Bulgaria:
Monitoring Report

DIS-CONNECTED: DISABILITY-BASED CONNECTED FACILITIES AND PROGRAMMES FOR PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN IN BULGARIA

101049690- DIS-CONNECTED

DISABILITY-BASED CONNECTED FACILITIES AND PROGRAMMES FOR PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN IN BULGARIA (101049690 – CERV-2021-DAPHNE)

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General information on the Monitoring visit

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- Aneta Genova – Project Manager and Researcher, Kera Foundation, Lawyer;
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- Venera Simeonova – Researcher, Kera Foundation, Psychologist;
- Ana Tilova – Consultant, Expert by experience.

Aim of the Monitoring Visit and selection of the institutions

The purpose of the monitoring visit was to assess compliance with human rights standards in relation to gender- and disability-based violence in institutional settings. Additionally, the visit aimed to gather up-to-date information and data on all forms of such violence, including its manifestations, frequency, and dynamics. It also sought to examine the perceptions of residents, institutional staff, and other stakeholders regarding this type of violence.

Particular attention was given to the existing mechanisms for prevention, identification, and response, as well as to the effectiveness of measures designed to protect and support survivors. Beyond documenting the current situation, the monitoring visit aimed to establish a foundation for ongoing and constructive dialogue with all relevant stakeholders.

The monitoring was conducted by the team from Kera Foundation based on the Methodology for Identifying Cases of Gender- and Disability-Based Violence within Social Support and Healthcare Systems, developed as part of the project.

The monitoring team decided to carry out all visits within a single regional city, as it has a high concentration of diverse social services for people with disabilities, as well as services for individuals who have experienced violence.

Methods Used for Conducting the Monitoring

For the purpose of the monitoring visits, the following methods of data collection were

used:

1. Preliminary gathering and analysis of information about the selected services;
2. Interviews with staff members working in the services;
3. Interviews with residents;
4. Observation of interactions between residents and between residents and staff members;
5. Observation of the material environment;
6. Review of documentation;
7. Consultation with experts by experience before and after the monitoring visits.

Profile of the visited institutions

В рамките на мониторинговото посещение бяха посетени общо 10 услуги – от тях 7 резидентни и 3 нерезиденти от тип “Дневен център за пълнолетни лица с увреждания” и “Център за рехабилитация и интеграция”;

- Daycare Center for Adults with Disabilities – psycho-social disabilities and dementia (DCADPSDD)/Дневен център за пълнолетни лица с увреждания – психически разстройства и деменция (ДЦПЛУПРД);
- Daycare Center for Adults with Disabilities (DCAD)/ Дневен център за пълнолетни лица с увреждания (ДЦПЛУ);
- Center for Social Rehabilitation and Integration (CSRI) / Център за социална рехабилитация и интеграция (ЦСРИ);
- Family-type Residential Center for Adults with Dementia 1 (FTRCAD 1)/ Център за настаняване от семеен тип за пълнолетни лица с деменция 1 (ЦНСТПЛД 1);
- Family-type Residential Center for Adults with Dementia 2 (FTRCAD 2)/ Център за настаняване от семеен тип за пълнолетни лица с деменция 2 (ЦНСТПЛД 2);
- Family-type Residential Center for Adults with Psycho-social Disabilities 1 (FTRCAPSD 1)/ Център за настаняване от семеен тип за пълнолетни лица с психични разстройства 1(ЦНСТПЛПР 1);
- Family-type Residential Center for Adults with Psycho-social Disabilities 2

(FTRCAPSD 2) / Център за настаняване от семеен тип за пълнолетни лица с психични разстройства 2 (ЦНСТПЛПР 2);

- Protected Home for Adults with Psycho-social Disorders (PHAPSD or PH) / Защитено жилище за пълнолетни лица с психични разстройства (ЗЖПЛПР или ЗЖ);
- Transition Home for Adults with Mental Retardation (THAMR or TH) / Преходно жилище за пълнолетни лица с умствена изостаналост (ПЖПЛУИ/ПЖ).
- Family-type Residential Center for Children and Young Persons with Disabilities (FTRCCYPD) / Център за настастаняване от семеен тип за деца и младежи с увреждания (ЦНСТДМУ).

