited purpose (art. 11, analyzed in the second part of this text).

Regarding the extension of guardianship over personal and non-transferable rights[3], it is relevant to point out that the LBI reduces the scope of guardian's duties. According to article 6, disability does not affect the civil capacity for: marrying and entering affective relationships; exercising sexual rights and reproductive rights; exercising the right to decide how many children to have, and to obtain adequate information about reproduction and family planning; preserving fertility; exercising the right to family and community life; and exercising the right to be a guardian, a trustee, an adopter, or an adoptee in equal basis with others. Furthermore, article 85 states that guardianship will only affect acts related to patrimonial and contractual rights – it cannot provide for interference in ward's rights to bodily autonomy, to sexuality, to matrimony, to privacy, to education, to health, to entering the labor world, and to vote. Guardianship in general should constitute an extreme measure, and sentences that establish it must state the motivations for its definition, safeguarding the interests of the ward (art. 85, § 2º). Since guardianship cannot interfere with personal non-transferable rights, it would not be a stretch to claim that under the LBI there is no plenary guardianship other than the one

---

[3] The definition in Brazilian law of such prerogatives is "direitos personalíssimos", which encapsulates extra patrimonial rights non-transferable, permanent, and owed toward all. Since 'personality rights' do not encapsulate well this notion – because certain personal and non-transferable rights in Brazilian legislation are not directly connected to the protection of human dignity, such as the right to receive spouse or marital support (in Brazilian law stablished at CC's article 1.694). For that reason, I chose to translate these set of rights – which include the right to give consent when conditions for direct consent-giving are present – as "personal non-transferable right".

established by age. All other regimes of guardianship established due to relative civil incapacity should be deemed as limited to patrimony and contractual rights. This provision is made due to the long history of judicial recognitions of plenary non-tailored guardianships, which took Brazilian scholarship to call “curatela” the civil death (“morte civil”) of the ward (Souza; Silva, 2017; Menezes; Teixeira, 2016).

As the listed rights in articles 85 and 6 are classified as personal and non-transferable, they cannot be exercised under a substitute decision-making scheme – e.g., legally valid consent to sexual relationships could not be given by proxy. For the purposes of our discussion, the central question is whether the right to give consent to interventions such as hospitalization, when the circumstances for direct consent-giving are present, should also be understood as a personal and non-transferable right. The first issue to consider is whether there is, strictly speaking, a “right to consent”, not to be waived in any circumstances. In liberal democratic societies, the right to self-determination is widely recognized, yet self-determination does not always overlap with a right to informed consent. A person may waive the prerogative of being asked for consent by requesting not to be informed or may delegate decision-making authority to a third party. Where informed consent is a mechanism for self-determination to be operationalized, or whether it constitutes a personal and non-transferable right in itself, is a far more complex question. For present purposes, it is difficult to affirm, without sufficient safeguards, that a possible right to informed consent is necessarily personal and non-transferable. The second issue to consider is that informed consent is clearly not related to patrimonial matters. According to one interpretation, the wording of the LBI, guardianship cannot be used to provide consent by proxy in the name of the ward[4]. This does not mean, however, that no decision can ever be made on someone’s behalf in the personal sphere. Civil incapacity merely refers to a de jure acknowledgement that the person must be represented so that certain rights can be exercised. Health competency assessments, by contrast, do not always depend on a legal declaration and must be context-sensitive, varying according to the specific healthcare intervention at issue[5]. As explained by Leo, a patient

---

[4] This is, in a way, at odds with article 11, sole §, which allows for consent in health-related decision-making to be supplied in the case of persons under guardianship by means of surrogate decision-making, as provided by law.

[5] Supporting this interpretation, see Appelbaum, 2007; Grisso, Appelbaum, 1998, 1995, the proponents of a functionalities-based approach focused on assessing the specific skills required to make particular decisions. Such an approach is deemed flawed by the CRPD’s committee due to it being discriminatory towards people with

deemed to “lack capacity to make reasoned medical decisions is referred to as de facto incompetent, i.e., incompetent in fact, but not determined to be so by legal procedures” (LEO, 1999, p. 132). In a sense, such individuals would not be able to exercise the right to choose or refuse treatment, and they demand the presence of a de facto surrogate, to make decisions on their behalf.

The easy conflation between competence for consent and legal capacity has been useful for protecting physicians’ liability and for optimizing healthcare organization, since it is time- and effort saving to assume that all persons under guardianship must have their decisions made by someone else. In response to this conflation, Brazilian authors have recently suggested that civil or legal capacity should be differentiated from a distinct notion of “sanitary” or health-related capacity (Albuquerque; Antunes, 2021; Eler, 2022), which would allow, e.g., minors who objectively lack civil capacity to nonetheless possess competence to consent to certain treatments. Moreover, because there is no such a differentiation between legal capacity and healthcare decision-making competence, judicial ruling has directly contradicted the LBI’s explicit prohibition on extending guardianship into the realm of personal and non-transferable rights – such as the right to self-determination in healthcare decision-making. This is not only unconstitutional under the CRPD, but it also misconstrues the nature of health competency assessments, which cannot be treated as one-time evaluations conducted by court-appointed experts in isolation from specific, contingent, and time-sensitive healthcare contexts. Although proposing that competency assessment should not depend on guardianship raises several operational challenges, there are ways to mitigate the burden on healthcare professionals – for instance, by limiting the need for detailed assessments to cases involving intrusive or high-risk interventions.

