Fundamental rights protection of persons with disabilities living in institutions

Experiences and views of practitioners and persons with disabilities

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1. EXECUTIVE SUMMARY

Violence against disabled people ([1]) in institutions remains silenced as there is no reliable information or data about the phenomenon in Portugal. The lack of data on the issue emerges as a major problem preventing any estimate of the issue, leading to multiple readings and assessments of the reality and, consequently, impacting in the importance given to the phenomenon by public authorities, human rights bodies, and Victim Support and representative Organisations.

National public institutions/services either avoid assessing the phenomenon, choosing to complexify the reading, or to underestimate it; disability Civil Society Organizations (CSO) assess negatively the phenomenon in Portugal, as a widespread reality.

Three groups of people are identified as having an added risk towards violence inside institutions: 1) people with profound intellectual and multiple impairments unable to verbalise, 2) people with mental illness in psychiatric hospitals, and 3) people with double diagnosis (intellectual impairment and mental health problems).

Experts and stakeholders tend to have a compartmentalized view of violence, whereas disabled people report experiencing different forms of violence and the association between different manifestations of violence. Most common, continuous and interconnected experiences of violence reported by disabled people inside institutions include physical and/or emotional abuse, mistreatment, deprivation of liberty, disrespect, extortion, dehumanization, overmedication, ridicule and mockery.

The association of different manifestations of violence magnifies the psychological impact of the general violence suffered, and this impacts on disabled people's wellbeing and physical and mental health.

Portuguese legal framework enacted for the protection of disabled people against violence is praised for its excellence. This legal framework is, however, compromised in its application due to the big gap between the law and its implementation in practice, i.e. between the 'law in books' and the 'law in action'.

Five main challenges in preventing and responding to violence in institutions for disabled people in Portugal have been identified: 1) culturally dominant ideas of disability and of disabled people – disability stereotypes; 2) lack of training of the different actors and professionals involved; 3) favoured models in the design and governance of disability policies; 4) insufficient and, to a great extent, bureaucratic

([1]) This report uses the term "disabled people" instead of "persons with disabilities," which is frequently utilized in accordance with the language of the Convention on the Rights of Persons with Disabilities (CRPD). This choice reflects the understanding that language is not neutral and aims to emphasize the idea that disability is a form of social oppression experienced by those accredited with any form of impairment. Consequently, it is posited that people do not have disabilities, rather, they are disabled by society.

monitoring and inspection of institutions; and 5) slowness and patronizing views regarding disabled people by judicial system's entities and actors.

Regulatory monitoring mechanisms are under the responsibility of the Institute for Social Security (a public body under the Ministry of Labour, Solidarity and Social Security). The Institute for Social Security conducts two types of monitoring: inspections and follow-up visits. Criminal offenses are forwarded to and investigated by the Public Prosecutor's Office. Independent monitoring mechanisms are ignored by most participants. The study identified two independent monitoring mechanisms: the independent monitoring conducted to institutions for disabled people in Portugal contracted by the European Commission to the University of Porto and the National Preventive Mechanism of the Ombudsperson's Office that monitors the respected for human rights inside places of deprivation of liberty. The effectiveness of the monitoring conducted by the Institute for Social Security to prevent violence against disabled people in institutions is assessed negatively by most participants in the research, due to its focus on administrative and bureaucratic procedures, and reduced concern for human rights issues.

The study identified one independent complaint mechanism specifically aimed at disabled people: the 'disabled citizen's line'. This direct telephone line is run by the Ombudsperson's Office.

Research reveals a lack of accessible information and of advertising of regulatory monitoring mechanisms and independent complaint mechanisms inside the institutions for disabled people. Most institutions rely on internal complaint mechanisms, that include the Complaints' Book and an informal system of complaints, based on oral or written complaints that can be submitted to intermediate professionals (which will take them to the board of directors) or directly to the institution's management.

Cooperation and work coordination is exercised in three main areas and levels. The first is mainly dedicated to inspection and investigation purposes. The second level is dedicated to facilitating the design and development of awareness-raising campaigns directed to specific publics. The third shows that cooperation is highly dependent on the availability of resources (human and material).

2. VIOLENCE AGAINST PERSONS WITH DISABILITIES IN INSTITUTIONS

2.1. Extent and manifestations of violence

The extent of violence against disabled people in institutions in Portugal is difficult to be assessed and impossible to quantify as there is no data collected on the issue and, therefore, there are no statistics. Plus, apart from the general analysis on violence against disabled people in Portugal developed by Fontes ([2]) and by Pinto ([3]), there are no thorough academic studies on the topic. As one interviewee revealed, the European Commission, following a mistreatment complaint summited by a disabled person living in a residential institution in Portugal, commissioned a report to an expert of the University of Porto; this report or its outcomes/results have not been made available to the public. As our interviewee reported:

"[…] we had a process, an investigation carried out by the European Commission, in a joint process between DG Regio and DG Employment, in which they essentially received some complaints […] about mistreatment. […] the European Commission decided to hire an expert in Portugal, a professor from the University of Porto, […]. Several autonomous visits were made, without prior notice, to different Residential Homes […] From these seven reports, very different realities were found, this was clear in the expert's own conclusions." (National policy maker)

As revealed by a national victims Civil Society Organization (CSO) this information is not part of the biographic information collected by them, despite knowing and

([2]) Fontes, F. (2016), 'Violência e crimes de ódio contra as pessoas com deficiência em Portugal' ['Violence and hate crimes against people with disabilities in Portugal'] in Martins, B. S. and Fontes, F. (eds.), *Deficiência e emancipação social: Para uma crise da normalidade*, Coimbra, Edições Almedina, pp. 161-182.

([3]) Pinto, P. C. (2019), 'Gritos na sombra: Relatos de violência contra raparigas e mulheres com deficiência em Portugal' ['Shouting in the shadows: Reports of violence against girls and women with disabilities in Portugal'] in Santos, A. S., Fontes, F., Martins B. S. and Santos, A. L. (eds.). *Mulheres, sexualidade, deficiência: Os interditos da cidadania íntima*, Coimbra, Edições Almedina, pp. 189-212.

following several cases of violence against disabled people inside institutions. Thus, the organisation has no statistics on the phenomena in Portugal.

"I think it is important here to make clear that we [name of the organisation] do not have statistics, we cannot have statistics on disabled people, it is not a statistical element that [name of the organisation] asks in the follow-ups it makes in the support processes and hence, in some way, we cannot, except with very concrete cases that we follow on the ground, understand the reality, if there is, if not. […] It is indeed a matter on which we, because of this scarcity and perhaps punctuality of the cases that we follow, are unable to make sense of it at national level and have a position and be able to see what the picture is at national level." (Representative of a national victims CSO)

This lack of information on the topic became evident when conducting the interviews, especially the ones to people in state coordinating positions, and emerges clearly in our analysis. As the analysis to the interviews of the different stakeholders in the area of disability in Portugal reveal, there is no accurate information about the problem in the country. This is a paramount conclusion that includes: National public officials responsible for regulatory bodies, policy makers, state agencies, local and national disability and mental health CSOs, human rights institutions and victims CSOs. These different stakeholders either: state their lack of information on the issue; underestimate the problem stating that this does not seem to be a particular widespread problem; overestimate the phenomenon, stating that this is a widespread problem; or avoid giving a concrete answer, preferring to distinguish between the different types of violence and introducing nuances in the reading. Policy makers tend to avoid a straightforward answer, choosing to complexify the reading and/or to underestimate the phenomenon, while national and local disability and mental health CSOs tend to portrait a less positive view of the reality in Portugal. The lack of data on the issue emerges as a major problem preventing any estimate of the problem, leading to multiple readings and assessments of the reality and, consequently, impacting in the importance given to the phenomenon by public authorities, human rights bodies, and representative CSOs.

A general analysis evidences that most authorities and representative CSOs agree that disabled people living in institutions are more exposed to violence than non-disabled people. This assessment derives from the supposed added vulnerability of disabled people compared to non-disabled people. This idea of vulnerability is critical for one of the public prosecutors interviewed, for whom vulnerability is the touchstone in this respect, and impairment equates with other vulnerability factors, such as old age.

"I have many difficulties from the point of view, as a lawyer, of accepting disability as a more important vulnerability factor than all the others that can also make people especially undefined. Therefore, a 90-year-old or 80-year-old person may have a

defence incapacity very similar to a young person who has a serious physical disability, but which perhaps allows a defence capacity that an 80-year-old person without any disability does not have. So, for me, I treat people equally, according to their special vulnerability." (Public prosecutor)

Another interviewee representing a human rights body, referring to the specific case of disabled people living in prisons, educational centres, forensic psychiatric units and other places of deprivation of liberty, also states that it is not impairment *per se* causing situations of undignified treatment, it is a general trait affecting most people in places of deprivation of liberty.

This is especially problematic, coming from institutions and bodies responsible for investigating, prosecuting and overseeing human rights in Portugal, in the context of existing research developed in the areas of Criminology and Disability Studies evidencing disabled people's higher risk and incidence of violence ([4]). It has been estimated that disabled people are 1.5 times more likely to experience violence than non-disabled people ([5]).