Of the ten services visited, nine are part of a social services complex managed by a commercial company. This complex has existed in its current form since 2010, but the buildings it occupies date back to the 1950s. Originally, they were used to accommodate people classified as having "reduced work capacity". Since their establishment, these buildings have been directly linked to the institutionalization of people with disability. Some of the current residents have been directly affected by the transformation of these facilities, having been formally moved from one institution to another as the services housed within the buildings evolved over time.

The tenth service visited is also part of a social services complex and was established as part of Bulgaria’s ongoing deinstitutionalization process. This process, led by the authorities, involves closing down large, old institutions—commonly referred to as “group homes”—and relocating residents to smaller facilities. The intention behind deinstitutionalization is to replace large-scale institutions with community-based services and independent living; however, concerns remain regarding the actual conditions in these new facilities and whether they truly provide a better quality of life for residents.

Location of the Services

According to the monitoring team’s observations, all of the visited institutions are located in unwelcoming areas, far from the city center. The large social services complex and the smaller institution are within walking distance of each other, but the path connecting them is in poor condition, surrounded by overgrown weeds and litter.

Nearby, there is a segregated neighborhood, and the surrounding area is dominated by car repair shops, tire service stations, and similar businesses. There are no recreational

spaces, cultural venues, or areas for social activities in the vicinity.

Despite being marked in navigation systems, the large complex is difficult to find, as it is located in an industrial-looking part of the city, hidden behind several auto repair shops.

Material Conditions

Many of the services are housed in visibly renovated and well-maintained buildings. The large complex is located in an older building, but most areas have been refurbished. According to staff, further improvements are planned for the sections that have not yet been renovated. However, in the large building attached to this complex, strong odours are present in the corridors, particularly on the top floor, where the least renovation work has been done.

The smaller institution (that was not part of the complex) is located in a new building, and its communal spaces appear welcoming. However, the monitoring team was not allowed access to the dormitory areas in this institution.

Despite being divided into smaller services, the large complex still feels like a massive institution. The individual services within it cannot be viewed as truly separate, as they function in strong dependence and share common resources and infrastructure. This is particularly evident on each floor, where two residential services are located side by side, yet the separation between them is symbolic or entirely non-existent.

> "Prioritizing the renovation of common and administrative areas can be seen in the context of a power imbalance, where the comfort of the staff is given priority while the residents are expected to wait. Even if this is not done consciously or intentionally, this differentiation and prioritization play a significant role in understanding the dynamics of relationships within the institution."
>
> *Comment from an expert by experience*

Profile of the Residents

The majority of residents in the visited institutions do not come from a family environment.

Instead, they have been transferred from larger institutions as part of the deinstitutionalization process.

The monitored daycare services are used by the residents from the same large complex, individuals from nearby large institutions, and people living in the community.

Profile of the Staff

Most of the staff at the small group home that was not part of the bigger complex has been working there since its opening. The manager noted that finding new employees is challenging, as there are few applicants for the positions.

In the large complex, some services face a shortage of qualified staff. For instance, the residential services lack a psychologist.[1] In the protected home and transition home units within the same complex, employees generally have relevant higher education and have undergone psychological training. However, some caregivers in the complex have low literacy levels.

When cases of inappropriate or abusive behaviour toward residents are identified, the responsible staff members are dismissed. However, the overall staff shortage makes it difficult to promptly detect and address such issues.

Gender and disability based violence

Understanding of gender-based and/or disability-based violence

Interviews with both staff and residents reveal that the concept of *gender-based violence* is understood in a very limited way, mainly referring to its most visible forms—sexual and physical violence. Other forms of violence, such as psychological control, overmedication, restrictions on personal freedom and autonomy, and the imposition of punishments, are not recognized as forms of violence.

There is a lack of specialized training that could improve awareness and response to these issues. In residential facilities for people with dementia within the large social services complex, staff receive training on preventing violence and managing aggressive behavior through psychological support.[2] However, such training is not systematically

1 From an interview with manager of a residential service.

2 From an interview with manager of a residential service.

provided across all service.