Another way to think about this relationship between legal capacity and decision-making competence is through a reconsideration of the biopsychosocial model of disability. According to art. 2, § 1º, of LBI, the evaluation of disability, when needed, will be biopsychosocial, carried out by a multi-professional and interdisciplinary team. It will consider: the impairments in the functions and structures of the body; the socio-environmental,

---

disabilities and because it presumes an ability to accurately assess the inner workings of the human mind; when a person fails such an assessment, he or she is consequently denied equal recognition before the law (Committee, 2014, par. 15) psychological and personal factors; the limitation in the performance of activities; and the restriction in participation. § 2º of the same article points out that the government will create instruments to evaluate disability according to said factors. This orientation was aimed at getting away from an identification fundamentally based on biomedical diagnosis. To this end, it seeks to guide the identification of incapacity in a manner compatible with the metrics of the ICF (International Classification on Functioning, Disability, and Health) produced by the World Health Organization (WHO). While the International Classification of Diseases (ICD/WHO) provides codes for classifying pathological conditions, underlying medically centered models of disability, the ICF is designed to understand an individual's functionality and health experience. As Bickenbach states the center of gravity of ICF is "the universal human experience of functioning across a spectrum, from the most basic biological function to activities simple to complex, to, ultimately, the most complex, and relatively more socially constructed, domains of participation" (2019, p. 57). Other biopsychosocial tools include the Nagi model and the Québec model, but so far the ICF remains the most influential and the most extensively tested across cultural and linguistic contexts[6].

The first uses of a biopsychosocial model in public policies for disability in Brazil date back to the MDS/INSS Joint Ordinance no. 1/2009, which included the participation of social workers in the evaluation of the criteria that must be met for a person to receive a welfare benefit – namely Benefício de Prestação Continuada (BPC). Along these lines, Law nº 12.435/2011 qualified a person with disability, for the purpose of access to said benefit, as the one who has long-term impairments which, in interaction with several barriers, hinder his/her full and effective participation in society with other people. In the same year, a group composed by government and disability scholars began to adapt the ICF to the Brazilian context. The IF-Br (Índice de Funcionalidade Brasileiro) was then published in 2013 (Biz; Chun, 2019; Nunes; Leite; Amaral, 2022). This index comes into force along with Complementary Law nº 142/2013, which establishes the criteria for special disability-related retirement

---

[6] Another point should be made. The ICF is a classification tool for evaluation of the individual experience of disability, given that disability mapping must consider a spectrum of functionalities. On the other hand, the Washington Group guidelines, as well the Model Disability Survey of WHO, are tools for collection of epidemiological data about disability at national and regional level. What matters to us the most is to highlight that the idea of a biopsychosocial model of disability started to slowly enter the national scenario both through orienting epidemiological tools for data collection and through reforming the tools that were used in disability-related to policies to evaluate the presence of a disability correlated to legal claims.

(Pereira; Barbosa, 2016). In view of the biopsychosocial assessment recognized by the LBI, and the fact that different instruments are still in use for different disability-related policies, it was created in 2017, by Decree nº 8.954/ 2017, the Committee of the National Registry for the Inclusion of Persons with Disabilities and the Unified Disability Assessment, formed by members of the Government and researchers from University of Brasilia. After a validation period, the index was renamed and published as the IFBr-M. The main difference between the first and second versions is that the initial instrument had been validated within a very narrow population: workers with disabilities seeking special retirement. The second version, on the other hand, was validated with the participation of more than 8000 persons with disabilities in Rehabilitation, Psychosocial Care, and Health Centers across both urban capitals and rural areas in all five Brazilian regions. It is therefore the most comprehensive tool developed to capture the multiple realities of disability in the country. Following the validation of the IFBr-M, a new Working Group was established to examine which normative modifications would be necessary to standardize the instrument's use. The final report of this group, created by Decree nº 10.415/2020, stated that the IFBr-M cannot be applied to determine disability status for policy purposes, given the binary architecture of most disability-related programs – that is, most policies do not treat the spectrum of functionality as normatively relevant, but instead rely on a disability/non-disability binary for rights attribution. Thus, the very strengths of the IFBr-M – namely, its in-depth and individualized assessment based on a biopsychosocial framework - were the reasons why the report of the last Working Group considered it inadequate to deal with the way disability policies are constructed.

Although this description of the events concerning biopsychosocial assessment seems, at first glance, to argue against the usefulness of the approach for evaluating competence to consent to health procedures, it could prove valuable for operationalizing a complex decision-making scheme that acknowledges self-determination while providing structured safeguards against heteronomous and potentially coercive interventions. Such a scheme must reframe consent not as a capable/incapable binary, but as an ongoing dialogically structured multistep process. Moreover, the very process of construction of the instrument – with the involvement of persons with disabilities, an explicit commitment to autonomy, and an evidence-based methodology – may provided important insights for an assessment metric for competence in healthcare decision-making. For this reason, just as the WHO's QualityRights initiative launched, in 2016, a module focused on the right to legal capacity, it will be necessary to articulate a similar instrument focused specifically on assessing competence to make health decisions. Such an instrument could be built in alignment with the ICF, which already employs a biopsychosocial perspective[7]. Establishing cut-off points will inevitably be difficult, and the more sensitive the scale must be to the contingent, context-specific nature of competence assessments, the greater the methodological challenges. Nevertheless, such assessments remain essential to ensure that disability-related support policies reach those who need them. Once we understand competence assessment as mechanisms that enhances, rather than restricts, decisional capacity – and not as another layer of structural ableism – it becomes possible to design tools genuinely committed to supporting self-determination.

One last observation about supported decision-making (Tomada de Decisão Apoiada - TDA) must be made before we deal with LBI's provisions related to forced interventions. This institute is established by the modification operated by the LBI in art. 1.783-A and its paragraphs in the Civil Code. The TDA aims to promote the interests of the person who requires support in conducting his or her patrimony-related affairs, while safeguarding that person's agency in the ownership and exercise of rights. In this sense, the person who enters into a TDA requires only the type of support that enables the direct expression of his or her legal capacity, in accordance with CRPD's article 12. It is relevant to recall that the CRPD Preamble establishestwo interpretative parameters for understanding the scope of supported decision-making. First, the guarantee of the protection and assistance necessary for the full and equal exercise of the rights of people with disabilities (preamble item x). Second, the recondition of the importance, for persons with disabilities, of their individual autonomy and independence, including the freedom to make their own choices (preamble item n). Taken together, these provisions create an interpretative guideline with dual orientation: safeguarding autonomy while ensuring the necessary protections. Moreover, there is a specific provision in CRPD's regarding the principle of respect for inherent dignity and

---

[7] It is, however, relevant to mention that the functionalities-based perspective is not immune to critiques. Although they seek to bring together biomedical and socio-political perspectives, functionality classifications face different kinds of critique within rehabilitation (Mosleh, 2019), the sociology of health (Imrie, 2004), critical disability theory (Campbell, 2012), and even from theorists of the social model themselves (Oliver; Barnes, 2012, p. 26). Overall, the central problem addressed by these critiques is that, in attempting to produce scales of limitation across different domains of functionality according to statistical parameters, such classifications fail to break with a logic that measures disability as an individual, deficit-based attribute.

individual autonomy, including the freedom to make one's own choices, and the independence of persons (art. 3, 'a'), which must be read together with the principle of respect for difference (art. 3, 'd'). From these, it follows that the convention guarantee is that at all times, including in crisis situations, the individual autonomy and decision-making capacity of persons with disabilities must be respected.

