

# Living in Tyrol – Part 3: Living like everyone else

36 questions for independent  
inclusive living and  
deinstitutionalisation



A Position Paper by the Tyrolean  
Monitoring Committee for promoting,  
protecting and monitoring the  
implementation of the Convention on the  
Rights of Persons with Disabilities



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# Contents

Contents .....	1
Foreword .....	3
Aim .....	3
General .....	4
Using the Questions .....	5
Individuals .....	5
Groups .....	5
Government and politics .....	6
36 questions when assessing residential facilities .....	6
Question 1: How big is the institution overall? .....	7
Question 2: Are there separate areas for living and working? .....	7
Question 3: Who lives in the institution? .....	7
Question 4: Do residents have a say in the selection of new residents? .....	8
Question 5: Is the institution subdivided into residential groups? .....	8
Question 6: How many people are rooms designed for? .....	8
Question 7: How are group facilities or shared accommodation arranged? .....	8
Question 8: How is housework organised? .....	9
Question 9: How is cooking organised in the residential group or shared accommodation? .....	9
Question 10: Who prepares meals in the residential group or shared accommodation? .....	9
Question 11: How is the meal plan created? .....	10
Question 12: Who does the shopping? .....	10
Question 13: What happens when it comes to choosing a doctor? .....	10
Question 14: How are therapists selected? .....	12
Question 15: Is there internet access? .....	12
Question 16: Can residents make phone calls privately and independently? .....	12
Question 17: Can residents leave the institution by themselves (to run errands, attend appointments, go on visits, go shopping, go for walks, do leisure activities, go to concerts or the cinema, etc.)? .....	13
Question 18: Can residents have visitors? .....	14
Question 19: Are long-term relationships supported? .....	14
Question 20: What rules are there in the residential group or shared accommodation? .....	15
Question 21: Is data protection guaranteed? .....	15
Question 22: How does the institution deal with personal documentation? .....	16
Question 23: Is Easy Read (ER) and plain language used? .....	16
Question 24: Are Augmentative and Alternative Communication (AAC) methods and communication materials used? .....	16
Question 25: Are non-verbal forms of communication observed and taken seriously? .....	17
Question 26: Is validation used in communication with older people with disabilities or people with progressive memory loss (dementia)? .....	17
Question 27: What support is provided to people who do not communicate? .....	17
Question 28: What aids and resources are available? .....	17
Question 29: How are holidays/travel organised? .....	18
Question 30: How are adult representatives (as provided for under the Second Protection of Adults Law) involved with supported decision-making? .....	18
Question 31: Do residents have control over the money available to them? .....	19
Question 32: Are person-centred planning meetings organised and/or is person-centred planning undertaken? .....	19
Question 33: Is it possible to change institution, form of support or support person? .....	19
Question 34: Do residents have a say at the institution? .....	20

Question 35: Are there any restrictions on freedom? .....	20
Question 36: Are residents able to lodge complaints? .....	22
Implementation .....	23
Quality criteria .....	24
Conclusions .....	24
List of community-based services .....	25
Publication details .....	27
Appendix/Final notes .....	28

## **Preliminary remark 2025**

The following 36 questions were adopted by the Tyrolean Monitoring Committee on the Rights of Persons with Disabilities in February 2021 and later published in German. This was before the adoption of the UN Committee's [Guidelines on deinstitutionalisation, including in emergencies](#) in September 2022. Therefore, these 36 questions are sometimes more cautious than the UN guidelines. Nevertheless, with their many detailed questions, they can be valuable for processes of implementing deinstitutionalisation and are now made available here in English.

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Tyrolean Monitoring Committee on funding, protecting and monitoring the rights of persons with disabilities  
under the UN Convention on the Rights of Persons with Disabilities

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# Statement Living 3 – 36 questions for independent, inclusive living and deinstitutionalisation

## Foreword

In its Position Statement, the Tyrol Monitoring Committee refers to the UN Convention on the Rights of Persons with Disabilities, also abbreviated to the UN Disability Rights Convention or UN CRPD.

The Tyrolean Monitoring Committee makes every effort to integrate non-binary gender identities into the grammar of its texts.

## Aim

The aim of these questions is to prompt specific, detailed discussions on the requirements for community-based, supported living as set out in the UN CRPD.