Regarding the impact of personal characteristics and of the type and degree of impairment on the experiences of violence, the interviewees raised more concerns towards three groups of people that according to them may have an added risk: 1) people with profound intellectual and multiple impairments unable to verbalise, 2) people with mental health problems in psychiatric hospitals, and 3) people with double diagnosis (intellectual impairment and mental health problems). The first, since they have more support needs, require more support from staff at institutions and are unable to verbalize, are more vulnerable to abuse. The second, due to the dominance of medical diagnosis over people's may have their freedom and autonomy limited and

([4]) See, in particular: Emerson, E., Roulstone, A. (2014), 'Developing an evidence base for violent and disablist hate crime in Britain: Findings from the life opportunities survey', *Journal of Interpersonal Violence*, Vol. 29(17), pp. 3086-3104; Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T. and Officer, A. (2012), 'Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies', *Lancet*, Vol. 379(9826), pp. 1621-1629.; Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., Bates, G., Mikton, C., Shakespeare, T., and Officer, A. (2012), 'Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies', Lancet, Vol. 380(9845), pp. 899-907

([5]) Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T. and Officer, A. (2012), 'Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies' https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61851-5/abstract, *Lancet*, Vol. 379(9826), pp. 1621-1629.

their human rights suspended. This is particularly acute, according to one of our interviewees, as there seems to be a reversion in terms of old medical practices, with the return of electric shocks as an accepted medical practice inside psychiatric hospitals. According to this interviewee, this practice affects mostly women over 60 years old. An interview conducted with a mental health survivor is particularly alarming with regards to the suspension of people's civil and human rights. As this interviewee reported:

"This came about because I want to seek help, I want to have a second opinion, which was one of the things that cost me the most internment and when I went to court, halfway through my hospitalisation, I went to court because I asked. I couldn't get the information. I was in hospital, I didn't understand why, and there was information from the court, or from the Public Prosecutor's Office, from whoever orders the hospitalisations, that never arrived. I had no access. I couldn't complain, I didn't have access to anything, I didn't have my mobile phone. The phone wasn't working. I've had a number of days where I've been uncontacted." (Person with a disability)

The third group people with double diagnosis (intellectual impairment and mental illness) – is presented as the main challenge for institutions, due to the newness of this reality that makes them unprepared to guaranty the respect of people's dignity and to the lack of adequate support from the health sector. As the interviewees from national and local disability CSOs stated, the residential institutions for disabled people are not prepared to deal with mental health issues. As one interviewee summarises:

"In fact, organizations are not prepared, many of them, like us, for this new reality [refers to the increase of mental health problems within people in their residential homes], and this also causes internal stress in organizations, doesn't it? Because, suddenly, they have to change the chip, or add one more to what is your answer and what is your specialization and answer, right? And, in fact, it's also stressful for us as an organisation to have to deal with a situation like this. And then not having that support from the health department. Time and time again, we've asked for health support, in terms of follow-up, and the answer is: 'There are no resources. Be patient. There are no resources.' So, what do we do? Do we put the kids outside the emergency room, or do we throw them out, because they're destroying everything in here? If they have access, do they destroy everything they catch in front of them? And who pays?" (Manager of a local disability CSO)

Moreover, as the interviewees, also, alerted, this may cause higher levels and a diversification of the forms of violence:

"What we were often faced with was that the person could be suffering enormously from the point of view of their mental health, suffering enormously, but then, in a way,

even the health sector understood that this was the result of being a person with multiple disabilities and this didn't allow us to act in a way that ensured better conditions and more dignity for people." (Representative of a national disability CSO)

Looking at the different manifestations of violence, the prevalence of physical violence is underrated by most of the interviewees, arguing that this form of violence has decreased substantially over the years and gave rise to 'other forms of violence', 'subtle forms of violence', 'undignified treatment', or 'erratic approaches' from professionals. The latter, referring to attitudes, behaviours and conducts by the professionals that disrespect disabled people's dignity and human rights and compromises their wellbeing and security. Not denying a change in the violence pattern observed in institutions for disabled people, this assessment of the interviewees seems to be, at least, partly contradictory to the cases of violence they report. In fact, our interviewees reported mostly cases involving physical violence:

"It was [a case of] physical violence against a young man who was behaving a bit uncontrollably, he was tied to a chair, so he was tied to the chair, and, at some point, the staff member slapped him. So that was it. [...] He was fired immediately. [...] It was physical violence." (Manager of a local disability CSO)

"The last case I received was from a person, this was four months ago, was from a collaborator who reacted to a client who has a double diagnosis, who sometimes has moments of crisis, and slapped the professional and the professional thought that the way to react was to return a slap, ready." (Representative of a national disability CSO)

The analysis reveals and the reports of disabled people highlight that, violence manifests in different ways, isolated or concatenated. As evidenced by the data collected in the interviews, experts and stakeholders tend to have a compartmentalized view of violence, i.e. their interviews report and focus on isolated forms of violence, disabled people report experiencing different forms of violence, that in most cases emerge associated with one another. In fact, abuse, mistreatment, deprivation of liberty, disrespect, extortion, dehumanization, overmedication, ridicule and mockery are common, continuous and interconnected experiences reported by disabled people inside institutions. Disabled people interviewed have paradigmatic experiences on this respect.

Case 1

One of the respondents, a woman with a physical impairment living in a residential home for disabled people, since early adulthood, reports a wide range of types and episodes of violence directed at herself and at other residents of the institution.

Psychological violence is reported as a continuous day-to-day phenomenon. This form of violence is exerted through the imposition of decisions that go against her will (and those of other residents), and through the professionals' indifferent attitudes towards her specific needs.

"And they also often say: 'Now's not the time to pee!'. Like, it's lunchtime and you think: 'Oh, I'm dying to go to the loo!'. 'Now is not the time to pee!'. […] You have to be grumpy; you have to scream, you have to be loud, you have to be nervous. Once you're very nervous, you can do it there. Can you imagine what this is every day?" (Disabled person)

This quote alerts to another form of violence, i.e. the abuse of power by workers. As narrated by the interviewee, this violence manifests, mainly, in a lack of flexibility to residents' wishes and decisions, and in the imposition of timetables for activities. Lack of care and negligence in the provision of care, emerges as a more episodic form of violence but anyway present. It is visible in the reported episodes of non-provision of food to residents as a form of reprisal or in the narrated episodes of indifference and non-provision of adequate care/support by professionals. Reprisals, personal persecution, intimidation emerges as another continuous form of violence, aggravated by the described connivance of the institution's employees and local community services. According to this interviewee, there is a pattern of reprisals, intimidation and internal harassment against residents who express disagreement with the management's decisions, and/or who complain about the quality of the services or the lack of competence of the professionals working in the institution. The isolation from the outside is described as a later adding to the initial forms of violence, emerging after the end of the second COVID-19 lockdown. She describes being isolated from the outside world without being able to contact or being contacted by people outside the institution, and the impossibility to receiving visitors in her bedroom.

Case 2

A man living by himself with a diagnosis of schizophrenia and with the experience of being hospitalized in a psychiatric ward, reports several episodes of violence and of violations of his civil, political and human rights. He reports being compulsorily admitted to a psychiatric hospital. He described being tied by the clinical team on his arrival to the service, after what he recounted being given an injection and forced to take two pills against his will, that cause him to "blacked out" for three days without any memory for this period. During hospitalization he reports being overmedicated, without any information and without his consent, that caused him to be frightened and outraged by this lack of control. As he explained:

"The medication was changed without anyone talking to me, inside the hospital. One day I'd take five tablets at night, the next day seven. I had to ask what they were; I didn't even know what they were. It came in a little cup, they poured it into my hand. And I had to take them. I didn't know what those two were. 'It was the doctor who changed it'. 'You have to talk to me, you can't change it without talking'. […] But they can do whatever they want. Any attempt on our part to argue, to question, is seen as sickness." (Person with a psychiatric diagnosis)

Moreover, he reports being isolated from the outside world, not being able to access a mobile phone, and later when he did it, access was very restricted. He describes this experience as an imprisonment against his will. After a first attempt to leave the ward, in which he demanded and was present to a judge that confirmed the medical diagnosis and reiterated the decision on compulsory hospitalization, he reports receiving more medication (injectable medication on top of oral medication), what he interprets as a form of reprisal for going to court and a medical strategy to make him more docile and less demanding. As he described, he only managed to be discharged from the psychiatric hospital ward, after realising his lack of power and deciding to become more docile and stop complaining. The proposed medical discharge contained, however, what he described as "blackmail", as the doctor obliged him to sign a document committing himself to taking a monthly injection and being an outpatient. As he words it:

"I accepted everything, I stopped questioning, I signed the paper. It was the paper for freedom, which, even if it was limited, was better than that context." (Person with a psychiatric diagnosis)

Case 3

A woman with multiple sclerosis currently living at her own place with the support of a personal assistant, funded by an independent living service but with an ample experience of Long-term Care Units ([6]), reports a wide range of undignified situations and episodes of violence. Constant exposure of body intimate parts, lack of privacy and psychological violence emerges as the most common and continuous forms of violence

([6]) The National Integrated Continued Care Network (RNCCI) was created in Portugal in 2006, with the aim of supporting people who, regardless of age, are in a situation of dependency requiring long-term care and social support. In this field, there are several typologies of residential units: Convalescence Units (for stays up to 30 days); Medium Term and Rehabilitation Units (for hospitalizations of between 30 and 90 days); Long Term Units and Maintenance (for stays of more than 90 days). The interviewee's three experiences were in Long Stay and Maintenance Units. For more information, see the Institute for Social Security's website.

experienced by the respondent. She reports lack of respect for her intimacy and privacy, with her body constantly being exposed to different eyes and talked and mocked in the corridor by untrained and insensitive staff.