In the case of TDA, the supporter acts as a facilitator in the decision-making process, providing the assistance necessary for the supported person's will to be expressed. He or she is not a mere adviser, since the supporter has standing to bring before the judiciary an objection to a legal transaction that, even if approved by the supported person, may pose risks (art.1.783-A, §6, of the CC). Given the lack of provision that the TDA is restricted only to patrimonial and contractual acts - as we see in relation to the guardianship – it may be assumed that a TDA can be established to provide support even in the exercise of non-transferable personal rights, as in matters related to intimacy and health care. As Menezes points out, nothing prevents it [TDA] from even influencing domestic routine decisions or those pertaining to personal health care" (2018, p. 1207).

PROTECTION AGAINST FORCED HEALTH INTERVENTION UNDER THE LBI

According to art. 25 of the CRPD, persons with disabilities have the right to enjoy the highest attainable standard of health, and it is necessary to ensure the requirement of informed consent prior to any medical or research intervention. Specifically, regarding consent to medical or scientific experimentation, the CRPD equates this practice when conducted without free consent to inhuman treatment (art. 15, 1)[8]. This assurance of informed consent is intimately connected to the recognition of legal capacity on an equal basis with others (art. 12) and to the ban on non-consensual institutionalization on the basis of disability (art. 14). This normative framework is directly incorporated into Brazilian domestic law through article 12 of the LBI, which provides that "the prior, free, and informed consent of the person with a disability is indispensable for the performance of treatment, procedures, hospitalization, and scientific research" (article 12). In situations where the person is under

---

[8] This is in line with the Newak report, in which it is stated that "whereas a fully justified medical treatment may lead to severe pain or suffering, medical treatments of an intrusive and irreversible nature, when they lack a therapeutic purpose, or aim at correcting or alleviating a disability, may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned" (2008, p. 47).

guardianship, the statute requires that "his or her participation must be ensured, to the greatest extent possible, in the process of obtaining consent" (article 12, § 1).

Along those lines, there is also a specific provision prohibiting forced interventions, stating that "a person with a disability shall not be compelled to undergo clinical or surgical intervention, treatment, or forced institutionalization" (article 11). This relates to Brazil's history of disrespect for human dignity in health-related contexts enabled by psychiatric diagnoses. This is the reason why the Committee recommended, in its final report on monitoring the CRPD's implementation in Brazil, that the country should take steps to abolish the practice of involuntary commitment or hospitalization, to prohibit forced and medical treatment, in particular psychiatric treatment, on the basis of impairment, and to provide sufficient community-based alternatives (COMMITTEE, 2015, par. 29). It also expressly manifested a deep concern that children and adults under guardianship can be sterilized without their free and informed consent, due to Law nº. 9.263/1996, reporting concern that the LBI would authorize "surgical treatment on persons with disabilities under curatela, in the absence of free, prior and informed consent, on an equal basis with others" (COMMITTEE, 2015, par. 34)[9]. In Brazil, the case of sterilization without informed consent of women with disabilities under guardianship is still a matter of concern, even after the enactment of the LBI (Adriano Araújo; Araújo, 2021; Nielsson; Weiler, 2025)[10].

These procedures of forced sterilization and forced institutionalization are of relevance to national disability legal scholarship due to the fact that, after the enactment of LBI, the legislative scenario in these matters drastically changed in order to ensure self-determination

---

[9] This manifestation was particularly sensitive, considering that, at the time the Committee issued its final conclusions on the Brazilian report, the LBI was yet to come into force in January 2016. In the years that followed that report, we also saw the publication of the Report on the Right to Health by the Special Rapporteur on the Rights of Persons with Disabilities, in which a clear concern was shown with the existence of regulations that still allow the performance of interventions of clinical nature without the informed consent of the affected person In this report, the need to eliminate all substitute decision-making schemes and use the best interest standard is reaffirmed, in addition to highlighting the non-respect of free and informed consent as a human rights violation (UN, 2018, par. 15, 72). In line with these observations, a new report on ableism in clinical settings was released in 2020, recommending that all domestic legislations should recognize the right of persons with disabilities to provide free and informed consent to any medical and scientific procedure, and provide the necessary support to exercise this right (UN, 2020, para. 76, b).

[10] There is an intimate correlation in judicial reasoning between forced interventions such as involuntary sterilization and denial of legal capacity. As stated by Keys (2017, p. 334), "if a person is deemed to lack capacity and sterilisation is considered in her best interests as the least intrusive means, then it is likely that the sterilisation will be carried out". However, it should be also noted that even in supported decision-making, such intrusive actions could be committed, and, what is more, with less accountability on the deemed to be supporter of the decision.

of the person forced to undergo intervention. What is more, as stated by Stein, Stein and Blanck, laws providing for lifelong involuntary institutionalization and forced sterilization are outcomes of "paternalism, alleged public health and safety concerns, and the presumed incompetence of people with disabilities to participate in ordinary social functions" (2009, p. 334).