Mechanisms for Identifying, Reporting, and Responding to Violence

In the visited small group home outside the large complex, there are written guidelines on handling cases of violence, as well as instructions for staff to refrain from disrespectful behaviour toward residents. However, no specific mechanism exists for addressing gender-based violence, nor is there a protocol for response. In case of incidents, staff are expected to notify the management or the relevant authorities. However, most residents lack the means to file complaints due to the absence of accessible resources, including technical aids, and their restricted access to the outside community.

A written procedure for submitting complaints to the service management exists, with the option to appeal decisions to social assistance authorities. Complaints can be submitted orally or in writing, but there is no procedure for individuals who have limited mobility.

A significant number of residents are unable to communicate through traditional methods, and no alternative communication systems have been introduced. As a result, violence against them is primarily identified through physical signs and is only considered in the context of physical assault.

In the big complex, various protocols exist for responding to different situations, yet there is still no mechanism specifically for identifying, reporting, and addressing gender-based or disability-based violence.

The large complex is equipped with communication devices, referred to as "Communicators,"[3] which could potentially serve as an alternative means for nonverbal residents to report violence. However, the monitoring team found that these devices lack Bulgarian-language software, rendering them unusable for this purpose. Additionally, there was no apparent effort by the staff to facilitate their use. Instead, the staff expressed scepticism about the ability of nonverbal residents to benefit from such tools, which likely

[3] The Communicators are tablets, equipped with special software that transforms various signals into speech. In the visited day center, however, they are primarily used as interactive games where residents match identical pictures and engage in similar activities, rather than for their intended purpose—enhancing communication for nonverbal residents. These devices are used only once or twice a year for so-called "screening" of some residents, rather than being integrated into their daily communication support.

explains the lack of initiative to implement them effectively.

Cases of Violence in the Monitored Institutions

The topic of experienced violence is not openly discussed. The interviewed managers and staff of the monitored institutions shared that incidents of violence within the services are rare or do not occur at all. Moreover, some staff members hold the belief that the residents lack self-awareness regarding gender and sexuality.

At the same time, during the monitoring process, the team from Kera Foundation gathered information on multiple cases of violence. The monitoring team observed that many of these cases are not recognized by the staff as acts of violence.

In one of the institutions, punishment is frequently used but is perceived as a form of care rather than as a disciplinary measure. The management of this service informed the monitoring team that a female resident, who had previously been a victim of violence in another institution and in the community, is denied her favourite beverage as a form of punishment for entering the rooms of other residents. When this resident experiences distress, the staff locks her in her room. The manager also reported that the same woman had jumped from the second floor of the institution’s building. No investigation was conducted, and psychological support was provided only to the manager. The manager stated that since the other residents had not witnessed the incident, they did not require any support. An external psychologist and supervisor of the service evaluated the case as a "consequence of the resident’s multiple diagnoses," without recognizing trauma or violence as contributing factors. In the same institution, the manager shared that punishment is encouraged and that this particular resident has become so accustomed to the practice that she is now allowed to choose her own punishment.

In the context of the described cases, punishment is not seen as a sanction for unwanted behavior but rather as a form of care. However, this masks the actual nature of violence. In essence, when punishments involve isolation, restriction of access to personal belongings and resources, physical aggression, shouting, or medical overprescription, they become methods of exercising control that contribute to the traumatization of the residents. The justification for these measures is often rooted in residents’ diagnoses, which shifts attention away from their actual needs for professional support and assistance.

Another case identified during the monitoring involved a young woman who reported being pursued by a "persistent" male staff member in the service where she resided. He allegedly entered her room and sought to spend more time with her. After she reported

the incident to the manager, the employee was dismissed. However, the woman shared that, despite the staff member's dismissal, the attitude of the remaining staff towards her changed. No support was provided to her following the incident.