“The staff make fun of a situation that isn't meant to be made fun of at all. […] The conversation in the corridor got to the point where they were discussing whether I had breasts or not.” (Disabled person)

The respondent also describes limitations of autonomy, lack of security and bad quality of life inside these structures, mainly due to problems with the infrastructure and logistical conditions. As she reports, the buildings of the three institutions she lived in, presented structural problems that jeopardised the wellbeing and safety of both patients and staff, and the autonomy of the residents. The lack of food security was also described as a serious problem of some of these units, even causing the interviewee severe health problems.

Lack of care, negligence, rigidity and standardisation in routines have been reported by multiple respondents, in their opinion these issues are mainly due to a lack of human resources and a lack of adequate training of the existing ones. In the case of one respondent, this lack of staff mirrored in the poor quality of hygiene care and healthcare, as well as in the rigidity of times and routines. Moreover, the above interviewee reports restrictions on her freedom to exit the institution and receive medical care outside. As she described, despite the institution's regulation allowing her to leave, the clinical staff was not very receptive to it, to the point that she missed a medical appointment at the hospital due to the difficulties created for her to leave. Finally, the respondent described a general low quality in the provision of clinical care to deal with the specific needs of her medical condition with a great danger of jeopardising her health and putting her life at risk.

Case 4

Another man with a physical impairment (quadriplegia), who currently lives at his own place with the support of personal assistants and leads a professional active life, lived for several years in a care home for elderly people. He reports this experience as one of the ‘most terrible’ and sad episodes of his life. This traumatic experience, as it is reported, resulted from a lack of alternatives in the community. The respondent reported a huge variety of phenomena and episodes of violence experienced by himself and/or witnessed. His interview details a myriad of situations, including: infantilisation; rigid discipline/rules; loss of financial independence; control of residents' money and blackmail for the purchase of goods (for example, only buying clothes or cigarettes to the residents if they ‘behave well’); depersonalisation/loss of individuality (marking of clothes with numbers, seeing other people dressed with his

clothes, impossibility of choosing which clothes to dress); loss of freedom of movement; lack of security in the protection of personal property (the constant theft of belongings by staff members); disrespect for the cultural specificities of the users (for example, giving beef to an Hindu person, but saying it was turkey); a ban on love relationships and sexual life; abuse of power and authoritarianism by the staff (with reprisals against those who make demands or complaints). Moreover, he also reports psychiatric overmedication (to make the person quiet); inadequate/violent forms of communication by staff members (shouting, mockery, general disrespect); lack of hygiene care, negligence in care with impact on his quality of life, but that also jeopardise the dignity, self-esteem and even the health condition of the residents. The respondent's most traumatic experience at the institution had to do with the way in which the staff managed his bowel issue. As he describes:

"[…] my big concern was bowel training. [...] When it came to faeces, in order to avoid wearing nappies and to lead as normal a life as possible, every other day we each took a laxative in the morning and a suppository in the evening, and we stayed in bed. Those who couldn't get into the shower chair and then into the toilet, defecate and then take a shower, had to do it in bed. And that's what they did there [in the care home]. [...] For me, what makes sense for all of us [people with quadriplegia] is that when we put the suppository in, we have to put the suppository in half an hour before, the person has to be with us half an hour after, because we have slight sensations, they put us in a chair that has a hole, which is the toilet, which fits into the toilet, it's much more dignified for us to defecate directly into the toilet [...] And then, what happened there was, 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. If we're with other mates in the room, it's awful, because the others go through all that, they know what's going on with 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. And I never felt that I had proper hygiene. It was horrible. I felt super unpleasant. To this day, I still have a thing when I put perfume on, and I also put it here, on these parts, on my genitals, and I always get the feeling that it might be dirty or that people are going to smell it, because they did." (Disabled person)

Again, this interviewee's narrative is fertile in different forms of violence and how these forms relate to each other and their connections with structural problems common to the Portuguese institutional landscape.

Case 5

A second man with a physical impairment interviewed (quadriplegia), who currently lives alone in his own home with the support of domiciliary care services and a personal assistant, spent a couple of years in two different care homes for elderly people after his main carer passed away due to a lack of family and community support. His narrative, also, evidences several episodes and phenomenon of violence, from constant exposure of body intimate parts to different people due to the high turnover of professionals; to the disregard of the physical violence inflicted on him by another user who punched him in the face leaving him bleeding and his face swollen; to the submission to inadequate care practices putting his life at risk, by, for example, imposing him the use of a permanent urinary catheter insert through the urethra, which may cause septicaemia, as it happened to him in the past. But this respondent's case is paradigmatic of the imprisonment to which some of these institutions force its users. As he reports, in the first care home, after an incident testified by him that compromised the care home's reputation, he was banned from leaving the institution, even during the day to get medication from the local pharmacy:

"[...] they thought I was probably going to [tell people what I'd seen]. I'm not like that, I'm very, very quiet. So, they immediately tried to ban me from going out. I wanted to go to the pharmacy to get my medication. The XXX [person in charge] there [...] immediately forbade me to go and get my medication. [...] 'We'll buy it, and you'll pay for it at the end of the month,' she told me. But their medicines aren't at the price we go to the pharmacy to buy, they're always inflated." (Disabled person)

He ended up moving to a second care home, where he lived for a similar period. In this second place, with no institutional connection with the first, he felt even more deprived of his liberty. Again, he was not allowed to leave the premises of the care home for, allegedly safety reasons, and he felt completely isolated as he couldn't have a conversation with the other residents as most of them had dementia.

"Most patients are patients with Parkinson's, Alzheimer's, psychological illnesses and strokes. There's no communication, why? Because I'm a communicative person. I went there when I was XX [age of the respondent] and my intellect was intact. So, I had an impairment, I wanted to leave the home in my chair to go to [name of the village], [...] I was forbidden, they wouldn't let me leave. I was in a prison, let's say, where I didn't have anyone to talk to because nobody understood me [...]. I was a prisoner, I was a prisoner who hadn't committed any crime, I don't have a criminal record, I don't have anything. […] in their minds, they thought I didn't know how to ride an electric wheelchair, they'd never seen an electric wheelchair, it's going to spread and then [name of village] is also a medieval village, a bit medieval and it also has problems with

inclusion, with accessibility. But I know what a one-way street is and what a no-way street is, I know that very well." (Disabled person)

Despite his efforts and written demands to the president of the institution to leave permanently this care home, the respondent reports that his letters where never answered and that he only managed to leave the care home after he phoned a prominent friend that contacted a local politician and interceded on his behalf.

As it is possible to conclude, the combination of these different manifestations of violence, that commonly occur in the lives of disabled people interviewed, magnifies the psychological impact of the general violence suffered, and translates at physical level into the wellbeing and health of that person.

2.2. Effectiveness of the existing legal and policy frameworks

Existing legal framework enacted for the protection of disabled people against violence is regarded of high standard by most experts and stakeholders interviewed. These interviewees majorly praise the excellence of Portuguese legal framework and, specially, of the Portuguese Constitution, described as one of the best in the world. It is, however, worth nothing that less positive assessments of Portuguese legal framework in this area derive from representatives of national and local disability CSOs. As it is stated, violence against disabled people living in institutions is not effectively addressed within the existing legal and public policy framework in Portugal. Interestingly, a policy maker interviewed, seems to support this conclusion, when questioning the existence in Portugal of legislation addressing this specific issue:

"CES – […] in your opinion, the issue of violence against people with disabilities living in institutions is dealt with effectively in legislation and public policies in Portugal? Or are there gaps that would need to be addressed?

INT – I don't know if I have enough information to answer that. My sensitivity tells me that we don't exactly have specific standards that address this specific topic, within the phenomenon of violence." (National policy maker)

Representatives of national and local disability CSOs identify several gaps and problems in the existing legislation, namely: a gap in terms of instruments aimed at prevention, training and action; the absence of a culture of preventing abuse and mistreatment; and the fact that it promotes an institutional culture rather than an

organisational culture. By the latter, the representatives of disability service providers mean that existing legislation favour a culture of institutionalisation very standardised and rigid in terms of responses, not allowing each organisation to develop services and answers more flexible and adapted to the needs of the surrounding community, that would allow to create this organisational culture.

Despite the positive assessment by most people interviewed, they all highlighted, however, the big gap existing in Portugal between the law and its application, i.e. between the 'law in books' and the 'law in action'. As described the application of law in Portugal is very often compromised by a lack of material and human resources. This assessment emerges mainly from those that are public officials, responsible for public services, as they refer there is no lack of legislation, what they experience is a lack of resources to enforce the existing law. Several examples were provided during the interviews regarding the different services involved in the enforcement of law as well as in the monitoring and inspection of the institutions, these are included in the main challenges in preventing and responding to violence in institutions (please see section 2.3).

Worth noting is also the contradictory perspectives, from two different public bodies, regarding a Dispatch of the Prosecutor General of the Republic, dating from the 22 March 2023 ([7]). This Dispatch was described by a Public Prosecutor interviewed as an important advance in the Portuguese justice system, as it gave the Central Department of Investigation and Criminal Action (DCIAP) legal competences to investigate and prosecute crimes of ill-treatment against 'especially vulnerable people' (interviewee's own words) living in institutions and allowed DCIAP to collect information at national level, contrary to the past where this information was disjointed and scattered. Another public official, in a state coordinating position, referred that this dispatch created confusion regarding who has competences to investigate mistreatment. Moreover, it is argued that this Dispatch centralized the work and responsibility on one single Prosecutor and, therefore, created an excessive volume of work and a delay in resolving cases.

