EUROPEAN UNION AGENCY
FOR FUNDAMENTAL RIGHTS

# PLACES OF CARE
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# PLACES OF SAFETY?

# VIOLENCE AGAINST PERSONS WITH DISABILITIES IN INSTITUTIONS

REPORT

FRA

# Places of Care = Places of Safety?

## Violence against persons with disabilities in institutions

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# Foreword

For the EU Agency for Fundamental Rights, deinstitutionalisation remains the only solution to the manifold assaults on the fundamental rights of people with disabilities living in institutions. It is with significant concern that we watch the deepening gap between rhetoric and reality around Article 19 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which obliges States Parties to facilitate the full inclusion and participation of people with disabilities in the community.

Not only is the number of people with disabilities in institutions not decreasing; in this regard, we are regressing. The European Union and Member States must take responsibility for the stark failings in their deinstitutionalisation processes and tackle the issue with a renewed urgency and vigour. The EU has an additional and vital role to play in this, most notably through ensuring that EU funding is only used to build and maintain person-centred societies for all, in line with obligations under the UNCRPD and the EU Charter of Fundamental Rights.

As we work towards building societies in which independent and inclusive living is the norm, we must uphold and defend all rights held by the 1.4 million people living in institutional settings. And for many of those people, their right to be protected against violence, and their right to adequate recourse are continuously violated.

The breadth and depth of the manifestations of violence we see in this report are staggering. Some are explicit, some subtle. Some are physical, others psychological or emotional. We heard reports of neglect, deprivation of liberty, financial abuse, isolation and overmedication. This is all underpinned by the normalisation of institutional culture in our societies, and the prevailing reliance on practices embedded in the medical model of disability.

In this report, we propose many opinions, ranging from strengthening protection from violence, to amplifying prevention through monitoring to enforcing responses to violence. The opinions are applicable to all who purport to uphold the rights of persons with disabilities.

As we approach the 20th anniversary of the UNCRPD, let us reaffirm our commitment to the 100 million EU citizens with disabilities who are still waiting for their fundamental rights to be realised. At a time when the equality agenda is facing such pushbacks, we must be braver and louder on behalf of our citizens who face compounding challenges in the face of increasing focus on defence and security, climate change, and geopolitical instability. This is not the time to scale back our efforts - it is a time to push harder. The values upon which the EU is built must remain our guiding light; we cannot allow them to become choices that are derogated from when times get tough.

**Sirpa Rautio**
Director

# Contents

# Key findings and FRA opinions

Violence against persons with disabilities in institutions remains widespread yet largely under-reported across Europe. Acts of violence include a wide spectrum of exploitative, abusive and degrading acts that contravene EU and EU Member States' obligations under international and European human rights law. Protection against violence is grounded in the UN Convention on the Rights of Persons with Disabilities (CRPD), the primary human rights treaty for the equal enjoyment of all human rights and fundamental freedoms by persons with disabilities. The CRPD obliges States Parties to ensure that the rights to life, freedom from violence, autonomy, liberty and security are upheld within institutions. The absolute prohibition of torture and obligations to prevent torture and investigate torture allegations are enshrined in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the International Covenant on Civil and Political Rights (ICCPR), the European Convention on Human Rights (ECHR) and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. States are required to protect against torture and ill treatment in all contexts, including in institutions – understood as segregated settings where people live together without choice and lack control over their lives.

The Treaty on European Union (TEU) and the Charter of Fundamental Rights of the European Union (the Charter) enshrine the foundational values and human rights standards of the EU through a combination of fundamental rights, principles and secondary law, and through alignment with international human rights instruments such as the CRPD, which is ratified by the EU and all Member States.

Collectively, these instruments establish a robust protection framework obliging the EU and its Member States to uphold the right of persons with disabilities to freedom and protection from violence and to ensure accountability within institutions.

This European Union Agency for Fundamental Rights (FRA) report aims to support national authorities in their efforts to uphold their state's legal obligations to protect against, prevent and respond to violence against persons with disabilities in institutions. The report's evidence and recommendations are based on sociolegal analysis that draws on data from desk research in the 27 Member States and in Albania, North Macedonia and Serbia and on qualitative research from 10 Member States (Croatia, Germany, Ireland, Italy, Latvia, Malta, Poland, Portugal, Slovakia and Slovenia).

By systematically applying a human-rights-based lens, this report outlines a three-part framework for implementing effective measures to end violence against persons with disabilities in institutions.

First, it examines the specific legal standards and safeguards that **protect** individuals from different forms of violence.

Second, it considers structural safeguards and mitigating measures that **prevent** violence from happening in the first place.

And third, it analyses the processes used to **respond** to incidents of violence, once they have occurred, to ensure accountability.

While applicable human rights law provides us with the rationale for action (i.e. **why** action is needed), this framework helps to elaborate the operational steps that are required (i.e. **what** needs to be done). It further argues that the action taken should employ a human-rights-based approach (HRBA) (i.e. **how** such action should be taken or shaped). The HRBA is a normative conceptual framework directed towards promoting and protecting human rights in accordance with binding human rights law. The five principles that underpin an HRBA – participation, accountability, non-discrimination, empowerment and legality – along with the CRPD's general principles, set out in Article 3 – including 'respect for inherent dignity [and] individual autonomy' – provide an effective operational framework for addressing violence against persons with disabilities in institutions.

FRA offers the following opinions to support national authorities in upholding their legal obligations and to ensure accountability within institutions. These opinions complement, reinforce and sometimes reiterate previous FRA opinions on the rights of persons with disabilities and victims' rights.

In responding to these opinions, EU institutions and Member States should ensure the active involvement of persons with disabilities and their representative organisations, as required by Article 4(3) of the CRPD and consistent with the HRBA principles of participation and empowerment.

## STRENGTHEN PROTECTION FROM VIOLENCE

*'I would say that the only solution on how to prevent institutional violence is to get rid of institutions. Because the system cannot be changed; the only way is to put a bomb under it and blow it up.'*

Representative of a national civil-society organisation (CSO), Latvia

### Embedding a human-rights-based approach in national law and policy

Embedding an HRBA in laws and policies regulating the care and support for persons with disabilities residing in institutions would help align national frameworks with the general principles of Article 3 and the obligations of Article 4 of the CRPD. Moreover, Articles 10, 12, 14, 15, 16 and 19 of the CRPD require states to ensure that the laws and systems governing care uphold the rights to life, legal capacity, liberty and protection from violence and the right to live in the community. This will shift the focus of all aspects of legal protection and the provision of support from institutional control to autonomy, dignity and inclusion. Under wider international and European human rights law, persons with disabilities are also protected from torture and ill treatment by the CAT (Articles 1, 2 and 16), the ICCPR (Article 7) and the ECHR (Article 3). The ECHR plays a crucial role in protecting the rights of persons with disabilities in institutions by guaranteeing the right to life (Article 2), the right to liberty and security (Article 5) and the right to respect for private and family life (Article 8). The European Court of Human Rights (ECtHR) has affirmed that states have a positive obligation to protect individuals within institutions from harm.

EU primary law, particularly the Charter and Article 6 of the TEU, provides the basis for developing comprehensive human-rights-based responses at the EU level. The fundamental rights of all persons with disabilities are reflected in EU policy instruments, including the EU strategy for the rights of persons with disabilities for 2021–2030, the European Pillar of Social Rights and the European care strategy. In line with Article 153(1)(j) of the Treaty on the Functioning of the European Union (TFEU), EU-level initiatives regarding the modernisation of social protection systems complement Member State obligations and are oriented to encourage cooperation between Member States.

### FRA OPINION 1

Member States are encouraged to undertake a thorough assessment of the compliance of their national legal and regulatory frameworks governing institutionalised care with their legal obligations under international and European law.

To ensure that responses are evidence-based and to track progress, Member States should collect and collate reliable, comparable and timely information and data on legal and policy efforts and their outcomes in terms of protecting against, preventing and responding to violence against persons with disabilities in institutions.

Yet FRA's findings show that many national legal provisions still fail to protect the rights and dignity of persons with disabilities, particularly in the context of protection from violence in institutions. All Member States have developed national disability policy frameworks, but very few specifically protect persons with disabilities from violence.

There is limited knowledge on the nature and scale of violence against persons with disabilities in institutions across Member States, which underscores the need for the systematic collection of reliable data. Health-related legislation tends to regulate, rather than prohibit, certain forms of violence, such as coercive or involuntary treatment, reinforcing the medical and charity models of disability. There are substantial gaps in ensuring effective monitoring of institutions to prevent violence and ensure accountability. There are also substantial gaps in access to information and accessible complaint mechanisms, hindering victims' access to redress. In its 2025 concluding observations on the EU's second and third periodic reports, the Committee on the Rights of Persons with Disabilities (CRPD Committee) recommends that the EU '[i]mprove implementation of the Convention' and adopt, within its competences, initiatives to support Member States in delivering on their legal obligations by 'developing standards … on the prevention of and investigation into deaths in institutions that receive European Union funding'.

## Ending institutionalisation

## FRA OPINION 2

Pursuant to their CRPD obligations and to counter the inherent risks of violence in institutions rooted in limiting autonomy and that lack safeguards, Member States should renew and intensify their efforts to close institutions. Deinstitutionalisation strategies should include specific targets and deadlines, be adequately funded and include person-centred pathways for the inclusion of people with disabilities in the community.

The EU legislator should ensure that the EU fully respects its human and fundamental rights obligations under the CRPD and the Charter within the regulations of the post-2027 multiannual financial framework. Where cases of violence are found to have occurred in EU-funded institutions, the European Commission should use its accountability framework to suspend or recover EU funds.

States Parties to the CRPD, which include the 27 Member States and the EU itself, recognise the equal right of all persons with disabilities to live independently and be included in the community, as enshrined in Article 19. Abolishing institutionalisation is essential for the realisation of all rights of persons with disabilities, including the right to autonomy and dignity (Article 3), liberty and security (Article 14) and protection from all forms of exploitation, violence and abuse (Article 16).

The EU and its Member States have developed policies to support the right to independent living. Member States use EU funding instruments within the multiannual financial framework – including the European Social Fund and the European Regional Development Fund – to support national efforts towards the transition from institutional to community-based services. The EU funding is available subject to compliance with the CRPD, and EU mechanisms exist to suspend or recover funds in the event of misuse. In its 2025 concluding observations on the EU's second and third periodic reports, the CRPD Committee called on the EU to use its accountability framework to suspend or recover EU funds where cases of violence are found to have occurred in EU-funded settings, and especially in cases where preventable deaths have occurred in institutions.

Moreover, recent data show that efforts to end institutionalisation have not yet generated meaningful change for the people directly affected by it, which has also been highlighted in past FRA research. In 2024, the European Commission published specific guidelines for Member States on the use of EU funding to accelerate the transition from institutional care to community-based services.

Participants across countries and stakeholder groups have underscored the importance of acting on national commitments to deinstitutionalisation, including by assessing, reviewing and implementing strategies that are already in place. In addition, many stressed that deinstitutionalisation initiatives should be human-rights-based and person-centred and should not simply involve creating smaller facilities that retain the characteristics of institutionalised and depersonalised forms of care.

### Promoting cohesive and effective frameworks

The regulatory landscape in the 30 countries covered reveals significant divergences in how they design legal and policy safeguards and how institutions follow them.

Persons with disabilities residing in institutions often fall through the gaps of existing protection frameworks. Oversight mechanisms and safeguards vary between different types of institutions – most notably between mental health and social care services – but also across jurisdictions at the local level. This results in unequal levels of protection for persons with disabilities that depend on the type or location of the institution they are in and the nature of the oversight mechanisms in place. Moreover, protection provisions also vary by group – groups such as women, children, older persons or persons with psychosocial or intellectual disabilities – resulting in inconsistent levels of protection and diluted accountability. FRA findings show that standards or rules for the operation of institutions explicitly address protection from and the prevention of violence in fewer than half of the 30 countries covered.

In its 2024 judgment in the case of *Validity Foundation on behalf of T. J.* v *Hungary*, the ECtHR highlighted that deficiencies arise from the ineffective enforcement of existing frameworks, which is often due to inadequate resources. This finding was corroborated by experts interviewed as part of this research, who referred consistently to the gap between the legal frameworks in place (law in theory) and their actual application in practice (law in action).

Another recurring theme was the lack of practical guidance and tools to support the effective implementation of existing legislation and policies and to ground protection efforts in prevention rather than response. The lack of nationwide minimum standards and the reliance on internal institutional mechanisms for reporting violations further exacerbate protection gaps.

## FRA OPINION 3

Member States are urged to review, develop and implement CRPD-compliant national protection frameworks that are sensitive to gender, age and individual support needs.

Such frameworks should be coherent and adequately funded and include rights-based practical guidelines, protocols and toolkits on how to prevent and respond to cases of violence for all types of settings that provide care to persons with disabilities.

## AMPLIFY PREVENTION THROUGH MONITORING

*‘Here I am talking about legal frameworks on how an institution should act in cases of detecting certain types of violence. [It] is always left to the institutions themselves or their management …’*
Representative of an independent monitoring body, Slovenia

### Harmonising and strengthening monitoring

### FRA OPINION 4

In accordance with the OPCAT and Articles 16 and 33 of the CRPD, Member States should ensure that monitoring bodies are independent and sufficiently resourced and have the mandate to implement regular, transparent and unannounced visits to all institutionalised care facilities for persons with disabilities, including public and private services and those run by non-governmental organisations or charities.

Member States should harmonise monitoring practices and foster cooperation between different monitoring bodies by developing nationwide minimum standards for monitoring that are embedded in human rights and explicitly address violence. Member States are also called upon to make violence prevention measures a prerequisite in licensing and accreditation procedures for all types of facilities and services for persons with disabilities.

Minimum standards should be complemented by specialised monitoring protocols that are age- and gender-sensitive and tailored to the unique needs and vulnerabilities of persons with disabilities with different intersecting characteristics.

Effective monitoring is central to preventing violations. Article 16(3) of the CRPD requires States Parties to ensure that all facilities designed to serve persons with disabilities are monitored by independent authorities to prevent all forms of exploitation, violence and abuse, while Article 33(2) provides for an independent framework that monitors the implementation of the convention as a whole.

Independent national monitoring mechanisms not only prevent violence but are also essential for fulfilling the obligations set out in the CAT and for ensuring accountability. The Optional Protocol to the CAT (OPCAT) requires countries to establish national bodies – national preventive mechanisms (NPMs) – that are fully independent from governments, are adequately funded and have the mandate to visit any place under a State Party’s jurisdiction or control where persons are or may be deprived of their liberty. The UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (subcommittee on torture) has clarified that the term ‘places of deprivation of liberty’ (Article 4 of the OPCAT) should be understood to encompass public and private social care establishments where persons may be deprived of their liberty, *de jure* or *de facto*, including institutions in which persons with disabilities reside.

FRA research reveals a diverse range of public bodies responsible for this monitoring. In almost all countries covered, monitoring is spread between many actors, such as government authorities, regulators of health and social care services, and regional administrations.

Moreover, due to a lack of any standardised guidelines, monitoring bodies use different standards and methodologies. The scope and frequency of monitoring varies too. Many public and independent monitoring bodies do not have sufficient financial or human resources to conduct regular visits, leading to rather reactive, case-driven responses once incidents become public. This leads to protection gaps, discrepancies in the effectiveness of monitoring and potentially contradictory monitoring outcomes. The lack of independent monitoring is a substantial limitation when monitoring is performed primarily by government agencies.

Member States still lack truly independent monitoring bodies. Treaty bodies continue to stress that monitoring bodies should have the legal authority to investigate and impose sanctions for abuses and to ensure the transparent reporting of findings to parliaments and the public with a view to ensuring accountability. In FRA’s fieldwork research, independent monitoring bodies were seen as being more effective than public or internal monitoring bodies, but most of them lacked the resources and/or the authority to conduct inspections, adequately cover numerous institutions or enforce change due to the non-binding nature of their recommendations.

Participants in the research noted that effective and prevention-oriented monitoring relied on cooperation between different actors performing similar monitoring functions, but also on the involvement of key stakeholders and experts, including representative organisations of persons with disabilities.

### Building institutional capacities

The effective implementation of existing national legal and policy frameworks for preventing violence relies upon the allocation of adequate resources, the development of targeted tools and the reinforcement of human resources capacities of care providers and authorities responsible for monitoring and responding to violence in institutions.

A recurring theme across the Member States examined during fieldwork was the absence of effective prevention measures and structural safeguards to deter violence. This points to states not properly fulfilling their duty under international human rights law to enact laws and implement policies and measures that prevent human rights violations. Effective prevention systems would include sustained capacity-building initiatives directed towards all professional groups tasked with the responsibility to act on international, European and national obligations to protect against, prevent and respond to violence in institutions, with the aim of equipping them with the necessary knowledge, skills and tools to carry out this role.

Participants highlight that existing training is inadequate, sporadic and often not mandatory. They contend that the beneficiaries of training need to extend beyond staff in institutions to include members of monitoring teams (from both public and independent bodies) and staff of criminal justice authorities and the judiciary. Training should cover the key principles of the CRPD but should also build capacity to recognise and address violence against persons with disabilities in institutions.

## FRA OPINION 5

Member States should establish compulsory expert training to enable professionals who work with persons with disabilities to recognise, prevent and respond to violence. Training courses should bring together professionals working in different fields to promote cooperation and coordination across different authorities.

Member States are called upon to supplement the outcome reports from monitoring visits with consistent practical and methodological support on how recommendations from inspections and monitoring visits should be implemented in practice.

## Ensuring participation and rights awareness

## FRA OPINION 6

Member States should ensure the full and effective participation of persons with disabilities, including through their representative organisations, in the design, implementation and evaluation of policies and programmes – including those on preventing and addressing violence in institutions – in line with Article 4(3) of the CRPD and the CRPD Committee's General Comment No 7.

As regards the monitoring of institutions, efforts should be made to ensure monitoring teams are multidisciplinary by engaging social care workers and external actors, such as impartial medical professionals, human rights experts, persons with disabilities and persons with lived experience of institutions.

Member States should establish appropriate rights-awareness and empowerment programmes for persons with disabilities living in institutions. Such programmes should focus on how to identify risk, potential violations and inappropriate behaviour and how and where to seek advice and redress. The programmes should be fully accessible to all persons with disabilities and sensitive to age, gender and other characteristics.

In line with CRPD Article 4(3), and subsequent guidance provided in General Comment No 7, any entity tasked with monitoring facilities for persons with disabilities – be it the national Article 33(2) body, an NPM or a distinct other 'independent authority' in line with Article 16(3) – should actively involve civil society and representative organisations of persons with disabilities, as appropriate, in monitoring activities.

FRA's research finds no evidence of structured engagement of representative organisations of persons with disabilities in the public monitoring of institutions and only isolated examples of engagement of such organisations in monitoring carried out by independent monitoring bodies. Consistent with the principles of an HRBA, interviewees stress the importance of establishing internal user-led monitoring, as well as involving persons with disabilities and persons with lived experiences of institutions, as experts, in monitoring activities.

In addition, interviewees also highlighted that multidisciplinary monitoring is essential for increasing the effectiveness of monitoring activities as it combines resources and capacities and pools diverse expertise, perspectives and methodologies. Applying multidisciplinary and participatory methods strengthens accountability and prevention initiatives by building trust, which enables early detection of hidden risks, systemic gaps and subtle forms of violence that external monitors might overlook, fostering coordinated responses and promoting the development of targeted, rights-based safeguards to prevent violence in institutions.

Preventing violence also requires the dismantling of disempowering institutionalised forms of care, which remain prevalent in many countries. The pervasive lack of understanding of what constitutes abuse is a key challenge. Due to an absence of awareness raising about their rights, persons with disabilities are, in many instances, not aware that some of the practices they are subjected to are in fact prohibited and inappropriate, leading to the 'normalisation' of various forms of violence, often from a very young age.

## ENFORCE RESPONSES TO VIOLENCE

> *'As far as people with cognitive and relational problems are concerned, the complaint has to be picked up in precisely a different way. The very strong risk we run, as institutions are closed structures, is that in those cases the expression of malaise is simply ignored.'*
>
> Representative of a regional CSO, Italy

### Strengthening reporting and support mechanisms

Accountability is a foundational principle of the HRBA: international human rights require states to respond effectively to violence against persons with disabilities. Accountability within the CRPD and other international treaties mandates response measures – including providing information and ensuring complaint mechanisms are accessible – as essential to upholding the rights and dignity of persons with disabilities and addressing protection failures in institutions.

Member States have an obligation to provide effective remedy to victims of all crimes, pursuant to Article 47 of the Charter, Article 13 of the ECHR, Article 13 of the CRPD and Article 2 of the ICCPR. Under Articles 9(2)(f) and 21 of the CRPD and recital 15 of the Victims' Rights Directive, unrestricted access to justice and support requires an awareness of the existence of and access to information on the functioning of available complaint and reporting mechanisms.

Holding duty-bearers accountable for upholding human rights and ensuring access to justice for persons with disabilities relies on victims and witnesses coming forward to report incidents. However, persons with disabilities in institutions frequently encounter legal, communication, physical and attitudinal barriers to coming forward. Fear of retaliation or secondary victimisation and a lack of viable care alternatives form another barrier discouraging people from reporting incidents of violence, especially those highly dependent on institutional staff.

The research findings also point to the need to establish or expand proactive monitoring, which can also serve as a response mechanism, giving victims a practical way to report crimes.

Within institutions, providing information about complaints and reporting violence are almost exclusively the responsibility of the service providers. Internal complaint mechanisms vary across countries, regions, target groups, types of institution and individual facilities. Their establishment, functioning and oversight are largely left to individual institutions.

Articles 8 and 9 of the Victims' Rights Directive establish that victims have a right to free and appropriate victim support services. The scope of the present FRA research does not extend to an analysis of the victim support services available; nevertheless, the data confirm that victim support services in many countries are not adequately tailored to the needs of persons with disabilities. Services often lack accessibility features and fail to provide individualised support, such as assistance with completing and following up on a complaint, legal advice or advocacy, or psychological counselling.

## FRA OPINION 7

To ensure effective responses to violence against persons with disabilities in institutions, Member States should adopt measures that ensure accessible and empowering structures that facilitate reporting within institutions.

Member States are called upon to ensure that all victims and persons reporting violations can reliably and effectively benefit from measures that protect against secondary and repeat victimisation in accordance with Article 47(1) of the Charter and Article 23 of the Victims' Rights Directive.

Member States should guarantee whistle-blowers protection and create safeguards against retaliation for third parties who report abuse. Minimum standards for responses to reported violence in care settings should include the temporary removal or suspension of suspected perpetrators and the immediate relocation of victims to alternative care settings, ensuring the continuity of care.

Article 25 of the Victims' Rights Directive obliges Member States to provide officials likely to interact with victims with general and specialised training appropriate to their level of contact with victims. This training aims to, among other things, increase their awareness of victims' rights and needs. Persons with disabilities face structural barriers to accessing legal support, including procedural complexity and a scarcity of tailored assistance – issues that have been described as both persistent and deeply disempowering.

While some countries have comprehensive approaches to reporting violence, and a few transferable practices exist – particularly from the field of support for child victims – these examples remain limited, highlighting the need for more systematic and thorough efforts to ensure accessible, trustworthy and effective access to information and support.

### Investing in joined-up responses and referrals

An effective response to violence in institutions demands structured coordination to ensure accessible reporting, swift referrals and individualised, victim-centred services to overcome the current fragmentation of services, which leaves victims without much-needed support.

There is limited coordination between responsible authorities in cases of violence, with referral mechanisms either lacking or not being structurally or institutionally embedded. Effective referrals of cases of violence require joined-up responses and the structured involvement of service providers, regulatory bodies, monitoring and complaint mechanisms, and criminal justice authorities. Enhanced cooperation includes working meetings, collaborative efforts within policy development forums, joint advocacy, peer-to-peer learning, the promotion of participatory structures and the meaningful involvement of representative organisations, both in policymaking processes and in monitoring and complaint mechanisms.

## FRA OPINION 8

Member States are called upon to ensure integrated responses to cases of violence. Joined-up responses should draw on standardised procedures that involve all responsible authorities and should have a cross-professional capacity to assess risk situations and establish effective referral mechanisms.

# Introduction

*'Violence is much more than slapping. Violence is someone living in a residential home and not being able to leave independently because the door is locked ...'*

National policymaker, Portugal

*'The institution itself is violent. And people who come to the institution will certainly be exposed to violence at some point during their stay in the institution.'*

Representative of a civil-society organisation (CSO), Slovenia

Fundamental rights violations against people with disabilities occur at a higher rate than those against people without disabilities, regardless of where they live (1). Evidence suggests that people living in institutions are particularly vulnerable to violence, which can manifest in many ways: isolation and neglect, verbal and emotional abuse and physical and sexual violence. All of these can occur behind closed doors with limited oversight and reporting mechanisms. This situation is, in part, due to the inherently restrictive environment of institutions in which persons with disabilities live,

which are typically large, segregated settings where people live together without autonomy or control over their lives. This can perpetuate social isolation, power asymmetries and depersonalisation. Victims lack the option to seek independent advice or support and face considerable barriers when they attempt to report violations or access justice and redress.

This European Union Agency for Fundamental Rights (FRA) report examines how EU Member States uphold their obligations under international human rights law, European human rights law and EU law to protect persons with disabilities in institutions from all forms of violence. It explores the nature of human rights violations against persons with disabilities in institutions by presenting evidence on existing safeguards and accountability standards purporting to regulate the provision of institutional care. The report argues for a human-rights-based approach (HRBA) to ensuring the rights of persons with disabilities in institutions that is anchored in the principles of meaningful and inclusive participation, non-discrimination and equality, empowerment, accountability and legality.

An HRBA seeks to empower rights holders to claim their rights and strengthen duty-bearers' capacity to meet their obligations and protect against, prevent and respond to violence in institutions. The findings of this report are presented for those with a direct responsibility to create safe environments, including those responsible for designing policies, those accrediting institutions, managers and staff providing support to the millions of people living in institutions and those mandated to enforce applicable laws and policies, from inspection bodies to criminal justice authorities. This report is also aimed at statutory human rights bodies, especially independent monitoring institutions (national preventive mechanisms (NPMs) created under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)), bodies investigating complaints (national ombuds institutions) and those tasked with monitoring the implementation of the Convention on the Rights of Persons with Disabilities (CRPD) through the independent monitoring mechanisms provided for under Article 33(2) of the CRPD.

The target audience extends beyond national-level stakeholders; the findings and opinions also aim to support efforts at the EU level. They provide evidence that supports the EU's CRPD focal point and thus assist in addressing the concluding observations of the Committee on the Rights of Persons with Disabilities (CRPD Committee) on the EU's second and third periodic reports. They also support the effective implementation of the EU Victims' Rights Directive, which ensures that victims with disabilities receive the same level of protection, support and access to justice as other victims of crime.

The report builds on FRA's established body of work on victims' rights and on the rights of persons with disabilities. It also complements FRA's work as a member of the EU framework for monitoring the CRPD (2). Finally, it responds to a call in the EU strategy for the rights of persons with disabilities for 2021–2030 inviting FRA to examine the situation of persons with disabilities living in institutions (3).

The report is based on findings from two types of research: desk research from the 27 Member States and Albania, North Macedonia and Serbia (FRA's observer countries) and qualitative fieldwork research from 10 Member States (Croatia, Germany, Ireland, Italy, Latvia, Malta, Poland, Portugal, Slovakia and Slovenia). The 10 Member States selected reflect a range of geographical regions and approaches to how institutional care is regulated. Data collection was conducted by FRA's multidisciplinary in-country research network, Franet (4). In collaboration with the European Network on Victims' Rights (5), FRA collected additional information from members of the network, which was used to complement some of the findings from the FRA research.

The purpose of the desk research is to provide an overview of the relevant legal and policy frameworks in the 30 countries considered. It summarises information relating to gaps and shortcomings in these frameworks. It also provides an overview of the nature and scope of the monitoring carried out by public and independent bodies and of measures intending to uphold accountability through effective access to justice.