The Tyrolean Monitoring Committee has already published two position papers on the topic of living regarding the UN CRPD. This paper is the third statement to address the details of inclusive living and deinstitutionalisation through 36 questions. The aim is to raise awareness, encourage reflection, and support planning and preparation for specific further development according to the UN CRPD (please see in particular Art. 19, “Living independently and being included in the community”):

- The 36 questions are designed to help people with disabilities evaluate their own living situations. What does inclusive living mean; what rights and obligations come with it; what support is useful; and what is right for me?

- The 36 questions are also designed to help everyone indirectly affected by disability and all employees working in disability services, to understand the rights of persons with disabilities and to encourage the enforcement of these rights.
- The 36 questions are intended to help decision-makers and politicians recognise what kind of environments foster inclusive living and to identify changes that need to be made in organising support services for persons with disabilities. Which services and what quality of support are required in and by support facilities to protect the rights of persons with disabilities? The key word here is deinstitutionalisation, as stipulated by the UN Disability Rights Convention.

These 36 questions are a work in progress. The Tyrolean Monitoring Committee will make every effort to ensure that future versions take into account the experience of those using them.

## General

What is deinstitutionalisation?

“This is the process of transforming support services: Instead of living in homes and residential facilities, persons with disabilities should live like everybody else.”<sup>1</sup>

Independent/inclusive living and deinstitutionalisation require structural changes in the provision of assistance and services for persons with disabilities, and continuous quality improvement on the part of service providers. The basic principle of “from care to attendance” has long been recognised and now needs to be pursued and enhanced by institutions and at all levels of planning, education and training. Firstly, people with disabilities must be guaranteed that these principles are recognised. Secondly, they need to have the possibility to demand the implementation of those principles. Independent/inclusive living and deinstitutionalisation form part of an important strategy that must be acknowledged politically and publicly,

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<sup>1</sup> Quote from the German Institute of Human Rights, see: [Deutsche Institut für Menschenrechte](#);

in order to reduce violence in institutions. As a quote from the official Austrian study on violence against persons with disabilities (BMASGK 2019) highlights: “In discussions with experts, it was repeatedly pointed out, that violence between residents is usually the result of conflict arising from cohabitation and is attributable to disproportionate structural restrictions on autonomy and independence, such as the lack of opportunity to get away, invasions of privacy (including by caregivers), fixed washing and eating times and so on. Structural violence therefore intensifies interpersonal violence. A further structural risk factor for experiences of violence is lack of freedom of choice in the selection of support persons.”<sup>2</sup>

## Using the 36 questions

### Individuals

Individuals can read the questions and compare what they have read with their own situation, experience and knowledge. They can also use them as the basis for initiatives to improve their living conditions.

### Groups

We expressly recommend using these questions as a basis for group discussion or peer counselling. Groups of people with disabilities – or mixed inclusive groups – can work with a group leader (e.g. from peer counselling, coaching or professional group leadership) to consider different issues addressed in the questions. This encourages people to talk about their own experiences with living conditions and discuss those with others. It also encourages people to think about ways of supporting people with disabilities, including political demands, negotiations and activities.

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<sup>2</sup>Quote from an Austrian Federal Ministry for Social Affairs, Health Care and Consumer Protection (BMASGK) study by Hemma Mayrhofer, Anna Schachner, Sabine Mandl, Yvonne Seidler (2019): “Erfahrungen und Prävention von Gewalt an Menschen mit Behinderungen” (Experiences of Violence Against Persons with Disabilities and how to Prevent Them) Vienna: BMASGK, page. 463.

## **Policy makers and public administration**

Those who are responsible for introducing measures to meet the obligations of the UN Convention on the Rights of Persons with Disabilities can use the 36 questions to develop realistic and specific goals for everyday inclusive living and deinstitutionalisation in Austria.

This will enable the development of indicators for the implementation of the UN Disability Rights Convention, the review of regulation and funding programmes relating to governance and the planning of/decisions on resource redistribution to promote further deinstitutionalisation. These questions are designed to support good public planning that takes account of human rights.

## **36 questions for evaluating residential facilities**

Often, more than one potential answer is provided to the 36 questions below. They represent realistic estimations of what constitutes deinstitutionalisation within the meaning of the UN Convention on the Rights of Persons with Disabilities. Discussion about the different answers will help with awareness-raising (UN CRPD, Art. 8(2)(d)). Comments associated with the questions – where these are available – should equally be understood and applied.