Finally, there are general criticisms to disability policies, not specific to the issue of violence against disabled people, but with potential impact on the area. A first general criticism relates to the lack of definition of the concept of community by the law and/or policy documents. As reported, the policies and legal documents refer to the movement towards the community and interventions in the community but do not define what 'community' means, with clear impacts on people's inclusion in the community.

([7]) For more information, see the website of the Public Prosecutor's Office.

"[…] policies say that people have to go to the community, but they don't specifically define what community means. Therefore: 'No! Mental health goes to the community', but they don't specify. […] They say, but do not define, what community is. Therefore, the community has to be what is defined. And what happens? Sometimes violence, abuse and coercive practices happen because this has not been defined. So, there is a whole set of organizations and practices that are thought to belong to the community, right? But that is, once again, a way of..., but that does not guarantee that the person is being included in the community. The person is in the community but is not part of the community." (Representative of a national mental health CSO)

A second general criticism relates to the model favoured in the design and governance of disability policies in Portugal, namely its favouring of an institutional culture and solution for the lives of disabled people and the model of cooperation established between the state and the third sector, that in Portugal is responsible for operating most of the disability services, including residential homes. This has been included in the main challenges in preventing and responding to violence in institutions (please see section 2.3).

2.3. Main challenges to and key enablers in preventing and responding to violence in institutions for persons with disabilities

The research findings point to five main challenges in preventing and responding to violence in institutions for disabled people in Portugal: 1) culturally dominant ideas of disability and of disabled people – disability stereotypes; 2) lack of training of the different agents and professionals involved; 3) favoured models in the design and governance of disability policies; 4) insufficient and bureaucratic monitoring and inspection of institutions; 5) slowness and patronizing views of disabled people by judicial system's entities and agents.

Culturally dominant stereotypes of disability emerge as one of the main challenges for preventing a responding to violence against disabled people in institutions. Despite a lack of operationalization of these stereotypes by interviewees, they emerge in the description of the manifestations of violence offered by disabled people, and in the description of specific cases made by national and local disability CSOs. These

stereotypes include dehumanised understandings of disabled people and underestimation of their capacities. Disabled people are, thus, understood as less human, innately dependent, childlike and their rights are, therefore, reduced. This explains the mockery described by the aforementioned respondent about her body by the staff in the corridors of the care unit (please see case 3 in section 2.1.), the disregard for another interviewee's demand and voice and total reliance on the medical report and voice of the judge to whom he was presented during his involuntary hospitalisation (please see case 2 in section 2.1.), the staff abandonment reported by a third respondent after an accident with a support equipment that injured her body and left her bleeding (please see case 1 in section 2.1.), as well as the slaps given by professionals to disabled people inside institutions reported by national and local disability CSO representatives interviewed. As the analysis of the different interviews revealed, the combination of these biased ideas about disability and disabled people, with the lack of training of the different professionals and agents involved and with a dominant hierarchy of power that disregards disabled people's voices and their opinions, is at the root of most of the violence experienced by disabled people.

The lack of training of staff emerges in disabled people's interviews and their description of care provided, and in the interviews conducted to national and local disability CSOs about the difficulty of hiring and maintaining professionals at the institutions due to the low wages practiced, unappealing career and demanding and exhausting physical activities. As these organisations report, there is a high turnover of professionals at these institutions with a direct impact on disabled people's exposure and violation of intimacy (please see 2.1.) and the difficulty of the institutions to continuously provide and fund training for new professionals.

The interviews also reveal that part of the problem relies on the model favoured in the design and governance of disability policies in Portugal. As described, the current model favours bigger and centralised institutions due to economic efficiency, rather than arrangements targeting to ensure disabled people's autonomy, decentralisation and proximity to families, less people and smaller units, and a move towards independent living. As advocated in some interviews:

"[…] this violation [the interviewee refers to the violation of a women with a mental impairment at a psychiatric hospital by another patient reported by the media] continues because we continue to see these structures. And as long as these structures exist, between walls, right? Coercive practices will always continue; violence will always continue. Why? Because the reason, for example, why domestic violence is a public crime, is because it is in the eyes of the community to know how to resolve and intervene in these issues. When we close these people away, we stop considering them

human beings who participate in society, and we lock them up in institutions, what happens is that these practices can happen, and be justified by the lack of professionals or lack of resources." (Representative of a national mental health CSO)

"[…] I think there are only two instruments against... […] Which is the closing of institutions and creating mechanisms for independent living." (Representative of a national mental health CSO)

"I am not very much in favour of this model of cooperation. I am not in favour of institutionalizing people. […] what the state spends in cooperation, would spend less, and people would be happier and better treated, if families were supported and watched over. I think it's a very cold model." (Public official in a state coordinating position)

Another challenge identified has been the insufficient and bureaucratic monitoring and inspection of institutions, under the responsibility of the Institute for Social Security (this issue is further developed in section 3.1.).

Moreover, the mandate of the monitoring and inspection responsibilities of the Institute for Social Security does not include violence against people inside the institutions as this is a criminal offense. As reported, when there are signs of violence, the matter is by obligation passed on, within ten days, to the Prosecutor's Office, who investigates it further:

Finally, regarding the judicial system, the main challenge identified is the delays in the processes. One interview conducted with the representative of a local disability CSO, reveals a case reported to the Public Prosecutor's Office three years ago with no result yet. This fact is confirmed in the interview with a disabled woman with an experience of violence in her residential home. As she reported, with great disappointment for the length of time taken without an answer to her case, she filled a complaint to the Public Prosecutor's Office a couple of years ago against her residential home for mistreatment and violence, without being able to get information about the progress of the case or checking its status after all this time. When we conducted the second interview the only information, she had managed to gather about the case, was that the Public Prosecutor's Office had already interrogated some of the employees she named as witnesses. This difficulty was partly confirmed by the words of a public prosecutor interviewed:

"[…] is there a lack of resources? There is. I have thousands and thousands of cases to be dealt with, in specialised chambers, dealing with violence against people, and they're just not being dealt with because there are no judicial staff." (Public prosecutor)

Later, during the interview, this participant contradicted, however, his/her previous words and those collected from other interviewees, by stating that he/she doesn't believe this is a problem in Portugal.

"The issue of slowness in the position of justice, I don't think it will be so much about these cases, because in general, we even manage to speed things up when we have victims who are particularly vulnerable and particularly vulnerable because of some kind of disability. I'm not saying that they can't exist, but there haven't been any major cases." (Public prosecutor)

Another challenge identified, refers to the way judges and courts interpret and impose the law, described as evidencing a patronizing view of disabled people and of their capacities. This resulted in several cases of workers from disability institutions dismissed for being "grossly negligent or even mistreating" having to be re-employed due to contrary court decisions. Moreover, judges and court decisions are criticised for being biased towards medical professionals and reproducing a hierarchy of power that prioritizes medical voices and disregards disabled people's voices and the opinions of disability institutions. This seems to be confirmed by another interviewee's reported experience when he was presented to a judge during his involuntary hospitalization in a Psychiatry ward. As he described, in the court room the judge read the medical report and said the decision to keep him hospitalised would stand. As the interviewee reasoned in our interview:

"The doctor's voice had much more power than anything I could say. The doctor told me that the hospitalisation was ordered by the judge. But the judge made the order based on the doctor's opinion. The doctor sends it to the judge, and the judge sends it to the doctor. I felt like I was in that game of push and shove." (Person with a psychiatric diagnosis)

List of main challenges identified by the participants.

- Patronizing and biased understandings of disability and of disabled people.
- Lack of training of the professionals working in residential institutions for disabled people.
- Disability policies dominated by a culture of institutionalization.
- Cooperation model between the State and third sector organizations.
- Procedural delays and patronizing views of disabled people by judicial system's entities and agents.

List of key enablers identified by the participants.

- Enhancing human rights literacy - such literacy should be aimed at all the actors involved in organisational contexts, i.e. managers, professionals, families, the community and disabled people. Literacy involves empowering disabled people to claim their rights and to have easy access to complaints mechanisms.
- Training and capacity building, giving a prominent role to survivors of violence who can contribute through their experience to the empowerment and advocacy of disabled people.
- Training of professionals on violence prevention – "To ensure the effective use of these tools, all professionals working in organisations providing support services to people with disabilities should receive mandatory training on violence prevention and the use of the tools available for this purpose" (Representative of a national disability CSO).
- Designing and improving tools to identify violence and enhancing knowledge and accessibility of reporting tools, as well as continuing to monitor the effectiveness of their implementation.
- Producing guidelines around violence against disabled people in institutions and defining action protocols to cover different risk situations.
- Establishing cooperation protocols between victim support services, justice professionals and disability service providers to provide an effective response to disabled victims with disabilities and optimize between services.
- Developing of awareness-raising initiatives on violence directed to disabled people, institutions and families.

3. MONITORING OF INSTITUTIONS

3.1. Effectiveness of monitoring visits

Regarding the existing regulatory monitoring mechanisms, the participants reported that they were only aware of visits carried out by the Institute for Social Security (a public body under the Ministry of Labour, Solidarity and Social Security).

The general assessment of the monitoring effectiveness of the Institute for Social Security was highly negative. Most criticisms were voiced by representatives of local and national CSOs, and by disabled people who have experienced violence in institutions. Least critical assessments originate in public officials who occupy or have occupied coordination positions, with national level competences, i.e., more distant from the ground/direct work with disabled people.