At the moment, it is still possible to find judicial decisions authorizing the procedure when the person to be sterilized is under guardianship (Adriano Araújo; Araújo, 2021; Nielsson; Weiler, 2025) . This is so because the provision on judicial authorization for such procedures remains in force in article 10, § 6º of the Family Planning Law, even after the parliament had the opportunity to reform the statute to remove the requirement of spousal consent for competent women who request sterilization (cf. Law nº 14.443). The maintenance of this possibility in our legal system is deeply concerning, especially considering 1) the irreversibility of such interventions; 2) the undue conflation between sexual rights and reproductive rights; 3) the perpetuation of myths regarding persons' with disabilities competence for motherhood and for sexuality – separately; and 4) the continued use of a rationale that sterilization is a practice aiming at protection[11].

Yet another common practice regarding undue interference in sexual and reproductive rights is the increasing use of chemical castration methods which supposedly tame undue sexual behaviors. Dealing with a specific case of a parental request for chemical castration of a 12-year-old autistic male, Coshway et al. (2015) have demonstrated the number of problems related to conducting such an intervention, including not only long-term individual side effects, but a continuation of "the long historical context of involuntary sterilization of individuals with ID [intellectual disability]" (2015, p. 3)[12] [13]. As they state, before hormonal

---

[11] This rationale was found in decisions granting authorization for sterilization (Araújo et al., 2017). This is, however, a non-justified rationale. In fact, it could be said that the sterilization, besides being a second violation, also puts sterilized persons at a greater risk of sexual abuse. Such rationales are the outcome of a "web of negative assumptions about the sexuality and possible future maternity of women with mental disabilities" (Jackson, 2001, p. 55).

[12] The story of Chemical castration and autism is more complex than the mere reducing of inappropriate sexual behavior. Given the widespread theory of the "extreme male brain" proposed by Baron-Cohen, a series of studies aiming at reducing such extreme maleness were conducted in the first decade of the 2000's (cf. Fitzpatrick, 2009, p. 62). In 2006, specific research reported the treatment of 100 autistic children with what was called the Lupron protocol. It combined the administration of a synthetic gonadorelin analogue to inhibit the production of androgens with heavy metal chelation. The withdrawn paper can be assessed at Geier and Geier (2006).

[13] It is not yet known if pharmacotherapeutic treatments are indeed effective in containing sexual behavior in autistics. What is more, the widespread use of hormonal and psychotropic substances with the aim to reduce

therapy is considered, the patient in question “should receive developmentally appropriate sexual health education that includes discussion of the basic facts of life, reproduction, sexual intercourse, human growth and development, human reproduction and anatomy, and self-pleasuring/masturbation” (2015, p. 4). Even though non-consensual chemical castration can be more clearly framed as a breach on basic rights, we should also be aware of cases in which the sexually and reproductive invasive interventions are made under the disguise of health-related services, e.g., birth control and menstruation management[14] (Mykitiuk; Chadha, 2018, p. 191).

A recent legislative development of particular concern regarding sexual and reproductive rights of persons with disabilities is Bill nº 5.679/2023, currently under consideration in the Brazilian Chamber of Deputies, which proposes significant amendments to §6º of Article 10 of the Family Planning Law. The bill wants to expand the possibility of non-voluntary surgical sterilization, expressly authorizing the procedure for persons “with intellectual or mental disabilities who are unable to express their will”. Under the proposal, sterilization could be carried out upon judicial authorization, with mandatory participation of the Public Prosecutor’s Office. By requiring solely judicial authorization, the bill renders the provision self-executing, dispensing with the regulatory decree that the current provision conditioned implementation upon[15]. It is also established priority for the procedure within the public health system.

The bill’s exposition of motives hinges on deeply problematic assumptions, including the claim that “persons with disabilities or severe mental disorders with exacerbated sexuality” create “family dramas” involving successive pregnancies of “newborns with sequelae, unwanted and maltreated,” which allegedly burden grandparents and caregivers. Based on this eugenic line of reasoning, the facilitation of judicial authorization for sterilization is qualified as a preventive measure to “avoid greater harm” and even as mechanism for

---

sexual behaviors can cause many harmful side effects. The use of luteinizing hormone in a growing child, for example, has been associated with longstanding hypogonadism, osteoporosis, and higher incidence of fracture. Short term side effects “include injection site pain, abscess or local reaction, and growth suppression from loss of testosterone-mediated growth” (Coshway et al, 2015, p. 2).

[14] What is more, menstrual management itself can be used as a justification for guardians to require sterilization. According to the report ‘Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement’, “women and girls with intellectual disabilities may receive involuntary surgical treatments, such as endometrial ablation and hysterectomy, to induce amenorrhoea, on grounds of menstrual hygiene or menstrual management; treatments that result in sterility” (Who, 2014, p. 6).

[15] It is important to say that this regulation, however, never came to existence.

"optimizing sexual rights". The justificatory message further asserts that people with intellectual or mental disabilities are significantly less capable of responsible sexual behaviour than those with "preserved discernment". The use of this term resurrects a normative marker explicitly excluded by the LBI in its definition of civil capacity. Unsurprisingly, the proposal has been met with substantial critics (Rede-In; Coletivo Artigo 12, 2024; Nielsson; Weiler, 2025). Legal scholars and human rights advocates warn that its approval would exacerbate the vulnerabilities already entrenched by the existing wording of article 10, §6º. Rather than moving forward to align Brazilian legislation with the autonomy-based paradigm of the CRPD, the bill reinforces a paternalistic, carceral, and reproductive control approach toward persons with disabilities, a profound normative repression.