Potential answers are ordered in line with the Tyrolean Monitoring Committee's approach of using the first few categories to indicate circumstances that are widespread in institutions but do not comply with the requirements of the UN Convention on the Rights of Persons with Disabilities or scarcely comply with it. As the answer categories continue, they move closer to the requirements of the UN CRPD. However, the list should not be mistaken for a step-by-step guide to institutional reform. The aims of the UN CRPD are clear and explanatory comments from the UN Committee on the Rights of Persons with Disabilities are very useful for gaining a deeper understanding (CRPD 2017)<sup>3</sup>. Long-term development plans that take small steps are of course useful but the goals of the UN CRPD are best delivered by specific restructuring and redistribution (of funds, staff and structural resources) with a direct impact.

Do the structure and daily routine of residential facilities comply with the UN Disability Rights Convention? The following 36 questions can be used as a springboard for further reflection to assess and discuss about residential facilities:

**Question 1: How big is the institution?<sup>1</sup>**

- a. Bigger than 30 residents
- b. 10 to 30 residents
- c. 4 to 10 residents
- d. Single flat for up to 4 residents
- e. Independent living in a flat of different potential sizes (with free choice for external support services, living alone, living as a couple, living in a shared flat/house chosen by residents themselves, living in a family/living in a cohabitation arrangement)

**Question 2: Are there separate areas for living and working?<sup>2</sup>**

- a. Residential areas and sheltered workshop areas are both situated in the same complex; living arrangements and daily routines are interconnected for persons with disabilities; housemates and workmates are largely the same people.
- b. Areas for living and recreation are separate from work areas; housemates and workmates are not the same people.

**Question 3: Who lives in the institution?<sup>3</sup>**

- a. The institution accommodates people of all ages, from infants to the elderly, in predefined living arrangements.
- b. There is strict gender segregation at the institution.

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<sup>3</sup> CRPD – Committee on the Rights of Persons with Disabilities (2017): General comment No. 5 (2017) on living independently and being included in the community; [Convention on the Rights of Persons with Disabilities](#);

- c. The accommodation requirements of different age groups – children, young people, adults and older people – are taken into account.
- d. It is possible for people of different genders or sexual orientations to live together.
- e. People have real choices about their living arrangements and decisions about who lives with whom.

**Question 4: Do residents have a say in the selection of new residents?**

- a. The institution determines who joins the residential group or shared accommodation.
- b. The institution decides who joins the residential group or shared accommodation after a get-to-know-you meeting and after talking to current residents.
- c. Residents and institution managers decide together who will join the residential group or shared accommodation.
- d. Residents decide independently who lives with them.

**Question 5: Is the institution subdivided into residential groups?**<sup>4</sup>

- a. Into groups of over 10 residents
- b. Into groups of 5 to 10 residents
- c. Into groups of up to 5 residents

**Question 6: How many people stay in one room?**

- a. Over 5 people
- b. 3 or more people
- c. 2 people
- d. Single rooms

**Question 7: How are group facilities or shared accommodations arranged?**

- a. Toilets and washrooms are located outside the living areas (e.g. in the corridor).
- b. Residents cannot lock their own living space/do not have a key.
- c. The furnishings are already provided and cannot be changed or only limited changes are possible.

- d. Rooms have their own lockable washroom with toilet and shower.
- e. Residents' living areas are lockable and residents have their own key.
- f. Residents have their own front door key.
- g. Access to the residential complex is designed in accordance with the "Two-Senses Principle" (audible, visible, touchable). Residential complex refers to the resident's private living space/room and information systems.
- h. Residents can arrange the furnishings in their own living space if they wish.
- i. Doorbells are labelled with residents' names not the name of the institution.

### **Question 8: How is housework organised?**

- a. Housework is organised by the institution.
- b. An external cleaning service does the cleaning, tidying, etc.
- c. Residents do some of the housework themselves.
- d. Residents make their own decisions on housework themselves; there are support meetings with institution employees.
- e. Residents do the cleaning, tidying etc. themselves with some assistance.

### **Question 9: How is cooking organised in the residential group or shared accommodation?**

- a. There is no cooking – all meals are provided and there are fixed mealtimes.
- b. Residents can prepare snacks, but only in some cases.
- c. Main meals are sometimes cooked in the residential group.
- d. Main meals are always cooked in the residential group.
- e. All meals are prepared in the residential group.
- f. There is restricted, controlled access to the kitchen, fridge and food.
- g. The kitchen and fridge are open and accessible at all times.
- h. Regular discussions take place and decisions are taken jointly about when (main) meals are cooked and eaten.