Additionally, other residents interviewed in the same facility reported frequently becoming indirect victims of violence, as they were often witnesses to conflicts and arguments among staff members. They also shared accounts of being subjected to shouting and physical aggression by staff towards residents of the institution.

In many institutions, a review of documentation by the monitoring team revealed that a large proportion of residents are subjected to medication treatments. It is difficult to determine whether the prescribed medication is intended to manage symptoms or control behaviour. In one instance, a resident told a monitoring team member that the people in the neighbouring room *"sleep all day because of the medication*." In another service, a manager explained that residents are periodically sent to a psychiatric institution: *"We can sense when they are about to enter a crisis, and they are sent to a psychiatric clinic to have their medication adjusted. Some residents even request to go there themselves."* [4]

Cases of violence against residents have also been identified within the services, including in daycare centers. These cases involve violence from family members (in the case of daycare centers) or between residents themselves. [5] However, no mechanisms are in place to prevent violence, provide support to victims, or address the behaviour of perpetrators. When aggression occurs between residents, staff members intervene through verbal discussions, attempting to calm them down. A review of case files in the large social service complex revealed that, at the policy level, physical restraint of residents is permitted. The staff denied using such measures.

Handling Cases of Violence

Cases of violence are not effectively addressed, likely because they often go unrecognized. In one of the daycare centers within the large complex, the monitoring team met with an art therapist and a psychologist to discuss their understanding of violence, trauma, and any follow-up or initial support (upon admission). After conducting interviews, the team was left with the impression that trauma and violence are initially denied even by professionals whose expertise should be directly focused on these issues. The art therapist at the daycare center shared that the primary goal of therapy is for

[4] From an interview with manager of a residential institution.

[5] From an interview with a staff member.

trauma to be forgotten. As the conversation progressed, the therapist agreed that all individuals who have gone through institutions experience some form of trauma and that many of them have been victims of gender-based violence.

Regarding trauma assessment, even when it has occurred before admission to an institution, the monitoring team documented a case that clearly illustrates the need for such a practice. In a residential institution for people with dementia, the team met an elderly man who had been placed in the service after being severely beaten by his sister. [6] The peculiarity of this case is that the victim does not suffer from dementia; however, immediately after the violent incident, he was referred to a territorial expert medical commission (ТЕЛК), diagnosed with dementia, and placed in a residential care center for adults people with dementia, with no possibility of ever leaving.

Another case involved an elderly woman who was diagnosed with dementia following an incident of violence—her daughter and granddaughter abused her, at one point leaving her naked in a room. Her son, who lived elsewhere, found out about the abuse and pursued legal action. The elderly woman went through the medical commission and was diagnosed with dementia. However, it doesn't seem like the woman have dementia; but she is definitely a victim of severe violence.

The trauma resulting from such severe forms of domestic violence, as well as the emotional consequences for the victims, has not been assessed or addressed by the monitored institution. The lack of an evaluation of the violence experienced before admission to the institution results in an inability to understand these individuals' real needs and to provide adequate psychological support.

Unrecognized Violence, Independent Living and Deinstitutionalization

During the monitoring visit, the team observed a form of violence that often goes unrecognized and underestimated – violence that is carried out through structural and organizational mechanisms. This violence manifests in several ways:

Residents are perceived through their diagnoses, which are used for categorization and to limit their potential for independence. *"The dementia unit are the hardest unit"*[7]*; "Those who are not mentally intact cannot engage in meaningful activities";*[8] *"Those with self-harming behaviour cannot understand it";* [9] *"She has schizophrenia, nothing can be*

[6] From an interview with the service manager and the victim himself, as well as a review of the documentation.
[7] From an interview with a staff member in a residential service.
[8] From an interview with a staff member in a residential service.
[9] From an interview with a staff member in a residential service.

done."[10]

The understanding and distinction between “intact” and “non-intact” residents is shared among all staff in all of the visited institutions. A staff member mentioned that only the *“more intact”* residents are allowed to go to the seaside. In another service, staff explained that only *“intact”* residents have the right to go out freely.

In one of the visited residential services, residents are required to sign declarations every time they leave the institution, stating where they are going and when they will return. If a resident fails to return, the staff may request assistance from the police.