The case against forced sterilization is comparatively more straightforward than the case against forced institutionalization. One of the reasons for this is that sterilization procedures – whether through hormonal contraception, surgical methods, or chemical interventions – rarely meet the threshold of urgency or necessity to prevent imminent harm. In contrast, the rationale behind forced institutionalization is often framed in terms of public health and safety. Psychiatric interventions, particularly involuntary hospitalization, are frequently justified based on preserving the collective good and mitigating perceived threats to social order. In Brazil, the history of forced institutionalization reflects both a crude logic of social hygiene and a paternalistic claim to protecting the public from the so-called dangerousness of certain individuals (Amarante, 1998, 2003; Amarante; Nunes, 2018; Amarante; Torre, 2018). A paradigmatic example is the case of Damião Ximenes Lopes, who died on October 4, 1999, after being institutionalized for psychiatric treatment at the Casa de Repouso Guararapes in Sobral, Ceará. His death led to the first condemnation of Brazil by the Inter-American Court of Human Rights for violations of his rights to life and personal integrity, as enshrined in articles 4.1, 5.1, and 5.2 of the American Convention on Human Rights. The case brought international attention to systemic abuse and mistreatment occurring in Brazilian psychiatric institutions. It is precisely in response to this historical backdrop that Brazil's psychiatric reform movement emerged, culminating in the enactment of Law nº 10.216/2001, according to which psychiatric hospitalization must be based on a detailed medical report justifying the necessity of the intervention[16] (art. 6). Hospitalization is deemed "involuntary" when it "occurs without the user's consent or at the request of a third party" (art. 6, II), and "compulsory" when determined judicially (art. 6, III). When involuntary psychiatric hospitalization occurs, it must be immediately communicated to the Public Prosecutor's Office for monitoring, and the termination of such intervention occurs at the guardian's request or when prescribed by a treating specialist.

In the wording of the LBI, the reference to "forced institutionalization" constitutes a more explicit recognition of the violence inherent in such practices. This terminological choice aligns with the language employed in the Report of the III National Mental Health Conference, held in the same year as the enactment of the Psychiatric Reform Law. However, the original text of Bill 7699/2006, which originated the LBI, was even more unequivocal in its repudiation of such practices. Article 15 of the original bill reads as the following: "Persons with disabilities shall not suffer forced interventions or forced institutionalizations aimed at the correction, improvement, or alleviation of any perceived or actual disability". As several other Bills were appended to the original proposition, this provision was replaced by a less direct, though still protective, formulation. Nevertheless, the final text retains a clear stance against forced institutionalization. The inclusion of such a provision reflects not only the influence of disability rights discourse but also the normative and political maturation of the legal debated spurred by Brazil's psychiatric reform movement. It should be mentioned, in this sense, that in 2014, the National Council of Justice made the following recommendation in its 1st Statement of the I Conference on Health Law

> In individual lawsuits for hospitalization of psychiatric patients and/or those with alcohol, crack and other drug problems, when the judiciary grants the imposition on the public sector to provide comprehensive care in mental health (according to the medical report and/or therapeutic project prepared by mental health professionals of SUS), the a priori determination of psychiatric hospitalization is not recommended, especially considering the risk of institutionalization of patients for long periods (CNJ, 2014).

---

[16] The afterlife of forced institutionalization has three faces: the involuntary hospitalization; the "open" unities of the social service destined to shelter persons in situation of abandonment (cf. Article 90, IV, of Law nº. 8.069/1990); and the safety measure of hospitalization imposed on the ones lacking criminal capacity inserted in the Penal Code (articles 26 and 97), which is applied in the case of presumed social dangerousness. Whereas the provision of shelter is destined to enable assistance – and only in a distorted manner becomes an asylum-like apparatus –, the latter can still use the logic of dangerousness of people deemed to lack criminal capacity, which results on a number of people who are institutionalized for longer they would be imprisoned were they deemed competent.

In the years following the LBI's enactment, the discussion over forced institutionalization begins to suffer a major setback through Executive Orders and Resolutions from the Ministry of Health that diminish the potentials of the reform and point to a return of the asylum-based logic. This reversion was paralleled by the growing privatization of psychiatric services, either through fully private institutions or public-private partnerships. A central argument mobilized to justify these shifts was that individuals released through the deinstitutionalization process had been left without adequate support, thus framing the return to institutional care in caritative and social assistance-oriented terms (Almeida, 2019; Amarante; Torre, 2018; Amarante; Nunes, 2018). This logic finds its apex in the issuance of Technical Note no. 11/2019[17] by the General Coordination of Mental Health, Alcohol and Other Drugs of the Ministry of Health. Among other measures, the note pointed to the expansion of psychiatric beds in the RAPS, in addition to the purchase of electroconvulsive therapy devices (Ministry of Health, 2019). This "third act of the mental health field" (Costa; Lotta, 2021) is marked by the opening breaches in the logic of deinstitutionalization, so that it appears hasty and insensitive to the demands of people under psychic distress. As stated by Amarante and Torre (2018, p. 1097-1098), through a re-organization of the sanitary services still under the light of institutionalization, institutions of violence become institutions of tolerance. This is a re-edition of the asylum-like devices under the appearance of care and shelter. Even through referred Technical Note was withdrawn after major civil society reaction (Almeida, 2019), in the same year of 2019, Law nº 13.840/2019 was enacted establishing involuntary hospitalization as the major central strategy in the care of persons with drug dependence. We are yet to see how disinvestment in community-centered care and promotion of asylum-oriented policies that happened in those years are to be reverted.

It is also relevant to point out that deinstitutionalization was never meant to be limited to the physical dismantling of asylums. Instead, it was conceived as a broader political and ethical project aiming at transforming the locus of care, shifting from institutional control to community-based support. Yet, despite its transformative ambition, the implementation of

---

[17] Relevant documents adopting the same asylum-based logic that precede this are CIT Resolution No. 32/2017, of December 17, 2017; Ordinance GM/MS No. 3588, of December 21, 2017; Interministerial Ordinance No. 2, of December 21, 2017; Ordinance GM/MS No. No. 2663, of October 11, 2017; Portaria GM/MS No. 1315, of March 11, 2018; CONAD Resolution No. 1, of March 9, 2018; Portaria SAS/MS 544, of May 7, 2018; Portaria GM/MS No. 2434, of August 15, 2018; CIT Resolution No. 35/2018, of January 25, 2018; and CIT Resolution No. 36/2018, of January 25, 2018.

deinstitutionalization now faces a troubling reconfiguration. Increasingly, the long-term confinement and control of persons with psychosocial or intellectual disabilities have shifted from psychiatric hospital to other institutional settings, particularly shelters (abrigos) and therapeutic communities (comunidades terapêuticas). This author dealt directly with two processes of deinstitutionalization in two shelters, in the periods of 2016-2018 and 2021-2022. Both were destined exclusively for persons with psychosocial, intellectual and mental disabilities. In both there were persons who were institutionalized for more than 30 years. In the first, there were 16 children and adolescents, 21 women, and 38 men – 6 of these persons were diagnosed with "infatile autism" (Classified in ICD10 as F84) (CEDEF, 2017; CEDH, 2017). In the second, in which 34 women with disabilities were found suffering inhuman treatment and sexual abuse, there was harder to identify the specific condition of each service user. In both institutions there were service users detained or restrained, including being locked up in cages (CDHC-CE, 2021; CDHC-CE, 2022). Also, in both, there was financial exploitation. In the first one, the workers of the shelter were pointed judicially as the guardians of the service users, which gave them the power to control all aspects of their life, including the access to their social assistance benefit. In the latter, it was found that not only the workers were the judicially appointed guardians, but that they also charged an amount correspondent to a minimum wage for the "hospitalization"[18].