**Question 10: Who prepares meals for the residential group or shared accommodation?**

- a. Residents are never or rarely involved.
- b. Residents are present during cooking and can perceive the activity with all their senses.
- c. Residents are involved with cooking.
- d. Residents perform specific cookery tasks.
- e. Residents cook independently, alone or with others.
- f. Residents cook independently with personal assistance or with the support of in-house staff.

**Question 11: How is the meal plan created?**

- a. By staff.
- b. Residents participate to a certain extent in the creation of the plan.
- c. The plan is drawn up together with residents.
- d. If necessary, images of meals are used when drawing up plans together.
- e. Residents draw up their own meal plan independently.
- f. “Unhealthy” dishes are also permitted in the meal plan.
- g. Residents draw up their own meal plan as they wish, with assistance or with the support of in-house care staff.

**Question 12: Who does the shopping?**

- a. A bulk purchase is delivered.
- b. A daily purchase is delivered.
- c. Residents sometimes go shopping, possibly with support staff.
- d. Residents often go shopping, possibly with support staff.
- e. Residents go shopping by themselves.
- f. Residents choose their own products independently.

**Question 13: How are doctors selected?**

- a. One doctor is responsible for the whole institution or the institution selects a doctor (doctors).
- b. Medication is prepared for and administered to residents without employees providing more detailed information.
- c. Residents can visit the doctor individually.

- d. Residents are supported in their contact with doctors. The nature of illnesses, treatment options and therapies are presented in an understandable way.
- e. Residents make decisions about treatment on the basis of the support provided.
- f. Health advice is provided and support is given to residents to help them choose their own doctor.
- g. Medication is only administered to treat individuals (and is not used as a sedative or tranquilliser in order to make everyday life at the institution manageable – for the purposes of “social regulation”).
- h. Residents are involved in the preparation of their medication (e.g. filling pill boxes together).
- i. Residents are well informed about effects and side-effects and know what the medication they are prescribed is for.
- j. Medication is taken independently by residents with appropriate support.
- k. Medication is kept with residents, who make independent decisions about taking it.
- l. Residents are involved in decisions on treatment options. Alternative treatment methods are explained to them. They are therefore supported to enable them to make decisions about treatment methods.
- m. Residents are supported to evaluate the risks of treatment themselves, particularly surgical procedures. So that they can make decisions about it and in particular whether they wish to proceed with surgery.

#### **Question 14: How are therapists selected?**

- a. Therapists are directly employed by the institution – residents have no choice.
- b. External therapists are brought in by the institution.
- c. Residents are given the opportunity to choose external therapists.
- d. Residents are advised, informed and supported when selecting therapists; they understand the alternatives and choose the therapy or type of therapy and the therapist (no therapy against residents’ will).
- e. Therapists also do home visits if it is not possible for residents to visit them independently.

**Question 15: Is there internet access?**

- a. Not available to residents.
- b. Available to residents.
- c. Available to residents; use is supported.
- d. Residents are supported to enable them to acquire and use high-quality technical devices and to access the internet.
- e. Residents are adequately informed about the risks and dangers of internet usage (data protection, purchase offers, internet crime, etc.) and given support so that they do not expose themselves to obvious risks.

**Question 16: Can residents make phone calls privately and independently?**

- a. The institution does not have the technical equipment for making/receiving private phone calls.
- b. No independent support, i.e. people independent of institution staff, is available to residents making phone calls (the institution does not have independent staff or offer personal assistance).
- c. Residents do not have mobile phones.
- d. Residents can make phone calls in private using phones provided by the institution.
- e. Personal mobile phones are made available to residents.
- f. Residents are supported to acquire and use high-quality technical devices to make and receive phone calls.
- g. Full support is provided to enable residents to make private phone calls, either independently or with support.
- h. Deaf residents are being enabled to make video calls.
- i. Residents are also supported to use alternative communication methods (WhatsApp, Signal, Skype, Zoom, etc.).

**Question 17: Can residents leave the institution by themselves (to run errands, attend appointments, go on visits, go shopping, go for walks, do recreational activities, go to concerts or the cinema and so on)?**

- a. Residents need to ask for permission if they wish to leave the institution.
- b. Residents are generally only permitted to leave the institution in groups.
- c. Residents must inform staff if they wish to leave the institution and give their reason for doing so.