The empirical social research component, carried out in 10 Member States, contextualises the secondary research findings and provides important insights from people with disabilities, those with lived experiences of institutions and key stakeholders at the national level. In total, 143 in-depth interviews were conducted with (a) persons with disabilities who live in, or have experience of, institutional care; (b) key stakeholders, including those responsible for designing policies; (c) those tasked with implementing those policies (e.g. managers and staff of institutional services); and (d) relevant experts such as representatives of ombuds institutions, national human rights institutions (NHRIs), CRPD monitoring bodies, representative organisations of persons with disabilities and victim support services. Experts and key stakeholders were interviewed using semi-structured topic guides. Unstructured, in-depth, individual narrative interviews were held with persons with disabilities to ensure they could share their personal accounts, in their own words, in relation to protection from violence in institutions. All national reports from both components of the research are available on the FRA website (6), and Annex II provides a detailed description of the research methodology used.

Applying an HRBA, the report presents the findings in terms of three key aspects: protection against, prevention of and responses to violence in institutions. These are addressed across the five chapters listed below.

Chapter 1 explains the reality for persons with disabilities living in institutions.

Chapter 2 presents relevant international, European and EU legal and policy frameworks, outlining the EU’s obligations as a party to the CRPD.

Chapter 3 sets out the national legal and policy frameworks in place, highlighting gaps in the existing legal and regulatory landscape. This chapter also presents findings from the fieldwork research related to effectiveness and gaps in implementation.

Chapter 4 presents an overview of the scope and nature of the monitoring of institutions conducted by both public and independent bodies and discusses findings from the fieldwork research concerning the effectiveness of monitoring visits.

Chapter 5 covers states’ efforts to uphold accountability through effective access to justice by examining measures related to the provision of information and access to complaint mechanisms. It highlights findings related to effective access to justice for persons with disabilities in institutions identified in FRA’s fieldwork research.

# Terms and concepts

### Persons with disabilities

The CRPD acknowledges that disability is an evolving concept, defining persons with disabilities as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (Article 1).

### Models of disability and the CRPD paradigm shift

- **Medical model.** Individuals have a health condition that must be fixed to enable them to participate in society.
- **Charity model.** Individuals are seen as objects of pity or charity and should be helped.
- **Social model.** We need to eliminate barriers to enable the participation of persons with disabilities in society.
- **Human rights model.** Persons with disabilities have equal and inalienable rights like everyone else.

The adoption of the CRPD represents a revolutionary shift in our understanding of disability as it legally recognises persons with disabilities as rights holders and human rights subjects (*).

### Institution

There is no commonly agreed-upon definition of what constitutes an 'institution' for persons with disabilities. For the purposes of this research, an institution is 'any place in which persons with disabilities, older people, or children live together away from their families. Implicitly, a place in which people do not exercise full control over their lives and their day-to-day activities' (**). For the purposes of this research, data relate mainly to the classical notion of the institutional model of care – that is, care in larger settings (e.g. social care homes, psychiatric institutions).

### Violence

The wide and complex spectrum of violent, exploitative, abusive and degrading acts and practices performed against persons with disabilities in institutions makes the definition of violence challenging. The challenge is compounded in the context of both disability and institutionalisation because of what is termed disability-specific violence. For ease of reference, this report uses the term violence to refer to a variety of actions.

### Human-rights-based approach and PANEL principles

The HRBA is a normatively based conceptual framework that aims to promote and protect human rights in accordance with legally binding human rights law (***). Five principles, known as the PANEL principles, underpin the HRBA: participation, accountability, non-discrimination, empowerment and legality. These can support states in protecting against, preventing and responding to violence against persons with disabilities in institutions:

- by enabling persons with disabilities to **participate** in decisions that affect their rights;
- by ensuring duty-bearers' **accountability** for fulfilling their obligations to persons with disabilities in institutions through effective monitoring and access to redress when their human rights are violated;
- by realising the right of all persons with disabilities to **non-discrimination**, including intersectional discrimination;
- by **empowering** persons with disabilities in institutions to claim and exercise their rights and engaging them in developing policies that affect their lives;
- by upholding **legality** by grounding all relevant legal and policy responses in international, European and EU human rights law and national laws.

*Note:* For a complete terminology list, see Annex I.

(*) Office of the United Nations High Commissioner for Human Rights, ***What is disability?***, presentation. See also Degener, T., **'Disability in a human rights context'**, *Laws*, Vol. 5, Issue 3, 2016, p. 35; Aco Institute, **'Theoretical models of disabilities: Part 7 – Understanding the charity model of disability'**, 2023; United Nations Human Rights Council, **'Report of the Special Rapporteur on the rights of persons with disabilities'**, A/HRC/31/62, 2016; and Harpur, P., **'Embracing the new disability rights paradigm: The importance of the Convention on the Rights of Persons with Disabilities'**, *Disability & Society*, Vol. 27, Issue 1, 2010, pp. 1–14.

(**) See Figure 2, 'Physical and cultural characteristics of institutional settings', in FRA, ***From institutions to community living for persons with disabilities: Perspectives from the ground***, Publications Office of the European Union, Luxembourg, 2018. See also World Health Organization (WHO) and World Bank, ***World Report on Disability***, WHO, Geneva, 2011, p. 305.

(***) For more information, see United Nations Sustainable Development Group, **'Human rights-based approach'**, UN website; European Commission, **'Human rights based approach'**, European Commission website; and United Nations Development Programme, ***Applying a human rights-based approach to development cooperation and programming***, United Nations Development Programme, 2006.

# Endnotes

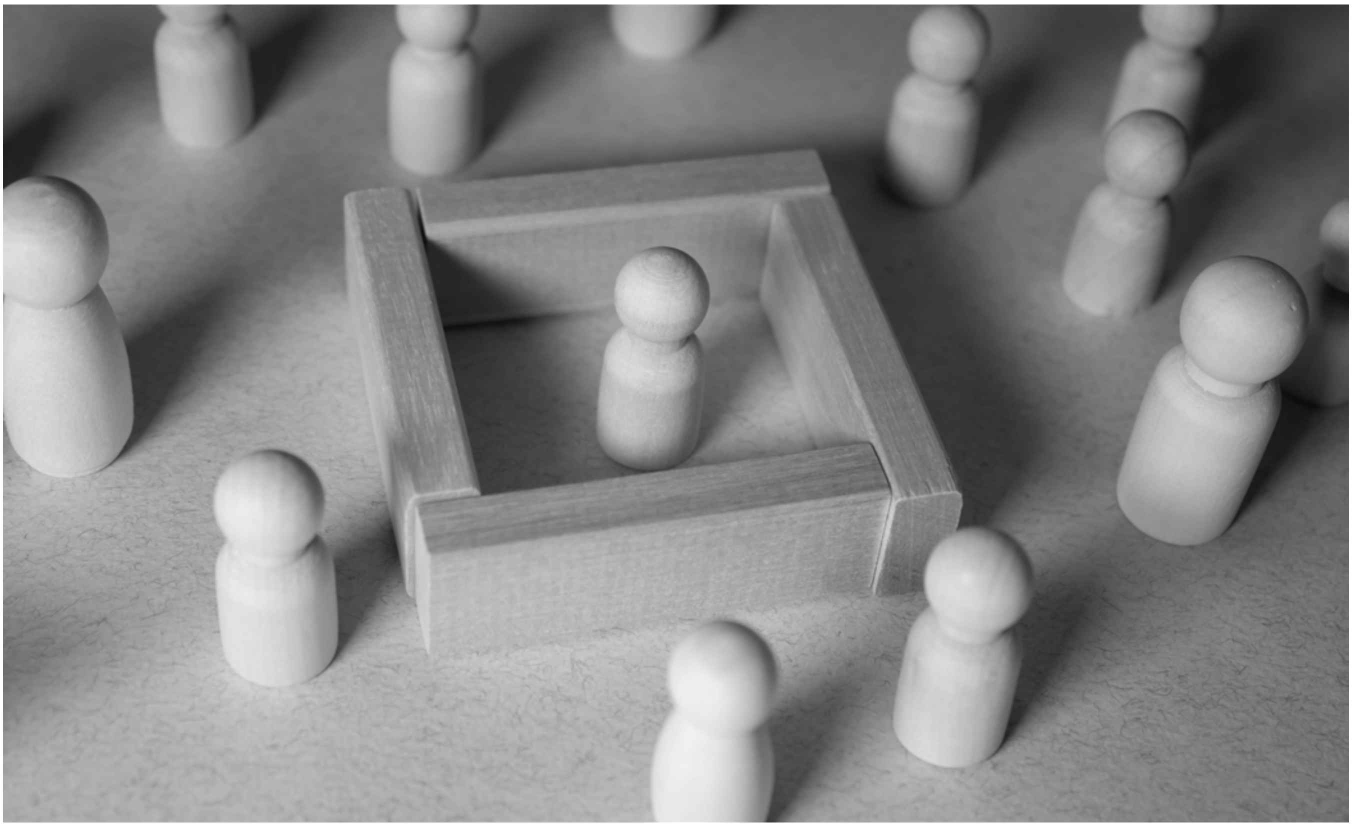
(1) Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G. et al., **'Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies'**, *The Lancet*, Vol. 379, Issue 9826, 2012, pp. 1621–1629.
(2) See FRA, **'EU CRPD framework – Monitoring'**, FRA website.
(3) European Commission, ***Union of Equality – Strategy for the rights of persons with disabilities 2021–2030***, Publications Office of the European Union, Luxembourg, 2021, Section 5.6.
(4) See **the page on Franet** on the FRA website.
(5) See the website of the **European Network on Victims' Rights**.
(6) FRA, **'Country data 2025 – Institutions places of care'**, FRA website.

# 1

# PLACES OF CARE = PLACES OF SAFETY?

> *'The concept of violence expands when we talk about the right to independent living: it is already a violence to have to choose to live in an institution to survive ... Inside [an institution] one is a prisoner; one depends, as if on an umbilical cord for an indefinite period, on the availability of services that are denied elsewhere. Dependence on a context makes one weak, fragile.'*
>
> Representative of a regional CSO, Italy

There are numerous types of institutions in which persons with disabilities reside. They can be large-scale social homes, care homes with mainly older residents but where some young persons with disabilities reside, psychiatric wards or separate spaces in schools. However, all these examples share common characteristics. They are often segregated from the local community, deprive people of their liberty and allow for little interaction with the outside world. They deny their residents any individuality and they rarely offer a space where the 'freedom to make one's own choices' (Article 3 of the CRPD) can be granted. The CRPD explicitly recognises institutionalisation as a form of violence; it amounts to a prohibited form of discrimination, can lead to various abuses and infringes upon the fundamental rights of persons with disabilities (1).



An ‘institution’ is characterised less by size or location and more by specific organisational features that result in residents experiencing a lack of choice and control over their day-to-day lives, separation from family and segregation from community life (2). While giving effect to the right to independent living remains a goal of commitments made at both the EU (3) and the national levels (4), institutions are still the primary place of residence for millions of persons with disabilities in Europe (5).

All this should be kept in mind when considering the manifestations of violence covered in this report. Given the environment in which they occur, they may bear a resemblance to domestic violence, as an institution may be the only home the victim knows (6). Perpetrators may be either people who live with the victim or staff members who are entrusted with their care and have unlimited access to their personal space.

Understanding the wide-ranging and complex causes, extents and manifestations of violence against persons in institutions is vital for developing measures to protect against, prevent and respond effectively to the problem. The solution starts with challenging structural impediments, the normalisation of violence and an ‘out of sight, out of mind’ attitude.

This chapter illustrates the reality for persons with disabilities living in institutions – a significantly under-researched group who are often overlooked in efforts by States Parties to implement the letter and spirit of the CRPD. It draws on FRA’s fieldwork research in 10 Member States, recommendations from treaty, expert and national human rights bodies and previous research from FRA and others.

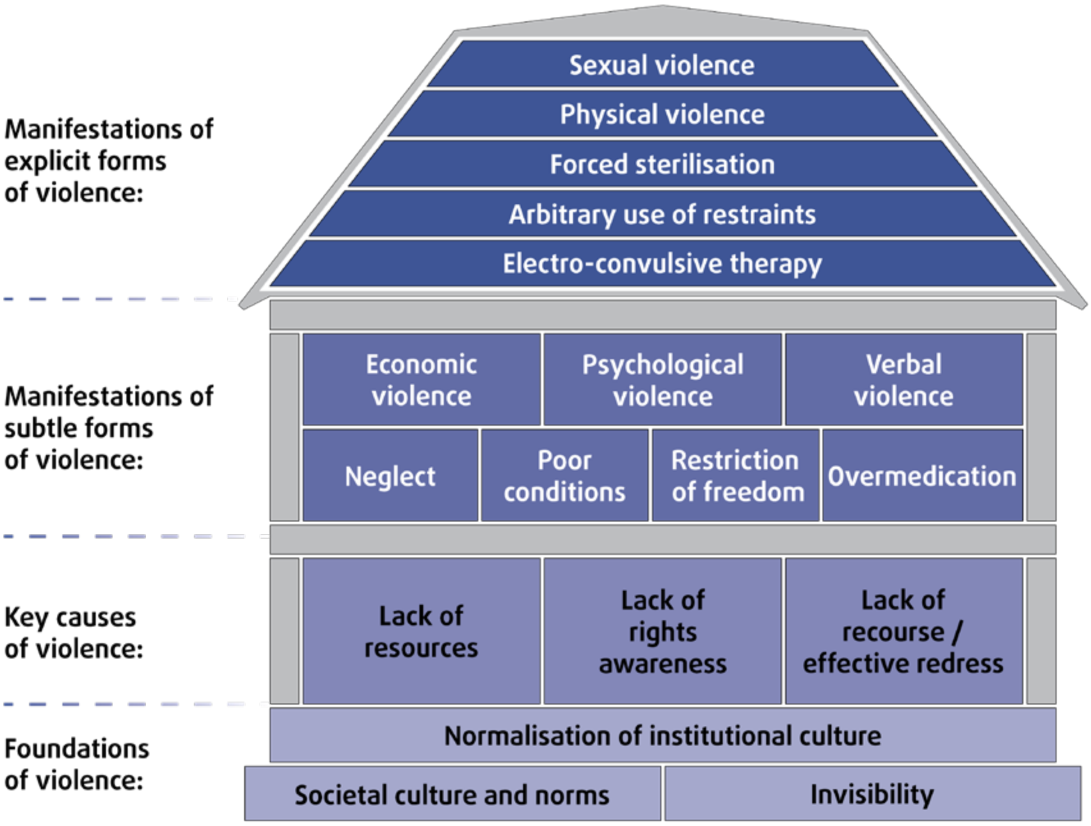
What emerges clearly from the desk research and the fieldwork is that addressing violence in institutions requires the deconstruction of the structural causes of violence that enable its manifestations – whether as explicit violent acts or more subtle dehumanising forms of violence such as emotional violence and neglect. **“Figure 1”** presents the evidence from FRA’s research in the form of a ‘house of violence’, featuring:

- the ‘foundations’ of violence (the invisibility of the issue, prevalent societal norms and the normalisation of institutional forms of care);
- the key causes of violence (the lack of resources, rights awareness and access to redress);
- the manifestations of violence (its subtle and explicit forms).

The ‘foundations’ reinforce and define some of the key causes of violence and are grounded in outdated norms and routines that leave little room for societal connectedness or personalised approaches to care. The key causes of violence are the lack of resources, lack of rights awareness and inadequate recourse/redress mechanisms.

The institutional culture of care (the base of the house) is grounded on a foundation of societal norms and attitudes that alienate persons with disabilities as different, abnormal or misfits. This is patriarchal, protectionist and rooted firmly in the medical model of disability. People living in institutions are deprived of the opportunity to develop and experience their own identity beyond ‘merely [being] associated with [their] disability’, in the words of a respondent with physical disability in Italy.

**FIGURE 1: THE FOUNDATIONS, CAUSES AND MANIFESTATIONS OF VIOLENCE AGAINST PERSONS WITH DISABILITIES IN INSTITUTIONS**



*Source:* FRA, 2025.

Participants in FRA’s research underlined that institutionalisation can be characterised as violence due to its inherent restrictions and the considerable control held over the lives of residents. ‘You don’t live life, you simply exist’ was the conclusion of a self-advocate interviewed in Latvia. Comparisons to prison emerged several times in the fieldwork. Even if interviewees had not experienced violence themselves, almost every participant had witnessed or heard of violent behaviour towards others, contributing to a sense of danger and threat and turning institutions into places of insecurity instead of places of safety.

> *‘Where torture begins … there is often controversy regarding the assessment … I believe that many institutions are still unaware that what they consider to be the right thing to do from a paternalistic point of view, how they deprive people of their freedom, is actually classified as torture under international law.’*
>
> Academic expert, Germany

Building upon the social and institutional culture surrounding care for persons with disabilities, FRA's research participants highlighted that the lack of resources, lack of rights awareness and inadequate access to recourse/redress further contribute to an environment where violence is normalised or tolerated. In a sense, they are the 'pillars' holding up the 'house of violence'.

Budgetary restrictions and staffing issues were mentioned in every desk research report and in every Member State during fieldwork. The fact that staff in institutions are overstretched, under-resourced and underqualified was put forward as a reason for the prevalence of abuse by most interviewees.

> *'What happens when you have one or two people on the night shift supervising 200 people. I know that things have happened that should not have happened.'*
>
> Representative of a CSO, Slovenia

Although some staff undoubtedly employ inappropriate methods when engaging with residents – whether verbally or physically – it should be noted that in many cases staff do not receive the training or support required to work in such settings. Staff often face difficult choices for which they are ill-prepared; for instance, if a resident is displaying challenging behaviour, they may choose to restrict the movements of all residents, thereby depriving them of their liberty, but they do so in the interests of safety. The high turnover of staff in this line of work, paired with the often low wages and poor working conditions (7), contributes to an environment lacking qualified personnel trained in core disciplines such as psychology, occupational therapy or social care.

> *'So, I can say that there is maybe no intentional violence, but the lack of staff, overcrowding, material conditions and the overall picture of social and psychiatric institutions can lead to situations where the staff behaves towards people, users and patients with certain violent actions, [lack of] care and so on.'*
>
> Representative of an independent monitoring body, Croatia

> *'[This] also subjects people with disabilities to a permanent rotation of people, doesn't it? People who deal with them, with their intimacy, with their care … I mean, this is so horrible … This permanent exposure of the person to strangers is a form of violence.'*
>
> Representative of a CSO, Portugal

A second harsh fact that contributes to the perpetuation of violence is that victims do not realise that they are being mistreated (see **"Section 5.3.3"**). Persons with disabilities living in institutions often lack education and awareness not only about their rights and the protections available to them, but also about boundaries and boundary-setting. As a result, mistreatment and violence often become normalised. This can also be attributed to a belief that the mistreatment is directly connected to their disability (e.g. they blame themselves because they believe that their own behaviour brought about the ill treatment in question) or to residents simply being accustomed to it due to the institutionalised lives they lead, often from a very young age. Such lifelong normalisation blurs a person's understanding of bodily, psychological and personal integrity and ingrains in them a deep sense of disempowerment and acceptance of being denied choice and control, sometimes even before an understanding of those rights could be developed. Education and awareness raising around rights and safeguards is an important preventive mechanism that is currently underdeveloped and underutilised in all researched countries.

> *'A lot of people in residential, you know, community-type residential settings quite often communicate differently, quite often may not be aware of the abuse or neglect that's occurring within their lives … I mean, if you're living in a place for 20, 30, 40 years, and it's run to a certain system, you know, you're not going to recognise it as institutional abuse.'*
>
> Representative of a CSO, Ireland

Those who do understand that this treatment is wrong face barriers to seeking redress and face the fear (and reality) of retaliation or secondary victimisation if they report it (see **"Section 5.3.4"**). The fieldwork shows widespread awareness of the depth of the dependency that people in institutions can have on staff. The perceived need to remain compliant in order to continue to receive care takes precedence over the quality of that care. Another particularly concerning finding relates to the lack of effort to support and empower people with disabilities to enjoy legal capacity – an explicit obligation on States Parties under Article 12 of the CRPD. This gap renders people in institutions wholly dependent on those providing them with care or holding the power to make decisions for them. It forces them to accept a quality of life determined by somebody else.

Built upon the abovementioned foundations, and reinforced by a lack of resources and rights awareness, are multiple forms of violence in institutions identified in this research. The fieldwork participants spoke about the violence they had experienced and/or witnessed (or heard about), such as physical and sexual violence, overmedication, involuntary treatment (including electroconvulsive therapy (ECT)), the arbitrary use of restraints, verbal and psychological abuse, labour or financial exploitation, neglect (which is also reflected in poor conditions), peer-to-peer violence, the restriction of freedom, isolation and systemic abuse. Participants highlighted that persons with intellectual and psychosocial disabilities, children and older persons are more at risk of becoming victims of violence ([8]).

At the most basic level, and in every country, people's freedoms are consistently and repeatedly restricted through behaviours performed under the guise of treatment that may not amount to criminal offences but constitute violence and violate their fundamental rights. For example, their liberty may be deprived, whether by something seemingly innocuous such as locking doors in the name of 'protection', by overmedicating or by placing them in physical restraints ([9]).

> *'The medication was changed without anyone talking to me … I had to ask what they were. It came in a little cup; they poured it into my hand. And I had to take them … They can do whatever they want. Any attempt on our part to argue, to question, is seen as sickness.'*
>
> Man with psychosocial disability, Portugal

> *'It's inhumane to be tied like this … all your limbs stretched out, tightened so that everything hurts, you can't move. This is completely inhumane. I mean, a person could be restrained somehow differently. Locked in a room or I don't know what. You don't need to be stretched like that. Across the entire bed, all the limbs spread apart so you can't move and then be like that sometimes all night long, so you can't fall asleep. It's terrible. You're already in trouble, and then there's this.'*
>
> Woman with psychosocial disability, Slovenia

Examples of violence identified in the fieldwork include allegations of a criminal nature, including instances of sexual abuse, sometimes by other residents but also by staff members (10).

> *'And they [four medical professionals] tried to pin me down on the table so that they could take the swab, and I couldn't stay still … and they couldn't understand why I was doing this. They couldn't understand my reaction to them pinning me down to go inside my vagina to get a swab.'*
>
> Woman with psychosocial disability, Malta

People's right to dignity is often violated when they are forced to live in poor conditions, such as in overcrowded, inaccessible institutions, or when they are neglected and left to sit in soiled clothes and beds (11).

> *'They make us do it in bed … we put the suppository in, we stand to one side and do it in bed, no nappy, nothing. We do it in bed, with the cover of the bed and all that rubbish. We stay there for half an hour; it's terrible for us … That was very embarrassing for me. I tried to change the situation, they said no, no way, because they didn't have time to come in half an hour later … So we'd get out of bed with the poo softer or not, depending on the faeces, all dirty, when they washed me, right there, in bed, and I'd spend the whole day with the feeling and, it's true, with the smell impregnated in us …'*
>
> Man with quadriplegia, Portugal

Emotional violence was also reported by participants. Examples of emotional violence include deprivation of care being used as a disincentive or punishment (12) and shouting, insulting or belittling comments being experienced every day (13). People's right to choose is flagrantly denied in respect of when and what to eat, how to spend their free time and money, with whom to live or by whom they are assisted (14). Respondents in several countries also reported financial exploitation (15).

> *'We were punished by sending us to our rooms … We were placed behind locked doors. I was rampaging there and then I was locked in my room. And wasn't even given any food … I said "Lunch, can you bring me lunch to my room?" "No!" Occasionally, they wouldn't give us food if we were punished.'*
>
> Woman with psychosocial and intellectual disability, Latvia

> *'The institution withheld the state disability allowance from residents. Out of their disability allowance, residents initially only received 10 pounds, then 20 pounds, and eventually a maximum of 30 euros … He says they never saw the extra Christmas bonus money … He had to advocate to get this bonus for himself and other residents.'*
>
> Man with intellectual disability, Ireland

Overall, FRA's research reveals that the various manifestations of violence built upon an under-resourced, rights-denying and dehumanising institutional and societal culture are the reality for many persons with disabilities in the EU. As one CSO representative from Latvia put it: 'It is an iceberg. We don't fully know what's going on and to what extent it's going on.' This and other findings (16) underline the need for Member States to act without delay as a matter of legal accountability. Abolishing the practice of institutionalisation and closing institutions is the first step to take to safeguard people's right to liberty and to a life of dignity that is free of violence, in compliance with the CRPD.

# Endnotes

(1) CRPD Committee, **‘Guidelines on deinstitutionalization, including in emergencies’**, CRPD/C/5, 2022, paras 6 and 59.

(2) CRPD Committee, **General Comment No 5 (2017) on living independently and being included in the community**, CRPD/C/GC/5, 2017, para. 16(c); and UN General Assembly, ***Thematic study on the right of persons with disabilities to live independently and be included in the community***, A/HRC/28/37, 2014, para. 25.

(3) European Commission, **Guidance on independent living and inclusion in the community of persons with disabilities in the context of EU funding**, C/2024/7188, 2024.

(4) See FRA, ***From Institutions to Community Living – Part I: Commitments and structures***, Publications Office of the European Union, Luxembourg, 2017.

(5) European Foundation for the Improvement of Living and Working Conditions (Eurofound), ***Paths towards independent living and social inclusion in Europe***, Publications Office of the European Union, Luxembourg, 2024; and European Commission: Directorate-General for Employment, Social Affairs and Inclusion and Grammenos, S., ***COVID-19 and Persons with Disabilities – Statistics on health, care, isolation and networking***, Publications Office of the European Union, Luxembourg, 2021. See also Šiška, J. and Beadle-Brown, J., ***Report on the transition from institutional care to community-based services in 27 EU Member States***, European Expert Group on Transition from Institutional to Community-based Care, 2020.

(6) See Council of Europe, **Convention on preventing and combating violence against women and domestic violence (CETS No 210, Istanbul Convention)**, Art. 3: ‘“domestic violence” shall mean all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim.’

(7) See Eurofound, ***Social Services in Europe: Adapting to a new reality***, Publications Office of the European Union, 2023; and Organisation for Economic Co-operation and Development and European Commission, ***Health at a Glance: Europe 2024 – State of health in the EU cycle***, OECD Publishing, Paris, 2024.

(8) See Mayrhofer, H., Schachner, A., Mandl, S. and Seidler, Y., ‘Experiences and prevention of violence against persons with disabilities’ (**‘Erfahrungen und Prävention von Gewalt an Menschen mit Behinderungen’**), Federal Ministry for Work, Social Affairs, Health and Consumer Protection, Vienna, 2019; Murphy, K. and Bantry-White, E., **‘Behind closed doors: Human rights in residential care for people with an intellectual disability in Ireland’**, *Disability & Society*, Vol. 36, Issue 5, 2020, pp. 750–771; Barnrättsbyrån, *‘... And I Couldn’t Breathe’ – An examination of violence against children in state youth homes* (***”... och jag kunde inte andas” – En granskning av våld mot barn på de statliga ungdomshemmen***), Stockholm, 2021, p. 92; and Lithuanian Disability Forum, ***Additional information to UN Committee on the Elimination of Discrimination against Women (CEDAW) review of Lithuania in its session 74***, 2019.

(9) See Gurbai, S., Simeonova, V. and Tsaneva, T. (eds), ***‘Poor Her, for Having Dreams’ – Monitoring report on torture and ill-treatment of persons with disabilities in Bulgarian institutions, including small group homes***, Validity Foundation and Network of Independent Experts, 2024, p. 26; Murphy, K. and Bantry-White, E., ‘**Behind closed doors: Human rights in residential care for people with an intellectual disability in Ireland’**, *Disability & Society*, Vol. 36, Issue 5, 2020, pp. 750–771; and Dunbar, P., Hazelwood, E., Wang, Q., McMahon, M., Walsh, K. A. et al., **‘Incidence and type of restrictive practice use in residential disability facilities in Ireland, a cross-sectional study’**, *Health & Social Care in the Community*, Vol. 30, Issue 6, 2022, e6009–e6017.

(10) See, for example, Baradji, E. and Filatriau, O., ‘Disabled people are more often victims of physical, sexual and psychological violence’ (**‘Les personnes handicapées sont plus souvent victimes de violences physiques, sexuelles et psychologiques’**), *Etudes et Résultats*, No 1156, 2020. See also Danish Institute for Human Rights, *Sexual Abuse in Residential Facilities – An analysis of the vulnerability of people with disabilities* (***Seksuelle overgreb på botilbud: Analyse af udsatheden for mennesker med handicap***), Copenhagen, 2022.