In the wake of re-asylumization (remanicomialização) of mental health policy in Brazil, it is also relevant to mention the inclusion of therapeutic communities (TCs) in the Pysychosocial Care Network (RAPS) in 2011, through Ministry of Health's Ordinance n nº 3.088. This ordinance classified TCs under the category of "residential care services of a transitional nature", designed to offer continuous residential care for up to nine months to adults with clinical conditions arising from the use of crack, alcohol, and other drugs. Research has shown that the care model employed by TCs is largely grounded in moral and religious treatment frameworks and governed by rigid disciplinary regimes (Barretto; Merhy, Junior; 2024; Corrêa; Lima, 2024; Ferraza; Sanchez, 2017), in a sense that aligns these institutions

---

[18] For details on referred deinstitutionalization process, see: Report on technical visits to the Abrigo Estadual Desembargador Olívio Câmara, a conjoined mission by the State Committee on the Prevention and Combat of Torture, the Human Rights State Council, the Cearense Coalition of Anti-Asylum Struggle, the State Council of Psychology (11º section), and the Regional Council of Social Service (2017); and Report of the Cojoined Mission of the Socialism and Freedom Party and Human Rights National Council – Mental Health and Rights of Women from Cariri (2022).

with a broader process of psychiatric counter-reform in Brazil[19]. This configuration poses challenges when considered through the lens of disability rights. Residents of TCs are frequently persons with psychosocial disabilities, and their placement in these institutions often occurs involuntarily. In many instances, the referral to TCs results from judicial mandates, family pressure, or the failure of public services to offer community-based alternatives, creating a de facto system of coercive care (Barreto; Merhy; Junior, 2024; Silva et al, 2017; Fossi; Guareschi, 2015). Such practices are thus in direct conflict with the right to legal capacity, freedom from arbitrary detention, independent-living and non-discriminatory access to health care, as enshrined both in the CRPD and in the LBI.

CONCLUSION

The persistence of forced interventions a decade after the LBI came into force reveals the limits of formal legal change in the absence of structural transformation. While the law signalled a shift towards equal recognition before the law, in alignment with CRPD's article 12, its implementation has been obstructed by enduring perspectives that equate disability with vulnerability, risk, or lack of discernment. These perspectives allow for frameworks that continue to authorize coercive practices under the guise of care, effectively hollowing out the legal guarantees of autonomy and equality. This tension has become increasingly evident in current legislative debates. The recent proposal to revise the Civil Code and reintroduce "discernment" as a criterion for civil capacity marks a retreat from the normative commitments of the LBI and the CRPD. By reinstating a means for capacity assessment that hinge on vague standards, such a reform risks legitimizing the continuation of exclusionary practices that were never fully dismantled, despite there being no place for their validity under the CRPD.

Considering this tension, the arguments made in this text sustain the claim that the prohibition of forced interventions must be reinterpreted not merely as a minimum safeguard, but as a necessary condition for effective realization of equal recognition before the law. For that, practices such as forced sterilization and forced institutionalization must be understood

---

[19] It is important to note that these institutions have already been the subject of reports denouncing practices of torture and other serious human rights violations within said institutions (MPCT, 2025, CFP, 2011; CFP, MPCT, MPF, 2018).

as systemic violations directly at odds with the rights-based frameworks established by both the LBI and the CRPD. Ultimately, the transformative promise of the LBI depends on embedding legal capacity as a lived reality – one that is not conditional, revocable, or mediated by paternalistic gatekeeping. In the face of broader counter-reforms and pushback that threatens disability rights as conceived under the human rights model of disability, reaffirming the centrality of the prohibition of coercion becomes an urgent matter.

REFERÊNCIAS

ALBUQUERQUE, Aline; ANTUNES, Cintia Maria Tanure Bacelar. Tomada de decisão compartilhada na saúde: aproximações e distanciamentos entre a ajuda decisional e os apoios de tomada de decisão. **Cadernos Ibero-Americanos de Direito Sanitário**, v. 10, n. 1, p. 203-223, 2021.

ALMEIDA, José Miguel Caldas de. Política de saúde mental no Brasil: o que está em jogo nas mudanças em curso. **Cadernos de Saúde Pública**, v. 35, p. e00129519, 2019.

AMARANTE, Paulo. **Loucos pela vida**: a trajetória da reforma psiquiátrica no Brasil. SciELO-Editora FIOCRUZ, 1998.

AMARANTE, Paulo et al. A (clínica) e a Reforma Psiquiátrica**. Archivos de saúde mental e atenção psicossocial**, v. 1, p. 45-65, 2003.

AMARANTE, Paulo; NUNES, Mônica de Oliveira. A reforma psiquiátrica no SUS e a luta por uma sociedade sem manicômios. **Ciência & saúde coletiva**, v. 23, p. 2067-2074, 2018.

AMARANTE, Paulo; TORRE, Eduardo Henrique Guimarães. "Back to the city, Mr. citizen!"— psychiatric reform and social participation: from institutional isolation to the anti-asylum movement. **Revista de Administração Pública**, v. 52, p. 1090-1107, 2018.