In the large complex, there is security— the monitoring team learned that leaving is only possible with a "pass." For longer outings, a "declaration" is required. When asked what happens if someone is late or does not return, the response was that this does not happen. If residents are late, they inform the staff by phone because they know these are the rules.

Life in an institution is presented as a protective measure, as illustrated during the monitoring visits through the stories of various residents. Those who have attempted to live independently have not received support; moreover, they are used as examples of why leaving residential services is not advisable. A woman residing in one of the visited institutions shared her experience of trying to leave the service—she did not receive prior support within the institution and was not prepared for life outside. When living outside residential care proved too difficult, she returned but was placed in a different service. She still wishes to live in the community but expresses concerns about leaving and the lack of alternatives afterward. Restrictions—such as the mandatory signing of declarations for leaving and returning, control over access to basic resources (e.g., locked food), and the regular use of punitive measures—undermine residents' personal freedom. Every aspect of their lives is organized by the staff. In one of the small group homes, meals take place in a separate building. In the large complex, the monitoring team observed that at least one of the services has a refrigerator where residents can store their food, but access to it is granted only with the service manager’s permission. The room where the food is located remains locked at all other times.

The monitoring team found that very few people have left residential services. In one of the centers, only three individuals have left over the entire existence of the service—two children who were adopted and a woman who moved into the community.

10 From an interview with a staff member in a residential service.

"We are not a prison"[11] shared the manager of a social service when discussing independence and autonomy. However, in the same service, all debit cards are held by the manager, who centralizes each resident's income—pensions and other benefits. From these funds, the service fee is deducted, and the remainder is distributed according to a pre-determined monthly budget. This model of centralized financial management limits residents' ability to exercise independence and make personal decisions about their expenses. Personal choices are also restricted in areas such as leaving the facility, selecting activities, and social interactions. In one of the daycare centers for people with dementia, the team spoke with an elderly man from a family environment who was observing an activity for making Christmas decorations. When a team member asked if he enjoyed the activity, he responded, *"If someone likes these kinds of things, they would probably enjoy it."*

When it comes to sexual relationships, censorship is imposed through the tabooing of this topic. Staff members at many of the visited facilities describe themselves as a family: *"We are their mothers and fathers"* and the residents themselves seem to be perceived as children, as "brothers and sisters," with no discussion of sexual relationships. Despite this patriarchal perspective among staff, residents in the monitored institutions do share about their intimate relationships. The team met a young man who spoke about his girlfriend from another unit within the same complex, jokingly adding that he has many girlfriends. This contrasts sharply with the staff's belief that residents perceive each other as siblings and have no sexual interest in one another. In a small group home for adults with intellectual disabilities, the monitoring team also identified a romantic relationship between at least two residents, including jealousy from another female resident. However, despite the relationship, the couple was not given the opportunity to live together, even though there were no actual barriers preventing it.

It appears that unrecognized violence manifests through the language and practices of institutional organization—ranging from labelling with diagnoses and ignoring prior trauma to the absence of genuine deinstitutionalization programs. These factors, combined with restrictive measures, reinforce a system of institutional dependence and suppress opportunities for genuine integration and autonomy. In this way, institutionalization becomes a continuation of violence in a broader sense. Additionally, the monitoring team observed a clear undervaluation of the interests and talents of individual residents. While their achievements were used to showcase the institution's successes, the individuals themselves were not fully supported in developing their interests and talents.

11 From an interview with a manager of residential institution.

It is noticeable that some residents have an interest in music, painting, and other activities. However, it seems that their inclinations and strengths do not receive special attention. The staff claims to be their family, yet there are no warm, emotionally friendly relationships built on equality. Instead, there is a clear division—the professionals are like gods from Mount Olympus, while the residents are mere mortals, wearing diapers and facing restricted mobility.

It is unfortunate that social services function merely as administrative units, and the residents are reduced to mere numbers.