(11) See also Rosenthal, E., Milovanovic, D. C., Rodríguez, P. and Ahern, L., ***Serbia’s Forgotten Children***, Mental Disability Rights Initiative of Serbia, Belgrade, 2021, p. 7; and Romanian Ombuds (**Avocatul Poporului**), ‘Special report on the monitoring of the implementation of ECtHR decisions on involuntary admissions to psychiatric hospitals’ (**‘Raport special privind monitorizarea implementării deciziilor CEDO în cazul internărilor nevoluntare în spitalele de psihiatrie’**), 23 January 2024, pp. 33–36.

(12) See also Iwanowska, A., Jóźwiak, J. and Krzysztoń, D., *Rights of residents of social care homes. How can we jointly ensure a dignified life for elderly, sick people and people with disabilities? Report on the activities of the Commissioner for Human Rights of the National Mechanism for the Prevention of Torture* (***Prawa mieszkańców domów pomocy społecznej. Jak wspólnie zadbać o godne życie osób starszych, chorych i z niepełnosprawnościami? Raport z działalności RPO Krajowego Mechanizmu Prewencji Tortur***), Bureau of the Commissioner for Human Rights, Warsaw, 2017.

(13) For example, Gurbai, S., Simeonova, V. and Tsaneva, T. (eds), ***‘Poor Her, for Having Dreams’ – Monitoring report on torture and ill-treatment of persons with disabilities in Bulgarian institutions, including small group homes***, Validity Foundation and Network of Independent Experts, 2024.

(14) For a lack of autonomy, see Gulya, F. and Hoffman, I. (eds), ***Restricting the legal capacity of adults in Hungary*** *(A nagykorúak cselekvőképességének korlátozása)*, Orac, Budapest, 2024.

(15) For lack of financial independence in Malta, see Buhagiar, S. and Azzopardi Lane, C., **‘Freedom from financial abuse: Persons with intellectual disability discuss protective strategies aimed at empowerment and supported decision-making’**, *Disability & Society*, Vol. 37, Issue 3, 2022, pp. 361–385.

(16) FRA, ***From institutions to community living for persons with disabilities: Perspectives from the ground***, Publications Office of the European Union, Luxembourg, 2018. See also Thomas, A., **‘The state of play of independent living and deinstitutionalisation for persons with disabilities in the EU’**, Background paper for EMPL workshop, Policy Department for Economic, Scientific and Quality of Life Policies, Luxembourg, 2024.

# 2

# LEGAL INSTRUMENTS FOR THE PROTECTION AGAINST, PREVENTION OF AND RESPONSES TO VIOLENCE AGAINST PERSONS WITH DISABILITIES

An HRBA requires that states' actions are explicitly anchored in the recognition of rights, corresponding obligations and legal accountability. This approach places individuals – particularly those at risk of being left behind – at the centre of legal and policy responses, ensuring that their dignity and autonomy are respected. States are legally bound to respect, protect and fulfil the rights of all people ([1]).

For persons with disabilities, these obligations are grounded in international, European and EU law, with the CRPD being the principal instrument enshrining the rights of persons with disabilities and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) reinforcing the absolute prohibition of torture and ill treatment and providing a complementary legal framework for those in institutions (2). Other relevant instruments are the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and international human rights treaties that address the rights of specific groups while also considering the intersecting risks for those with disabilities, such as the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women.

This chapter provides a brief overview of the key provisions in international and European law, employing the following three-part framework.

1. **Protection from violence.** Establishing the legal baseline for protecting individuals from different forms of violence, enshrining their rights in law and enforcing these rights.

2. **Prevention of violence.** Defining mitigating measures and structures to prevent violence from happening in the first place.

3. **Responding to violence.** Establishing processes for responding to incidents of violence once they have occurred to ensure accountability.

This framework is consistent with the '3 Ps' – prevention, protection and prosecution – enshrined in recent conventions that address violence, such as the Istanbul Convention (3).

International and European law also sets out horizontal principles derived from an HRBA that should guide the implementation of legal and policy responses across all three areas. These include, among other things, the participation of persons with disabilities (one of the pillars of the CRPD); empowerment; coordination and cooperation; and data collection, which ensures transparency by making states accountable and enables evidence-based policymaking.

Member States are required to shift from institutional models of care to human-rights-based, community-supported alternatives in accordance with the jurisprudence of the European Court of Human Rights (ECtHR). Substantive guidance on the nature and scope of states' legal obligations is provided in general comments and concluding observations.

Together, these instruments mandate an approach to care that is rooted in autonomy, inclusion and the inherent dignity of all persons, regardless of age, gender or disability. As a result, deinstitutionalisation and protection from violence and ill treatment are not merely policy options but binding legal obligations.

This report addresses selected aspects of the protection, prevention and response framework (**"Figure 2"**).

FIGURE 2: SELECTED KEY PROVISIONS IN INTERNATIONAL, EUROPEAN AND EU LAW ON PROTECTION AGAINST, PREVENTION OF AND RESPONSES TO VIOLENCE AGAINST PERSONS WITH DISABILITIES

**Protection**

- **Protection of the right to life** (Article 10 of the CRPD; Article 2 of the ECHR; Article 2 of the Charter)
- **Prohibition of torture and cruel, inhuman or degrading treatment** (Article 15 of the CRPD; Articles 1, 2 and 16 of the CAT; Article 7 of the ICCPR; Article 4 of the Charter; Article 3 of the ECHR)
- **Protection from all forms of exploitation, violence and abuse** (Article 16(1) of the CRPD)
- **Right to liberty** (Article 14 of the CRPD; Article 9 of the ICCPR; Article 6 of the Charter; Article 5 of the ECHR)
- **Right to live independently and be included in the community** (Article 19 of the CRPD; Article 10 of the ICESCR; Article 26 of the Charter; Article 15 of the European Social Charter)

**Prevention**

- **Protection of the integrity of the person** (Article 17 of the CRPD; Article 3 of the Charter)
- **Respect for human dignity** (Article 3 of the CRPD; Article 2 of the TFEU; Article 1 of the Charter)
- **Educational measures to prevent abuse** (Article 16(1–2) of the CRPD)
- **Independent monitoring** (Articles 16(3) and 33(2) of the CRPD; Articles 17–23 of the OPCAT)
- **Equal recognition before the law and support in exercising legal capacity** (Article 12(3) of the CRPD; Article 21 of the Charter)

**Response**

- **Effective identification, investigation and prosecution** (Article 16(5) of the CRPD)
- **Psychological recovery and the provision of protection services** (Article 16(4) of the CRPD)
- **Right to appropriate victim support** (Articles 8 and 9 of the Victims' Rights Directive)
- **Training of officials on victims' rights and needs** (Article 25 of the Victims' Rights Directive)
- **Access to information on complaints** (Articles 9(2) and 21 of the CRPD; Article 41(2) of the Charter)
- **Access to justice and procedural accommodations** (Article 13 of the CRPD)
- **The right to a fair trial** (Article 6 of the ECHR; Article 47 of the Charter)

*Source: FRA, 2025.*

*Note:* Charter, Charter of Fundamental Rights of the European Union; ECHR, European Convention on Human Rights; TFEU, Treaty on the Functioning of the European Union.

This chapter describes national legal and policy measures aiming to ensure protection from violence, along with the gaps and shortcomings in their implementation.

Deinstitutionalisation is considered the most effective legal safeguard for persons with disabilities, as it ensures their right to liberty, autonomy and community inclusion in line with the CRPD. FRA has thoroughly researched the path to ending all forms of institutionalisation, isolation and segregation for persons with disabilities (4). Despite significant efforts, institutional care for people with disabilities persists across the EU. Strengthening national efforts to realise the right of persons with disabilities to live independently and be included in the community therefore remains pertinent.

Similarly, while prevention can be achieved through a variety of means, this report focuses on monitoring – by both public and independent bodies – as a key measure for deterring violence, as monitoring ensures that duty-bearers are held accountable for upholding the rights and safety of persons with disabilities. Nevertheless, effective prevention goes hand in hand with comprehensive national planning, efforts to raise awareness, the training of caregivers and justice personnel and the empowerment of persons with disabilities.

With respect to effective responses to violence, this research explores the provision of information and support to victims with disabilities in institutions allowing them to access tailored complaint and reporting mechanisms. Measures that ensure victims' rights beyond the reporting stage, such as procedural accommodations and safeguards in the justice system, have been the subject of previous research conducted by FRA and others (5).

Finally, while conceptually distinct, protection, prevention and response are not siloed aspects of the provisions against violence in place for persons with disabilities – they form an interconnected and interdependent framework. Protection ensures immediate safety, prevention addresses root causes to stop violence before it occurs and responses to violence provide legal and procedural recourse when incidents occur. In practice, these elements often overlap; for example, prosecution can deter future violence, monitoring can either uncover violent practices and generate responses or be initiated after reports of violations, and accessible complaint mechanisms can also serve as a form of prevention. The implementation of an HRBA across these three areas, including in relevant legal and policy instruments, should be promoted, as violence must be addressed holistically, not just by reacting to harm but also by anticipating it and safeguarding against it.

## 2.1. THE EU'S LEGAL AND POLICY FRAMEWORK

EU primary law is undergirded by a commitment to fundamental rights, as enshrined in Articles 2 and 6 of the Treaty on European Union (TEU) and the Charter. The Charter (6) is relevant to the protection of the rights of persons with disabilities through provisions emphasising the indivisible, universal, interdependent and interrelated values of human dignity, freedom, equality and solidarity in Articles 1–4 (7). These core protections are complemented by the prohibition of discrimination on the grounds of disability (Article 21) and recognition of the right to independence and social inclusion for persons with disabilities (Article 26). The Charter's legally binding nature obliges both EU institutions and Member States to uphold these fundamental rights when implementing EU law (8).

Despite this, the EU has not yet delivered a comprehensive secondary legal framework ensuring substantive equality for persons with disabilities that is consistent with the Charter and the CRPD. Most of the instruments that have been adopted are in fields in which the EU shares competences with its Member States (9). Of relevance to this report is the Victims' Rights Directive (10) (which, at the time of writing, is under revision (11)).

Despite providing some protections for victims of violence, these measures have been criticised (12) for emphasising reactive actions, such as offering support once abuse has been reported, rather than focusing on prevention.

In line with its obligations under international human rights law, the EU has developed a range of policy instruments that aim to protect the rights of persons with disabilities. In addition to the strategy for the rights of persons with disabilities for 2021–2030 (the third of its kind, and the first to specifically address violence, including in institutions) (13), several other EU frameworks address the provision of care and the rights of specific groups, such as women (14), children (15) and victims (16).

As part of this strategy, the Commission commits to developing guidance for Member States and practitioners, including police officers, to improve support for victims of violence who are persons with disabilities. At the time of the completion of this report, this guidance had not yet been published.

Other relevant EU policy instruments include the European Pillar of Social Rights (17), the EU strategy on victims' rights (2020–2025) (18), the European care strategy (19), Council recommendations on long-term care (20), the Commission's communication on a comprehensive approach to mental health (21), the high-quality long-term care principles (22), the EU quality framework for long-term care services (23) and the voluntary European quality framework for social services (24).

In respect of the last three instruments mentioned above, a recent review of the disability-relevance of quality assurance systems in social services in Europe concluded that quality assurance focuses 'on formal criteria, input parameters and complex structural elements (e.g. size of the premises and equipment, personnel requirements, all necessary permits, staff–client ratio) and not so much on outcome indicators to assess how the service contributes to an improved quality of life for the individual' (25). This conclusion highlights the need to shift towards results-oriented, rights-based indicators that reflect the lived experiences of persons with disabilities.

The consistent application of an HRBA across all these policy instruments would require that empowerment and participation not be limited to rhetorical commitments but be translated into concrete, enforceable policies. This would include legal reform, institutional monitoring, inclusive governance structures and access to remedies for rights violations. The sufficient allocation of resources and funding is crucial.

Ultimately, realising the rights of persons with disabilities – and particularly their right to live free from violence and institutional abuse – depends on the robust implementation of an HRBA across all levels and types of EU and Member State action.

## 2.2. OBLIGATIONS INCUMBENT ON THE EU AS A PARTY TO THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

The EU acceded to the CRPD in 2010. The obligations introduced as a result of its ratification of the CRPD bolster existing EU primary law.

### The CRPD Committee's 2025 concluding observations on the second and third periodic reports of the EU

In its concluding observations from March 2025, the CRPD Committee urged the EU to 'improve implementation of the Convention by ensuring that the Convention has direct effect in its law' and conduct a comprehensive review of EU laws and policies to ensure compliance with the CRPD. Selected recommendations from the CRPD Committee focus on the following areas.

- **The human rights model of disability.** Shift from the medical model to a rights-based approach in disability assessments.
- **Funding and monitoring.** Ban EU funding for institutions / small group homes and strengthen the monitoring of fund usage while actively involving persons with disabilities.
- **Deinstitutionalisation and independent living.** End institutionalisation, promote community-based support, investigate deaths in institutions and enforce accountability.
- **Access to justice and legal capacity.** Replace substitute decision-making with supported decision-making and ensure that justice systems are accessible for persons with disabilities.
- **Freedom from violence.** Prohibit forced treatments and strengthen protections against gender-based violence.
- **Data collection and monitoring.** Improve the disaggregation of data, include persons in institutions in data collection and establish independent monitoring mechanisms that comply with the Paris Principles.

*Source:* CRPD Committee, **Concluding observations on the combined second and third periodic reports of the European Union**, CRPD/C/EU/CO/2-3, 2025.

In the context of the CRPD, the EU has various competences to act depending on the area in question ([26]). As both the EU and its Member States are parties to the CRPD, each has independent legal obligations. EU law obliges Member States to implement the convention to the extent that its provisions fall within the EU's competence. Moreover, the EU has its own obligation to ensure that all EU funds are used to further the implementation of the CRPD. The Council decision on the conclusion of the CRPD specifically mentions the European Social Fund and the European Regional Development Fund as areas in which the EU has competence ([27]). The 2021–2027 Common Provisions Regulation (CPR) ([28]) and the fund-specific regulations ([29]) have increasingly emphasised the obligation of Member States ([30]) to ensure respect for fundamental rights and compliance with the Charter and the CRPD in the implementation of the funds in line with the horizontal enabling conditions applicable to funding under the CPR. Despite this, there is evidence ([31]) that EU funds have been allocated to support settings with institutional characteristics, contravening Article 19 of the CRPD. Furthermore, the mechanisms used to suspend or recover funds in cases of misuse are seldom employed, undermining the credibility and enforceability of the conditions related to human rights and the CRPD embedded in EU funding frameworks (32).

## 2.3. PERSONS WITH DISABILITIES AND THE EUROPEAN CONVENTION ON HUMAN RIGHTS

The ECHR protects persons with disabilities in institutional care through the right to life (Article 2), the right to protection from torture and inhuman or degrading treatment or punishment (Article 3), the right to liberty and security (Article 5), the right to a fair trial (Article 6), the right to respect for private and family life (Article 8) and the prohibition of discrimination (Article 14). In addition, ECtHR case-law (33) on cases of involuntary treatment and placement in mental healthcare facilities (34) has steadily moved towards interpreting these rights in line with the CRPD (35).

The ECtHR has repeatedly affirmed that there is a positive obligation on states to safeguard the lives of people in institutions (36) and has consistently ruled that degrading living conditions, physical restraint and forced treatment in care facilities may amount to violations of the prohibition of torture and inhuman or degrading treatment (37). A number of ECtHR cases (38) have recognised that forced sterilisation is a violation of both Article 3 and Article 8 of the ECHR (the right to protection from torture and inhuman or degrading treatment or punishment and the right to respect for private and family life), establishing a precedent for protecting persons with disabilities from abusive medical practices.

Article 5 (the right to liberty and security) has been increasingly interpreted with respect to the CRPD's Article 14, which states that disability shall not justify deprivation of liberty. And, while the ECtHR has tightened safeguards, ruling that a meaningful judicial review of detention is required (39), tensions remain between this and the CRPD's absolute ban on disability-based detention. This is highlighted in *Mihailovs* v *Latvia* (2013) (40), where the court allowed confinement if 'necessary'. The ECtHR has also emphasised the right to family life for persons with disabilities (41) and more recently found that unnecessary institutionalisation without community-based options violates Article 8 (42). Despite these advances, gaps persist. Academic critiques contend that the ECtHR remains overly deferential to states in resource allocation cases and diverges considerably from the CRPD provisions related to the legal capacity and rights of people with intellectual and psychosocial disabilities (43).

# Endnotes

(1) See **'International human rights law'** on the Office of the High Commissioner for Human Rights (OHCHR) website.

(2) Sveaass, N. and Madrigal-Borloz, V., **'The preventive approach: OPCAT and the prevention of violence and abuse of persons with mental disabilities by monitoring places of detention'**, *International Journal of Law and Psychiatry*, Vol. 53, 2017, pp. 15–26; and Perlin, M. L. and Schriver, M., **'"You that hide behind walls": The relationship between the Convention on the Rights of Persons with Disabilities and the Convention against Torture and the treatment of institutionalized forensic patients'**, *NYLS Legal Studies Research Papers*, No 13/14, #76, 2014; and Center for Human Rights and Humanitarian Law, ***Torture in Healthcare Settings: Reflections on the Special Rapporteur on torture's 2013 thematic report***, Washington DC, 2013.

(3) Council of Europe, **'Explanatory report to the Council of Europe Convention on preventing and combating violence against women and domestic violence'**, *Council of Europe Treaty Series*, No 210, 2011, p. 12, para. 63.

(4) FRA, ***From institutions to community living for persons with disabilities: Perspectives from the ground***, Publications Office of the European Union, Luxembourg, 2018.

(5) FRA, ***Underpinning Victims' Rights – Support services, reporting and protection***, Publications Office of the European Union, Luxembourg, 2023. See also the outcomes from Validity's project **'Enabling inclusion and access to justice for defendants with intellectual and psychosocial disabilities'**.

(6) See the FRA website for more on the **EU Charter of Fundamental Rights**.

(7) See also the **Vienna Declaration and Programme of Action**, 1993, I(5).

(8) As confirmed in judgment of 26 February 2013, ***Åkerberg v Fransson***, C-617/10, ECLI:EU:C:2013:105.

(9) European Commission, ***Annotated review of European Union law and policy with reference to disability***, Publications Office of the European Union, Luxembourg, 2024, p. 137.

(10) **Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA** (OJ L 315, 14.11.2012, p. 57).

(11) For more information, see **'Revision of the victims' rights acquis'** on the European Parliament's Legislative Train Schedule website.

(12) López, S., 'The EU Victims' Rights Directive and its impact on national legal systems: A critical approach', *International Journal of Law, Crime and Justice*, Vol. 56, pp. 32–44; and Pemberton, A. and Das, S., 'The EU Directive on Victims' Rights: From reparation to prevention?', *European Journal of Criminology*, Vol. 17, Issue 2, pp. 153–170.

(13) European Commission, ***Union of Equality – Strategy for the rights of persons with disabilities 2021–2030***, Publications Office of the European Union, Luxembourg, 2021.

(14) **Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions – A union of equality: Gender equality strategy 2020–2025**, COM(2020) 152 final of 5 March 2020.

(15) For instance, in **Proposal for a Council recommendation on the revision of the Barcelona Targets on early childhood education and care**, COM(2022) 442 final of 7 September 2022, as part of the European care strategy.

(16) **Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: EU strategy on victims' rights (2020–2025)**, COM(2020) 258 final of 24 June 2020.

(17) European Commission, **'European Pillar of Social Rights'**, European Commission website.

(18) **Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: EU strategy on victims' rights (2020–2025)**, COM(2020) 258 final of 24 June 2020.

(19) European Commission, **'A European care strategy for caregivers and care receivers'**, press release, 7 September 2022.

(20) **Proposal for a Council Recommendation on access to affordable high-quality long-term care**, COM(2022) 441 final of 7 September 2022.

(21) **Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health**, COM(2023) 298 final of 7 June 2023.

(22) Annex to the **Proposal for a Council recommendation on access to affordable high-quality long-term care**, COM(2022) 441 final of 7 September 2022.

(23) WeDO, ***European Quality Framework for Long-term Care Services***, AGE Platform Europe, Brussels.

(24) Social Protection Committee of the European Commission, ***A voluntary European quality framework for social services***, SPC/2010/10/8 final, 2010.

(25) European Commission, ***Disability-relevance of Quality Assurance Systems in Social Services***, Publications Office of the European Union, Luxembourg, 2023, p. 11.

(26) See **Council Decision of 26 November 2009 concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities** (OJ L 23, 27.1.2010, p. 35), Appendix. See also Waddington, L., **'The European Union and the United Nations Convention on the Rights of Persons with Disabilities: A story of exclusive and shared competences'**, *Maastricht Journal of European and Comparative Law*, Vol. 18, Issue 4, 2011, pp. 431–453.

(27) See **Council Decision of 26 November 2009 concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities** (OJ L 23, 27.1.2010, p. 35), Appendix.

(28) **Regulation (EU) 2021/1060 of the European Parliament and of the Council of 24 June 2021** (OJ L 231, 30.6.2021, p. 159).

(29) **Regulation (EU) 2021/1060 of the European Parliament and of the Council of 24 June 2021** (OJ L 231, 30.6.2021, p. 159).

(30) **Consolidated version of the Treaty on the Functioning of the European Union** (OJ C 202, 7.6.2016, p. 47), Arts 9 and 151; **Consolidated version of the Treaty on European Union** (OJ C 326, 26.10.2012, p. 13), Art. 6; and the **EU Charter of Fundamental Rights**, Art. 34. See also the EUR-Lex **summary on social policy**.

(31) European Network on Independent Living (ENIL), ***Shadow report on the implementation of the UN Convention on the Rights of Persons with Disabilities in the European Union***, Brussels, 2022, pp. 4–8; ENIL, ***Update to the shadow report on the implementation of the UN Convention on the Rights of Persons with Disabilities in the European Union***, Brussels, 2024, pp. 16–24; and FURI (EU funds for Fundamental Rights), ***1.1 billion euros, 63 projects, six countries, one pattern – How EU funds violate fundamental rights***, 2025.

(32) ENIL, **'Stopping the use of EU funds to support institutionalisation and segregation'**, 2022.

(33) See the ***2024 ECtHR thematic factsheet on persons with disabilities and the ECHR***, which provides an overview of most relevant cases.

(34) Council of Europe and ECtHR, ***Research Report – Rights of persons in relation to involuntary placement and treatment in mental healthcare facilities***, 2022.

(35) Fiala-Butora, J., **'The influence of the Convention on the Rights of Persons with Disabilities on the European Court of Human Rights in the area of mental health law: Divergence and unexplored potential'**, *International Journal of Law and Psychiatry*, Vol. 94, 2024, 101965.

(36) ECtHR, ***Keenan v the United Kingdom***, No 27229/95, 3 April 2001; and ECtHR, ***Validity Foundation on behalf of T.J. v Hungary***, No 31970/20, 10 January 2025. See also **'A milestone in disability rights jurisprudence'** on ENIL's website.

(37) ECtHR, **_Stanev_ v _Bulgaria_**, No 36760/06, 12 January 2012; ECtHR, **_Đorđević_ v _Croatia_**, No 41526/10, 24 July 2012; ECtHR, **_Rooman_ v _Belgium_**, No 18052/11, 31 January 2019.

(38) See the 2023 **ECtHR thematic factsheet on reproductive rights**, which provides an overview of most relevant cases.

(39) ECtHR, **_D. D._ v _Lithuania_**, No 13469/06, 9 July 2012.

(40) ECtHR, **_Mihailovs_ v _Latvia_**, No 35939/10, 22 April 2013.

(41) ECtHR, **_Kutzner_ v _Germany_**, No 46544/99, 10 July 2002.

(42) ECtHR, **_Z. H._ v _Hungary_**, No 28973/11, 8 November 2012.

(43) Ferri, D. and Broderick, A., **'The European Court of Human Rights and the "human rights model of disability" – Convergence, fragmentation and future perspectives'**, in Czech, P., Heschl, L., Lukas, K., Nowak, M. and Oberleitner, G. (eds), *European Yearbook on Human Rights*, Intersentia, 2019.

# 3

# NATIONAL LEGAL AND POLICY FRAMEWORKS

As demonstrated in Chapter 2, the EU and its Member States have made a range of legal and policy commitments designed to protect the fundamental rights of persons with disabilities, including when they are victims of crime. As social policy is primarily the purview of Member States, this chapter provides an overview of Member States' and FRA observer countries' legislative and policy frameworks for addressing violence against persons with disabilities in institutions. It then summarises the findings from FRA's empirical research in relation to the adequacy and effectiveness of national legal and policy frameworks.

## 3.1. LEGAL PROTECTION FROM VIOLENCE AT THE NATIONAL LEVEL

Regulatory frameworks governing the sectors responsible for the provision of health or social care typically include both general laws and sector-specific instruments. For example, some laws create secondary regulatory frameworks, like sector-specific accreditation standards, to further ensure protection in certain care contexts. These sector-specific instruments sometimes include elements that aim to prevent violence; however, they lack harmonisation. Variations in legal protections exist not only between Member States but also at the local and regional levels.

Additionally, differences in regulatory approaches to protection can be observed. Similarly to EU legislation, most national laws prioritise responsive measures; only a few include provisions for the prevention of violence, and these are often underdeveloped. National policies, on the other hand, focus more on prevention (see **"Section 3.2"**).

The national legal and regulatory frameworks governing the provision of care also reveal disparities in how the rights and needs of various groups, such as women, children and older persons, or those with different types of disability (e.g. psychosocial disability), are addressed. The focus tends to be on regulating more extreme forms of violence, such as involuntary treatment or forced sterilisation, with less attention paid to less visible or systemic human rights violations (1). Moreover, violence in institutions can be perpetrated either by other residents or by caregiving staff who have unrestricted access to victims' personal spaces. In some respects, this bears a resemblance to 'domestic violence' (2) as these institutions often function as the victims' homes. As noted by the CRPD Committee, the isolation inherent in institutions demands greater efforts to ensure residents are protected, particularly against the forms of violence that tend to be prevalent in institutional care settings, such as emotional abuse (3). The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has also highlighted the specific risks faced by persons with disabilities in institutions (4). The Special Rapporteur on the right to health has underscored the crucial link between health, protection from violence and the right to rehabilitation. This link highlights that the institutionalisation of persons with disabilities, combined with inadequate health systems, often leads to violations of their rights to both health and protection from violence (5).

> *'The ingrained fear and stigma of mental illness is still very strong, fuelling prejudice and the narrative that persons with mental health problems pose a danger to themselves and to society … Mental health laws that normalise closed institutions and forced treatment confirm and reinforce these prejudices.'*
>
> Council of Europe Commissioner for Human Rights (6)

## Institutional culture affecting legal responses

Institutional culture, which normalises violence, impacts more than just the attitudes of residents and employees in residential settings. The phenomenon of violence against persons with disabilities is often taboo and thus overlooked by national authorities (*), politicians and legislators (**). This invisibility is perpetuated by stigma and silence, which allow violence and neglect to continue unchallenged.

A fundamental shift – the 'paradigm shift' called for by the CRPD – is urgently required to effectively address violence against persons with disabilities. To uphold an HRBA, the provision of care must be fundamentally restructured to recognise persons with disabilities as autonomous rights holders entitled to dignity, legal capacity and agency, and the equal protection of these rights under the law.

Legal transformation must therefore go beyond surface reforms. In legal terms, reversing such a long-standing 'culture' requires that disability assessments are compliant with human rights and with a social-contextual understanding of disability that focuses on barriers (***). In the case of institutional violence, reform requires both deinstitutionalisation processes and the adoption of meaningful violence prevention measures while deinstitutionalisation is still under way.

(*) Council of Europe, PACE Committee on Equality and Non-Discrimination, 'Equality and inclusion for people with disabilities', **Doc. 13650**, 12 December 2014.

(**) United Nations Office on Drugs and Crime, ***Strengthening crime prevention and criminal justice responses to violence against women***, New York, 2014, p. 8.

(***) See also CRPD Committee, ***Concluding observations on the combined second and third periodic reports of the European Union***, CRPD/C/EU/CO/2-3, 2025, paras 10–11.

### 3.1.1 What drives change?

In practice, changes in legislation and policy responses are often triggered by high-profile cases of abuse or prompted by the rulings and recommendations of international bodies, which are then amplified by media coverage or political mobilisation. These can serve as the catalyst for the creation of targeted legal measures, which may focus on addressing specific violations or improving oversight mechanisms.