ARAÚJO, Geórgia Oliveira; ARAÚJO, Luana Adriano. Esterilização compulsória de mulheres com deficiência: uma perspectiva feminista interseccional. **Teoria e Cultura**, v. 16, n. 1, p. 32-53, 2021.

ARAÚJO, Luana Adriano. Crits e crips: conectando estudos críticos de deficiência e estudos jurídicos críticos. **Revista Direito e Práxis**, v. 12, p. 1270-1315, 2021.

ARAÚJO, Luana Adriano. Guerra ao autismo: da violência simbólica à urgência legal. **Peri**, v. 14, n. 2, p. 78-99, 2022.

ARAÚJO, Luana Adriano; XAVIER, Beatriz Rego; FREITAS, Raquel Coelho. Liberdade é pouco? o que eu desejo já tem nome: direito ao próprio corpo de pessoas com deficiência. In: Anais do III SIDHF da UFF, 2017.

ARSTEIN-KERSLAKE, Anna; FLYNN, Eilionóir. The right to legal agency: domination, disability and the protections of Article 12 of the Convention on the Rights of Persons with Disabilities. **International Journal of Law in Context**, v. 13, n. 1, p. 22-38, 2017.

BARIFFI, Francisco. Article 8 Awareness-raising. In: **The UN Convention on the Rights of Persons with Disabilities**. Oxford University Press, 2018.

BARRETTO, Leandro Dominguez et al. Comunidades Terapêuticas no Brasil: uma revisão de escopo entre 2001 e 2021. **Revista Psicologia Política**, v. 24, 2024.

BICKENBACH, Jerome E. The ICF and its relationship to disability studies. In: **Routledge handbook of disability studies**. Routledge, 2019. p. 55-71.

BIZ, Maria Cristina Pedro; CHUN, Regina Yu Shon. Operacionalização da Classificação Internacional de Funcionalidade, Incapacidade e Saúde, CIF, em um centro especializado em reabilitação. In: **CoDAS**. Sociedade Brasileira de Fonoaudiologia, 2019. p. e20190046.

BRAGA, Luiz Paulo da Silva. Uma Análise do Processo de Construção da Lei Brasileira de Inclusão–LBI (2000–2015). **ANPUH. Brasil–31° simpósio nacional de História–Rio de Janeiro/RJ**, 2021.

CAMPBELL, Fiona Kumari. Stalking ableism: Using disability to expose ‘abled’narcissism. In: **Disability and social theory: New developments and directions**. London: Palgrave Macmillan UK, 2012. p. 212-230.

CEARÁ. Comitê Estadual de Prevenção e Combate à Tortura; Conselho Estadual de Direitos Humanos; Coalizão Cearense de Luta Antimanicomial; Conselho Regional de Psicologia – 11ª Região; Conselho Regional de Serviço Social. **Relatório das visitas técnicas ao Abrigo Estadual Desembargador Olívio Câmara**. Fortaleza: [s.n.], 2017.

CNJ. Nacional Council of Justice. **I Journey of Health Law**. 2014. Available at : https://www.cnj.jus.br/wpcontent/uploads/2014/03/ENUNCIADOS_APROVADOS_NA_JORNADA_DE_DIREITO_DA_SAUDE_%20PLE NRIA_15_5_14_r.pdf

COMMITTEE ON THE RIGHTS OF PERSONS WITH DISABILITIES. United Nations. General Comment nº 1, 11 April 2014. **Article 12: Equal recognition before the law**. 2014. Available at: https://documents-ddsny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement

COMMITTEE ON THE RIGHTS OF PERSONS WITH DISABILITIES. United Nations**. Concluding observations on the initial report of Brazil. CRPD/C/BRA/CO/1. 2015a**. Available at https://documents-ddsny.un.org/doc/UNDOC/GEN/G15/220/75/PDF/G1522075.pdf?OpenElement

CONSELHO FEDERAL DE PSICOLOGIA**. Relatório da 4ª Inspeção Nacional de Direitos Humanos: locais de internação para usuários de drogas**. Brasília: Conselho Federal de Psicologia, 2011. 200 p. ISBN 978-85-89208-42-0.

CONSELHO FEDERAL DE PSICOLOGIA; MECANISMO NACIONAL DE PREVENÇÃO E COMBATE À TORTURA; PROCURADORIA FEDERAL DOS DIREITOS DO CIDADÃO (MPF). **Relatório da Inspeção Nacional em Comunidades Terapêuticas** – 2017. 1. ed. Brasília, DF: CFP, 2018.

CONSELHO NACIONAL DOS DIREITOS HUMANOS (CNDH). **Relatório da Missão Conjunta** – Saúde Mental e Direitos das Mulheres do Cariri. Fortaleza: [s.n.], 2022.

CORRÊA, Luisa Motta; LIMA, Rossano Cabral. A neoinstitucionalização no contexto da reforma psiquiátrica: uma análise sobre o percurso de usuários de CAPS. **Ciência & Saúde Coletiva**, v. 30, p. e00752024, 2025.

COSHWAY, Loyal et al. Medical therapy for inappropriate sexual behaviors in a teen with autism spectrum disorder. **Pediatrics**, v. 137, n. 4, p. e20154366, 2016.

COSTA, Maria Izabel Sanches; LOTTA, Gabriela Spanghero. De “doentes mentais” a “cidadãos”: análise histórica da construção das categorias políticas na saúde mental no Brasil. **Ciência & Saúde Coletiva**, v. 26, 2021.

DE ANDRADE FERRAZZA, Daniele et al. Comunidades Terapêuticas em novas configurações do manicomialismo. **ECOS-Estudos Contemporâneos da Subjetividade**, v. 7, n. 2, p. 363-375, 2017.

DE MENEZES, Joyceane Bezerra. Tomada de decisão apoiada: o instrumento jurídico de apoio à pessoa com deficiência inaugurado pela lei no. 13.146/2015. **Novos Estudos Jurídicos**, v. 23, n. 3, p. 1191-1215, 2018.

DE MENEZES, Joyceane Bezerra; TEIXEIRA, Ana Carolina Brochado. Desvendando o conteúdo da capacidade civil a partir do Estatuto da Pessoa com Deficiência. **Pensar-Revista de Ciências Jurídicas**, v. 21, n. 2, p. 568-599, 2016.