The monitoring practice delivered by the Institute for Social Security is assessed as ineffective in preventing violence and/or in promoting services of quality. As several participants explained, this model is based on 'follow-up visits', that are announced in advance, and focus on administrative and bureaucratic procedures, without any concern for human rights issues. This is evidenced by a disabled woman interviewed, when she describes that she used to hear staff commenting that the institution was going to receive a monitoring visit, and to watch everyone moving around to offer a good image of the facility. However, as she stated, after the monitoring visit everything went back to normal and there was no improvement in the way the institution worked.

"[There were monitoring visits], but everything was prepared for the visit. Things were cleaner, the intention was to show better organisation. That day, I knew, because the assistants were talking to each other. [Monitoring visits] exists, but in practice it doesn't have any beneficial consequences for the way things work. […] Although you can't change much, but everything was more organised, cleaner. 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." (Disabled person)

As reported, mostly by representatives of local and national disability and mental health CSOs, unannounced inspections by the Institute for Social Security result from complaints, reinforcing the previous idea that inspections are reactive rather than proactive or preventive. Moreover, inspection actions and monitoring visits, i.e. follow-up visits, are similarly focused on administrative/bureaucratic matters. Two professionals who hold management positions in a local disability CSO reported that

their institution was only inspected once, and that the issue of violence and discrimination was not addressed.

"[Participant.1] As I'm telling you, the issue of violence, discrimination, whatever, all these issues are never addressed. [...] They're not discussed during monitoring visits. They weren't in this inspection, and they weren't in the follow-up visits either. [Participant.2] [...] They come to look at the files. Everything that isn't in the legislation, all the criteria, what we have to comply with, is administrative." (Managers of a local disability CSO)

The Institute for Social Security reported reduced capacity to carry out proactive inspections. As reported, unannounced monitoring actions, *"most often, [take place] in the event of a complaint*" (public official in a state coordination position). Outside the complaint context, the aforementioned 'follow-up visits' prevail as the most common monitoring mechanism. The lack of human resources is pointed out as a major constraint that limits the capacity of the Institute for Social Security to adequately fulfil its monitoring role. Financial constraints that prevent the hiring of new inspectors, but also the difficulty to attract and retain these professionals, are also advanced as constraints. As it was clarified the Inspection Department of the Institute for Social Security has to attend cases in the entire country and in the different areas of social care (disabled people, the elderly, children, etc.), as well to institutional offences against the Social Security (fraud, swindling etc.). Moreover, this department is reported as having a shortage of human and material resources. As a participant from a human rights institution mentioned, in a recent newspaper report it was published that the Institute for Social Security had, only, one car and three professionals available to monitor all the nursing homes in the entire Algarve region (a region in southern Portugal).

"Just recently I saw news in the press about the limited resources of the Social Security inspection department. They were talking about inspecting nursing homes. […] They realised that in the whole of the Algarve there was one car and three people, something like that […]." (Representative of a human rights institution)

Furthermore, information gathered from the different participants confirms this administrative focus of the monitoring procedures developed by the Institute for Social Security. As it is blatant, the inspection is administrative and aims to assess the functioning of social responses, plus, the visit/inspection follows a script to thoroughly cover all the issues of compliance with the law, from hygiene and quality of the food to staff qualifications.

"[The] competence is to evaluate the functioning of social responses. […] [to] say if it has adequate human resources, according to what the law prescribes, if there is hygiene and food safety […] guided by [a] script, precisely […] not forget anything that the law provides." (Public official in a state coordination position)

In fact, the biggest weakness identified by most interviewees in the visits/inspections of the Institute for Social Security was the focus on administrative procedures, as well as on the requirements of the social responses to comply with the legislation (interpreted, very often by participants, as unrealistic logistical demands), rather than disabled people's well-being and protection against violence.

"[…] the results of the [monitoring] visits are, let's say, okay, opportunities for improvement or corrective actions: 'the regulations weren't printed and posted on the wall in three copies, the timetable wasn't posted I don't know where, article 5.3 of the internal regulations doesn't comply with the general law on Private Social Solidarity Institutions'. Bear with me!" (National policy maker)

"[…] what happens is that [these monitoring visits] often fall back on procedural and administrative issues, such as checking that contracts have been signed, checking that files have been organised. […] that has nothing to do with the contact and relationship that should exist from the point of view of the approach of the professionals, the approach to the people we support […]." (Representative of a national disability CSO)

"I had 50 customers […] 25 are men, so I do the math for 25 men, that is, I only needed 3 urinals […] it was rejected because I had to have twice as many urinals […] "So, sir, if 50% are men and 50% are women, I only have 25 men, therefore, 25 men, I don't need to have 50 urinals, because women don't use them!" "Ah, you're really right, let's take half of it! But you have to have both bars!" And I: "But what do I need two bars for […] those who are in wheelchairs don't even use the urinals, but let's suppose we even have someone who goes there (…) You can only hold it with one hand because the other has to be holding the thing, right?" That's it, and I managed to get him to leave me with just one bar […]." (Manager of a local disability CSO)

Indeed, many participants – mostly representatives of local and national disability and mental health CSOs) – were very critical about the fact that the Institute for Social Security's visits/inspections did not give any importance to human rights issues and preventing violence against disabled people living in institutions. Managers and practitioners interviewed in this study explicitly said that they had never been approached about these issues during the monitoring of their institutions. A manager of a local disability CSO that provides residential services for disabled people expressed his/her regret at this omission, saying:

“[The Social Security] is funding something for which it is not responsible, morally speaking.” (Manager of a local disability CSO)

One of the explanations given by another manager of a disability CSO is that these issues are not in the script of the Institute for Social Security's inspectors: “It’s not even in the script”.

It was widely reported by participants, from the different groups, the general lack of human rights training of the Social Security's inspectors/technicians. The absence of this training is identified as a major weakness of the current monitoring model, which, along with the other fragilities mentioned before (e.g., the lack of human resources and the fact that inspections follow a strictly administrative script), is seen as a contributing factor to the inattention to issues of violence. On this point, several participants argued that such training should be considered a public policy measure. One interviewee, representing a national disability CSO, said:

“I'll also say this: on the Social Security side, many of the monitoring visits are carried out by professionals who are not at all prepared for a monitoring visit. […] we also need, on the public policy side and on the Social Security side, to prepare teams to be able to identify signs, to realise that there are signs, that people's rights are being compromised. And 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, obviously with diagnostic tools and above all with professionals who are prepared to act and see where there are signs of abuse or signs of violence or signs of mistreatment.” (Representative of a national disability CSO)

Disabled people's narratives present another criticism to the way the monitoring of institutions is carried out. As it is described, during their visits, the inspectors/technicians from Social Security do not speak to the people that live in these institutions, they only interact with managers and senior professionals.

A disabled man interviewed is very elucidative about this issue, plus, his report describes the passivity of the inspectors towards the infantilization of the users and the disrespect of their intimacy and dignity by the managers of the institutions.

“[The technicians from the Institute for Social Security] had to go to the room to see why the person was bedridden and talk to the person separately. [They don't talk to people.] They usually go, with the technical director, to the room where all the children [the interviewee is purposely mimicking the language used by the director] are: ‘Are the children well? Good morning’, just like at school. [...] The inspector doesn't speak. It's

the technical director who comes to the front: 'Good morning, children. Hello, and I don't know what. Super malformed. They have no ethics. For example, imagine, and then talk about the problems: 'So, are you wearing a nappy tonight? So you've got a little thing on your testicle? Do we have to take care of that?' in front of everyone at mealtimes, especially when everyone is sitting down. 'So you fell over last night, did you? What did you do? What have you been up to?' In other words, they talk about everyone's intimate problems in front of everyone." (Disabled person)

The words of another disabled woman with a long living experience in a residential institution are, also, very elucidative. As she recounted, on one occasion after the many abuse and violence complaints (which even involved the police authorities and the Public Prosecutor's Office) submitted to Social Security, the inspection visit maintained the focus on administrative issues and did not speak with the residents (victims of mistreatment). This fact led the respondent's legal representative (present at the time of our interview), that felt outraged by the situation, to confront the inspector directly. The reply of the inspector is enlightening.

"So, Social Security went there, but they didn't listen, they went as if they were going to inspect the building. And I complained and said: 'I'm sorry, but she filled the complaint, you only heard the Institution's side, you didn't hear the other side and, secondly, in the inspection, you [didn't hear the residents]'. And she replies like a yardstick: 'I don't have to listen to them!'." (Disabled person's legal representative)

Moreover, in another situation, following another complaint, the technician of the Social Security suggested her to leave the institution and look for another place to live.

"And they even invited me to look for another institution The Social Security technician [asked me]: 'Have you thought about changing institutions?' […] And I replied: 'But am I the one who's wrong?'." (Disabled person)

Other comment in relation to the effectiveness of inspections in the context of psychiatric institutions include the lack of familiarity with the concepts of *community mental health* and *recovery.* According to a representative of a national mental health CSO, this means that the monitoring actions often reproduce the logics of institutionalisation. A particular challenge is the fact that inspections often require economic resources to be applied according to standard operating logics, which do not respect people's individuality and social inclusion. In the following interview extract, the participant gives a very specific example, related to the requirements for the development of occupational therapies.