Regarding the rights of persons with disabilities, legal reforms are also sometimes prompted by the incorporation of the CRPD into national law. This was the case for Ireland's adoption of the Assisted Decision-Making (Capacity) Act (7) in 2023. Other reforms have occurred because of the need to implement recommendations from bodies such as the CRPD Committee or the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Following an ad hoc visit of the CPT to Bulgaria (8), the Bulgarian parliament appointed an ad hoc committee to propose suggestions for legislative changes (9), resulting in a draft law to amend the national Health Act (10).

ECtHR case-law has also led to revisions aimed at upholding the rights of persons with disabilities in institutions. Belgium (11), Finland (12), Greece (13) and Romania have made legal changes to implement rulings from the ECtHR. For example, as a result of the 2014 *Câmpeanu* case, Romania introduced legal reforms to its guardianship system and created a series of guarantees to safeguard against abuse (14). A national council responsible for monitoring the implementation of the CRPD was established, and the same law granted non-governmental organisations (NGOs) *locus standi* in proceedings involving persons with disabilities appearing before courts and independent bodies (15).

During the coronavirus (COVID-19) pandemic, the dire situation of persons with disabilities in institutions raised concerns (16). France is one of the few Member States where the pandemic triggered in-depth review processes, resulting in a national strategy to combat abuse (2024–2027), which includes measures for persons with disabilities in institutions (17).

Strategic litigation is another pathway for victims to access to remedy and drive change at the national level, as in the TopHáz case (18) in Hungary, the *Černáková* (19) case in Slovakia or the case of *Dorota Šandorová* (20) in Czechia.

In some cases, an a posteriori assessment of the implementation of legal instruments through commissioned studies (21), reports (22), audits (23) and evaluations (24) can motivate the responsible authorities to incorporate preventive approaches into their legal and policy planning.

Still, substantial legal reforms with a preventive focus remain rare, indicating that systemic changes to prevent violence in disability care have yet to be fully realised across the EU.

### 3.1.2 Shortcomings in general and disability-specific legal provisions

All Member States have human rights related to violence protection enshrined in their constitutions, which call for the protection of human dignity and the prohibition of torture and cruel, inhuman and degrading treatment by law (25). These provisions apply equally to persons with disabilities. In Finland, for example, the constitutional clause that prohibits torture (26) has been interpreted to include protections against the misuse of medication (27).

Legal provisions regarding protection from violence found in national legislation are mainly general provisions (i.e. predominantly seen in criminal laws) that sometimes consider aggravating circumstances or enhanced penalties for a wide variety of crimes (28) in view of the victim's 'health status' (29), 'the state of vulnerability' (30), 'lack of defence' (31) or 'helplessness' (32). While reflecting the aggravated nature of crimes that harm persons with disabilities is warranted, it is important that the law avoid reinforcing the stigma against persons with disabilities through terms that diminish their autonomy or imply that they cannot claim their rights.

Even though disability is not included in the EU's hate crime legislation (33), several Member States include disability as a recognised protected characteristic in their criminal codes (34), providing either for enhanced penalties (e.g. Belgium (35)) or for an aggravating factor (e.g. Finland (36)). FRA has repeatedly recommended that legislation adopted at the Member State level should cover all forms of bias motivation equally, including when people are motivated by bias against a person because of their disability (37).

Beyond constitutional and criminal frameworks offering general protections to all individuals, national regulatory frameworks also include provisions regarding disability-specific forms of violence, such as involuntary treatment, sterilisation, physical and chemical restraints, and isolation. Legal provisions that allow or introduce exceptions to the prohibition of certain practices are scrutinised (38) for their compatibility with the principles of the CRPD (39). The CRPD Committee has consistently called for States Parties to repeal laws that allow forced treatment, the use of restraints or solitary confinement (40). Here, the question of whether persons with disabilities are recognised as rights holders or merely viewed as objects of protection once again comes to the forefront.

Previous FRA work has also illustrated the challenges that the EU and its Member States may face in reconciling the non-discrimination principles of the CRPD with traditional mental healthcare practices and other (contrasting) human rights provisions (41). The Oviedo Convention's draft additional protocol about involuntary placement and treatment within mental healthcare services (42) – which allows for involuntary placement and/or involuntary treatment, albeit in specific and limited instances – has been a subject of controversy between the Council of Europe (43) and the CRPD Committee (44). The committee has called on the EU to urge Member States to withdraw from the draft protocol and to work with the Council of Europe to develop a non-coercive framework on mental health in close cooperation with representative organisations (45).

Furthermore, many forms of violence experienced by persons with disabilities in institutions are not classified as criminal offences, and thus fall below the legal threshold for prosecution. Psychological violence, as a form of intimidation or coercion, is often not explicitly or consistently addressed across different national legal frameworks.

FRA findings show that legal barriers persist in cases where persons with intellectual and psychosocial disabilities are restricted in or deprived of their legal capacity (46). The CRPD Committee (47) has repeatedly called on Member States to amend their legal framework to ensure that any decision on placement in an institution or on treatment is made by the affected person, based on free and informed consent, and not by a guardian (48). Academic research has also demonstrated the need for avoiding coercion and adopting a rights-based approach by aligning mental health laws more closely with the CRPD, increasing the participation of mental health service users in treatment and policymaking, and providing community-based care and support (49).

Most countries still have provisions in place regulating substitute decision-making, which is when persons with disabilities are placed under 'guardianship' or other relevant forms of third-party legal representation, affecting their legal position and power of self-determination. A recent monitoring report on persons with disabilities in Bulgarian institutions (50) listed placement under guardianship as one of the 12 forms of torture and ill treatment that were observed. Some positive developments regarding laws on involuntary placement or treatment have been identified, such as those in Spain (51) and Ireland (52).

An illustrative example of the normalisation of violence through existing legal provisions is the use of physical and chemical restraints and isolation, which are regulated in all Member States. Such practices are common in psychiatric care, mental healthcare and social care, and in care institutions for older people.

Countries like Belgium (53), Bulgaria (54), Czechia (55), Denmark (56), Finland (57), France (58), Hungary (59) and Lithuania (60) have detailed regulations stipulating time limits and conditions for the use of restraints, such as necessity, proportionality and the risk of harm. Spain (61) requires a formal commitment to restraint-free care for accreditation. Some countries, like Croatia (62), are also developing institution-specific guidelines.

Permissible time frames for segregation vary significantly between countries – up to three days is permitted in Lithuania (63), and 48 hours per month is allowed in a diagnostic institute, a children's home with a school, or an educational institute in Czechia (64) – despite international recommendations advocating the minimal use of isolation and continuous supervision by trained personnel (65).

Forced medication and ill treatment through the maladministration of medication, such as overmedication or withholding medication, are still not expressly prohibited across the EU. Some countries have reported regulating such practices in their legal frameworks, permitting them only as an exception to an overall ban on involuntary treatment (e.g. Poland (66) and Serbia (67)). Such exceptions are permitted subject to the conditions of necessity and proportionality and in cases where persons pose a threat to themselves or others.

The ECtHR has addressed the need to provide for robust procedural safeguards where laws permitting forced medication exist. For example, following the case of *X* v *Finland* (68), Finland's national Mental Health Act was amended to ensure that forced medication is implemented by way of an administrative decision that is subject to appeal in an administrative court (69).

Consistent with the view of the CPT, the use of unmodified, non-consensual ECT (70) is deemed a form of inhuman and degrading treatment. However, this is not yet reflected in the legal and practical application of all Member States. For example, in Greece, there is no specific legislative framework on medical treatments with serious and/or irreversible effects, such as ECT or psychosurgeries. According to the country's general penal provisions (71), such acts could be considered to constitute serious bodily harm. The CRPD Committee has also commented on the lack of ECT prohibitions in its concluding observations to France (72), Spain (73) and Sweden (74). The CPT has also voiced concerns about the improper use of ECT in Slovakia (75).

While most Member States have put in place explicit prohibitions against forced sterilisation (including in respect of persons with disabilities, persons deprived of their legal capacity and minors), it is not uniformly recognised as a form of violence across all Member States (76). Recommendations by the CRPD Committee (77) have played a significant role in prompting national reforms that criminalise the sterilisation of persons with disabilities without their full and informed consent, as was the case in Spain (78) and, most recently, in Malta (79). In some cases, the prohibition is implied on the basis of the protection of other rights, like the right to informed consent (e.g. in Belgium (80)), or on the basis of the criminalisation of other acts, like causing bodily harm (e.g. in Bulgaria (81), Greece (82) and Italy (83)). Nevertheless, the sterilisation of persons with disabilities is still permitted in places, for example in Hungary (84), albeit as an exception that is subject to detailed procedural safeguards, on the ground that a person's physical or mental condition does not permit the expression of informed consent (85). In other countries, like Italy, forced sterilisation is considered not a specific offence in itself but an aggravating circumstance (86). However, according to a 2024 report by the Italian Disability Forum, it appears to remain a common practice often carried out under the guise of other medical procedures (87).

Regarding less visible forms of violence, legal provisions addressing the issue of financial exploitation have been identified in very few Member States. For example, in Spain (88), Law 8/2021 expands the powers of the Public Prosecutor to monitor such cases with the aim of preventing incidents of financial exploitation and the abuse of institutionalised persons.

### 3.1.3 Disparate protection in law and policy across sectors and groups

National laws and regulations on women, children, older persons and, in a few instances, persons with a substance use disorder are also relevant to persons with disabilities, particularly in cases where persons with disabilities are placed in care settings for older people, or when adolescents with challenging behaviour who are deemed to be a risk to others are institutionalised (89). Persons with disabilities in institutions have heightened protection needs, given that both young/old age and being female are factors that increase the likelihood of victimisation. Studies in Austria (90), Germany (91), Lithuania (92), North Macedonia (93) and Sweden (94) illustrate the increased vulnerability of persons in whom disability and characteristics such as old/young age and a non-male gender intersect. However, some of the existing regulations addressing these groups fail to explicitly address the heightened risk for persons residing in institutions, leading to protection gaps. Nonetheless, the research also found some promising examples. It highlighted Ireland's Children First Act (95) as a good example of legislation on the process of investigating allegations of abuse and mentioned that the country's Domestic Violence Act (96) could be a suitable legal mechanism for addressing neglect and preventing abuse in congregated settings.

Most legal provisions and safeguards tailored to psychiatric or mental health institutions are governed by specific mental health acts (e.g. in Bulgaria (97), Czechia (98), Ireland (99), Lithuania (100), Malta (101), Poland (102), Portugal (103) and Slovenia (104)). These typically focus on involuntary placement and treatment, where the deprivation of liberty is more explicit and, therefore, more rigorously regulated.

In contrast, persons with disabilities placed in more general social care facilities – such as residential homes, nursing homes or general long-term care institutions – do not typically benefit from dedicated legislation. These settings are more frequently governed by general legislation for residential accommodation, codes of ethics or professional standards, which typically do not specifically address violence or the particular support needs of residents. For example, in fewer than half of Member States is protection from and prevention of violence addressed explicitly within the standards or rules of operation that social care institutions need to comply with. Albania (105), Lithuania (106), Malta (107) and Romania (108) are examples of where this is the case.

This indicates a regulatory gap: while involuntary treatment and confinement are closely scrutinised in psychiatric contexts, the same cannot be said of social care institutions, where violations may be more subtle or normalised and oversight and accountability mechanisms are weaker. Furthermore, existing safeguards are mostly found in regulations governing healthcare and places where persons are traditionally seen as being confined against their will, usually by means of an official administrative decision. Thus, they tend to focus more on decision-making rights than on protection from violence, exploitation and abuse.

The lack of a harmonised approach is also evident, with provisions for the prevention of and response to violence found in rules or policies adopted at the local level, or even at the level of institutions, instead of in national law or quality standards. For example, in the Flemish Region of Belgium (109), the protection against and prevention of violence is only specifically mentioned in national law for youth care facilities, and not in laws for psychiatric care homes, sheltered living initiatives or partnerships between psychiatric institutions and services. According to estimates by the German Institute for Human Rights (110), only 5 out of 16 *Länder* explicitly address the topic of violence in their acts on forms of residential accommodation and participation (111), while existing policies remain theoretical and lack practical application (112).

Secondary legal instruments – such as by-laws, accreditation guidelines, decrees and prosecutorial instructions – provide additional governance, but their scope, enforceability and consistency vary widely between different jurisdictions (113).

In terms of policy frameworks, FRA's research reveals an uneven landscape. Five Member States – Denmark (114), France (115), Ireland (116), Lithuania (117) and the Netherlands (118) – have policy instruments explicitly on violence against persons with disabilities in institutions. The measures vary in scope and content, but their focus is mainly on prevention, which they aim to accomplish by means such as strengthening inspections, access to complaints and staff training.

Almost a third of the countries researched have included some measures related to violence in institutions in their national disability policy frameworks, with most focusing on building institutional capacities through training and practical guidance (**"Figure 3"**).

Some national action plans focus on specific groups or settings. In Belgium (119), for example, the plan includes measures that target specific manifestations of violence (e.g. gender-based violence), specific settings (e.g. the correctional system) or specific groups (asylum seekers with disabilities in reception centres) (120). Similarly, the Netherlands' first national strategy for the implementation of the CRPD highlights groups that are more likely to experience violence or abuse, such as women, children and LGBTIQ+ people with disabilities (121).

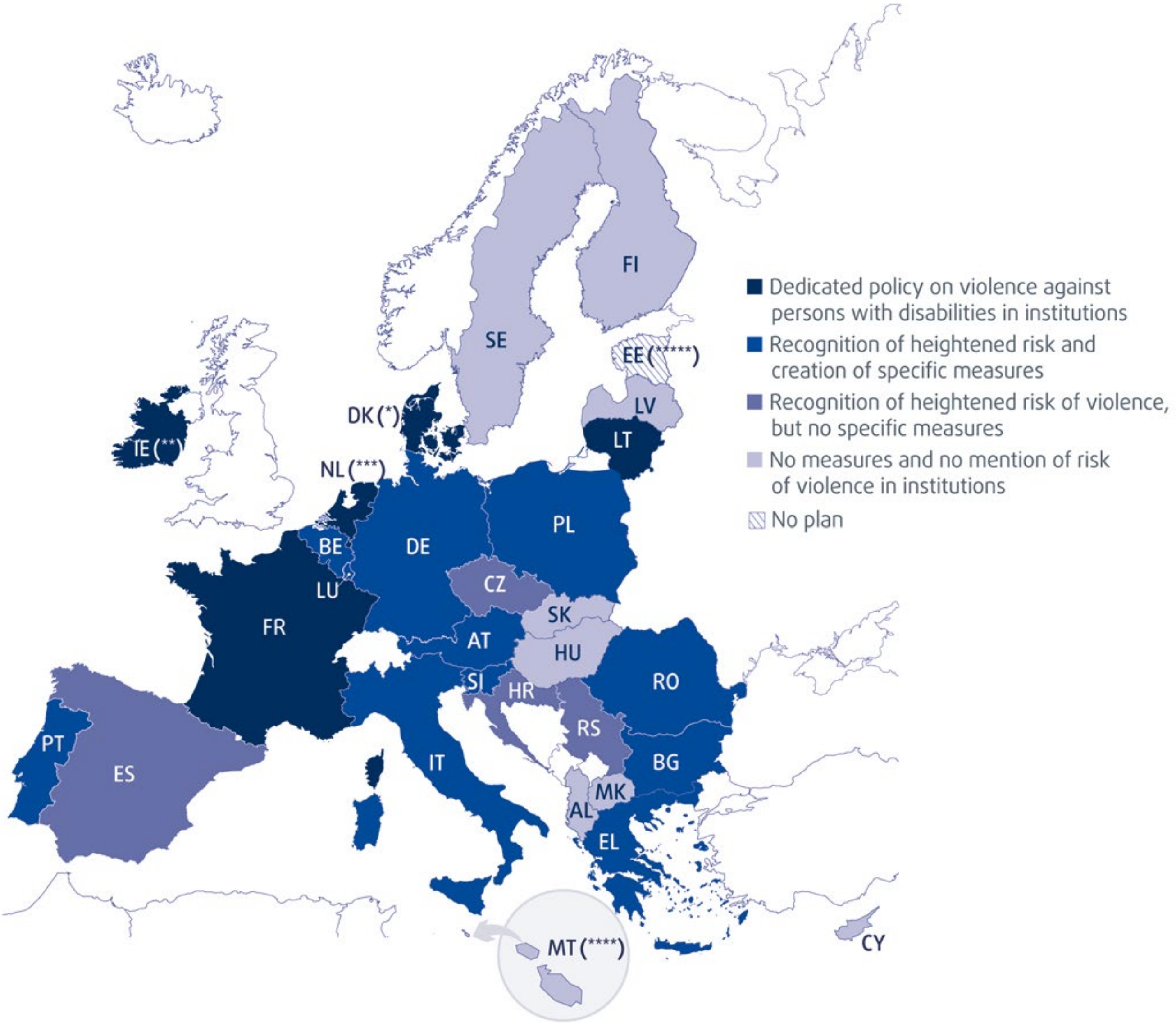
In a few countries – Croatia (122), Czechia (123), Serbia (124) and Spain (125) – national policy frameworks recognise the heightened risk of violence within institutions but do not set out any concrete actions for addressing it.

In another nine countries, national disability policies contain no measures against or mention of the risk of violence for persons with disabilities in institutions.

Similarly to the diverse regulatory frameworks implemented at the national level, the research also identified measures focused on the prevention of violence in institutions that appeared in policies specific to certain sectors (e.g. mental health) or groups (e.g. children).

FRA's evidence shows that some national policy frameworks are outdated or have not been evaluated, making it difficult to assess whether the envisaged measures were implemented or had any impact. For example, Italy's national programme – a two-year work plan – was approved in 2016 and has not been renewed (126). Similarly, the strategy for a long-lived society in Slovenia (127), adopted in 2017, has not been evaluated, nor has the 2015 Portuguese strategy for the protection of older people (128).

**FIGURE 3: NATIONAL DISABILITY STRATEGIES / ACTION PLANS AND OTHER RELATED POLICY FRAMEWORKS ON VIOLENCE IN INSTITUTIONS**



*Source:* FRA, 2025.

(*) In addition to a dedicated instrument, the most recent action plan on promoting equality for persons with disabilities is from 2013. The Danish government is working on a new disability action plan, but it does not address violence against persons with disabilities (Prime Minister's Office, *Responsibility for Denmark – The political basis for the Danish government (Ansvar for Danmark – Det politiske grundlag for Danmarks regering*), Copenhagen, 2022, p. 46).

(**) An update is under way.

(***) Three policy frameworks address disability and safety in care.

(****) Not in the national policy, but the internal policies of Aġenzija Sapport include measures on violence.

(*****) No disability action plan / strategy in place.

## 3.2. PERSPECTIVES FROM THE GROUND – THE EFFECTIVENESS OF NATIONAL FRAMEWORKS AND THEIR APPLICATION IN PRACTICE

This section discusses patterns emerging from the fieldwork research in 10 Member States regarding participants' assessment of the adequacy and effectiveness of national legal and policy frameworks.

### 3.2.1 Embedding a human-rights-based approach into care and harmonising protection levels

Findings from the fieldwork research reveal that outdated social norms and medical or charity models of disability still prevail in the regulatory frameworks and institutional settings of the 10 Member States covered. While participants noted progress in some Member States, they observed that the legal and policy frameworks addressing violence in institutions do not sufficiently reflect the paradigm shift brought about by the CRPD – which is legally binding on Member States – which is grounded in the principles of dignity, individual autonomy and choice. Moreover, national frameworks often adopt a one-size-fits-all approach, which falls short in ensuring person-centred care.

Another significant barrier to the development of effective legal and policy instruments is the political invisibility of the topic. Protecting the rights of persons with disabilities in institutional care is rarely a political priority. Funding is scarce and legal processes are slow, reducing the quality and sustainability of the frameworks created. Some participants also identified that existing measures or responses were often the result of serious incidents being exposed. These incidents led to a public outcry, mobilising political will in the short term and thus leading to the adoption of responses that are quick but often based on specific cases and not necessarily more widely applicable.

> *'The lack of public attention to institutions, together with the perception of rights of persons with disabilities as a secondary political issue, results in "grey areas" where episodes of segregation, abuse and violence are more likely to occur.'*
>
> Policymaker and person with a motor disability, Italy

Research participants also identified challenges relating to a lack of clarity surrounding concepts and measures; inconsistency between different regulatory frameworks; gaps in the material scope of existing frameworks, creating uneven protection provisions; and the predominant focus of legal instruments on regulating responses to violence rather than preventing violence.

These inconsistencies result in gaps. For instance, the definition of what constitutes violence, what community-based support is or what the regulation of protection measures and quality standards should be (e.g. the application of restraint measures or the need for staff with professional skills) is not sufficiently regulated in law and policy, leaving room for interpretation depending on the awareness, capacities and will of each institution. A Croatian participant pointed out the difference between the legal provisions regulating the use of coercive measures in psychiatric institutions and the lack of similar regulations in social care homes, leading to an ombudsperson recommendation to the responsible ministries that restraint measures should be defined by laws, not by-laws.

> *'And that regulation on quality standards … it is left to the will of the institution … but if it does not reach them, it is as if there are no sanctions. It's a matter of goodwill.'*
>
> Representative of an independent monitoring body, Croatia

The importance of clearly regulating issues related to violence with legally binding acts and not soft-law instruments (i.e. policies or internal rules of institutions) was also highlighted.

> *'The thing about legislation is, it will set out you need to report and by the way, if you don't report, this is what might happen to you, a professional, for not reporting. Whereas with policy, it's a bit wishy washy … It can be applied differently.'*
>
> Representative of a national CSO, Ireland

In terms of gaps in the material scope of existing frameworks, participants in Ireland and Malta noted that the lack of specific preventive measures for the protection of vulnerable adults was a weakness. Some participants noted an increased awareness and focus on the protection of some groups – like children and women – but, overall, little has been done to ensure the protection of all persons in institutions.

### 3.2.2 Investing in the practical implementation of existing standards

Despite the gaps and challenges in existing legal frameworks, there was agreement among the research participants that a major challenge is the divergence that exists between law in theory and law in action (129). Across all fieldwork Member States, participants spoke about gaps, fragmentation and shortcomings in the implementation of existing standards.

> *'We don't need any more acts, we need to go back to our existing policies, procedures, legislation, because … what's the point in having more legislation where we're not even implementing?'*
>
> Representative of national CSO, Ireland

The implementation of regulatory frameworks varies greatly. In some countries, it is dependent on the region (particularly in federal states or in states where responsibility for social care is decentralised), in others it depends on the type of facility (due to different regulatory frameworks and levels of protection, regulated by healthcare or social care acts, or to distinct frameworks for community-based support) and in still others it depends on the management of each individual institution (depending on whether the institution is functioning under a public authority or is a private entity).

Research participants also noted that, while the legal framework is evolving, the lack of regulation clarifying and detailing implementation in practical terms hinders meaningful change on the ground.

> *'When it comes to laws concerning combating violence, they are really at a good level. However, when it comes to those more detailed regulations and internal organisational policies, there is a significant problem.'*
>
> Manager of a private institution, Poland

### 3.2.3 Enhancing resources to ensure that law in theory translates into law in action

Underfunding and resource constraints were widely cited as a challenge. Frameworks did not provide for or secure the human or financial resources necessary for the effective implementation of proposed measures. This was widely interpreted as reflecting insufficient political will. Participants in the fieldwork stressed that, due to the lack of resources and alternatives, measures such as sanctions or even the closure of a facility are underused. Another issue participants spoke about was staff shortages, resulting in a poorer quality of care being provided.

> *'Key barriers to more successful implementation are both personal and financial resources that are limited or insufficient.'*
>
> Employee of a private institution, Germany

Challenges to the effective implementation of existing legal protections were also linked to a lack of training and understanding of disability-related violence – not only among staff working in care institutions, but also among police and criminal justice professionals. Access to legal support is limited and procedures are complicated and lengthy.

Finally, FRA's research reveals divergent views across stakeholder groups about the perceived effectiveness of existing laws and policies. Government authorities and policymakers tended to highlight progress, while downplaying challenges. In contrast, CSOs voiced their dissatisfaction with the slow pace of progress and lack of participation of persons with disabilities in decision-making processes. Some public officials acknowledged legislative shortcomings but pointed out the responsibility of the institutions to apply sufficient safeguards.

Service providers and representative members of institutional staff complained that practical realities on the ground were difficult to reconcile with technical legal norms. A shared experience among those implementing legal requirements was the challenges due to staff shortages and resource constraints. Another was that the national legislature lacked in-depth understanding of disability-related aspects of violence.

> *'It is impossible to legislate on these issues if you don't have a meaningful understanding of how it translates into people's everyday lives.'*
>
> Services manager of a CSO, Malta

## 3.3. CONCLUSIONS AND KEY TAKEAWAYS

In the last decade, many countries have introduced law and policy advancing the implementation of the CRPD – a key instrument in driving change. FRA desk research reveals, however, that the issue of violence against persons with disabilities remains insufficiently regulated in domestic legal frameworks.

General provisions – predominantly found in criminal laws – typically provide for aggravating circumstances or enhanced penalties in view of the victim's 'vulnerability' or 'dependency' but fail to account for the realities of people with disabilities in institutions.

Practices that would be considered violent or criminal in respect of the general population are normalised or trivialised as forms of 'treatment' or 'protection' for persons with disabilities. ECT without consent and forced sterilisation – intrusive and irreversible medical treatments recognised as forms of inhuman and degrading treatment by the CRPD Committee, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment and the CPT – are not yet universally prohibited across the EU.

Protections vary depending on the target population (children, older persons, persons with psychosocial or intellectual disabilities) and/or the types of institutions (social care or healthcare) and between local jurisdictions or individual institutions, resulting in uneven levels of oversight and accountability. In addition, there is uneven and inconsistent regulation and implementation of safeguards against violent practices in different settings. Some forms of violence, such as involuntary treatment, are scrutinised and regulated in the context of psychiatric institutions, whereas more subtle forms that are more prevalent in social care homes are normalised and accountability for them is weaker.

The desk research underscores the urgent need for harmonised and comprehensive legal standards and coherent, inclusive and rights-based regulatory reforms that address the full spectrum of rights to which persons with disabilities are entitled across all types of care contexts.

While interviewees in all 10 fieldwork Member States reported some level of progress, they also highlighted that existing frameworks fall short in centring an HRBA and CRPD-compliant measures. Moreover, despite progress on paper, all countries reported gaps and fragmentation in the practical implementation of these measures. In addition to implementation gaps and weak enforcement, underfunding and resource constraints were mentioned consistently. The lack of financial and human resources was interpreted, mainly by service providers and CSOs, as reflecting insufficient political interest in this area. The lack of resources was also linked to a lack of understanding and training.

The box below summarises what the research participants identified as key enablers of strengthened regulatory and policy frameworks for protection against, prevention of and response to violence against persons with disabilities in institutions.

## Key enablers of robust legal and policy frameworks for protection against, prevention of and response to violence in institutions

**Centring an HRBA to care and harmonising protection levels**

- Create uniform standards to prevent, protect against and respond to violence that are based on binding international human rights law and aligned with the CRPD's basic principles.
- Invest in mainstreaming general services and making them accessible to persons with disabilities in line with Article 19(c) of the CRPD.

**Investing in the practical implementation of existing standards**

- Set up targeted and explicit step-by-step procedures, guidelines and protocols for identifying and addressing violence.
- Establish risk identification and management strategies.
- Embed an HRBA into training for all those involved, focused on person-centred approaches to the delivery of services and containing practical steps to adhere to legal norms.
- Draw upon transferable examples to enable inter-agency cooperation and responses to violence in different closed settings.

**Enhancing resources to ensure that law in theory translates into law in action**

- Support empowerment initiatives.
- Ensure that persons with disabilities and their representative organisations meaningfully participate in the design of all laws, policies and measures that have an impact on their rights.
- Promote supported decision-making frameworks.
- Invest in tailored assistance schemes and personalised care plans.

# Endnotes

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(3) CRPD Committee, **General Comment No 5 (2017) on living independently and being included in the community**, CRPD/C/GC/5, 2017, para. 83.

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(5) UNHRC, **'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'**, A/HRC/38/36, 2018.

(6) Council of Europe Commissioner for Human Rights, **'A paradigm shift is needed towards a human-rights approach to mental health care'**, Council of Europe website, 14 November 2023.

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(11) ECtHR, ***Cuyvers and others* v *Belgium***, Nos 19813/14, 67545/14, 70332/14 and 255/19, 17 May 2023.