DEGENER, Theresia; DE CASTRO, María Gómez-Carrillo. Toward Inclusive Equality: Ten Years of the Human Rights Model of Disability in the Work of the UN Committee on the Rights of Persons with Disabilities. In: FELDER, Franziska; DAVY, Laura; KAYESS, Rosemary (Orgs.) **Disability law and human rights**. Springer International Publishing, 2022.

ELER, Kalline Carvalho. Da incapacidade civil às capacidades evolutivas: tomada de decisão da criança no contexto dos cuidados em saúde. **Civilistica. com**, v. 11, n. 3, p. 1-22, 2022.

FRANCIS, Leslie Pickering. Supported decisions as the patient’s own?. **The American Journal of Bioethics**, v. 21, n. 11, p. 24-26, 2021.

IMRIE, Rob. Demystifying disability: a review of the International Classification of Functioning, Disability and Health. **Sociology of health & illness**, v. 26, n. 3, p. 287-305, 2004.

JACKSON, Emily. **Regulating reproduction: Law, technology and autonomy**. Bloomsbury Publishing, 2001.

KEYS, Mary. Article 17 [Protecting the Integrity of the Person]. In: **The United Nations Convention on the Rights of Persons with Disabilities**. Springer, Cham, 2017. p. 327-337.

LANNA Junior, M. C. M. (Comp**.). História do movimento político das pessoas com deficiência no Brasil.** Brasília: Secretaria de Direitos Humanos, Secretaria Nacional de Promoção dos Direitos da Pessoa com Deficiência, 2010.

LEO, Raphael J. Competency and the capacity to make treatment decisions: a primer for primary care physicians. **Primary care companion to the Journal of clinical psychiatry**, v. 1, n. 5, p. 131, 1999.

MECANISMO NACIONAL DE PREVENÇÃO E COMBATE À TORTURA (MNPCT). **Relatório de inspeção**: Comunidades Terapêuticas do Rio de Janeiro. [S.l.]: MNPCT, 2025.

MENEZES, Joyceane Bezerra. O Risco do Retrocesso: Uma Analise sobre a Proposta de Harmonizacao dos Dispositivos do Codigo Civil, do CPC, do EPD e da CDPD a Partir da Alteracao da Lei No. 13.146, de 06 de Julho de 2015. **Revista Brasileira Direito Civil**, v. 12, p. 137, 2017.

MINISTRY OF HEALTH. **Technical Note Nº 11/2019-CGMAD/DAPES/SAS/MS**. Clarifications about the changes in the National Mental Health Policy and the National Drug Policy Guidelines. Brasília: Ministério da Saúde, 2019. Disponível: https://pbpd.org.br/wp-content/uploads/2019/02/0656ad6e.pdf.

MINISTRY OF HUMAN RIGHTS AND CITIZENSHIP. **Final report produced by the Interinstitutional Working Group on the single model of biopsychosocial assessment of disability**. 2022. Available at: https://www.gov.br/mdh/ptbr/navegue-por-temas/pessoa-com-deficiencia/publicacoes/relatorio-final-gti-avaliacao-biopsicossocial

MOSLEH, Donya. Critical disability studies with rehabilitation: re-thinking the human in rehabilitation research and practice. **J Human Rehab**, p. 1-12, 2019.

MYKITIUK, Roxanne; CHADHA, Ena. Article 6–Women with Disabilities. In: **The UN Convention on the Rights of Persons With Disabilities: A commentary**. 2018. p. 171-197.

NIELSSON, Joice Graciele; WEILER, Ana Luísa Dessoy. Justiça reprodutiva e esterilização de mulher com deficiência no Brasil. **Civitas: revista de Ciências Sociais**, v. 25, n. 1, 2025.

NUNES, Lauren Cristine Aguiar; LEITE, Lúcia Pereira; AMARAL, Gabriel Filipe Duarte. Análise do Índice de Funcionalidade Brasileiro Modificado (IFBr-M) e suas implicações sociais. **Revista Brasileira de Educação Especial**, v. 28, p. e0161, 2022.

OLIVER, Michael; BARNES, Colin. **The new politics of disablement**. Bloomsbury Publishing, 2012.

PEREIRA, Caio Mário da Silva. **Instituições de direito civil**. 19. ed. Rio de Janeiro: Forense, 2002.

PEREIRA, Éverton Luís; BARBOSA, Livia. Índice de Funcionalidade Brasileiro: percepções de profissionais e pessoas com deficiência no contexto da LC 142/2013. **Ciência & Saúde Coletiva**, v. 21, n. 10, p. 3017-3026, 2016.

PYANEANDEE, Coomara. **International disability law: A practical approach to the United Nations Convention on the Rights of Persons with Disabilities**. Routledge, 2018.

REDE-IN; COLETIVO BRASILEIRO PELO ARTIGO 12 DA CDPD. **Nota pública sobre o PL nº 5.679/2023, que prevê a esterilização cirúrgica não-voluntária de pessoas com deficiência mental ou intelectual que não possam exprimir sua vontade**. [S.l.], 2024.

ROCHA, Luiz Renato Martins da; OLIVEIRA, Jáima Pinheiro de. Análise textual pormenorizada da Lei Brasileira de Inclusão: perspectivas e avanços em relação aos direitos das pessoas com deficiência. **Práxis Educativa**, v. 17, 2022.

SERIES, Lucy; NILSSON, Anna. Chapter Article 12 CRPD: Equal Recognition before the Law. In: **The UN Convention on the Rights of Persons with Disabilities**. Oxford University Press, 2018.

STEIN, Michael Ashley; STEIN, Penelope J. S.; BLANCK, Peter. Disability. In: KATZ, Stanley N. et al. (ed.). **Oxford International Encyclopedia of Legal History**. v. 2. Oxford: Oxford University Press, 2009.

TARTUCE, Flávio. O Estatuto da Pessoa com Deficiência e a capacidade testamentária ativa. **Revista Pensamento Jurídico**, v. 10, n. 2, 2017.