Comment from an expert from opinion

Key Findings

After analyzing all the collected information, the monitoring team reached the following conclusions:

- There is a lack of sufficient knowledge on gender-based and/or disability-based violence in institutional settings;
- There is absence of training on human rights for both staff and residents;
- The punishment is perceived as a form of care;
- The institutionalization of people with disabilities is seen as a protective measure;
- There is a lack of mechanisms for identifying, reporting, and responding to cases of gender-based and/or disability-based violence;
- Institutionalization is basis for re-traumatization.

In the visited institutions, there is a lack of human rights training programs for either staff or residents. Internal training sessions are conducted by supervisors affiliated with the institutions, but no specific training is offered on gender-based and/or disability-based

violence. The staff does not demonstrate a deep understanding of GBV or violence in general and often does not consider that such situations could occur within their service.

Cases of violence prior to institutional placement, as well as within the services themselves, are often downplayed or entirely overlooked/denied, resulting in a lack of support for residents in overcoming the consequences of their experiences. The concept of trauma assessment before entering institutions is unfamiliar to staff across all monitored services. In many of the case files reviewed by the team, there is a complete absence of information regarding residents' experiences before admission. This hinders the understanding of their specific needs and the development of appropriate support and violence prevention mechanisms. Failing to assess and document violence is a systematic error that leads to re-traumatization—residents do not receive the necessary psychological support, their traumatic experiences remain unrecognized, and the cycle of violence is further entrenched through institutional dependency: *"There is no violence; most of them don't go out anyway."*[12]

Limited contact with the outside world is perceived as a protective measure. The staff seems to believe that violence can only occur outside the institution, not within it. Although individual support plans formally include goals related to community integration and achieving independent living, there are no concrete steps to implement these goals in practice. This creates an illusion of change, while the reality remains the same—residents are trapped in institutional dependency, deprived of meaningful opportunities for autonomy.

Despite the evident material improvements, the current model of social support does not offer real alternatives for transitioning to independent living. Through its control over personal life, financial resources, and daily activities, the system reinforces institutional dependency, confining residents within an established framework that closely resembles the large institutions of the past. This creates a significant power imbalance, where the institution—presented as "protection"—ultimately becomes a tool for oppression and punishment, depriving individuals of meaningful social inclusion and autonomy.

For the purposes of this report, it is essential to highlight that at the core of all forms of violence—particularly gender-based violence and violence against people with disabilities—lies a power imbalance. In an institutional setting, all service users are placed in relationships defined by this imbalance: they are the "children" under the authority of highly authoritarian "parents" in the form of the institution. These "parents" set the rules,

[12] From an interview with a manager of residential institution.

organize daily life, and impose punishments when the rules are not followed. Punishments are perceived as a form of care rather than as acts of violence. In reality, punishments such as isolation, restriction of access to personal belongings and resources, physical aggression, shouting, or medicalization serve as mechanisms of control. These methods contribute to the re-traumatization of users and divert the true needs of violence survivors away from professional support and assistance.

Medical measures, such as periodically sending individuals to psychiatric hospitals as a preventive strategy for managing a "crisis" through medication—rather than offering psychotherapeutic support—can be seen as a means of suppressing undesirable behaviours and disciplining service users. This raises the question of whether these measures are genuinely aimed at improving health or are instead a method of exerting control over vulnerable groups.

The power imbalance is also evident in the way staff communicate within the visited institutions. Labelling and defining residents based on their diagnoses is a normalized practice. Diagnoses are not merely medical classifications but become a tool for marginalization. The entire institutional framework—even the informal naming of different floors—is based on diagnostic categories. This reinforces discrimination and entrenches stereotypes, limiting the ability of residents to participate fully in life both inside and outside the institution.

The case of the elderly man diagnosed with dementia upon entering an institution illustrates a dual problem: on one hand, the trauma he experienced before institutionalization, and on the other, the systemic failure to examine that trauma, which leads to continued violence under the guise of treatment and protection. This case highlights how violence extends beyond physical assault—it is embedded in how the institutional system treats the victim. The man was swiftly referred to a hospital, diagnosed with dementia, and placed in an institution. Through the forced application of diagnostic labels, the system subjects him to institutional dependency, where violence is reframed as "care" and control methods contribute to a suppressed, discouraging, and hopeless environment.