(12) ECtHR, ***X* v *Finland***, No 34806/04, 3 July 2012, leading to the amendment of the Mental Health Act.

(13) ECtHR, ***Karamanof* v *Greece***, No 46372/09, 26 July 2011.

(14) Romania, Law No 140 of 17 May 2022 on some protection measures for people with intellectual and psychosocial disabilities, amending and supplementing some normative acts (**Lege nr. 140 din 17 mai 2022 privind unele măsuri de ocrotire pentru persoanele cu dizabilități intelectuale și psihosociale și modificarea și completarea unor acte normative**).

(15) Romania, Law No 8 of 18 January 2016 on the establishment of mechanisms provided for by the Convention on the Rights of Persons with Disabilities (**Lege nr. 8 din 18 ianuarie 2016 privind înființarea mecanismelor prevăzute de Convenția privind drepturile persoanelor cu dizabilități**), Art. 4(i).

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(31) Greece, Penal Code (**Ποινικός Κώδικας**), Arts 79 and 82A.

(32) Bulgaria, Penal Code (**Наказателен кодекс**), 2 April 1968, last amended 6 October 2023, Chapter 2, Arts 115–161; Denmark, Section 218 of the Penal Code. Legislative decree No 1360 of 28 September 2022 (**LBK nr 1360 af 28/09/2022**); and Serbia, Criminal Code (Krivični zakonik), Official Gazette, Nos 85/05, 88/05, 107/05, 72/09, 111/09, 121/12, 104/13, 108/14, 94/16 and 35/19, Art. 126 on abandonment of a helpless person and Art. 179 on sexual intercourse with a helpless person.

(33) EU law currently criminalises hate speech and hate crime only if it is related to race, colour, religion, descent or national or ethnic origin. For more information, see **Council Framework Decision 2008/913/JHA of 28 November 2008 on combating certain forms and expressions of racism and xenophobia by means of criminal law**.

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(36) Finland, Criminal Code (**Rikoslaki**/**Strafflag**), Act No 39/1889, 19 December 1889, Chapter 6, Section 5.

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(43) **Comments by Dunja Mijatović**, Council of Europe Commissioner for Human Rights on the draft Additional Protocol to the Convention on Human Rights and Biomedicine concerning the Protection of Human Rights and Dignity of Persons with Mental Disorder with regard to Involuntary Placement and Involuntary Treatment, Strasbourg, 8 November 2018.

(44) CRPD Committee, **Open letter to the Secretary-General of the Council of Europe, the Committee of Ministries of the Council of Europe, the Committee on Bioethics of the Council of Europe, the Steering Committee for Human Rights, the Commissioner of Human Rights, the Parliamentary Assembly of the Council of Europe and other organizations and entities of the Council of Europe**, January 2025.

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# 4

# PREVENTION OF VIOLENCE THROUGH MONITORING

Applying an HRBA requires effective monitoring of the implementation of States Parties' obligations to uphold accountability. Standards contained in the CRPD and in the CAT, in particular, address monitoring as a means to prevent violence.

The role of independent national monitoring mechanisms in preventing violence is also essential to fulfilling obligations set out in the CAT. NPMs established in accordance with the OPCAT must be fully independent from governments, adequately funded and empowered to conduct unannounced inspections of all care facilities – both public and private (1) – including institutions for persons with disabilities (2).

Furthermore, the Council of Europe's CPT has a role in safeguarding persons with disabilities in institutional settings given that its mandate extends to 'public and private social care establishments where persons may *de jure* or *de facto* be deprived of their liberty' (3). The CPT further stresses that monitoring bodies should include persons with disabilities and their representative organisations in inspections, in line with their obligations under the CRPD (Articles 4(3) and 33(3)). This is also consistent with an HRBA to protecting the rights of persons with disabilities in institutions, which emphasises participation and empowerment.

Accordingly, to prevent violence in all its forms, States Parties are required to set up independent authorities and bodies that regularly inspect the residences of persons with disabilities, psychiatric wards and special institutions such as sheltered workshops or special education institutions (4).

This chapter provides a comparative assessment of the two main types of bodies – public and independent – that monitor institutions for persons with disabilities in the 30 countries covered by this research. It then summarises the findings from FRA's empirical research with respect to the effectiveness of inspections and monitoring visits.

## 4.1. MONITORING BODIES AT THE NATIONAL LEVEL – A DIVERSE LANDSCAPE

As shown in Chapter 3, national legal frameworks regulating the protection of persons with disabilities in institutions from violence and degrading treatment are diverse in their nature, scope and content. Similar observations have been made in terms of monitoring. FRA's research has uncovered a patchwork of monitoring functions carried out by diverse bodies. Still, a general distinction can be drawn between public bodies performing monitoring functions (e.g. health inspection bodies) and independent monitoring bodies (e.g. NPMs or independent monitoring mechanisms, as required under Article 33(2) of the CRPD).

Public bodies are understood as being within or under the purview of public administration, while independent monitoring bodies are statutory human rights bodies that monitor the whole spectrum or a specific group of human rights (5).

Public bodies are mainly tasked with the inspection and monitoring of social and health services for persons with disabilities and institutions or psychiatric hospitals for persons with psychosocial disabilities. Judges are sometimes tasked with visiting places where people are deprived of their liberty, so their scope covers (mainly) psychiatric hospitals and/or services. In terms of independent monitoring, national human rights bodies are tasked with monitoring institutions for persons with disabilities and/or institutions where people are (de facto) deprived of their liberty.

FRA analysis reveals a multilayered system within both types of monitoring mechanisms, with both types of bodies facing different challenges in relation to their respective mandates. This chapter showcases the key aspects affecting the effectiveness of monitoring, such as the frequency of visits, prior notice of visits and the diversity of monitoring bodies' powers, such as the power to

investigate or impose sanctions in cases of violence. Moreover, the fieldwork research revealed that, in several Member States, monitoring is performed primarily by government agencies, which lack the necessary impartiality, leading to potentially biased findings or creating a conflict of interest.

### 4.1.1 Public monitoring bodies

In all 30 countries covered by this research, there is at least one public monitoring mechanism in place that assesses compliance with legislation and examines the implementation of relevant policies and standards. FRA's research shows that monitoring responsibilities are usually shared between several public bodies and are defined in different regulatory instruments, whose implementation they monitor/inspect. Accordingly, these different bodies are linked to or located in different ministries.

In most countries, there are different bodies entrusted with overseeing social care and healthcare services. While in half of the analysed countries there is at least one public monitoring body that checks all facilities, in others (e.g. Latvia, Lithuania, North Macedonia, Serbia, Slovakia and Slovenia) there is a clear split between inspections of social care and healthcare services. Institutions or psychiatric hospitals for persons with mental health problems form another distinct group usually covered by yet another regulatory instrument and public monitoring body. In addition to this sectoral grouping, another differentiation is found regarding the level of government responsible for the monitoring. In countries with a federal, quasi-federal, regional or compound constitutional structure, the overseeing of social services is entrusted to regional administrations. In terms of bodies within the criminal justice system, the research found some examples of prosecutors and judges visiting places where people are deprived of their liberty, including both psychiatric and social care facilities. This is the case, for example, in Bulgaria (6), Czechia (7), Poland (8), Slovakia (9) and Spain (10).

Public inspectorates of social care homes and homes for older people or children are typically located within a department or an agency of the ministry of labour / social affairs or welfare, while the inspectorate responsible for institutions for people with psychosocial disabilities is often within the ministry of health (as in Romania (11)). In some countries (e.g. in Sweden (12)), health and social issues are combined into one ministry. By contrast, in Austria (13) and Hungary (14), the Ministry of Justice and the Ministry of Interior, respectively, are the central bodies responsible for monitoring institutions in which people with disabilities reside. Some governments have established semi-governmental commissions or committees consisting of professionals and advocates, such as family members or civil-society representatives (e.g. the governments of Croatia (15) and Cyprus (16)).

Further public monitoring bodies exist for other closed facilities and settings, such as detention centres or places of juvenile detention, both of which may also accommodate persons with disabilities, but these lie outside the scope of this research.

In federal states, such as Austria, Belgium or Germany, monitoring is often decentralised and organised by *Land*, state or region. In Austria, the residential advocacy service VertretungsNetz (17) – a central organisation – visits facilities on behalf of the Ministry of Justice in every *Land* except for Vorarlberg. In some other countries, a central national mechanism is in place, but the responsibility for monitoring, the actual inspecting and the issuing of recommendations fall to administrators at the regional or local level, such as the mayors of municipalities (Bulgaria), governors of provinces (Poland), regional offices (Czechia, Latvia) or public municipal agencies (Denmark).

**FRA ACTIVITY**

## Persons with disabilities in criminal detention

The latest review of FRA's detention database, which provides information on detention conditions in all 27 Member States, reveals that specific measures exist for detainees with disabilities in about half of the Member States. About two thirds of the Member States have specific standards in place for providing specialised care to those with mental health issues.

*Source:* FRA, **'Criminal Detention Database 2015–2022'**, FRA website.

Finally, the research reveals examples of other entities visiting institutions, such as representatives of prosecutors' offices (e.g. in Poland (18) and Spain (19)). They are tasked with supervising the lawfulness of the execution of penalties and other coercive measures in places of detention where people undergo compulsory treatment imposed by a court order, such as psychiatric hospitals and care facilities. Since prosecutors' offices usually have a restricted monitoring mandate when it comes to institutions for persons with disabilities – as they either specialise in detention facilities or act as criminal investigators – none of the national systems researched has entrusted the public prosecutor with all monitoring tasks, meaning that prosecutors usually visit only a narrow range of institutions or focus on specific aspects of institutionalised living.

*Types and frequency of monitoring visits by public bodies*

Public monitoring bodies carry out different types of inspections: (a) general/regular visits, which are, by default, planned; (b) thematic visits, which can be either planned or ad hoc; and (c) emergency/extraordinary visits, which are always ad hoc.

The frequency of general/regular monitoring visits is usually defined by the legal framework and expressed in years, such as once a year or every two, three, four, five or six years, but in some cases it is also defined in months or weeks (e.g. in the case of prisons). In the analysed countries, there are also examples of regularity standards that are imposed neither by national legislation nor by the monitoring mechanisms themselves (e.g. those in Austria, with its residential advocacy service (20), and Czechia, with its regional offices (21)). The research reveals different factors that influence how the frequency of monitoring visits is determined:

- some factors relate to the institution itself: the size of the institution, the date of registration/opening of the institution, the type of institution and the existence of a history of non-compliance or the outcomes of previous monitoring visits;
- other factors are responsive and stem from the outcomes of risk assessments or external information from patients, service users, staff and CSOs;
- finally, internal factors – such as financial and human resources or the thematic priorities of the monitoring body – determine the frequency and choice of institutions to be monitored.

With respect to the power to conduct ad hoc or unannounced visits, in a few cases it is not provided for in the law (22), and in others it is explicitly excluded (23). In some cases, ad hoc visits are possible with restrictions, such as time constraints or limits on which institutions may be visited. For example, the Care Inspectorate in Belgium cannot visit forensic psychiatric centres unannounced (24), and the Health Inspectorate in Latvia must arrange its visits to prisons and other restricted-access facilities and areas in advance (25).

Some monitoring bodies have the right to visit institutions outside normal working hours (e.g. those in Luxembourg), although only in cases where there are serious indications of a breach (26). Judicial inspections of psychiatric hospitals, social care homes and 24-hour care facilities in Poland (27) can be ad hoc but not unannounced.

**PROMISING PRACTICE**

## Enhanced public monitoring of quality standards

In Slovakia, the Inspectorate of Social Affairs – a separate organisational unit of the Ministry of Labour – supervises compliance with regulations related to the provision of social services (*) and oversees the implementation of measures for social guardianship and the social and legal protection of children (**). Monitoring is anchored in legislation and has a dedicated budget, and the results of the inspections are public. The inspectorate uses established methodologies and exercises its powers independently.

(*) Slovakia, Law No 448/2008 Coll. on social services as amended (**Zákon o sociálnych službách a o zmene a doplnení**), 30 October 2008.

(**) Slovakia, Law No 305/2005 Coll. on socio-legal protection of children and social custody as amended (**Zákon o sociálnoprávnej ochrane detí a o sociálnej kuratele a o zmene a doplnení niektorých zákonov**), 25 May 2005.

*Investigative and sanctioning powers of public monitoring bodies*

With a few exceptions (28), public monitoring bodies in all analysed countries have the power to conduct (administrative) investigations during monitoring visits. This may include entering the premises, interviewing staff and residents, obtaining information and looking into any documents necessary for assessing situations. In cases where irregularities are found, the supervisory authority of the institution being monitored (the body that accredits institutions and grants licences) is contacted, and it may conduct further investigations, issue decisions and impose sanctions. Still, many interviewees highlighted the need for an independent monitoring system, as current public bodies are often perceived as lacking the necessary impartiality. See **"Section 4.2"**.

The monitoring mandates of actors in the public administration vary in terms of their power to impose sanctions. Most public monitoring bodies can impose sanctions, such as administrative or corrective measures or fines; revoke licences; dismiss, suspend or ban an operation; or issue recommendations, including for preventive measures, such as training or systematic supervision.

Some monitoring bodies under public administration also have the obligation to report to the public prosecutor or to initiate criminal procedures by referring allegations of violence to the police. As illustrated earlier, in some countries (e.g. Bulgaria, Czechia, Spain), public prosecutors also visit institutions, meaning that criminal proceedings may be invoked directly and immediately. In Austria (29), France, Italy (30) and Poland (31), the inspection report is submitted not only to administrative authorities but also to the judicial authorities – in Poland, it is submitted specifically to the Minister for Justice – so that a judicial review or criminal proceedings can be initiated immediately.

### 4.1.2 Independent monitoring bodies

Ensuring effective and independent monitoring of institutions for persons with disabilities is part of preventing violence, as it reduces the risk of fundamental rights violations. The research reveals that monitoring of institutions for persons with disabilities is carried out by an independent monitoring body (single-agent model) or bodies (multi-agent model). In other words, independent monitoring is carried out either by (a) one single institution, typically the ombuds institution, or (b) multiple independent bodies. Regardless of whether monitoring is done by a single agent or by multiple agents, independent monitoring bodies are tasked with:

- monitoring the implementation of the CRPD (under Article 33(2) of the CRPD) – independent monitoring mechanisms (32);

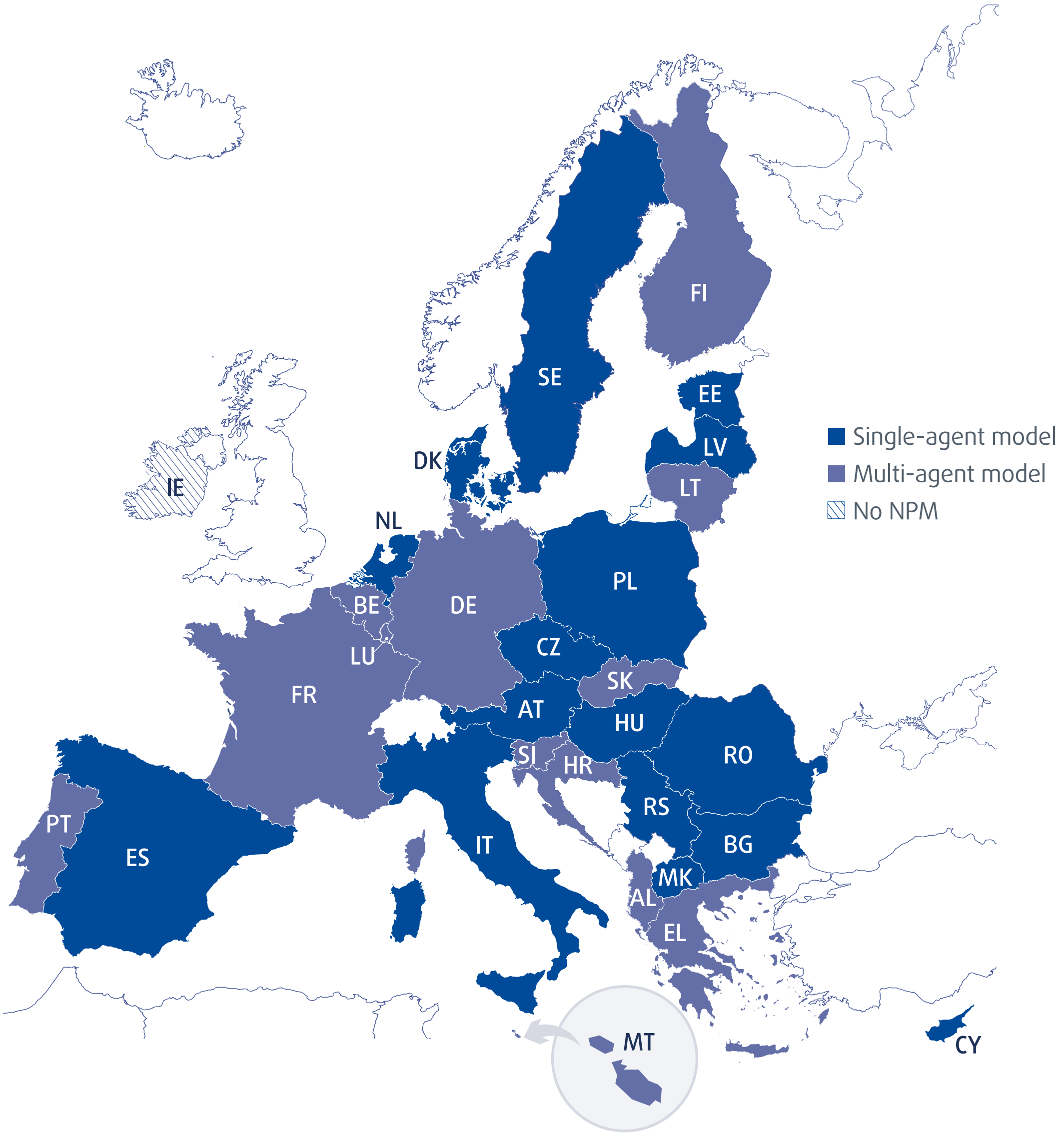
- monitoring the treatment of persons deprived of their liberty in places of detention (under Article 19(a) of the OPCAT) – NPMs.

Independent monitoring mechanisms under Article 33(2) of the CRPD should include one or more independent bodies that are established in accordance with the Paris Principles (33). These are statutory human rights bodies (34), such as ombudspersons, commissioners, defenders, chancellors, guarantors, protectors and others, that have various monitoring mandates.

Statutory human rights bodies, particularly those designated as NHRIs, often also have an NPM mandate under the OPCAT – since the OPCAT, like the CRPD, makes reference to the Paris Principles (Article 18(4) of the OPCAT). This enables NPMs to undertake the regular examination of the treatment of persons deprived of their liberty in places of detention (Article 19(a) of the OPCAT) in all contexts of care, including psychiatric and social care institutions and private care facilities (35).

Sixteen countries have a single-agent model, where a single institution takes up the role of monitoring. Typically, this is the ombuds institution, but not in the Netherlands, where it is the Netherlands Institute for Human Rights [36]. By contrast, 13 countries have a multi-agent monitoring model, where multiple independent bodies monitor institutions for persons with disabilities and/or places of detention (**"Figure 4"**). In Ireland, the Irish Human Rights and Equality Commission, Ireland's NHRI, acts as the CRPD monitoring mechanism; however, it does not have a mandate to monitor residential institutions or to conduct inspections. Since Ireland has not yet ratified the OPCAT, there is no independent monitoring body that regularly visits places of detention in Ireland.

**FIGURE 4: USE OF SINGLE- AND MULTI-AGENT MODELS OF MONITORING/INSPECTION IN THE 30 COUNTRIES COVERED IN THIS RESEARCH**



*Source:* FRA, 2025.

In the single-agent model, ombuds institutions may conduct visits to institutions for persons with disabilities as part of:

- their regular ombuds mandate to investigate cases of maladministration based on individual complaints, follow up on the implementation of their previous recommendations or initiate procedures *ex officio* (e.g. Estonia);
- their independent monitoring mechanism mandate under Article 33(2) of the CRPD (e.g. Austria, Czechia, North Macedonia, Poland);
- their NPM mandate under the OPCAT (e.g. Hungary, Italy, Romania);
- a combination of these mandates (e.g. Bulgaria, Cyprus, Latvia, Serbia, Spain and Sweden).

Ombuds institutions can, therefore, conduct monitoring visits not only as part of their NPM mandate but also to act upon complaints or other notifications of a suspicion of violence. In such cases, the monitoring is part of their investigative activities and not a pre-planned stand-alone monitoring activity.

It is the decision of the body governing the ombuds institution which mandate to utilise in each given case. Some ombuds institutions have separate departments for fulfilling their CRPD and OPCAT monitoring mandates (e.g. those in Czechia and Poland). In these cases, the monitoring of institutions for persons with disabilities does not necessarily take place under their NPM mandate. In fact, the Subcommittee on Torture recommends that NPMs and

ombuds institutions 'should clearly separate their respective mandates – that is, the budget, human resources and handling individual complaints … – so that each of them has enough means and resources to carry out … their respective mandates effectively and independently' (37).

A contrasting example emerges in Italy, where the National Guarantor for the Rights of Persons Detained or Deprived of Liberty has a broad NPM mandate, which includes visiting institutions for persons with disabilities. A newly appointed National Guarantor for the Rights of Persons with Disabilities also has a mandate to monitor care settings (38).

The frequency of visits and composition of the visiting teams will be determined depending on which mandate the monitoring body chooses to invoke (because of the different competences and powers associated with each mandate). Likewise, the nature of the monitoring may vary from acting upon individual complaints (seen as a rather reactive activity) to launching ad hoc visits to institutions (seen as a preventive monitoring activity) (**"Table 1"**).

**TABLE 1: HOW OMBUDS INSTITUTIONS OPERATE UNDER DIFFERENT MANDATES**

| Elements | Classic mandate | Independent monitoring mechanism mandate under Article 33(2) of the CRPD | NPM mandate under the OPCAT |
|---|---|---|---|
| **Competences and powers** | Specified by the enabling legislation | Specified by the enabling legislation | Specified by the enabling legislation |
| **Composition of the monitoring team** | General | Specific | Specific (legal, medical, psychological) |
| **Reporting** | Reporting to parliament | Reporting to the CRPD Committee – contributing to state reporting and/or submitting shadow reports | Reporting to the Subcommittee on Torture |
| **Cooperation** | Specified by the enabling legislation | With representative organisations of persons with disabilities | With the Subcommittee on Torture and competent national authorities |
| **Frequency of visits** | Upon complaint | Planned or ad hoc | Planned or ad hoc |
| **Nature of monitoring** | Reactive | Reactive and preventive | Preventive |
| **Approach** | Constitutional- and administrative-law-based approach | Human-rights-based approach | Human-rights-based approach |

*Source:* FRA, 2025.

In countries using a multi-agent model, there are multiple independent monitoring bodies, and at least one of them has an NPM mandate. For example, in Malta, three statutory human rights bodies have mandates to monitor institutions for persons with disabilities: the Commission for the Rights of Persons with Disabilities, as the entity designated to do so by the CRPD (39); the ombudsman (40); and the Commissioner for the Promotion of Rights of Persons with Mental Disorders (41). The last has unofficially taken on the role of an NPM in relation to persons deprived of their liberty on mental health grounds (42), while the Board of Visitors for Detained Persons and the Board of Visitors of the Prisons are NPMs for the OPCAT, with a mandate limited to detention centres (43). In contrast, in Slovakia three independent bodies carry out monitoring and each holds an NPM mandate. The Commissioner for Persons with Disabilities monitors institutions for persons with disabilities, the Commissioner for Children visits special educational establishments and institutions for children and the Public Defender of Rights monitors detention centres.

In terms of the specific material scope of these mandates and which types of institutions are covered, some discrepancies can be observed between countries – particularly with regard to bodies with an NPM mandate. As previously discussed, the Subcommittee on Torture requires 'places of deprivation of liberty' to be interpreted broadly. In many cases, it is the monitoring body itself that adopts a limited interpretation of the places falling within its mandate. FRA's fieldwork research reveals that often a lack of capacity – due to a lack of resources or specific skills – results in monitoring with a limited scope; see **"Section 4.2"**.

### *Types and frequency of monitoring visits conducted by independent bodies*

While the CRPD does not contain any provisions stipulating the frequency and other aspects of monitoring visits, the OPCAT declares that NPMs shall be granted the power '[t]o regularly examine the treatment of the persons deprived of their liberty' (Article 19(a) of the OPCAT) and '[t]he liberty to choose the places they want to visit' (Article 20(e) of the OPCAT). As the OPCAT also allows for flexibility regarding monitoring modalities, it is the national legislation, the rules of procedure or the (annual) plan of the monitoring body that sets a standard for the regularity of monitoring visits. There are also cases where regularity standards are imposed neither by national legislation nor by the mechanisms themselves.

Many monitoring bodies lack adequate funding and staff, leading to infrequent or superficial inspections. For instance, the Office of the Parliamentary Ombudsman of Finland conducts 4–10 inspections in institutions and residential units for persons with disabilities annually. Its limited number of staff does not allow for repeat visits to the same units (44). The ombudsman reported that regular visits were not possible because of the large number of sites (45).

Ombuds institutions – as discussed earlier – carry out monitoring visits that are triggered by complaints or other notifications. These emergency or extraordinary visits are carried out in a reactionary manner and usually launched unannounced (46).

### *Investigative and sanctioning powers of independent monitoring mechanisms and the enforceability of their recommendations*

To analyse the investigative and sanctioning powers of independent monitoring mechanisms that monitor institutions, it is important to distinguish between their different mandates. Ombuds institutions acting upon individual complaints examine alleged violations within their jurisdiction using their own rules of procedure. They then usually initiate further administrative proceedings with the superior authority of the institution under investigation by issuing recommendations. They also have the obligation to submit an annual report to the parliament of their country. Thus, their sanctioning power consists in making matters public.

The OPCAT explicitly requires that NPMs make recommendations to the relevant authorities (Article 19(b) of the OPCAT), which then examine these recommendations (Article 22 of the OPCAT) and produce reports (Article 23 of the OPCAT). Although the scope of NPMs' actions are usually limited to recommendations based on information gathered during visits, there are NPMs whose scope of action extends to conducting investigations, initiating criminal or judicial proceedings or even imposing sanctions.

Some countries, such as Croatia (47) and Lithuania (48), have introduced a positive obligation on NPMs to refer cases or report findings to competent criminal authorities for concrete actions to be taken.

A few monitoring institutions have the power to initiate or take part in judicial proceedings. The Federal Institute for the Protection and Promotion of Human Rights in Belgium is authorised to bring fundamental rights violations before the Council of State and the Constitutional Court (49). The Irish Human Rights and Equality Commission may appear as an amicus curiae in proceedings before the court (50). The ombudsman in Sweden may petition the court for the modification of a decision made by an authority in a case of disciplinary liability against healthcare personnel (51).

Beyond formulating recommendations and reports, in the analysed countries, a few independent monitoring bodies may impose fines (52).

### 4.1.3 Cooperation between various national actors in the context of monitoring

Cooperation between different actors performing similar monitoring functions, such as public and independent monitoring bodies, key stakeholders and experts (including representative organisations of persons with disabilities) is imperative for effective results.

The research found a few examples of structured cooperation between competent authorities. In Romania, for example, cooperation agreements exist between the Prosecutor's Office and the monitoring council and between the monitoring council and individual experts, and a cooperation protocol exists between the Prosecutor's Office and an NGO. Hungary's and Luxembourg's NPMs have recommendations and guidelines for service providers.

There are also examples of closer cooperation between various actors. In Latvia, for example, the Ministry of Welfare cooperates with the Ombudsman's Office and the Health Inspectorate in carrying out monitoring visits. In Bulgaria, the Sofia City Prosecutor's Office carried out an investigation of 10 mental health hospitals with the General Directorate of the National Police and the executive agency Medical Supervision (part of the Ministry of Health) following a monitoring visit from the CPT, which had flagged some irregularities (53).

Some monitoring bodies cooperate with service providers by providing them with self-assessment forms or other useful tools (Finland (54)), communication guidelines (Luxembourg (55)) or training (Austria (56), Germany (57)).

The picture is especially diverse when it comes to the involvement of CSOs in monitoring. In some cases, formal cooperation is prescribed by law, by cooperation agreements/protocols or by a memorandum of understanding. The involvement of CSOs can occur through their membership of existing advisory committees (to public or independent monitoring bodies), through a more fluid form of engagement – such as advising or consulting on issues (mainly found in the practices of independent human rights bodies, rather than public ones) – or by ensuring they have a permanent or ad hoc invitation to participate in monitoring visits.