- d. Residents must inform staff if they wish to leave the institution; they do not have to give a reason.
- e. Residents are told when they must be back at the institution.
- f. If residents require support to leave the institution, this is generally only possible in groups.
- g. Residents can access adequate support and assistance if they wish to leave the institution on their own.
- h. Residents can organise external/independent support workers and assistants if they wish to leave the institution.
- i. Residents are not subject to stricter rules than any other members of the community in the context of any general restrictions on going out. Residents are not affected by stricter rules than all other citizens, if restrictions on going out are applied. (such as during the Covid-19 crisis).
- j. Residents are permitted to stay out for longer periods, for example overnight.
- k. In principle, residents decide when they go out.

**Question 18: Can residents have visitors?**

- a. Visits are not possible or cannot be arranged freely.
- b. Visits are possible, but only when supervised by caregivers.
- c. Visits must be notified in advance.
- d. Visiting times are set by the institution.
- e. There are rules on visits, which are set by the institution.
- f. There are rules on visits, which are set by the residents themselves or they expressly agreed with them.
- g. Residents may host visitors outside of their own room, undisturbed.
- h. Visits to residents' rooms are possible/permitted.
- i. Residents may invite visitors to meals.
- j. Residents have the right to exercise their sexuality and may host other people in their own rooms, undisturbed.
- k. Partners of residents may stay overnight at the institution, if both partners wish to.
- l. Partners may also stay overnight in resident's rooms.
- m. Residents may visit each other's rooms within the institution.

**Question 19: Are long-term relationships supported?**

- a. Residents' relationships are impeded.

- b. Residents' relationships are not impeded.
- c. Advice and support is provided on the topic of partners and relationships.
- d. Support is available for the day-to-day conduct of relationships (e.g. support with travelling by bus, tram or taxi, if the partner lives elsewhere).
- e. Partners may live together in a shared flat.
- f. Assistance is provided on sexual matters.
- g. Assistance is provided with parenthood and parents may have their child living with them in the institution.

**Question 20: What are the rules governing the residential group or shared accommodation?**

- a. There are house rules, but not everyone is aware of them.
- b. Rules in the shared accommodation or residential group are fixed and cannot be altered or can only be altered to a limited extent.
- c. Privacy is not respected in the shared accommodation or residential group, e.g. rooms are entered without knocking.
- d. Residents can draw up, help to draw up or change the rules for shared accommodation or residential groups (e.g. who is responsible for what; whether pets are allowed; who does the cleaning; how is money spent jointly; what constitutes an acceptable noise level and when noise is allowed e.g. being considerate of others when having visitors or parties, etc.)
- e. Group rules are presented visually and explained to residents who cannot read.
- f. Residents may visit each other's rooms within the institution.
- g. Privacy is respected in the residential group. People knock before entering rooms.  
Other aids are available for deaf or hearing-impaired people, such as a mobile bell.

**Question 21: Is data protection guaranteed?**

- a. Residents do not have access to their own personal data and reports about their private circumstances. Personal data is not subject to any special protection and is passed on uncontrolled.
- b. Information is passed on confidentially, without the involvement of the individual.

- c. Information about residents is disseminated publicly or used in the media without the consent and authorisation of the person concerned (e.g. for advertising or publicity of the institution).
- d. People or institutions to which resident data is relayed are disclosed.
- e. The data relayed is disclosed.
- f. Information is relayed confidentially and only with the knowledge and involvement of the individual concerned.
- g. Information and data are only relayed or used in the media with the full consent and authorisation of the individual concerned.

**Question 22: How does the institution deal with personal documentation?**

- a. Residents do not have access to documentation.
- b. Residents are aware of documentation and occasionally have specific opportunities to view it.
- c. Residents are aware of documentation and have the right to view it any time.
- d. Residents have a say in what goes into documentation and can request that changes be made.
- e. Residents may get a copy of documentation if they wish.
- f. Residents automatically get a copy of documentation, in Easy Read language where necessary.
- g. Residents are systematically supported and accompanied in reviewing previous files.

**Question 23: Is Easy Read (ER) and plain language used?**

- a. The institution does not use Easy Read language.
- b. The institution uses some Easy Read language.
- c. Easy Read language is used as a matter of course.