"I think they [Social Security technicians] are not equipped to know what community mental health is […]. For example, there are many associations that do not provide

occupational therapies. Why? Because occupational therapies are contradictory to the human rights model, right? When what is described as what institutionalization is, these routines, congregating and segregating activities, people all making clay ashtrays or making wicker baskets, it has nothing to do with people's interests, it has to do with It's what some professional thinks is good for the diagnosis. This is, therefore, against human rights here, which is a form of violence. […] And one of the things they [Social Security technicians] told us here was: 'Ah! No. The Centre must have several water points for visual arts activities." (Representative of a national mental health CSO)

Finally, the monitoring of psychiatric institutions by the Institute for Social Security was assessed as abiding to the power of Psychiatry. The above participant referred that, in these visits, the Social Security inspectors are, usually, accompanied by the institution's resident doctors. He/she believes that the involvement of the psychiatric model in these monitoring actions jeopardises the identification of abusive practices. According to him/her, this involvement can lead to an 'easy justification' for violent practices perpetrated in the institution (e.g. forced restraint, isolation and overmedication), with the use of arguments defending that it is absolutely necessary for the patient's benefit.

"What happens, many times, I think is that [the doctors] justify the practices, placing blame, blaming the victim, placing the blame on people with mental illness, right? […] 'Ouch! They are very violent, so we have to put them…' Anyway! 'Ah! This one behaved very badly, so we have to lock her in the room. […] We have to control it, don't we?'." (Representative of a national mental health CSO)

Regarding independent monitoring mechanisms, the analysis revealed a general lack of knowledge, as most participants from the different groups exposed their unawareness of its existence ([8]). More specifically, managers and professionals of national and local disability CSOs stated that they were never contacted by an external body to carry out monitoring visits/inspections in their institutions and that, therefore, they were unaware of its existence. As an interview with a human rights institution revealed, adding to the lack of human resources on the side of the National Preventive Mechanism run by the Ombudsperson's Office, one of few independent monitoring mechanisms identified, there are ambiguities about the competences of this mechanism. As it emerges, the lack of human resources has prevented this mechanism to perform visits to other places of deprivation of liberty than prisons, moreover, its mandate is not clear regarding the monitoring of community psychiatric institutions,

([8]) Only two interviewees mentioned this kind of mechanism. On the one hand, reference was made to exceptional inspections carried out in response to a request from the European Commission (see supra-2.1.). On the other hand, it was reported an independent mechanism called the 'National Prevention Mechanism' under the Ombudsperson's Office.

nursing homes or other residential institutions for disabled people. This may justify the general lack of knowledge of our participants.

Participants favoured, however, the implementation of independent monitoring mechanisms, to overcome the criticisms pointed to the State's monitoring activity, and to overcome a signalled potential conflict by gathering in the same body the funding and monitoring of institutions. As argued, this conflict emerges from the fact that the Institute for Social Security, as a public body, plays a double role: it funds the institutions and monitors them. The delivery of an effective and impartial monitoring is, thus, questioned due to this combination of duties. As one participant, representing a national disability CSO, argued:

"[…] we could find a mechanism external to these stakeholder dynamics that could do this follow-up and monitoring. Because the Institute for Social Security is still an interested party, because it transfers funds and wants to see a set of rules and a set of investments and a set of services complied with, but because it has all this technocracy about it, it often devalues this human rights component, the dimensions of rights that are central to us. We're often in constant confrontation with the ISS because of the dominant thinking, which is to comply with the rules, to comply with the ordinance and regulations, to the detriment of people's rights and their wishes." (Representative of a national disability CSO)

Despite the consensus on the importance of setting up and empowering independent monitoring mechanisms, participants did not elaborate much on how to create and implement these mechanisms. Some ideas were, however, ventilated about the nature of these independent monitoring mechanisms. The most ventilated idea advocated that these mechanisms should be formed by people highly qualified in human rights issues. This led to the conclusion that disabled people's rights NGOs should play a leading role in these mechanisms. It was also argued that these mechanisms should include the voices of people living in institutions, including people from mental health institutions. The importance of including people from mental health institutions, raised by one person with a diagnosis of schizophrenia, and by a representative of a national mental health CSO, is symptomatic of the need to overcome the silencing imposed on people with mental health problems by the Psychiatry ([9]). Plus, these participants advocated the inclusion of people with diagnoses of mental illness who have lived

([9]) See, for example: Nogueira, C. (2023), *Para lá dos silenciamentos. Sofrimento mental, integralidade e (im)possibilidades de uma ecologia de cuidados [Beyond silencings. Mental suffering, integrality and (im)possibilities of an ecology of care],* Doctoral Thesis in Sociology, Coimbra, University of Coimbra.

experiences of violence in institutional settings in these independent committees for monitoring/inspection. In his/her words:

"The most revolutionary and most appropriate would be the people with experience themselves of mental illness, that they carry out this inspection, because they are the ones who have experienced what is violence first-hand. But we are far from giving this power to people." (Representative of a national mental health CSO)

Finally, participants raised the need to rethink the institutionalisation model underlying social responses to disabled people's needs, that is based, as argued, on a very closed/rigid and non-democratic institutional culture, that is conducive to violence and mistreatment. The prevalence of this model is seen, by several participants, as a structural weakness of social sector organisations, making them vulnerable to manifestations of this phenomenon and, thus, dependent on external monitoring mechanisms to ensure the protection of disabled people that live in their premises. As advocated, a paradigm shift is needed, to bring in a new open-door and community-based care model. In order to promote such shift inside institutions there is a need to: promote awareness-raising and training on human rights for all those involved (disabled people, families, managers, professionals from all areas, the community itself); end the restrictions preventing people from leaving the institutions; end the visiting schedules (families should be able to enter the institution at any time, without prior warning); and democratise the institutions by promoting disabled people and disabled people's families participation in their management. It is also advocated that organisations should set up internal self-monitoring mechanisms and users' committees to prevent and respond to violence. As one participant representing a disability CSO argues, the self-monitoring mechanisms could be used to promote critical reflection and self-evaluation in relation to the institution's complaint channels, as well as in relation to their ethical commitment and conduct more broadly. Plus, these self-monitoring mechanisms could be made accountable for reporting information and data regarding issues of ethical conduct inside the organisation to its general assembly. The user's committees are presented as an alternative by disabled people interviewed, also contributing to the democratisation of institutions. As one interviewee puts it:

"I don't know why there isn't, a users' committee, people who get together, one to be the representative, and to have capacity before whoever oversees them, which is Social Security, or whoever the entities are, that person who has more capacity, like, an association, like, who is the representative of those people, and who is there, and who can say: 'No, I also have power, I don't want it this way, I want it that way'." (Disabled person)

As this interviewee elaborates:

"[…] it could be an association of users, I don't know, or something like that, that the IPSS itself could create and see those people who wanted to, or who were more competent to do it, and give them, like, that freedom, and say: 'Look, we really want you to have your say too, to be at the meetings, to give us suggestions, to tell us how we should improve, what we should do.' Because sometimes it's a question of goodwill, it's not a question of money, it's not a question of anything. And for that person to be, in essence, a representative, just like there's the employees' representative for occupational safety, just like there's something else, for that person to be the representative, but to have autonomy, to have the power, together with the other entity, which is Social Security, to impose themselves, and say: 'Look, I'm sorry, we don't agree.' And even have access to things. 'We don't agree with the person taking medication indiscriminately.' But then, how are you going to overcome a doctor's opinion, right?" (Disabled person)

3.2. Key recommendations on improving existing monitoring practices

- Reinforcement of public investment in resources for regulatory monitoring actions, especially human resources (hiring specialised technicians/inspectors), as well as material resources (e.g., vehicles).
- Regulatory monitoring visits should properly address issues related to preventing and responding to violence, valuing the well-being, dignity and fundamental rights of disabled people. It should move away from the tendency to overemphasise procedural, administrative and bureaucratic issues (as has been the case so far) to the detriment of human rights issues.
- Investing in the training of the Institute for Social Security's technicians/inspectors in human rights, more specifically in the fundamental rights of disabled people and people with mental health issues, with a special focus on the prevention of violence, mistreatment and undignified treatment.
- Promoting partnerships between the Institute for Social Security and NGOs in the field of disability rights and mental health issues to collaborate in the area of capacity building/training for technicians/inspectors in this public body's inspection department.

- Inspections/monitoring visits should listen to (give a voice to) disabled people and people with mental illness living in institutions and not only to the technical and professional directors of those institutions.

- Promoting critical reflection on the integration of medical doctors (particularly psychiatrists) in monitoring visits, due to the tendency for these professionals (in line with the psychiatric narrative) to justify certain abusive and violent practices (such as forced restraint, isolation, psychiatric overmedication, etc.).

- Promotion of independent monitoring mechanisms (outside the state), which should be made up of impartial people (without conflicts of interest) who are highly qualified in human rights and have experience in this field. In this regard, it was mentioned that NGOs in the field of disability rights and mental health issues should play a leading role in these mechanisms.

- Independent committees for monitoring visits should include, as experts, people with mental illness diagnoses and disabled people who have lived experiences of violence in institutional settings.

- Promoting a paradigm shift towards deinstitutionalisation, which should definitely involve the implementation of an open-door, community-based care model.

- Organisations should reduce dependence on external action mechanisms by internally promoting self-regulatory approaches to prevent and respond to violence, for example.

Promising and transferable practices from other similar / closed settings.

'Informal carer' (among peers) used in prisons – this practice was observed in a prison in the UK and is suggested as an informal monitoring practice for institutions where people live. As described, this concept implies that a prisoner, earning a sum of money, becomes responsible for the care of a disabled prisoner. As described, this practice is not free from the risk of abuse, so it must be well prepared, especially with appropriate training for the prisoner-carer, however it can prevent other risks. As reported, in Portugal there is already a prison implementing the idea of the "informal carer", renamed prisoner-godfather/prisoner-godmother. This experience has not been specific to the care of disabled prisoners, but to the general hosting of recently arrived prisoners.