In Denmark, for instance, the ombudsman collaborates not only with the Danish Institute for Human Rights but also with the NGO DIGNITY (the Danish Institute against Torture) during inspection visits (58). Similar examples can be seen in Finland (59), Romania (60) and Serbia (61), where the ombuds institute or people's advocate has cooperation protocols with CSOs, which are invited to monitoring visits.

**PROMISING PRACTICE**

## User-led monitoring

Bodies that encourage participation such as representatives or councils are a more recent innovation and are seen as important by all respondents. The narrative interviews revealed that persons with disabilities consider councils to be both trustworthy and empowering. Participants suggested involving persons with disabilities and persons with lived experiences of institutions as experts in the monitoring teams, which is also in line with the WHO quality rights toolkit (*). The 2024 WHO guide for action (**) also provides step-by-step guidance to promoting health equity for persons with disabilities in the health sector.

Peer evaluations – such as the nueva initiative in Germany (***) – involve persons with disabilities in monitoring. They conduct interviews within institutions or with residents to assess various themes. This method not only evaluates institutional practices but also educates individuals, helping them understand and challenge existing rules and norms, which is particularly important in the context of violence prevention.

(*) WHO, ***QualityRights Tool Kit: Assessing and improving quality and human rights in mental health and social care facilities***, Geneva, 2012.

(**) WHO, ***Health Equity for Persons with Disabilities: Guide for action***, Geneva, 2024.

(***) For more information, see the website of the organisation **nueva**.

Nevertheless, the fact that cooperation is provided for in the law or in agreements does not necessarily mean that this cooperation functions satisfactorily in practice (62). On the other hand, it is important to note that a lack of a formalised cooperation agreement does not mean there is no cooperation at all. In Latvia, for example, while the legislation does not stipulate the compulsory involvement of other institutions in monitoring visits, the ombudsman frequently invites healthcare representatives and other professionals (63). Similarly, in Malta, the Commission for the Rights of Persons with Disabilities can also engage other relevant actors, such as healthcare professionals and, notably, disabled people's organisations, when convening a board to conduct the test of reasonableness (64).

## 4.2. PERSPECTIVES FROM THE GROUND – EFFECTIVE OVERSIGHT THROUGH A HUMAN-RIGHTS-BASED APPROACH TO MONITORING

This section discusses findings from fieldwork research in 10 Member States with respect to the effectiveness of inspections and monitoring visits.

### 4.2.1 Expanding the scope and depth of monitoring and harmonising monitoring practices

In terms of monitoring conducted by public bodies, managers and staff in institutions in particular spoke about a predominant focus on normative frameworks, as did CSO representatives. Some described inspections as 'superficial' and a 'paper check', with a focus on checking documentation and financial compliance rather than protecting the rights and dignity of people in institutions.

> *'As I'm telling you, the issue of violence, discrimination, whatever, all these issues are never addressed. They weren't in this inspection, and they weren't in the follow-up visits either.'*
>
> Manager of a local CSO, Portugal

The research found evidence that monitoring procedures appear to lack standardised guidelines in many Member States, leading to discrepancies in the effectiveness and thoroughness of inspections. A universal call from all fieldwork participants was the revision of existing standards or the development of national minimum standards for monitoring. These common minimum standards should focus on ensuring that the human rights, dignity and autonomy of persons with disabilities living in institutions are protected and respected. Prevention of and protection from violence should be central elements of each monitoring cycle, as should a substantive assessment of the quality of services, as opposed to procedural, technical and administrative issues, which are emphasised to the detriment of human rights.

> *'Some inspectors will then just give you their judgement. And they might not give you, you know, an insight into how they'd recommend you do this going forward, though.'*
>
> Manager of a private institution, Ireland

In terms of ways forward, respondents suggested that standards could be implemented by putting independent review groups that include service users in place at the policy level. These groups would assess and improve national quality frameworks.

Participants' accounts indicate inconsistent monitoring that is linked to the pronounced variation in monitoring practices. This variation concerns the frequency of monitoring visits, their duration and whether such visits are pre-announced. Most inspections are reactive, meaning that they are either case-driven (following a complaint) or pre-announced, for example by sending a request for documentation in advance. This arguably allows services to – at least temporarily – conceal existing problems.

> *'Everything was prepared for the visit [because the intention was to show better organisation of the service], and then it wouldn't show all of what was going on there ... But after [the visit], in terms of operation, everything worked as it had before.'*
>
> Woman with a physical disability, Portugal

While independent monitoring is seen as more effective than public or internal monitoring, in most Member States independent monitoring bodies lack the authority to conduct inspections, the resources to sufficiently cover all institutions or the mandate to enforce changes.

Research participants expressed their concern about the role of local authorities and local healthcare departments in inspections and monitoring, given that local authorities may also be responsible for authorising the creation of institutions and assessing compliance with the standards in place. As such, they may lack impartiality and have little interest in highlighting shortcomings, which may reflect poorly on them.

> *'In my view, the Ombudsperson is in the best position. The Ombudsperson, as they say, is not so tied to this normativity or regulation, and so their ways of expressing themselves, which is of course correct, are much freer.'*
>
> Manager of a public monitoring body, Latvia

### 4.2.2 Enhancing accountability through enforceability and follow-up on monitoring visits

The lack of ability to enforce the recommendations made by monitoring bodies was mentioned as a major challenge. Even when issues were identified during monitoring visits, changes did not occur due to a lack of enforceability mechanisms and/or resistance from the institutions.

There was reference to the lack of adequate sanctions or follow-up, with no consequences for non-compliance, which allows institutions to continue to operate despite violations.

Participants emphasised that monitored institutions should be provided with assistance and incentives to follow up on to monitoring visits. This could be in the form of (a) procedural support and sharing good practices for the implementation of monitoring recommendations, (b) an individualised quality enhancement plan based on the inspection feedback or (c) training the institution's staff on issues identified during the monitoring visit. For example, a practitioner in Poland noted that:

> *'It is certainly good practice to discuss all these post-inspection recommendations. Thinking about what can be improved, streamlined, what can be implemented according to those guidelines that were indicated there.'*
>
> Employee of a public institution, Poland

Without these post-visit dialogues, service providers might be left with the feeling of frustration.

> *'I came, I saw and I left … sometimes it is very painful when they come and, unjustifiably maybe … unjustifiably, without going deeper, without understanding exactly the specific situation …'*
>
> Manager of a public institution, Latvia

### 4.2.3 Investing in monitoring bodies by increasing resources and training monitoring staff

The research shows that many monitoring bodies – both public and independent – lack adequate funding and trained staff, leading to infrequent or superficial inspections. Interviewees voiced their concerns about the limited scope of the monitoring visits and the insufficient depth of the inspections, which result from inadequate human resources and insufficient time for monitoring.

> *'With respect to the institutions, I am supposed to do inspections in theory. But how can I do inspections if I do not have staff?'*
>
> Representative of an independent monitoring body, Italy

> *'We do not have, separately, staff that would do just that, but two of us, in addition to our 10 [other] areas that we deal with … we do not consider this to be sufficient capacity by any means … there are many people in institutions and there are many institutions, and they are all over.'*
>
> Representative of an independent monitoring body, Croatia

Limited resources may substantially affect the ability to remove people with disabilities from problematic situations. Even where irregularities are found, inspectorates might not be able to close an institution if they have no alternative place for the people within it.

The lack of capacity also results in limited monitoring, which in turn creates 'blind spots' where private care providers or services run by NGOs are not inspected at all. For example, in Ireland, research participants praised the Health Information and Quality Authority (HIQA)'s role in monitoring but also highlighted the significant gaps in the management of private providers and emergency placements.

> *'HIQA should have responsibility for inspecting all services, all residential centres. So that we would see as an absolute blind spot.'*
>
> Representative of an independent monitoring body, Ireland

In Poland, research participants responsible for policymaking pointed to the ineffective supervision of private care centres, which residents stay in based on civil contracts and which inspecting bodies cannot independently monitor. In addition, private centres often do not comply with post-inspection recommendations.

PROMISING PRACTICE

## Creating spaces for exchange

An Irish interviewee referred to ‘the immersion event’ as a promising practice. It brings together persons with disabilities, family members and key stakeholders – such as service providers and thought leaders – for a collaborative learning process. The meeting’s format enables transformative discussions in which participants listen to each other’s perspectives and experiences. A research participant reflected that this event helped bring to light the ‘painful truth’ about how current services and ‘supports’ are negatively impacting people’s lives and rights in a way that ‘acknowledged responsibility for driving change’ (representative of an organisation of persons with disabilities, Ireland).

Examples from various Member States highlighted the value of sufficient time for engaging in open dialogues with staff members and providing residents with a platform to express their concerns. Challenges related to a lack of specific skills for recognising abuse among the staff who carry out visits were identified. This emerged in relation to persons with intellectual disabilities.

> *‘[We need] to prepare teams to be able to identify signs … this look is not a procedural and administrative look … it’s a look that has to do with a look of quality interaction, interaction with people, the dialogues that need to be established in these follow-up visits.’*
>
> Representative of an organisation of persons with disabilities, Portugal

Carrying out interviews, as well as meaningful and effective observations, requires specific skills and might also require that specialists such as sign language interpreters, plain language specialists and communication intermediaries are involved in monitoring activities. Moreover, gaps in inspectors’ knowledge might lead to the mis-assessment of residents’ well-being.

> *‘No, someone who is not there cannot see the real problems, and a lot gets covered up. Because when they get there, they peek inside a little, they ask a little, but you don’t have the chance to tell; you don’t have the chance to tell anonymously.’*
>
> Representative of a national CSO, Slovenia

### 4.2.4 Ensuring participatory monitoring and enabling internal user-led monitoring

Research participants suggested that the effectiveness of monitoring could be enhanced by involving persons with disabilities and persons with lived experiences of institutions in monitoring activities as experts.

> *‘We have advocates here, but still, it’s something we would also like to strengthen … So, this peer-to-peer seemed very important to us, simply because we have quite a few “survivors” … who have come from institutions and psychiatric treatment … many who could ensure such a voice.’*
>
> National policymaker, Slovenia

Another promising practice is investing in multidisciplinary monitoring teams. These teams could include persons with disabilities, persons with lived experiences of institutions, social care workers and impartial medical professionals who are all trained in an HRBA to disability.

### 4.2.5 Strengthening cooperation

While the fieldwork findings reveal some good practices in some Member States, the overall effectiveness of their cooperation and coordination mechanisms was found to be inadequate. The main issues included ad hoc initiatives, bureaucratic barriers, limited human and material resources, inadequate multistakeholder and intersectoral cooperation and the insufficient involvement of CSOs.

Participants emphasised that cooperation depends on the willingness and involvement of individual institutions, which emerge from personal relationships and informal contacts, rather than structural facilitation.

> *'It [collaboration and coordination] probably depends on the contacts or network of the particular facility or statutory body … It's more like internal networking by whoever comes to mind. We don't have an official network for quality creation or anything like that.'*
>
> Manager of a public institution, Slovakia

In several countries, participants reported that the availability of funds and the willingness of different actors to cooperate depended on political interest.

> *'If the region doesn't give [the director of the facility] the money in the budget, if the members of regional parliament don't approve it, if the region doesn't give him the green light, he has limited powers.'*
>
> Representative of a national organisation of persons with disabilities, Slovakia

A lack of financial and human resources was also identified as a reason for insufficient cooperation.

> *'And it seems to me that it's only the lack of resources that causes there to be entropies [in cooperation], because otherwise, from the point of view of availability and wanting to help, in concrete terms, there is that willingness.'*
>
> Representative of a national independent monitoring body, Portugal

Another recurring theme was the limited involvement of civil society. Many interviewees mentioned that CSOs were frequently sidelined in the making and implementation of policy, constraining their ability to contribute effectively to violence prevention and victim support.

> *'Despite the organised chambers of social workers and psychologists, despite the Ombudsperson, despite all that, the legislative policymaking process is still very firmly in the hands of the ministry.'*
>
> Representative of a national organisation of persons with disabilities, Croatia

## 4.3. CONCLUSIONS AND KEY TAKEAWAYS

FRA's research reveals a diverse range of public monitoring bodies within each country that have obligations deriving from distinct regulatory frameworks and mechanisms situated within units, departments and agencies operating under different ministries. They have distinct mandates, are bound by various standards and have different methodologies and scopes. The research also reveals considerable differences between and within countries in terms of the frequency and modalities of inspections and the power of these bodies to impose sanctions.

A fragmented national system and a proliferation of processes may result in conflicting actions or outcomes when it comes to inspections, ultimately leading to ineffective monitoring and different levels of protection for persons with disabilities within institutions.

Like the organisation of public monitoring bodies, the landscape of national human rights structures is also diverse both within and across the 30 countries covered. The monitoring of institutions for persons with disabilities is the responsibility of either a single body or multiple bodies, with both approaches posing challenges.

The interviews conducted in 10 of the examined Member States reveal that the effectiveness of monitoring mechanisms varies significantly, with considerable discrepancies between assessments carried out by bodies within the public administration and those carried out by independent monitoring mechanisms. Monitoring by independent mechanisms was generally seen as adequate, but limits on these mechanisms' mandate and insufficient resources, and their lack of ability to enforce their recommendations, limit its effectiveness.

Moreover, participants identified the lack of independent monitoring as a problem area. In several countries, monitoring is performed primarily by government agencies, for whom revealing the real conditions in institutions is not necessarily in their best interests, leading to potentially biased findings and sometimes creating a conflict of interest.

Other issues emerging from the interviews include that inspectors often lack the specialised knowledge required to effectively assess the well-being of residents; there is also inadequate follow-up and limited accountability, allowing institutions to continue operating despite violations.

All these challenges reinforce the need for a strengthened focus on human rights standards in the establishment and implementation of monitoring. Research participants from the fieldwork countries identified several key enablers of effective monitoring (see box that follows).

## Key enablers for ensuring effective monitoring

**Expanding the scope and depth of monitoring and harmonising monitoring practices**

- Harmonise different monitoring bodies' practices by developing national minimum standards applicable for all settings that are complemented by monitoring protocols.
- Establish independent review groups that include service users to evaluate existing quality standards and policies.
- Embed an HRBA into monitoring, focusing on prevention and protection, and develop new accreditation and monitoring indicators that follow an HRBA.
- Make violence prevention measures a prerequisite in licensing and accreditation procedures.
- Shift from group- to person-centred approaches. Prioritise gathering information from persons with disabilities over the staff and managers of institutions during visits.
- Increase the duration and frequency of visits. Invest in unannounced monitoring.

**Enhancing accountability through enforceability and following up on monitoring visits**

- Increase enforcement capabilities by enabling corrective actions and the provision of enough resources for adequate follow-up on recommendations.
- Embed institutional capacity building into monitoring in the form of a follow-up plan, methodological support, practical examples, human-rights-based quality indicators and training.

**Investing in monitoring bodies by increasing their resources and training monitoring staff**

- Increase the human and financial resources of monitoring bodies and supervisory authorities.
- Train the members of monitoring teams on HRBAs, CRPD obligations, trauma-informed care, safeguarding, de-escalation techniques and effective communication.
- Conduct joint training that involves staff from different agencies and persons with disabilities to build a shared understanding and culture of rights.

**Implementing an HRBA to monitoring by ensuring participatory and multidisciplinary monitoring and enabling internal user-led monitoring**

- Invest in multidisciplinary monitoring teams that include social care workers and impartial medical professionals.
- Involve persons with disabilities and persons with lived experiences of institutions in monitoring activities as experts.
- Establish internal monitoring/supervision mechanisms within institutions, including alternative forms like peer support / trustee mechanisms.
- Collect data to better inform monitoring and prevention measures.
- Increase accountability by making inspection results publicly available.

**Strengthening cooperation**

- Promote complementarity by formalising cooperation between different mechanisms, ensuring the regular exchange of information and establishing unified/digitalised reporting systems.
- Establish protocols for cooperation beyond monitoring bodies that include victim support services, justice professionals and disability service providers.

# Endnotes

(1) Committee against Torture, **General Comment No 1 (2024) on Article 4 of the Optional Protocol (places of deprivation of liberty)**, CAT/OP/GC/1, 4 July 2024, paras 14–17; Committee against Torture, Concluding observations on the third periodic report of Romania (CAT/C/ROU/CO/3, para. 32); Committee against Torture, Concluding observations on the third periodic report of Lithuania (CAT/C/LTU/CO/3, para. 25); and Committee against Torture, Concluding observations on the seventh periodic report of Bulgaria (CAT/C/BGR/CO/7, para. 18).
(2) Committee against Torture, **General Comment No 1 (2024) on Article 4 of the Optional Protocol (places of deprivation of liberty)**, CAT/OP/GC/1, 4 July 2024, para. 9.
(3) CPT, **'Persons deprived of their liberty in social care establishments'**, 21 December 2020.
(4) Council of Europe, ***Freedom from exploitation, violence and abuse of persons with disabilities – Contribution to the Council of Europe strategy on the rights of persons with disabilities***, 2017, p. 28.
(5) For further explanation of national human rights structures, see FRA, **'Supporting national human rights institutions in monitoring fundamental rights and the fundamental rights aspects of the rule of law'**, FRA website.
(6) Constitution of the Republic of Bulgaria (**Конституция на Република България**), 13 July 1991, last amended 22 December 2023, Art. 127.
(7) Czechia, Act No 283/1993 Coll. on the Office of Public Prosecution (**Zákon č. 283/1993 Sb., o státním zastupitelství)**, Section 4(1)(b).
(8) Poland, Act on the Protection of Mental Health (**Ustawa o ochronie zdrowia psychicznego**), 19 August 1994, Arts 43–43a.
(9) Slovakia, Law No 153/2001 Coll. on Prosecution Office as amended (**Zákon č. 153/2001 Z.z. o prokuratúre v aktuálnom znení**), 28 March 2001.
(10) Spain, **Prosecutor's Office of the Chamber for the Protection of Persons with Disabilities and Older People**.
(11) The **National Centre for Mental Health and Drug Control** in Romania operates on the basis of Government Decision No 1424 of 18 November 2009, supplemented and amended by Government Decision No 625/2017 (**Hotărâre nr. 1.424 din 18 noiembrie 2009 privind înfiinţarea, organizarea şi funcţionarea Centrului Naţional de Sănătate Mintală şi Luptă Antidrog**).
(12) Sweden, Ordinance (2013:176) with instructions for the Health and Social Care Inspectorate (**Förordning (2013:176) med instruktion för Inspektionen för vård och omsorg**), 18 April 2013.
(13) In Austria, the association VertretungsNetz acts as the residential advocacy service in all *Länder* except Vorarlberg and has been working on behalf of the Ministry of Justice since 1980.
(14) Hungary, Government Decree 182/2022 (**182/2022. (V. 24.) Korm. rendelet**), 1 January 2024.
(15) In Croatia, a Commission for the Protection of Persons with Mental Disorders exists under the Ministry for Justice (Croatian Parliament, Protection of Persons with Mental Disorder Act (**Zakon o zaštiti osoba s duševnim smetnjama**), *Official Gazette*, NN 76/2014).
(16) In Cyprus, there is a separate semi-governmental **Committee for the Protection of Persons with Intellectual Disabilities** and another Committee for the Supervision and Protection of the Rights of Mentally Ill Persons (Cyprus, Psychiatric Hospitalisation Act 1997 (**Ο περί Ψυχιατρικής Νοσηλείας Νόμος του 1997**), Arts 20–24.)
(17) VertretungsNetz, 'VertretungsNetz: About us' (**'VertretungsNetz: Über uns'**), VertretungsNetz website.
(18) Poland, Act on the Protection of Mental Health (**Ustawa o ochronie zdrowia psychicznego**), 19 August 1994, Arts 43–43a.
(19) Spain, **Prosecutor's Office of the Chamber for the Protection of Persons with Disabilities and Older People**.
(20) Austria, Section 8 et seq. of the Nursing Homes Residence Act (**Heimaufenthaltsgesetz**), implemented in practice by VertretungsNetz; see VertretungsNetz, 'Tasks of the residents' representative' (**'Aufgaben der Bewohnervertretung'**), VertretungsNetz website.
(21) Czechia, Act No 372/2011 Coll. on health services and the conditions of their provision (Health Services Act) (**Zákon č. 372/2011 Sb. o zdravotních službách a podmínkách jejich poskytování/Zákon o zdravotních službách**).
(22) Belgium, Audit and Inspection Department of Agence pour une Vie de Qualité (**Direction de l'Audit et d'Inspection, AVIQ**), also known as Agence wallonne de la santé.
(23) Bulgaria, Ordinance No 1 of 28 June 2005 on the procedure for applying temporary physical restraint measures to patients with established mental disorders (**Наредба № 1 от 28 юни 2005 г. за реда за прилагане на мерки за временно физическо ограничаване при пациенти с установени психични разстройства**), 8 July 2005; and Spain, Ministry of Health and Social Policy, Resolution of 10 September 2010, of the Undersecretariat, approving the Charter of Services of the Permanent Specialised Office of the National Council on Disability (**Resolución de 10 de septiembre de 2010, de la Subsecretaría, por la que se aprueba la Carta de servicios de la Oficina Permanente Especializada del Consejo Nacional de la Discapacidad**), 10 September 2010.
(24) Such as in the Forensisch-Psychiatrisch Centrum of the Flemish Healthcare Department (**Departement Zorg**). Forensic psychiatric centres are one of the types of facilities that host internees. Although the decree and resolution on inspections do not make any exceptions for forensic psychiatric centres, the website of the Care Inspectorate itself mentions, in bold, that inspections of these centres are announced.
(25) Latvia, Cabinet of Ministers Regulation No 309 (Ministru kabineta 2019. gada 12 jūlija noteikumi Nr. 309), By-laws of the Health Inspectorate (**Veselības inspekcijas nolikums**), 12 July 2019, para. 5.8.
(26) Luxembourg, Act of 8 September 1998 regulating relations between the State and organisations working in the social, family and therapeutic fields (**Loi du 8 septembre 1998 réglant les relations entre l'Etat et les organismes oeuvrant dans les domaines social, familial et thérapeutique**), 24 September 1998, Art. 9.
(27) Poland, Act on the Protection of Mental Health (**Ustawa o ochronie zdrowia psychicznego**), 19 August 1994, Arts 43–43a.
(28) For example, the Bulgarian **Committees to supervise the application of temporary physical restriction measures**; the Croatian **Commission for the Protection of Persons with Mental Disorder; Ireland: Health Information and Quality Authority**; the Italian Senate's **Extraordinary Commission for the Protection and Promotion of Human Rights**; and the Portuguese **Commission to Monitor the Implementation of the Legal Framework for Involuntary Treatment**.
(29) Austria, Nursing Homes Residence Act (**Heimaufenthaltsgesetz**), *Federal Law Gazette I*, No 11/2004.
(30) See the Italian Senate's **Extraordinary Commission for the Protection and Promotion of Human Rights**; the **Higher Institute of Health**; and the **Food and Health Units** of the Italian Carabinieri.
(31) Poland, Act on the Protection of Mental Health (**Ustawa o ochronie zdrowia psychicznego**), 19 August 1994, Art. 43(11).
(32) For more information, see the **CRPD Independent Monitoring Mechanisms (IMM) Repository** on the OHCHR website.
(33) **UN General Assembly Resolution 48/134 – Principles relating to the status of national institutions (the Paris Principles)**, 20 December 1993.
(34) For more information, see **'Supporting national human rights institutions in monitoring fundamental rights and the fundamental rights aspects of the rule of law'** on the FRA website.
(35) Committee against Torture, **General Comment No 2 on the implementation of Article 2 by States parties**, CAT/C/GC/2, 24 January 2008; and **General Comment No 1 (2024) on Article 4 of the Optional Protocol (places of deprivation of liberty)**, CAT/OP/GC/1, 4 July 2024.
(36) Netherlands, Minister for Legal Protection, **letter to the House of Representatives on the national preventive mechanism**, 27 September 2023.

(37) Committee against Torture, ***Report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – Visit to Bulgaria undertaken from 24 to 30 October 2021: Recommendations and observations addressed to the State party***, CAT/OP/BGR/ROSP/1, 28 October 2022, para. 26.

(38) Italy, Legislative Decree No 20 of 5 February 2024 (**Decreto legislativo, 5 febbraio 2024, No 20**), Art. 4(1n).

(39) Malta, **Equal Opportunities (Persons with Disability) Act**, Chapter 413 of the Laws of Malta, 2000.

(40) Malta, **Ombudsman Act**, Chapter 385 of the Laws of Malta, 1995.

(41) Malta, **Mental Health Act**, Chapter 525 of the Laws of Malta, 2014.

(42) Malta, Office of the Commissioner for Mental Health, **‘Mental health and wellbeing – Challenges and opportunities: Annual report 2020’**, 16 March 2024, p. 14.

(43) Association for the Prevention of Torture, OPCAT Database, **‘Malta’**.

(44) Information received by email from the Office of the Parliamentary Ombudsman of Finland on 18 June 2024.

(45) Parliamentary Ombudsman of Finland, ***Summary of the Annual Report – 2022***, Hansaprint Oy, Turenki, 2023, p. 14.

(46) See, for example, Sweden, Act (2023:499) with instructions for the parliamentary ombudsmen (Lag (2023:499) med instruktion för Riksdagens ombudsmän (JO)), 29 June 2023, Section 17, or Portugal, Statute on the Ombudsperson (**Estatuto do Provedor de Justiça**), 9 April 1991.

(47) Croatian Parliament, Act on the Ombudsperson for Persons with Disabilities (**Zakon o pravobranitelju za osobe s invaliditetom**), *Official Gazette*, NN 107/207.

(48) Seimas of the Republic of Lithuania, Law on Seimas Ombudspersons (**Seimo kontrolierių įstatymas**), No VIII-950, 3 December 1998, last amendment No XIV-1997, 25 May 2023, Art. 19.

(49) Belgium, Law Establishing a Federal Institute for the Protection and Promotion of Human Rights (**Wet tot oprichting van een Federaal Instituut voor de bescherming en de bevordering van de rechten van de mens**), 12 May 2019, Art. 6(4).

(50) Ireland, **Irish Human Rights and Equality Commission Act 2014**, Art. 10(2)(e).

(51) Sweden, Act (2023:499) with instructions for the parliamentary ombudsmen (**Lag (2023:499) med instruktion för Riksdagens ombudsmän (JO)**), 29 June 2023, Section 25.

(52) The Commissioner for Protection from Discrimination does this in Albania, in accordance with Law No 10 221, dated 4 February 2010. In Malta, this power is granted by the **Equal Opportunities (Persons with Disability) Act**, Chapter 413 of the Laws of Malta, 2000.

(53) Prosecutor’s Office of the Republic of Bulgaria, ‘Sofia City Prosecutor’s Office carries out inspection of medical institutions providing psychiatric care’ (**‘Софийска градска прокуратура извършва проверка на лечебните заведения, предоставящи психиатрична помощ’**), press release, 8 November 2023.

(54) Human Rights Centre, ‘Self-assessment tool for operators providing special care for people with intellectual disabilities’ (**‘Itsearviointityökalu kehitysvammaisten asumispalveluiden järjestäjille’**), Human Rights Centre website.

(55) Luxembourg, Ombudsman, *Hospitalisation without consent of persons suffering from mental health problems – Follow-up report* (***L’hospitalisation sans leur consentement de personnes atteintes de troubles mentaux – Rapport de suivi***), Luxembourg, 2016, pp. 61 and 63–65; and Ombudsman, *External Control of Places of Deprivation of Liberty – Annual report: 1 January to 31 December 2022* (***Contrôle externe des lieux privatifs de liberté – Rapport annuel: 1er janvier au 31 décembre 2022***), Luxembourg, 2023, pp. 20 and 22.

(56) Ninlil – Empowerment and Counselling for Women with Disabilities, ‘Training “Prevention of sexual violence against women with learning difficulties or multiple disabilities”’ (**‘Schulung “Prävention von sexueller Gewalt gegen Frauen mit Lernschwierigkeiten oder Mehrfachbehinderung”’**), Ninlil website.

(57) Federal Association of Women’s Counselling Centres and Helplines (BFF), **‘Material’**, BFF website.

(58) Denmark, **Parliamentary Ombudsman**, ‘Supervision’ (‘Tilsyn’), Parliamentary Ombudsman website.