The patriarchal “parent-child” model of “care” not only perpetuates the marginalization of vulnerable groups and the division between the “capable” and the “incapable,” but it also creates direct risks for residents by suppressing critical topics.

The lack of open discussion about sexuality hinders the establishment of clear boundaries and consent. As a result, residents become more vulnerable to sexual violence and exploitation. Patriarchal parental models and censorship around intimacy reinforce

traditional stereotypes and leaves lasting psychological scars—women, in particular, may experience guilt, shame, and insecurity, increasing their vulnerability. Overcoming these issues require a fundamental rethinking of institutional culture, including the promotion of open dialogue. Additionally, the concept of "family relationships" within institutions makes separation and independence even more difficult, embedding psychological mechanisms such as guilt and fear into the idea of leaving.

Recommendations

1. **Recognizing that gender-based violence also affects individuals residing in social services.** This entails a review of legislation from the perspective of social services and protection against gender-based violence, identifying measures for:
    - Prevention of institutionalization, including cases resulting from experienced gender-based violence;
    - Identifying measures to prevent gender-based violence both in social services and in the community;
    - Establishing mechanisms for reporting cases of violence, including procedural facilitations, complementary and alternative means of communication (both low- and high-tech), etc.;
    - Ensuring support in exercising access to justice;
    - Guaranteeing psychological and social support for survivors of violence.

These actions should be undertaken by the Council of Ministers, in collaboration with the Ministry of Justice, human rights protection bodies such as the Ombudsman and the Commission for Protection against Discrimination, including in their role as monitoring bodies for the implementation of the CRPD.

2. **Providing comprehensive individual support and opportunities for the personal development of each resident**—education, social interactions, connections with relatives and the community, meaningful use of free time, employment, and other measures based on the principles of empowerment and personal autonomy—to end the institutionalization of people residing in residential services.

To implement this recommendation, the failure of the social system to address the individual needs of people with disabilities and the reasons for the continued return to institutional models must be analyzed. This requires the efforts of human rights bodies,

specialized state authorities such as the Agency for Social Assistance, authorities responsible for ensuring the quality of services such as the Agency for Quality of Social Services, service providers, and non-governmental organizations advocating for the rights of people with disabilities.

3. **Ensuring training for staff and residents related to human rights and handling cases of gender- and disability-based violence.**

To implement this recommendation, Agency for Social Assistance, the Agency for Quality of Social Services, human rights protection bodies, and law enforcement agencies must develop sensitivity to the need to address the issue and increase awareness and sensitivity to gender-based violence in social services. They must proactively seek resources to provide such training, which can be conducted by organizations and experts with expertise in this field. The experiences of survivors (experts by experience) should be taken into account when designing training programs and developing the content of educational curricula.

4. **Establishing mechanisms for identifying, reporting, and responding to cases of violence, including gender- and disability-based violence.**

Reporting mechanisms should include providing appropriate and individualized means, including technical solutions, that allow residents to submit reports to competent authorities and organizations working with survivors. Such means may include mobile phones, various forms of Augmentative and Alternative Communication, regular access to an independent monitoring entity, ensuring opportunities for contact with the community, and creating trust-based relationships with community members.

Response mechanisms should include mandatory notification of competent authorities, seeking support from other organizations (for staff), and providing psycho-social support to survivors.

Implementing this recommendation requires multidisciplinary collaboration between the Ministry of Justice, the Agency for Social Assistance, human rights protection bodies, NGOs, AAC experts, communication intermediaries, and others.

5. **Ensuring that national and European funding for social services strictly prevents institutionalization practices, neglect of individual approaches, and disregard for the traumatic experiences of survivors of gender-based violence, as well as any form of violence within services.**

To achieve this, managing authorities of European funds must be actively engaged, and a mechanism must be established to identify violations of fundamental rights when using

national and European funding. This mechanism should be accessible not only to potentially affected individuals but also to NGOs and human rights protection bodies.