This practice has the potential of preventing violence, of encouraging the establishment of emotional ties between disabled people living in institutions, as well as of stimulating a sense of interdependence and peer support, promoting safer spaces

and a peer advocacy movement. Additionally, this practice presents potential benefits in terms of the mutual sharing of lived experiences of violence, which could help to develop a greater level of awareness on this matter.

4. COMPLAINT MECHANISMS

4.1. Effectiveness of complaint mechanisms

The analysis conducted to the interviews of the different groups reveals a lack of knowledge about the existing complaint mechanisms (in a broad sense, i.e. in terms of the multiple issues that underlie it, from availability, accessibility, adequacy, effectiveness, etc.). This lack of knowledge is particularly evident in the interviews conducted with public officials, who hold state coordination positions. Indeed, their answers were often too vague, evasive, ambiguous and even contradictory with information gathered from interviewees from other groups, namely from national and local disability CSOs, and particularly from disabled people living in institutions.

Participants presented a great discrepancy in perceptions, answers and ideas on this subject, which is indicative of the absence of an official system for gathering information and processing statistical data (which would make it possible, for example, to identify existing complaint mechanisms, to access official statistical data regarding the complaints submitted). Public officials in coordination positions and public prosecutors, gave information mainly based on personal opinions and perceptions influenced by their compartmentalised professional experiences.

This discrepancy surfaces in two interviews carried out in the same field of intervention. One of them, a public official in a coordination position, expressed great disbelief in the complaint mechanisms for disabled people, considering them ineffective. A second participant, who works under the tutelage of the previous participant, gives a very positive assessment, widely believing in the effectiveness of the existing complaint mechanisms.

Another ambiguity was identified in an interview conducted to a public prosecutor, who devalued the importance of specific complaint mechanisms for disabled people. Despite assuming a lack of knowledge on the existence of complaint mechanisms inside institutions for disabled people, this participant downplayed the value of these mechanisms, stating that anyone who really wants to make a complaint does it (even without these mechanisms within the institutions). The participant expressed great confidence in the existing general external reporting mechanisms (for the general population) and in the ability of disabled people to access and use them. Disabled people's experiences are, however, contradictory of this optimist vision (please see infra for further analysis). As the public prosecutor puts it:

“[…] anyone who wants to report these kinds of situations does. Because nowadays it's very easy to make a complaint and it's very easy to find out where to send it. So, whoever wants to report it, does so. […] If you go online... Anyone who isn't info excluded, goes online and says: 'how do I make a complaint?' And it will appear, and you'll be referred to the electronic complaint portal. It comes in different forms. Anyone who wants to make a complaint today and is not info excluded is free to do so. Those who are info excluded continue to write letters and send them by post.” (Public prosecutor)

Despite the many contradictory opinions, participants presented, however, some common concerns regarding complaint mechanisms. A first concern relates to the lack of awareness and literacy in human rights matters, regarded as a major barrier for violence reporting. The development of awareness-raising campaigns and training sessions in human rights is pivotal for participants involved in organisations, moreover, it is also stressed the importance of giving special attention to the development of awareness-raising campaigns directed to disabled people. This is understood as a crucial step to allow disabled people to develop a greater awareness of their rights and, thus, better identify and report situations of abuse and mistreatment.

A second concern, shared mostly by representatives of human rights institutions, relates to the idea that certain impairments increase disabled people’s vulnerability level and decrease their ability to activate complaint mechanisms (a very particular concern is expressed about people with profound intellectual impairments). In these cases, there is a huge risk that experiences of violence and abuse remain invisible and out of the public light. Participants criticise the lack of independent impairment-specific complaint mechanisms, defending the need of adapted mechanisms, accessible to people with different impairments and to people in different contexts, including those who may be isolated in institutions.

The analysis revealed the existence of a single independent complaint mechanism directed to disabled people, the ‘disabled citizen's line’. This is a direct free telephone line made available by the Ombudsperson's Office aiming to provide information about disabled people’s rights and support, additionally, when necessary, this line may contact the relevant institutions and forward the situation to the competent authorities. Despite the official aim of this line, publicized in the Ombudsperson's webpage, the interviews revealed that this line is also used by disabled people as a complaint mechanism. The misuse of the ‘disabled citizen's line’, generated by the absence of other accessible independent complaint mechanisms, may explain some of the criticisms advanced by our interviewees.

“The ombudsman's line doesn't solve anything, because the ombudsman's line, we know, we call them: ‘Send an email explaining everything.’ And then, very often, people

only have that minute to make a complaint [...]. Then we're told to send an email? If you can't send an e-mail, someone has to switch on the computer, someone has to write and so on. [...] [I know of many people who have already complained via the ombudsman's line] Many. I do it a lot myself. I really enjoy complaining to the Ombudsman's Office. […] In the beginning, when I was naïve, I'd ring up and say: 'I'm in need.', 'No. You'll have to send an e-mail here and I don't know what, to address X.' So, from then on, I started sending emails. But in order to send emails, you have to identify yourself, everything has to be there, and I don't know what else." (Disabled person)

Moreover, apart from the mechanisms reported, disabled people can access the same reporting independent channels made available to the general population.

There is, however, a general lack of information about external complaint mechanisms inside the institutions. This was confirmed by those participants that occupy management positions or that are professionals at these institutions, as well as by disabled people that live or have lived in an institution. As reported, there is no signpost indicating contacts of organisations/bodies (e.g., the Ombudsperson's Office, Portuguese Victim Support Association, the Institute for Social Security, police authorities etc.) where to submit complaints. The managers and professionals of local and national disability CSOs interviewed, confirmed that there was no protocol for publicising these external and independent complaint mechanisms inside the organisations, nor on how to make it accessible to disabled people.

When questioned about the internal complaint mechanisms available in their institutions, managers and professionals revealed that the Complaints Book and an informal complaint system, are the most common channels. The second is based on oral or written complaints that can be submitted to intermediate professionals (which will lead them to the board of directors) or directly to the institution's management. The interviews revealed a general lack of critical thinking regarding the use of these informal mechanisms, and an excess of confidence in its effectiveness.

The words of a participant occupying a management position in a local disability CSO are revealing on this issue:

"Internally, in the residences, I don't know if they have a scenario, a document, anything, or if, in fact, it's a lot of direct contact, talking, isn't it? [...] More informal. People come and present the situation. Well, [name of participant 2] will confirm. But I think it will work that way. [...] It is, in fact, much more informal. We have a formal register, but then it's very informal, isn't it? Even, for example, when we receive families, it's in the context of a conversation, or with the social service, or any other technician, that they expose themselves. And so this way of explaining is informal-

formal. It's in a formal technical intervention situation. [...] She talks to a superior about the situation she's observed. At least, that's how it's worked." (Manager of a local disability CSO)

The interviews conducted to disabled people evidenced the void of adequate responses and the lack of efficiency of existing complaint mechanisms, and the hegemony of an informal mechanism within the walls of institutions. The latter was described as ineffective and favouring secondary victimisation, due to retaliation by staff on the person(s) issuing a complaint.

This was reported by a disabled woman interviewed. As she described, her multiple demands and complaints – both internally (within the institution) and externally (to the Institute for Social Security, the Ombudsperson's Office, the Public Prosecutor's Office, etc.) – produced an escalation of the situations of violence and abuse by the professionals and by the director of the institution, which she interprets as a form of reprisal.

The case of an interviewee with a psychiatric diagnosis is, also, emblematic in this regard. In the context of an involuntary hospitalization, he found himself faced with a situation of total impotence in reporting the multiple situations of violence and abuse directed to him. He realised that there were no complaint mechanisms available that he could use to reverse the situation of forced hospitalisation. He did not know whom to contact and was unaware of existing internal complaint mechanisms. He didn't think it was useful to speak to professionals, as they were part of that system, and they followed medical orders. On the other hand, he was barred from contacting the outside world. For a long time, he didn't have access to a mobile phone. When he did have access, it was very restricted, with limitations that made it difficult for him to search for information (about possible organisations he could contact) or to submit complaints. He described the intension of sending a complaint directly to the President of the Portuguese Republic but, given the limitations of access to his mobile phone, he was not able to write and send the complaint. According to the respondent, any attempts he made to question, protest or complain about the abuses he was experiencing, were systematically devalued, and interpreted "as signs of the disease", revealing the enormous power of psychiatry and of its labels. He also noticed that the more he questioned and complained during his hospitalisation, the higher doses of medication he was given.

"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 psychiatric diagnosis)

The case of another respondent is also emblematic on this respect. A disabled woman with Multiple Sclerosis, lived in four institutions and never noticed the existence of information about complaint mechanisms and how to forward these complaints. The respondent reports submitting a complaint against the 2nd Institution where she lived, but also reports that her first strategy was to speak directly to the professionals involved in the situation and to the institution's director. As explained, that initial strategy did not work. Due to the isolation she found herself in, the respondent wrote a complaint letter, that was forwarded later by her mother, outside the institution, to the regulatory body of the type of institution where she was living. She was not aware of any inspection or any consequences for the institution as a result of her complaint. According to her, the only outcome of that complaint was her transfer to another institution, with similar conditions and problems.