(59) Finland, Parliamentary Ombudsman, ***Summary of the Annual Report – 2022***, Hansaprint Oy, Turenki, 2023, p. 57.

(60) Romania, Law No 35 of 13 March 1997 on the organization and operation of the Ombudsperson (**Legea nr. 35 din 13 martie 1997 privind organizarea și funcționarea instituției Avocatul Poporului**), republished 27 February 2018, Arts 34 and 36.

(61) Protector of Citizens of the Republic of Serbia, Decision of the Ombudsman No 419/41-22 of 8 September 2022.

(62) See, for example, the recommendations of the Committee against Torture to the Hungarian NPM in ***Report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment – Visit to Hungary undertaken from 21 to 30 March 2017***, CAT/OP/HUN/2, 23 April 2021, paras 27–30.

(63) Latvia, Ombudsman’s Office, *Ombudsman of the Republic of Latvia – 2020 annual report* (***Latvijas Republikas Tiesībsarga – 2020 gada ziņojums***), p. 107, and information received during an interview with representatives of the Ombudsman’s Office on 30 January 2024.

(64) Malta, **Equal Opportunities (Persons with Disability) Act**, Chapter 413 of the Laws of Malta, 2000.

# 5

# RESPONSE TO VIOLENCE THROUGH ENSURING ACCESS TO JUSTICE

Member States have an obligation to provide for an effective remedy for victims of all crimes, as stated in Article 47 of the Charter, Article 13 of the ECHR, Article 13 of the CRPD and Article 2 of the ICCPR. Accountability under international human rights law, as part of an HRBA, requires states to provide an effective response to violence against persons with disabilities by investigating abuses, prosecuting perpetrators and ensuring redress and support are available for victims. Grounded in the CRPD and other international treaties, responsive measures are essential to upholding the rights and dignity of persons with disabilities and addressing failures of protection in institutional settings.

This chapter offers an assessment of the access to information, reporting and complaints that persons with disabilities in institutions have. It examines the situation in terms of two axes: internal (both formal and informal) and external complaint mechanisms. The scope of this FRA research does not cover the follow-up of complainants' cases (i.e. criminal prosecution or other outcomes and results of judicial proceedings). Finally, this chapter summarises the findings of FRA's empirical research regarding the main issues with access to justice and also presents key recommendations and promising practices.

## 5.1. SEEKING JUSTICE – THE PROVISION OF INFORMATION

Access to information is a precondition for effective complaint mechanisms and for ensuring accountability. Granting persons with disabilities access to information is necessary to enable them to (a) know and claim their rights, (b) recognise abuse or violence and (c) find available support and complaint mechanisms. The CRPD requires States Parties to provide persons with disabilities with 'information and education on how to avoid, recognise and report instances of exploitation, violence and abuse' (Article 16(2)). States should also take measures to promote assistance and ensure access to information (Article 9(2)(f)); ensure that people have the freedom to seek, receive and impart information through any forms of communication they wish to use (Article 21); and provide persons with disabilities with access to support to enable them to exercise their legal capacity (Article 12(3)). The Victims' Rights Directive also requires Member States to 'ensure that victims with disabilities ... benefit fully from the rights set out in the Directive on an equal basis with others' (1).

Access to information is ensured by service providers, monitoring bodies, the police or others. FRA research shows that most countries have legal standards or accreditation and quality standards that ensure access to information for persons with disabilities. In Czechia (2), for instance, quality standards oblige social service providers to inform their users about the possibility of lodging a complaint, how to lodge a complaint, who will handle the complaint and about the possibility of choosing which representative will receive and handle the complaint. Similar provisions are found in Greece (3) and Sweden (4). In relation to ensuring access to criminal justice complaint systems, examples include providing information to persons with disabilities 'in a barrier-free way', as in Austria (5), or 'in an understandable manner', as in Slovakia (6).

Some national laws provide for access to an external third party, such as an agency, a (victim support) service or a confidential individual, who ensures that persons with disabilities get the necessary information and support. Such entities exist in Ireland (7) and Malta (8), for example.

The scope of FRA's research does not extend to an analysis of victim support services; nevertheless, the analysed data confirm that victim support services rarely make their services accessible to persons with disabilities. Only a few examples were found of victim support services that are specifically aimed at people with disabilities, with accessibility ensured through, for example, their website (Finland (9)) or by using simple language and publishing video information for deaf people (Austria (10)). Other research (11) also shows major gaps in the accessibility of support services.

Often, information channels and support mechanisms for victims exist, but they are not aimed at or tailored to persons with disabilities living in institutions. In some cases, these avenues are accessible to relatives or guardians only, which limits the agency of persons with disabilities and potentially creates or reinforces their dependency on another person, all of which is inconsistent with an HRBA.

Examples of effective and appropriate access to information include awareness-raising campaigns (Spain), hotlines (Portugal), dedicated handbooks on support (Sweden), the distribution of leaflets (Lithuania), posters (Austria) and the display of relevant contacts in social care homes (Poland). In line with the EU Web Accessibility Directive (12), the research also identified examples of accessible institutional websites (in Austria, Belgium, Finland, Germany, Lithuania and Sweden).

Findings from national research, for example in Lithuania (13) and North Macedonia (14), attest to the manifold barriers – including legal, communication, physical and attitudinal barriers – that people with disabilities face. A study in Portugal revealed that 8 out of 10 women with disabilities were victims of gender-based violence (15). Most did not report it, and those who did had had negative experiences of the support received. A report by the Danish Institute for Human Rights (16) on violence and threats in residential facilities concluded that '[t]here are extensive dark figures in this kind of police report-based statistics … The actual level of violent offences against the person is expected to be considerably higher than the reported level in statistics based on police reports.' Moreover, there are very few concrete efforts or measures to ensure that the remedies offered by criminal justice authorities are accessible to and inclusive of persons with disabilities (17).

## 5.2. INTERNAL AND EXTERNAL COMPLAINT MECHANISMS

In addition to effective monitoring, holding duty-bearers accountable also requires ensuring access to effective remedies for human rights violations. However, that accountability depends upon victims in institutions and witnesses coming forward to report incidents to the competent authorities.

The CRPD does not refer explicitly to complaint mechanisms but calls upon States Parties to ensure effective access to justice for persons with disabilities (Article 13 of the CRPD) and to establish robust systems for the identification, investigation and prosecution of abuse (Article 16(4) and (5) of the CRPD). Thus, the CRPD echoes the HRBA's focus on strengthening duty-bearers' capacity to meet their legal obligations but also focuses on empowering rights holders to claim their rights.

This section presents the availability and function of complaint mechanisms in the 30 countries covered in the FRA research. Following the 'journey of the victim', the analysis starts with complaint mechanisms within institutions (both formal and informal), before turning to external complaint mechanisms (e.g. supervisory bodies, independent institutions or intermediaries, which are understood to be bodies that, regardless of whether they are within (e.g. confidential counsellors) or outside of institutions (e.g. victim support organisations), support victims in contacting the responsible complaint body). The role of criminal justice authorities is also addressed, as well as the availability of data on complaints, which concludes this chapter.

### 5.2.1 Internal complaint mechanisms

Should abuse or an instance of violence happen to a person living in a closed institution, the first step is for the incident to be flagged within the institution. Institutions for persons with disabilities have complaint-handling procedures that can be accessed formally or informally. However, the internal handling of complaints has been reported by some to be ineffective or biased, an issue compounded by the lack of transparency, potential conflicts of interest and non-reporting for fear of retaliation. See **"Section 5.3"**.

*Formal complaint procedures*

A variety of methods for establishing formal complaint procedures exist within facilities. In more than half of the countries studied, quality standards linked to the accreditation and licensing of institutions include having a complaint mechanism as a requirement. But the type of mechanism varies. For instance, in Portugal ([18]), service providers must have a complaints book; in Poland ([19]), 24-hour facilities should display the telephone numbers of relevant bodies.

Many countries have established specific mechanisms for groups or settings, including specific complaint procedures for persons with disabilities in psychiatric institutions (e.g. the Netherlands ([20]), Poland ([21]), Serbia ([22])), children and youth (e.g. Czechia ([23]), Poland ([24]), Slovenia ([25])) or older people (e.g. specific residential care lines in Belgium ([26])).

Efforts to ensure accessibility were found in several countries in the form of special online forms, such as those in Germany ([27]) and Ireland ([28]), or websites, as in France ([29]) and Sweden ([30]). These, however, are linked to supervisory or other authorities beyond the boundaries of the institution in which the complainant resides.

Depending on the type of complaint mechanism and the level of dependency of the person with disabilities, ensuring anonymity may be challenging (see **"Section 5.3"**). This was stressed by the NPM in Germany, which has called upon institutions to ensure confidentiality and access to anonymous complaint mechanisms ([31]).

**PROMISING PRACTICE**

## Educating care providers on violence detection and management

In Sweden, the National Board of Health and Welfare published a handbook (*) on social services' responsibilities that includes information on what avenues of help and support are available and how to file a police report and instructions for care providers on how to give information to the patient.

In Germany, an association of 23 supra-local providers of social welfare developed guidelines for the implementation of violence protection measures (**). Dedicated training and awareness-raising programmes focus on building the capacities of professionals in institutions (***).

In Croatia, an action plan (2021–2024) prescribed concrete training, including a curriculum, materials and good practices, for professionals working with persons with disabilities in healthcare and social care institutions (****).

(*) Sweden, National Board of Health and Welfare, *Your Obligation to Inform and Involve the Patient – Handbook for healthcare providers, managers and staff* (***Din skyldighet att informera och göra patienten delaktig – Handbok för vårdgivare, chefer och personal***), Stockholm, 2015.

(**) Federal Association of Supra-local Social Welfare and Integration Assistance Providers (BAGüS), ***Orientierungshilfe der BAGüS zum Gewaltschutz in der Eingliederungshilfe nach § 37a SGB IX (BAGüS-Orientierungshilfe Gewaltschutz)***, Cologne, 2023.

(***) Germany, Ministry of Labour and Social Affairs, ***Gewaltschutzstrukturen für Menschen mit Behinderungen – Bestandsaufnahme und Empfehlungen***, Nuremberg, 2021.

(****) Croatia, ***Akcijski plan izjednačavanja mogućosti za osobe s invaliditetom za razdoblje od 2021. Do 2024. Godine***, 2021.

Access to justice for persons with disabilities in institutions relies not only on accessible, anonymous and well-defined procedures but also on trained personnel. NPMs and ombudspersons (e.g. those in Lithuania (32), North Macedonia (33) and Slovenia (34)) have recommended that employees in the medico-social sector be trained in violence prevention and detection. A report by the Danish Institute for Human Rights highlighted how sexual violence against persons with disabilities in residential facilities goes unnoticed, stressing a 'lack of interdisciplinarity and specialised knowledge about various functional impairments. The psychologists at the centres are specialised in sexual abuse, but do not necessarily have in-depth knowledge of autism, ADHD, schizophrenia and similar diagnoses' (35). Similarly, the most recent HIQA disability overview report in Ireland highlighted concerns about the ongoing commitment to safeguarding arrangements, particularly considering issues with staff management and training (36).

### *Informal complaint procedures*

Informal complaint procedures within institutions complement formal complaints structures. They can take the form of an oral suggestion or complaint to an employee or to management within institutional settings, or they can be made through self-advocacy groups or residents' councils. The installation of an anonymous collection box for suggestions and complaints is another form often reported as existing within individual institutions. This procedure is a frequent recommendation of NPMs (37).

Informal complaint procedures within institutions are typically not regulated or required by national law or in quality standards, and there is no obligation for institutions to provide them. Examples of regulated informal complaint procedures were identified in only a few countries. In Lithuania, for example, the internal rules of procedures in social care homes stipulate that complaints may be submitted in writing, by email, verbally or anonymously in a 'Complaints, requests, suggestions' box (38).

Self-advocacy groups and residential councils are another avenue for submitting an informal complaint. In Austria, certain provincial laws allow residents to elect a representative or resident delegation to represent their interests (39). Residents' councils (40) and women's representatives (41) also exist in some of the *Länder* of Germany and serve as contact points, regularly talking with management, including about complaints. Spokespersons and resident councils form a widely disseminated informal complaint mechanism in reception and accommodation facilities for persons with disabilities in Luxembourg (42). National human rights bodies have, however, raised concerns that resident councils are not generally relied upon and have limited ability to influence and change existing practices (43).

PROMISING PRACTICE

## Tools for promoting informal complaining

In Finland, to support self-monitoring and the strengthening of residents' self-determination, the ombudsman recommended that the organisers and providers of residential services for persons with intellectual disabilities use the self-assessment tool produced by the Finnish Human Rights Centre and the Parliamentary Ombudsman (*).

In Denmark, the Ombudsman recommended that residential facilities have written guidelines regarding the prevention of violence and sexual abuse, as well as procedures to follow in case of the suspicion of abuse (**).

In Latvia, the Ombudsman recommended the development of a methodology for regularly surveying residents of institutions. In addition to direct feedback, it also encourages conducting periodic surveys of the residents' relatives (***).

(*) Human Rights Centre, 'Self-assessment tool for actors organising special care' (**'Itsearviointityökalu kehitysvammaisten asumispalveluiden järjestäjille'**), Human Rights Centre website.

(**) Denmark, Parliamentary Ombudsman, **'Thematic report 2020 – Institutions for children and young people with disabilities'**, 29 June 2021.

(***) Latvia, **'Report No 1-5/157 of the Ombudsman on a visit to the Rēzekne social care centre'**, 27 July 2021.

### 5.2.2 External complaint procedures

Internal complaint mechanisms are complemented by various complaint mechanisms external to institutions for persons with disabilities. Three types of external complaint mechanisms exist: supervisory and oversight bodies; independent bodies; and intermediaries, such as dispute committees, disciplinary boards or NGOs.

*Supervisory and oversight bodies*

Once a complaint is lodged internally, it may be escalated from the internal body of the institution to an external body, which in most cases is an inspectorate that is also responsible for overseeing the institution. Complaints to supervisory or oversight bodies are made either directly or via intermediaries. In Latvia, a person may submit a complaint in writing, electronically or orally directly to the Health Inspectorate (44). Meanwhile, in the Netherlands (45), the complaint officer has an obligation to report the complaint to the inspectorate and to refer the case to an independent dispute committee for a decision.

In some countries, complaint procedures are the responsibility of regional supervisory authorities (as in Austria and Czechia). In others, complaints are received by oversight bodies within social affairs ministries (as in Estonia and Slovakia), health ministries (Lithuania), medical chambers (Czechia) or courts of honour (Slovenia). Another example is Spain, which has established an administrative 'guarantee' system, that is, a system of infringements and sanctions in the field of equal opportunities, non-discrimination and universal accessibility for people with disabilities (46). Complaints can be lodged with the General Directorate of Rights of Persons with Disabilities (47).

PROMISING PRACTICE

## Division of labour

In Sweden, matters concerning the rights of children, social welfare and healthcare, care against one's will and self-determination are overseen by the Parliamentary Ombudsman. Complaints submitted to the Chancellor of Justice may be transferred to the Parliamentary Ombudsman.

*Source:* Sweden, Act on the division of tasks between the Chancellor of Justice and the Parliamentary Ombudsman (**Lag om fördelningen av uppgifter mellan justitiekanslern i statsrådet och riksdagens justitieombudsman**), Act No 330/2022, 13 May 2022.

*Independent bodies*

In addition to accessible and effective formal complaint procedures within and beyond institutions, persons with disabilities should also have access to external and independent complaint bodies.

In almost all 30 countries covered by the research, a national ombuds institution is the main independent complaint mechanism in place. Each ombuds institution has its own legal basis but generally these institutions serve as impartial investigators of complaints against the government or public administration at the state and local levels. As discussed in Chapter 4, ombuds institutions typically have no power to issue binding decisions or to enforce their recommendations. This restricted leeway was also criticised by various participants in the empirical research (see **"Section 5.3"**).

The research shows a variety of approaches in terms of territorial organisation or thematic focus. Some countries have regional ombuds institutions (48) or local ombudspersons (49). Beyond territorial divisions, there are specialised ombudspersons in hospitals – for example, in Flanders, Belgium, every hospital or mental health consultation platform has an independent ombudsperson (50). Other specialised services are in place for children and young people (e.g. in Czechia, Ireland and Poland), persons with disabilities (e.g. in Croatia, Malta and Slovakia), issues regarding mental health (e.g. in Malta) and equality issues (e.g. in Lithuania).

PROMISING PRACTICE

## Nationwide complaints offices

The German Lebenshilfe – a parents', professional sponsors' and self-help association for persons with disabilities – has an independent complaints office that deals with complaints against institutions that are part of Lebenshilfe. The complaints office redirects the information to the regional association in charge, which is asked to investigate and provide clarification and feedback to the complaints office.

*Source:* **Bundesweite unabhängige Beschwerdestelle für die Lebenshilfe** website.

There are also examples of independent formal and public complaint mechanisms within regulatory bodies, hospitals or care facilities. In Greece, the Special Monitoring Committee for the Protection of the Rights of Persons with Mental Disorders (51) is responsible for the protection of the rights of persons with psychosocial disabilities (52). In Luxembourg, the monitoring committees address complaints submitted by patients hospitalised without their consent in a psychiatric ward of a hospital or a specialised psychiatric establishment (53).

Ensuring diverse means of approaching low-threshold and accessible complaint mechanisms is a matter addressed by national human rights bodies in recommendations to their states and to individual facilities (54).

*Intermediaries*

Addressing the specific barriers that persons with disabilities in institutions face when trying to access support requires an individualised approach. In Sweden, assistance for victims who may require support in contacting other authorities is provided by a contact person assigned through the municipality (55). Persons receiving compulsory psychiatric care or forensic psychiatric care are entitled to a support person, a representative or counsel, as well as public legal counsel (56). In Hungary, the beneficiary rights representative assists residents of institutions in exercising their rights, including helping them file complaints (57). In Slovenia, upon admittance to an intensive care unit or secure ward, a person has a right to a mental health advocate (58) and a patients' rights advocate (59). The latter advises patients on their rights and makes enquiries on behalf of patients about alleged violations.

Disciplinary boards and dispute committees provide another route for complaints about the actions of health and care professionals. There are disciplinary boards in the Netherlands (60) and Sweden (61). It is, however, unclear how accessible these are and whether they are used by persons with disabilities in institutions.

PROMISING PRACTICE

## Confidential counsellors for patients

In the Netherlands, confidential counsellors (*) provide advice and assistance (including as part of the complaint procedure) free of charge. The patient's confidential counsellor is not employed by the care provider but works for an independent foundation. The National Health Care Report Centre can also support citizens who want to lodge a complaint against a care provider (**).

(*) Netherlands, Compulsory Mental Healthcare Act (**Wet verplichte geestelijke gezondheidszorg**), Chapters 11–12; and Care and Compulsion Act (**Wet zorg en dwang psychogeriatrische en verstandelijk gehandicapte cliënten**), Chapter 4a.

(**) Netherlands, National Health Care Report Centre, 'I want to report an incident' (**'Ik wil iets melden'**), Health and Youth Care Inspectorate website.

PROMISING PRACTICE

## Monthly commissioner

In Flanders, Belgium, every institution where young persons are deprived of their liberty has its own monthly commissioner. These are volunteers trained by the Supervisory Committee for Youth Institutions (*) who visit the institution they have been appointed to on a monthly basis without giving the institution prior notice. After each visit, a report is submitted to the administration of the Supervisory Commission. If there is a complaint, the commissioners mediate or transfer the complaint to the Children's Rights Commissioner (**). The regularity of the visits makes young persons feel like someone is always looking out for them and makes institutions feel that they are being supervised.

(*) Belgium, Decree of the Government of the French Community establishing a Commission for the monitoring of places of deprivation of liberty for young people (**Arrêté du Gouvernement de la Communauté française instituant une Commission de surveillance des lieux de privation de liberté des jeunes**), No 2019011917, 3 April 2019.

(**) For more information, see the **website of the Office of the Children's Rights Commissioner**.

PROMISING PRACTICE

## Employing 'survivors'

As part of its deinstitutionalisation strategy, Slovenia is planning to establish the Advocacy Centre (*), an independent body that will provide advice to individuals placed in institutions by employing individuals who were themselves previously placed in institutions, or 'survivors'.

(*) Slovenia, Ministry of Solidarity-based Future, *Strategy for deinstitutionalisation in social care for the period 2024–2034* (***Strategija Republike Slovenije za deinstitucionalizacijo v socialnem varstvu za obdobje 2024–2034***), Ljubljana, 2024, p. 32.

In some countries, representative organisations of persons with disabilities offer another means for victims to seek support and file complaints (e.g. in Cyprus (62), Estonia (63) and Portugal (64)). A study conducted in Czechia revealed the important role that disability-related organisations may play in victim support and assistance (65).

### 5.2.3 The role of criminal justice authorities

FRA research identified very few concrete measures that facilitate persons with disabilities' access to criminal justice authorities. Care providers and inspectorates that become aware of a crime in the performance of their duties typically have the legal obligation to forward complaints or reports to the police. This is the case, for example, in Albania, Finland, France, Malta and the Netherlands.

There are also cases (e.g. in Belgium, Bulgaria, Italy, Lithuania, Luxembourg, Malta and the Netherlands) where CSOs or other entities – such as the municipality in Denmark (66) or a facilitator within the Public Prosecutor's Office in Spain (67) – support victims in submitting reports to criminal justice authorities. In contrast, in Latvia, criminal proceedings may be initiated even if no application has been received from the injured party, if that party has a physical or mental disability (68).

### 5.2.4 Cooperation between the authorities supporting victims

Considering the importance of both internal and external complaint mechanisms in enabling access to justice for victims, their effective cooperation and coordination is vital, as noted in Article 26 of the Victims' Rights Directive.

Cooperation chains have been observed in several countries. The Public Prosecution Service in the Netherlands has instructions on cooperating with the police (69), who then refer people to victim support groups (70). In Sweden, healthcare workers have an obligation to report any known or suspected cases of violence. Upon receiving a complaint, the Health and Social Care Inspectorate contacts the public prosecutor, allowing it to reach multiple stakeholders and form a cooperative framework (71).

PROMISING PRACTICE

## Ensuring accessibility in reporting

The Centre for Legal Resources (*), an NGO, in partnership with the Public Prosecutor's Office attached to the High Court of Cassation and Justice in Romania, developed a web platform (**) and a mobile app (***) for people with disabilities in residential centres, homes, medical–social units and psychiatric wards or hospitals. These allow people to send complaints directly to the authorities.

(*) See the website of the **Centre for Legal Resources** for more information.

(**) See the web platform **Ceasul Bun**.

(***) The app is available from a link on the **website of the Centre for Legal Resources**.

Victim support agencies and social care groups have established cooperative networks and links with other competent authorities and CSOs to ensure that they can provide the necessary services to victims. In Lithuania (72) and Malta (73), victim support services have cooperation agreements that cover shared service provision and the exchange of information with both governmental and non-governmental entities to provide information and legal and psychosocial support to victims. Many countries (e.g. Belgium, Cyprus, Greece and Hungary) still do not have structured cooperative networks for victims. If they do, these are often not specifically tailored to persons with disabilities or those in institutions (74).

However, child protection systems and national frameworks for cooperation in cases of violence against children in most countries set out transferable practices. Formal cooperation agreements regulate the coordinated action taken by institutions, public organisations and other natural or legal persons protecting children's rights in, for instance, Bulgaria, Ireland and Latvia (75).

**FRA ACTIVITY**

## Cooperation through child protection systems

Coordinated cooperation between those involved in national child protection systems should be an integral part of all violence prevention measures (*). FRA's report on integrated child protection systems (**) shows that responses to the needs of child victims of violence within the EU largely focus on developing child-friendly justice (***), enhancing protection for child victims of crime (****) and promoting the development of the Barnahus Network (*****) by providing financial support to help set up its centres.

More national initiatives can be explored in FRA's report *Mapping Child Protection Systems in the EU* (******).

(*) FRA, ***Violence against Children with Disabilities: Legislation, policies and programmes in the EU***, Publications Office of the European Union, Luxembourg, 2015.

(**) FRA, ***Towards Integrated Child Protection Systems – Challenges, promising practices and ways forward***, Publications Office of the European Union, Luxembourg, 2025.

(***) FRA, ***Child-friendly Justice – Checklist for professionals***, Publications Office of the European Union, Luxembourg, 2017.

(****) Defence for Children International – Italy, ***E-Protect – Policy guidelines for Italy***, Genova, 2019.

(*****) See Child Circle, **'Promise'**, Child Circle website; and Barnahus Network, **'Progress in Europe'**, Barnahus Network website, Barnahus Network map, 2024.

(******) FRA, ***Mapping Child Protection Systems in the EU – Update 2023***, Publications Office of the European Union, Luxembourg, 2024.

PROMISING PRACTICE

## Lessons learned from failing protections

In Denmark (*), one of the purposes of the quality model that assesses the service is documenting insights from instances when force was used, for the purpose of learning from them. Similarly, in Lithuania (**), all incidents involving changes to a person's state of health or a violation of rights are recorded, the causes are analysed and decisions are taken to prevent future incidents.

(*) Denmark, Socialstyrelsen, **'Kvalitetsmodel for socialtilsyn – Temaer, kriterier og indikatorer for sociale tilbud'**, version in accordance with Executive Order No 2665 of 28 December 2021.

(**) Lithuania, Ministry of Social Security and Labour, On the adoption of the description of social care rules (**Dėl Socialinės globos normų aprašo patvirtinimo**), No A1-46, 20 February 2007, last amendment No A1-692, 20 October 2023, Annex No 4, Arts 6.6, 12.7 and 17.5.

### 5.2.5 Lack of (disaggregated) data on complaints

Article 31 of the CRPD obliges States Parties to collect and disseminate disaggregated data, which is a matter also addressed in the CRPD Committee's concluding observations on the EU. EU instruments (76) call for an increase in the collection of data on persons living in institutions in Member States. Overall, FRA research found that there are very few data on complaints, and almost none of the existing data are broken down in a way that reveals the number of complaints made by people living in institutions. Disaggregated data are rare. In Hungary (77) and Lithuania (78), for example, data are available but not disaggregated. Exceptions can be found in Belgium (79) and Sweden (80), where formal complaint mechanisms make their data publicly available.

Findings about the availability of data from ombuds institutions – the main independent complaint mechanisms for people in institutions – also reveal substantial gaps. While ombuds institutions submit annual or thematic reports to national parliaments, FRA research shows that these reports rarely allow for an understanding of the details of these complaints or the complainants.

## 5.3. PERSPECTIVES FROM THE GROUND

This section discusses patterns emerging from the fieldwork research conducted in 10 Member States regarding participants' assessment of the adequacy and effectiveness of national legal and policy frameworks.

### 5.3.1 Tackling inconsistent implementation

Participants in all Member States reported the existence of some form of complaint mechanism, whether internal (within institutions), external (independent bodies) or through a proxy (via family members and/or staff members). A common finding was that those mechanisms have been established and are implemented inconsistently across different facilities. Institutions also lack standard protocols for informing residents of their rights and existing complaint mechanisms. As a result, the effectiveness of complaint mechanisms appears to be rather institution-dependent.

> *'It is left to the will of the institution. Will they have that standard or not ... there are no sanctions. It's a matter of goodwill.'*
>
> Representative of an independent monitoring body, Croatia

Research participants in several Member States further stressed that follow-up mechanisms and responses to complaints were not consistent.

> *'It also happens that residents who file formal complaints do not receive any response ... I found a resident's complaints shoved into plastic sleeves, just ignored, concerning personal data, and nobody had responded to them.'*
>
> Representative of an independent monitoring body, Poland

Many participants viewed external complaint mechanisms more positively than internal ones, with the latter being seen as ineffective and/or biased. Participants in Ireland mentioned CSO and advocacy groups helping residents to complain and access support, while interviewees in Croatia reported the provision of legal counselling and support when launching a complaint. In many Member States, structures like residents' councils and/or quality control committees were highlighted as promising practices in which CSOs and advocacy groups played central roles.

However, external mechanisms also face challenges, as they are often underfunded, underused or difficult to access. Interviewees highlighted the need to strengthen external support systems in terms of their visibility, accessibility, competences and resources.