"That's not what I wanted, what I wanted was better service. Moving me doesn't work. The other one was similar. […] [The response to the complaint] was the transfer. It's solved on a case-by-case basis." (Disabled person)

About the 3rd institution where she lived, the respondent said that she even wrote a complaint on a computer available at the institution that was never sent. As she explained, the computer was installed in a place with no privacy, with people passing by and seeing her writing, she had difficulty handling with the computer and there was no one available to provide support. She did ask for support to a professional, but, as she reports, this person refused to provide support. Thus, as she explained, the document remained in the institution's computer without being able to submit the complaint.

4.2. Key recommendations on improving existing complaint mechanisms

- Need of an ethical commitment on the part of the institutions involved to act on these complaints - this ethical commitment demands a separation of roles between those who manage the institution and those who receive and analyse complaints.
- Need of institutions to create self-regulatory mechanisms aimed to promote critical thinking and self-evaluation based on their complaint channels - it should also be mandatory to provide accounts in terms of ethical conduct, such as, for

example, what concerns the complaints that have taken place during a certain period.

- Need to improve human rights literacy - knowledge should be promoted to all agents that are part of the 'ecosystem', including disabled people. Disabled people need to be made aware of what abusive behaviour is, as well as given the skills to report it.

- Need to strengthen the external complaint mechanisms – external monitoring mechanisms should be recognised by public authorities, their mandates and competences need to be clarified, and their financial and human resources reinforced.

Promising and transferable practices from other similar / closed settings.

Independent Commission for the Study of Child Sexual Abuse in the Portuguese Catholic Church - A reference to this Commission was made by a member of a national mental health CSO. Besides representing a good practice in terms of the cooperation dimension, it is also considered a promising transferable practice for facilitating the necessary conditions for the presentation of complaints, monitoring of the processes till the final phase of reparations. The Independent Commission for the Study of Sexual Abuse of Children in the Portuguese Catholic Church was an independent multidisciplinary team, set up to study of sexual abuse of children by members and/or collaborators of the Church. As it is described in the final report presented, ([10]) this commission placed the victim at the center of the study, encouraging them to testify and giving them a voice. This was operationalised by the set-up of a telephone line, followed by individual interviews with those people who identified as victims. This practice is presented in the following section (please see 5.2.).

([10]) Comissão Independente para o Estudo dos Abusos Sexuais de Crianças na Igreja Católica Portuguesa (2023), Relatório Final – Sumário Executivo.

5. COOPERATION AND COORDINATION

5.1. Effectiveness of cooperation and coordination mechanisms

As most interviewees assumed, effective prevention, protection and prosecuting of violence against disabled people in institutions demands cooperation between different entities and, in specific cases, demands work coordination.

The analysis reveals two main areas and levels of cooperation between the different entities and an intermediate level and area that creates channels between the two main levels. A first level of cooperation can be found between the different national public social regulatory bodies, the state agency for child protection, the Public Prosecutors Office, the police authorities and criminal research units, the Ombudsperson Office and other criminal investigation entities like the Health Authority and National Institute of Legal Medicine and Forensic Sciences, I. P. (INMLCF, I. P.). This level of cooperation has been established mainly for inspection and investigation purposes. The cooperation and coordination of work is organised and led by the Inspection Department of the Institute for Social Security and the Public Prosecutors Office, the other entities are mobilised whenever needed by these two key actors in the inspection and investigation of violence and crime against disabled people in institutions. A second level of cooperation can be found between national and local disability CSOs, and the regional delegations of the Portuguese Association for Victim Support (APAV). This cooperation is less rigid, but also more volatile and scattered. Volatile, as it has a limited duration in time. Scattered, as it does not cover the Portuguese territory, but only the areas of influence of those organisations who had the initiatives. This level of cooperation has been established mainly to facilitate the design and development of awareness-raising campaigns directed to specific publics, usually users, families of users and professionals of disability service providers. Differing from the previous form of cooperation, this cooperation is not hierarchical and, therefore, is more dependent on the initiative and dynamism of the entities. This was voiced by one interviewee:

“In other words, I think it depends a lot on the people in the organizations, of course. And so, even the associations that play a fundamental role, it also has a lot to do with

the dynamics of civil society, the people who come together in these organizations, or other organizations. But my experience has been very good. I haven't had any problems. Although it's a bit of a Portuguese characteristic of the little chapels, and everyone wants to protect their own, […].” (Public official in a state coordinating position)

Finally, an intermediate level of cooperation can be found between public national bodies (like state agency for child protection, for rehabilitation and inclusion, for social security) and national and local disability CSOs; or between the later and police forces (like the PSP or the GNR); or between these organisations and academic institutions (like universities or research units). This level of cooperation has been established mainly to implement awareness-raising campaigns, training workshops and research. It is more rigid than second level articulation, as it usually involves the implementation or development of a previously defined program or research plan, but with a certain degree of flexibility in order to allow its adaptation to the different disability CSOs. An example of this intermediate level of cooperation are the “Significant Blue Programme”, developed by the Public Security Police (PSP) and the “Support Programme for People with Disabilities” developed by the National Republican Guard (GNR) in cooperation with disability organisations, aimed at preventing violence against disabled people. As one interviewee explains:

“These are two community policing programs whose main aim is to promote the safety of people with intellectual disabilities in institutional, family and community contexts. These programs are based on the training of the different interlocutors, with the aim of creating synergies, bringing people closer together, promoting networking and communication between the security forces and organisations.” (Representative of a national disability CSO)

The analysis revealed, moreover, that first level cooperation and coordination is more stable, as it is more rigid and bureaucratically organised, and second and intermediate level cooperation is contingent, as it may change from one area of the country to another. This is blatant, for example, in the fact that some national and local disability CSOs refer cooperation with the Portuguese Association for Victim Support (APAV) in the design and delivery of awareness-raising campaigns for different audiences regarding types of violence, strategies to deal with it and responses to the phenomenon and, none of those disabled people with experiences of violence in institutions in Portugal interviewed, reported information about APAV and only one of them reports accessing its services for submitting a complaint. This is, also, blatant in the fact that public officials in coordination positions lacked information about cooperation of their own services at local and regional levels.

One of the key challenges identified, in the analysis within the different cooperation levels, is the available and availability of both human and material resources.

"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." (Public official in a state coordination position)

In order to cooperate, organisations and public bodies, need funding, but also need human resources. Their lack is, thus, identified as one of the main challenges to cooperation, but the availability of dedicated human resources emerges as a key enabler for cooperation. As one interviewee reports:

"Fortunately, we have some mechanisms to achieve this collaboration. But it depends on a daily job. With the ISS, we have almost daily contact, in fact, several times a day. Complaints relating to Social Security represent almost a third of complaints submitted […]. It's not an institutionalized channel where correspondence is lost. In fact, this contact is both formal and informal, depending on the situation." (Representative of a human rights institution)

5.2. Key recommendations on improving cooperation and coordination

- Need to provide the institutions with adequate human and material resources to promote effective cooperation.
- Promote some kind of additional training for police authorities so that they can act in these specific contexts.
- Develop awareness-raising campaigns to medical professionals, in articulation with the medical class, regarding the specificities of some impairments (in order to avoid, for example, overmedication).
- "Creating cooperation protocols between victim support service providers, justice professionals and organisations that support people with disabilities (e.g. extending the scope of the offices for victims of gender-based violence), in order to provide an effective response to victims with disabilities, helping them to overcome communication and other obstacles" (Representative of a national disability CSO).

- Involve disabled people and their representative organisations, disability service providers and victim support associations.

Promising and transferable practices from other settings / frameworks.

Three promising and transferable practices were identified by the interviews:

- Commissions for the Protection of Children and Young People (CPCJ) – the organisation and coordination capacity of these commissions, with a culture of regular community meetings, was reported a promising practice in order activate successful intervention strategies.

- Independent Commission for the Study of Child Sexual Abuse in the Portuguese Catholic Church ([11]) - this task force created by the Portuguese Catholic Church, with multiple dimensions of cooperation, is also regarded as a promising transferable practice for facilitating the needed conditions for the presentation of complaints, monitoring of the processes till the final phase of reparations. As the participant refers,

  "I liked the example of child sexual abuse, the creation of a task force, a specific team that came in, that brought multiple dimensions of collaboration, didn't it? And that it opened up a space, a private and respectful space in relation to the situation, so that people could have the opportunity to make complaints, and that their complaints would be investigated, and that the process would be followed through to the end, so that there would be reparation, for example, financial reparation for people, which is another thing that, nowadays, the movement of people with mental illness itself is asking for, which is financial reparation for the fact that they have been institutionalized. This is another very interesting thing, which is... But sometimes they're not just asking for money, they're asking for services that guarantee their rights." (Representative of a national mental health CSO)

- International cooperation the practice of cooperation with equivalent bodies/organisations at international level is described as potentially inspirational for national bodies and practices, for allowing on-site visits and training courses fertile of examples of initiatives to inspired them. One participant, for example, reports that the introduction of the figure of the 'informal carer' inside prisons in Portugal resulted from a bilateral exchange visit to the UK, arranged between his/her institution Portugal and its corresponding body in the UK. Another participant, representing a disability CSO, reports being inspired by similar

([11]) Comissão Independente para o Estudo dos Abusos Sexuais de Crianças na Igreja Católica Portuguesa.

organisations in Spain. He/she gave the example of stopping to focus their materials on professionals, to focus them on disabled people, as they realised by the example of their Spanish counterpart, that the more informed disabled people are about their rights the better they can defend themselves and make their rights respected.