### 5.3.2 Establishing robust accessible complaint mechanisms catering to the specific needs of persons with disabilities

Effective and accessible complaint mechanisms are essential to upholding accountability, which is a key tenet of an HRBA. In most cases, complaint mechanisms are not tailored to the specific needs of persons with disabilities and are not flexible enough to ensure an individualised approach. Certain groups are in particularly vulnerable situations, for example persons with intellectual disabilities or communication difficulties, persons with psychosocial disabilities and persons with dementia. Children were also mentioned as being especially vulnerable.

**PROMISING PRACTICE**

### Residents' councils

Some institutions in Croatia have created a council of users, where users can discuss complaint mechanisms and get information on how to file a complaint.

In one Slovak institution, persons with disabilities can address questions to an ethics committee composed of the director, staff and members of the residents' council (consisting of five persons with disabilities). The residents' council is elected by the residents every year and collects input from other residents on a regular basis.

In Poland, one practitioner referred to an institution having a residents' council that can mediate the process of filing complaints about the facility's operations. Every three months, meetings between residents and staff are held to discuss current issues.

Several participants mentioned bureaucratic difficulties, with formal complaint mechanisms perceived as being too rigid and/or too complicated. These difficulties further highlight the need for (specialised) support throughout the procedure.

> *'I can say about persons with intellectual difficulties, you can report to the ombudsperson. But who knows the number of the ombudsperson?'*
>
> Person with a disability, Croatia

The research also shows that many complaint mechanisms are physically inaccessible and no alternative accessible communication methods are in place.

> *'... to have information on a bulletin board if someone, for example, cannot move on their own or has restricted access, and ... if someone has a certain level of intellectual disability and does not understand such legal or formal communication? ... Several forms of communication should be developed.'*
>
> Manager of a victim support organisation, Poland

### 5.3.3 Increasing people's awareness of their rights and existing mechanisms

The lack of rights awareness and the normalisation of violent behaviour are distinct barriers that lead to under-reporting. This undermines accountability: victims do not necessarily realise that they are being mistreated or that their rights are being violated.

> *'Many of them don't know how to stand up for themselves, don't know how to write a complaint, don't know how to call, don't know how to tell ... And this is the category that needs extra help, well, extra support.'*
>
> Representative of an independent monitoring body, Slovenia

Access to information is therefore essential for persons with disabilities to enhance their awareness of their rights and – if their rights have been violated – their awareness of what remedies or support mechanisms are available to them. Despite information about rights and procedures being embedded in various accreditation and quality standards across the EU (see **"Section 5.2"**), the fieldwork research identified a lack of targeted methods to raise awareness of and facilitate reporting among persons with disabilities in institutions.

Persons with disabilities, their families and even institutional staff were often unaware of the complaint mechanisms available. Even where theoretically well-functioning complaint mechanisms exist, they often remain underutilised because institutions do not publicise their existence to residents. Several participants highlighted their work to raise awareness and improve the visibility of complaint mechanisms in institutions.

> *'A key aspect of an inspection visit is to raise awareness among residents that they can also directly contact the supervisory authority … This is done by speaking with residents.'*
>
> Representative of an independent monitoring body, Germany

### 5.3.4 Counteracting (the fear of) consequences and retaliation when complaining

The fear (and reality) of retaliation or secondary victimisation and the absence of viable care alternatives were perceived to be widespread issues, discouraging reporting, especially for those highly dependent on staff. Participants noted many people being reluctant to complain owing to (fear of) negative consequences, such as not getting the services needed and/or not being treated with the same level of care.

> *'For those people who have been used to living in institutions, the blackmail weapon many times is: we will send you away and you don't know where you will go. Then, for fear of even a possible transfer, the person keeps silent and lives under those conditions.'*
>
> Representative of a national organisation of persons with disabilities, Italy

> *'If I ever go to the hospital again, no, I don't intend to complain, so that I don't get a month of closed ward; I really don't want that.'*
>
> Person with a disability, Slovenia

> *'And they know very well that "If I rebel here now, they might be angry with me and not show me the same love and care when I go to the toilet", for example.'*
>
> Manager of a public institution, Germany

Participants also spoke about attitudinal barriers stemming from the still prevalent devaluation of the autonomy and competence of persons with disabilities. Persons with disabilities, especially those with intellectual or psychosocial disabilities, are considered less credible and experience mistrust or disbelief when it comes to the accuracy of their testimonies.

> *'Who are you going to report it to? If you do, you'll be [called] the biggest liar.'*
>
> Person with a disability, Slovenia

> *'In other words, the more I complained, the worse it got for me. In other words … for the doctor I was still very lucid, so she would increase my medication so that there wouldn't be this dialogue, which is what I feel the medication does. I get really critical about everything. Even in my life. It's a little complex.'*
>
> Person with a disability, Portugal

The atmosphere of disempowerment and dependency and a lack of trust in the ability of the system to help often stop persons with disabilities from seeking help and submitting complaints.

> *'Bear in mind that often remaining in silence is an instrument of self-protection because then in the end you [the person with a disability] are in the hands of the person who hurt you.'*
>
> Manager of a private institution, Italy

Respondents in about half of the Member States covered in this fieldwork emphasised confidentiality and anonymity as key enablers of complaints, as they counteract the fear of repercussions and the lack of trust.

> *'And then … during that campaign we were being called and told: "Please, please, don't reveal my identity, I am afraid that it will get worse" … Yes, we have heard of such a tendency.'*
>
> Representative of an independent monitoring body, Latvia

In a few cases, the relevance of whistle-blower protection frameworks was highlighted. These allow active staff members to report mismanagement or mistreatment without fear of retaliation.

> *'Now that could be also that persons with disability may be non-verbal and cannot express themselves, so we couldn't know, but I think staff sometimes do disclose about other staff when they see that the abuse … is escalated or is more than once.'*
>
> Manager of a public institution, Malta

## 5.4. CONCLUSIONS AND KEY TAKEAWAYS

Holding duty-bearers accountable for their human rights obligations and ensuring equal access to justice for victims with disabilities – along with enhancing existing legal and policy frameworks (see **"Chapter 3"**) and ensuring effective monitoring (see **"Chapter 4"**) – involves:

- empowering persons with disabilities by providing them with tailored and accessible information on their rights and on the complaint mechanisms and support available;
- facilitating reporting and ensuring support and complaint procedures are accessible;
- training service providers, the police and other officials to recognise specific needs and to provide necessary accommodations;
- ensuring measures are in place to avoid recurrence, retaliation and re-traumatisation while victims are pursuing remedy.

FRA's research revealed that, while the importance of being informed about one's rights and understanding complaint mechanisms is reflected in international treaties, existing regulations often fall short in addressing the specific context and needs of persons with disabilities in institutions, diminishing their access to justice and ultimately undermining accountability. The inaccessibility of existing complaint mechanisms – internal and external – is compounded by other barriers, including attitudinal and legal barriers, for those deprived of legal capacity.

This chapter reveals a complex system of external complaint mechanisms that is made up of oversight or independent bodies and intermediaries. A common emerging thread is how little evidence there is of tailored measures to ensure accessible, low-threshold access to these mechanisms for people with diverse support needs.

The lack of adequate disaggregated data inhibits the development of targeted protection and prevention policies and programmes. It also increases the risk of overlooking maltreatment and abuse, as it leaves complaint services unaware and unable to take responsibility, which leads to further accountability deficits. To this end, developing and using human-rights-based indicators – building on the framework devised by the OHCHR (81) – could support national efforts (82).

The fieldwork research conducted in 10 Member States confirmed widespread under-reporting or non-reporting, which was caused by victims not recognising violence, not being aware of the available support and complaint mechanisms or having a lack of trust and fearing retaliation or secondary victimisation. There were divergent views on the effectiveness of the available complaint mechanisms, with policymakers and service providers viewing the systems more positively but CSOs and persons with disabilities underscoring barriers and deficiencies.

Participants discussed the need to change the existing institutional culture around complaints by promoting awareness, trust, openness and responsiveness. Several key enablers emerged regarding strengthening national response mechanisms to cases of violence in institutions and upholding accountability through effective access to justice (see below box).

## Key enablers for upholding accountability through effective access to justice

**Tackling inconsistent implementation**

- Define clear legal obligations and create binding guidelines on complaint mechanisms, for example by making the existence of such mechanisms a prerequisite for licensing/accreditation and embedding them in (legal) guidelines for violence protection or in guidelines for audits.
- Establish (common) protocols requiring that all services provide accessible and tailored information on rights and complaint mechanisms.
- Establish clear sanctions for violations and impose dissuasive penalties.
- Increase partnerships with external services and victim support providers such as social or psychological services.
- Work with ombuds institutions and invest in accessible reporting channels, including by setting up third-party reporting mechanisms through CSOs.

**Establishing robust accessible complaint mechanisms catering to the specific needs of persons with disabilities**

- Introduce alternative and resident-inclusive internal complaint mechanisms like residents' councils, violence commissioners and confidential services.
- Enhance and ensure alternative/accessible ways to report issues, including easy-read texts, digital tools and QR codes linking to complaint forms.
- Boost cooperation between external complaint mechanisms, supervisory authorities and support structures.
- Address delays in the judicial process and amend statutory time-barring provisions by considering not only when the incident occurred but also when the person was able to report it (after leaving the institution, receiving support, etc.).
- Strengthen external complaint mechanisms – both public and independent – by enhancing the roles and competences of these bodies and increasing their resources.

**Increasing people's awareness of their rights and existing mechanisms**

- Increase the participation and engagement of service users through satisfaction surveys and self-evaluation mechanisms.
- Create information and awareness-raising sessions on the rights of persons with disabilities and the pathways available for reporting and complaining.
- Provide regular training on violence and its detection to persons working in institutions, family members and guardians.

**Ensure protection from retaliation when complaining**

- Ensure anonymous and confidential options are available.
- Provide personalised support for filing complaints through a residents' rights advocate, ethics committee, residents' council or quality control position.
- Train police personnel on how to receive reports from persons with disabilities, and train members of the justice system on the rights of persons with disabilities and on violence prevention.

# Endnotes

(1) **Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA** (OJ L 315, 14.11.2012, p. 57), recital 15.

(2) Czechia, Decree No 505/2006 Coll. implementing certain provisions of the Social Services Act (**Vyhláška č. 505/2006 Sb., kterou se provádějí některá ustanovení zákona o sociálních službách**), Annex 2.

(3) Greece, Law 2716/1999 on the development and modernisation of mental health services and other provisions (**Ανάπτυξη και εκσυγχρονισμός των υπηρεσιών ψυχικής υγείας και άλλες διατάξεις**), OG A' 96/17.5.1999, Art. 2.

(4) Sweden, Ordinance (2013:176) with instructions for the Health and Social Care Inspectorate (**Förordning (2013:176) med instruktion för Inspektionen för vård och omsorg**), 18 April 2013, Section 2.

(5) Austria, Code of Criminal Procedure (**Strafprozeßordnung**), *Federal Law Gazette*, No 211/1975, last amended by ***Federal Law Gazette I*, No 182/2023**.

(6) Slovakia, Law No 274/2017 Coll. on victims of crimes as amended (**Zákon č. 274/2017 Z.z. o obetiach trestných činov v aktuálnom znení**), 12 October 2017, Art. 3.

(7) **Safeguarding Ireland**.

(8) **Agenzija Sapport**.

(9) Victim Support Finland, **'Violence against people with disabilities'** (**'Vammaisiin ihmisiin kohdistuva väkivalta'**), Victim Support Finland website.

(10) Austrian Protection against Violence Centres (**Österreichische Gewaltschutzzentren**).

(11) Ludwig Boltzmann Institute of Human Rights and queraum, ***Access to specialised victim support services for women with disabilities who have experienced violence – Final short report***, 2014; Validity Foundation, ***Humanising Justice – International report from Voices for Justice: Communicating with victims of crime with disability***, Budapest, 2019; and Victims of Crime Implementation Analysis of Rights in Europe (Vociare), ***Vociare Synthesis Report***, 2021.

(12) **Directive (EU) 2016/2102 of the European Parliament and of the Council of 26 October 2016 on the accessibility of the websites and mobile applications of public sector bodies** (OJ L 327, 2.12.2016, p. 1).

(13) See, for example, Grigaitė, U. and Leonaitė, E., *Voices for Justice – People with disabilities affected by crime in Lithuania* (***Balsai už teisingumą – Nusikaltimus patyrę žmonės su negalia Lietuvoje***), Psichikos sveikatos perspektyvos, Vilnius, 2022.

(14) Kochoska, E., Jovanovska, B., Ortakovski, T., Stanojkovska-Trajkovska, N. and Georgievska, S., ***Situational analysis of the rights of persons with disabilities in the Republic of North Macedonia – 2021***, United Nations in North Macedonia, Skopje, 2022; and Dimitrovska, K. and Kochoska, E., ***Investigative Report – Preventing gender-based violence against women and girls with disabilities***, Organization for Security and Co-operation in Europe: Mission to Skopje, Skopje, 2022.

(15) RESPONSE project deliverable 2.1, **'State of the art report'**.

(16) Danish Institute for Human Rights, *Violence and Threats in Residential Facilities – The extent of personal criminal offences against adult residents in facilities for mental disorders* (***Vold og trusler på botilbud – Omfanget af personfarlig kriminalitet mod voksne beboere på botilbud for psykiske lidelser***), Copenhagen, 2019, p. 7.

(17) See, for example, Civil Rights Defenders, *The rights of victims of crime deprived of their liberty – A survey of the implementation of the Victims' Directive in Swedish compulsory care* (***Frihetsberövades brottsoffers rättigheter – En kartläggning av brottsofferdirektivens implementering i svensk tvångsvård***), Stockholm, 2021, p. 9.

(18) Portugal, Decree-Law 64/2007, which sets out the legal regime for the installation, operation and supervision of social support establishments managed by private entities (**Decreto-Lei 64/2007, que define o regime jurídico de instalação, funcionamento e fiscalização dos estabelecimentos de apoio social geridos por entidades privadas**), 14 March 2007.

(19) Poland, Act on Social Assistance (**Ustawa o pomocy społecznej**), 12 March 2004.

(20) Netherlands, Compulsory Mental Healthcare Act (**Wet verplichte geestelijke gezondheidszorg**), Chapter 10, and Care and Compulsion Act (**Wet zorg en dwang psychogeriatrische en verstandelijk gehandicapte cliënten**), Chapter 4, Arts 49–56(h).

(21) Poland, Act on the Protection of Mental Health (**Ustawa o ochronie zdrowia psychicznego**), 19 August 1994, Art. 10a(1)(4).

(22) Serbia, Law on the Protection of Persons with Mental Disorders (**Zakon o zaštiti lica sa mentalnim smetnjama**), *Official Gazette of the Republic of Serbia*, No 45/2013.

(23) Czechia, Act No 109/2002 Coll. on the performance of institutional education or protective education in school establishments and on preventive educational care in school establishments (**Zákon č. 109/2002 Sb. o výkonu ústavní výchovy nebo ochranné výchovy ve školských zařízeních a o preventivně výchovné péči ve školských zařízeních a o změně dalších zákonů**), Art. 20(1)(i); and Decree No 438/2006 Coll. regulating the details of the performance of institutional education and protective education in educational institutions (**Vyhlášce č. 438/2006 Sb. kterou se upravují podrobnosti výkonu ústavní výchovy a ochranné výchovy ve školských zařízeních**).

(24) Poland, Act on Support and Rehabilitation of Minors (**Ustawa o wspieraniu i resocjalizacji nieletnich**), 9 June 2022, Art. 107.

(25) Slovenia, Act on the Treatment of Children and Youth with Emotional and Behavioural Disorders (**Zakon o obravnavi otrok in mladostnikov s čustvenimi in vedenjskimi težavami in motnjami v vzgoji in izobraževanju**), 17 December 2020, Chapter VI.

(26) **Respect Seniors**, the Department of Care Residential Care Line (**Woonzorglijn**).

(27) Germany, State Office for Health and Social Affairs, 'Form for complaints to the Home Supervision Authority' (**'Beschwerde an die Heimaufsicht'**), State Office for Health and Social Affairs website.

(28) 'HSE – Your Service Your Say' feedback forms are available on the **'Make a complaint or give feedback'** page of the website of the Irish Health Service Executive.

(29) See the French government's website **Arrêtons les violence** ('Let's stop the violence').

(30) Sweden, Health and Social Care Inspectorate, 'Tell IVO' (**'Berätta för IVO'**), Health and Social Care Inspectorate website, 20 May 2025.

(31) Germany, National Agency for the Prevention of Torture, *Annual Report 2021* (***Jahresbericht 2021***), Wiesbaden, 2022, pp. 87–89.

(32) Lithuania, Seimas Ombudspersons' Office, 'Report on the human rights situation in the Jurdaičiai social care institution' (**'Ataskaita dėl žmogaus teisių padėties Jurdaičių socialinės globos namuose'**), No NKP–2023/1–1, 23 August 2023, pp. 68–69.

(33) Ombudsman of the Republic of North Macedonia, *Annual report on the degree of ensuring respect, promotion and protection of human freedoms and rights 2021* (***Годишен извештај за степенот на обезбедувањето почитување, унапредување и заштита на човековите слободи и права 2021***), Skopje, 2022, p. 52.

(34) **2023 visits to special welfare institutions** by the NPM. See also Human Rights Ombudsman, ***The report of the Human Rights Ombudsman of the Republic of Slovenia on implementing the tasks of the national preventive mechanism under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment for 2022***, Ljubljana, 2023, pp. 74–76.

(35) Danish Institute for Human Rights, *Sexual Abuse in Residential Facilities – An analysis of the vulnerability of people with disabilities* (***Seksuelle overgreb på botilbud – Analyse af udsatheden for mennesker med handicap***), Copenhagen, 2022.

(36) HIQA, ***Overview Report – Monitoring and regulation of disability services in 2022***, Dublin, 2023.

(37) See, for example, Poland, Commissioner for Human Rights, *Report of the Commissioner for Human Rights on the activities of the national mechanism for the prevention of torture in 2022* (***Raport RPO z działalności Krajowego Mechanizmu Prewencji Tortur w 2022 r.***), Warsaw, 2023, p. 177. See also Hungary, Office of the Commissioner for Fundamental Rights, ***Comprehensive report by the Commissioner for Fundamental Rights on the activities of the OPCAT national preventive mechanism in 2022***, Budapest, 2023, pp. 43 and 52; and Protector of Citizens of the Republic of Serbia, ***National Preventive Mechanism Report for 2021***, Belgrade, 2022, pp. 58–59.

(38) **Order No V-42 of the Director of the Dūkštas Nursing Home**, 'The procedure for submitting and examining complaints, requests and proposals of the Dūkštas Nursing Home' ('Dūkšto Globos Namų skundų, prašymų pasiūlymų pateikimo ir nagrinėjimo tvarka'), 23 October 2019.

(39) Austrian Ombudsman Board, **'Additional report and response to the list of issues submitted by the Austrian Ombudsman Board on the occasion of the 29th session of the CRPD (14 August–8 September 2023)'**, p. 10.

(40) See, for example, the Housing and Participation Act of Bremen (**Bremisches Wohn- und Betreuungsgesetz**), 1 January 2023; **informative guidelines** on setting up a council in an institution from the government of the state of Schleswig-Holstein; and the German Federal Network of Workshop Councils (**Werkstatträte Deutschland**).

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# Annex I: Terminology

Both the desk research and the fieldwork data collection used definitions stemming from the core international instrument on the rights of persons with disabilities – the CRPD. During the fieldwork, interviewers provided clarification on the purpose of the research and explanations and definitions of its key concepts.

**Institution.** There is no commonly agreed-upon definition of what constitutes an institution for persons with disabilities. For the purposes of this research, an institution is 'any place in which persons with disabilities, older people, or children live together away from their families' (1). While the types of institutional services available for persons with disabilities include sheltered or supported housing, group homes, care and nursing homes, boarding schools, day centres and other centres for family-type accommodation, the collection of both primary and secondary data often focused on the more typical understanding of an institution as a large facility for persons with disabilities. While FRA's research aimed to gather information, as much as was available, on any differences in the regulation of traditional larger institutions and other smaller types of care settings that also have institutional characteristics, little was revealed in the collection of either primary or secondary data.

**Violence, abuse, exploitation, torture and cruel, inhuman or degrading treatment or punishment.** For ease of reference, this report uses 'violence' as an umbrella term and does not always list the various forms and specific acts of violence, abuse, exploitation, torture and cruel, inhuman or degrading treatment or punishment being referred to at each mention. During both the primary and the secondary data collection conducted by Franet (2), the following definitions were used.

**Violence** is 'the intentional use of physical force or power, threatened or actual, against oneself, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation' (3).

**Abuse** is 'any act, or failure to act, which results in a breach of a vulnerable person's human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative' (4).

The term **exploitation** is used to describe various forms of abuse and violence, particularly those that have economic and sexual aspects.

**Torture or cruel, inhuman or degrading treatment or punishment** is 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person … for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity' (CAT, Article 1). The CRPD Committee describes other forms of violence that may be considered cruel, inhuman or degrading treatment or punishment and as breaching several international human rights treaties: 'Certain forms of violence, exploitation or abuse may be considered as cruel, inhuman, degrading treatment or punishment and breaches a number of international human rights treaties. Among these are forced, coerced and otherwise involuntary pregnancy or sterilisation; as well as any other medical procedure or intervention performed without free and informed consent, including those related to contraception and abortion; the invasive and irreversible surgical practises including psychosurgery, female genital mutilation or surgery or treatment performed on intersex children without their informed consent; the administration of electroshocks, chemical, physical or mechanical restraints; isolation or seclusion' ([5]).

# Endnotes

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# Annex II: Methodology

This report is based on research that FRA conducted in 2024 through its multidisciplinary in-country research network, Franet ([1]). There were two components to the research: desk research in the 27 Member States and Albania, North Macedonia and Serbia, and fieldwork research in 10 Member States.

## Desk research

FRA's in-country research network of legal and social science experts, Franet, collected background material produced through desk research covering all 27 Member States and Albania, North Macedonia and Serbia. The data were collected between March and May 2024. The report also draws on evidence from previous FRA research on the rights of persons with disabilities and victims' rights and other relevant national and international research.

The national reports cover the topics listed below.

- **Legal and policy frameworks**. This includes information on national legal and policy frameworks and regulatory norms relevant for the protection of people with disabilities in institutions.

- **Monitoring mechanisms.** Information and data are provided on the scope and nature of monitoring carried out by governmental authorities and independent monitoring bodies such as those that hold NPM mandates.

- **Complaint mechanisms.** Information is given on practices that facilitate reporting and mapping existing formal and independent complaint mechanisms.

- **Support given to victims.** This includes information on the support available to persons with disabilities who are victims of violence in institutions, including how to access information and specialised support, and on the existing avenues for cooperation between competent authorities.

- **Data and research.** This includes information from recent research studies or surveys on experiences of violence in institutional settings for people with disabilities.

- **Promising practices.** One to three practices focusing on preventing and addressing violence in institutions for people with disabilities are outlined. This information was requested only in the extended reports, which were delivered by 19 Member States.

While all core areas were covered in the research requested from all 30 countries, the situation was examined in more detail in 19 Member States. These Member States were selected based on in-house desk research and mapping and on considerations relating to budgetary restrictions. The extended information collected on the 19 Member States included responses to additional questions on the core themes and information on promising practices.

To complement the data collected by Franet, FRA, in cooperation with the European Network on Victims' Rights, collected additional information from members of the network, focusing on access to protection and support for victims of violence.

The topic of support for victims was addressed by Franet's data collection only in terms of (a) access to information and support for victims and (b) forms of cooperation between competent authorities. The questionnaire was circulated among the members of the European Network on Victims' Rights, and FRA received 15 replies (from Austria, Belgium, Croatia, Finland, France, Germany, Hungary, Ireland, Malta, the Netherlands, Portugal, Romania, Slovenia, Spain and Sweden).

## Fieldwork research

The desk research findings covering 30 countries are complemented by qualitative empirical social research conducted in 10 Member States: Croatia, Germany, Ireland, Italy, Latvia, Malta, Poland, Portugal, Slovakia and Slovenia.

Individual interviews were conducted with professionals, key stakeholders and policymakers in these 10 Member States. The choice of Member States was intended to reflect a range of geographical regions and a variety of approaches to law and policy. In total, 143 interviews – a minimum of 13 per Member State – were conducted from April to September 2024 using semi-structured questionnaires, with stakeholders falling into the following categories.

- **Policymakers.** National/local government officials / policymakers / public officials responsible for institutional services (total: 32).
- **Practitioners.** Managers and employees of a public or private, not-for-profit or charitable service provider (total: 31).
- **National human rights bodies.** NPMs, CRPD monitoring bodies, ombuds institutions and NHRIs (total: 18).
- **CSOs.** Victim support organisations and representative organisations (total: 25).
- **Persons with disabilities** who have experience of institutionalisation, either at the time of their interview or in the past (total: 37).

In addition, narrative interviews were also conducted with the 37 persons with disabilities who had experience of institutionalisation.

### *Expert interviews*

The interviews made it possible to have in-depth discussions with a variety of stakeholders who had different perspectives on the subject. Their responses allow for a better understanding of the important aspects of the forms and characteristics of violence against persons with disabilities in institutions and the prevention and protection measures taken across the EU. The findings outlined in this report are derived from the views of the stakeholders interviewed and illustrate, without being representative of, the situation in 10 Member States.

The interviews with key stakeholders in all 10 Member States followed the same guidelines and took the form of a semi-structured questionnaire, allowing for comparative analysis between different stakeholders and between all the Member States covered. Supplementary questions were asked to gather specific information on issues of particular importance depending on the respondents' areas of expertise and activities. The interviews lasted between 45 minutes and 2 hours and covered:

- **violence in institutions in the Member State and the law and policy in place,** including the extent and manifestations of violence in the Member State and the effectiveness of existing law and policy;
- **the monitoring of institutions,** such as the effectiveness of the regulatory and independent monitoring mechanisms in place, the scope of their mandate and the resources available;
- **complaint mechanisms,** including the effectiveness of complaint mechanisms available within institutions for persons with disabilities and formal, informal and independent statuary bodies within the Member State;
- **cooperation and coordination,** that is, the existence and functioning of cooperation and coordination frameworks between competent authorities and actors whose work and obligations relate to persons with disabilities in institutions;
- **challenges in and key enablers of preventing and responding to violence in institutions for persons with disabilities**;
- **ways forward and recommendations,** including suggestions on what practices should be developed or scaled up to ensure the prevention of and effective response to violence against persons with disabilities in institutions.

The quotes provided in this report have been literally translated from the speaker's language to English. The quotes have not been edited and thus may include language and terminology that is not compliant with international human rights standards.

### *Ensuring the participation of persons with disabilities in the fieldwork*

The research methodology used for this project builds on experience and knowledge acquired in FRA's previous work. As part of FRA's multiannual work on the right to independent living of persons with disabilities (2), FRA held dedicated meetings with persons with disabilities and their representative organisations – at the EU and national levels – throughout the fieldwork, from initial planning through to implementation and review. FRA adopted the same method – unstructured narrative interviews – for this research when conducting interviews with people with disabilities who live or have experienced living in institutions.

Unstructured, in-depth, individual narrative interviews were held with persons with disabilities so that they could give a personal account, in their own words, of their experiences of protection from violence in institutional settings. The narrative interview methodology was specifically chosen based on its suitability for persons with intellectual disabilities.

In total, 37 narrative interviews were conducted across the 10 Member States. These interviews consisted of two conversations. The first allowed participants to tell the story of their experience with deinstitutionalisation. The second conversation served to confirm and explore this story in more depth. Prior to the second conversation, the interviewer prepared a story based on the first conversation, which was shared with the participant. The second conversation allowed participants to comment on whether this story accurately reflected their experiences or whether they would like to remove, add or change elements so that the story would be true to their experience.

The overriding human-rights-based principle of doing no harm was respected throughout the data collection process (3), and all national researchers received information from FRA on the safeguards to be applied.

# Endnotes

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FRA EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

# PROMOTING AND PROTECTING YOUR FUNDAMENTAL RIGHTS ACROSS THE EU

This report looks at the breadth and depth of violence and neglect faced by people with disabilities living in institutions. It highlights the shortcomings by EU Member States in preventing violence and protecting those who are at a higher risk of experiencing it, in line with the UN Convention on the Rights of Persons with Disabilities. Based on research across all EU Member States and FRA observer candidate countries, the report calls for better protection, stronger prevention of violence, and clear accountability. It urges the EU and its Member States to implement their obligations around equality and fundamental rights.

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