**Question 24: Are Augmentative and Alternative Communication (AAC) methods and communication materials used?**

- a. AAC and communication materials are not used.
- b. Communication materials have to be requested.
- c. Non-electronic communication aids are used (for example pictograms).

- d. Electronic communication aids are used (e.g. talking devices, speech processors etc.) and are made available to individuals.
- e. AAC is used as a means of expression (for people who understand spoken language well but do not have adequate opportunities to express themselves).
- f. AAC is used as a means of language acquisition (for people whose spoken language requires additional aids or signing-supported communication).
- g. AAC is used as a linguistic device (for people who cannot use spoken language themselves).
- h. Sign language, easy sign language and AAC are used.
- i. Appropriate communication materials are always available.

**Question 25: Are non-verbal forms of communication observed and taken seriously?<sup>5</sup>**

- a. Not observed beyond routine, everyday requirements.
- b. Systematically observed and integrated into communication.

**Question 26: Is validation used in communication with older disabled persons or persons with progressive memory loss (dementia)?<sup>6</sup>**

- a. No awareness of validation.
- b. Some awareness of validation but rejected without explanation.
- c. Awareness of validation but rejected with explanation.
- d. Awareness of validation and elements of the technique are sometimes used.
- e. Awareness of the various communication methods involved with validation and application as part of everyday life by support persons and assistants.

**Question 27: What support is provided to people who do not communicate?<sup>7</sup>**

- a. Basic care and support to sustain life are ensured; the person concerned lives in isolation.
- b. Care and support using “as-if communication”.
- c. Nurturing care, support and attention using “as-if communication”.
- d. No exclusion from everyday social life; the person is given the chance to experience their environment.
- e. All support and assistance activities are reported verbally or in a form of communication that is accessible to the person concerned.

- f. Individual care and support plans include individuals' history and involve their relatives and friends (if desired).

**Question 28: Which assistive devices and resources are available?**

- a. Residents have very few assistive devices or resources. If they do, they are not provided with advices about them.
- b. Good-quality assistive devices and resources are available as necessary to meet the needs of different situations (range of wheelchairs etc.).
- c. Assistive devices of good quality are available to cope with everyday life.
- d. Mobile assistive devices and resources relating to vital needs are available (to aid breathing etc.).
- e. There is good advice on assistive devices and residents are involved with choosing tools and assistive devices (e.g. visiting rehab trade shows).

**Question 29: How are holidays/is travel organised?**

- a. Holidays are spent at the institution.
- b. Holidays are organised as group excursions.
- c. Holidays are organised in large groups to pre-defined locations/facilities.
- d. Holidays are made possible through desired und individual excursions.
- e. Holiday trips are permitted as requested and support is provided for individuals or small groups.
- f. Holidays can also be taken through third party providers.

**Question 30: How are adult representatives (as provided for under the Second Protection of Adults Law) involved with supported decision-making?**

- a. In practice, support is not much different from previous guardianship arrangements.
- b. Work is ongoing to develop or improve practical support for decision-making.
- c. Support for decision-making is provided by institution employees.
- d. Residents can select individuals to assist with supported decision-making; these may also be external persons.
- e. Supported decision-making is becoming the norm.

**Question 31: Do residents have control over the money available to them?**

- a. The institution has a direct influence over what residents spend their money on. Either counsellors are doing the shopping for the residents or they make money available only for certain types of shopping.
- b. The institution indirectly influences what residents spend their money on by asking residents to explain and/or justify what they intend to do with their money.
- c. The institution influences what type and quality of goods residents purchase with their own money, independently of the money available.
- d. Understanding support staff advise and support residents on how to use their money, keeping their own values to themselves.
- e. Residents are free to decide how to use the funds available to them.

**Question 32: Are person-centered planning meetings organised and/or is person-centered planning undertaken?**

- a. There is no awareness of person-centered planning meetings/meetings are not organised.
- b. A few person-centered planning meetings are organised.
- c. Person-centered planning meetings are regularly organised.
- d. There are long-term support circles.
- e. Peers are involved, designing person-centered planning meetings or individual plans for the future.

**Question 33: Is it possible to change institution, form of support or support person?**

- a. Living arrangements, place of residence and support persons are fixed; they cannot be changed.
- b. Residents are directly or indirectly hampered or prevented from changing their living arrangements and/or place of residence.
- c. It is possible to change residential group or shared accommodation.
- d. Requests to change support persons (employed at the institution) can be made without incurring either direct or indirect sanctions.
- e. Residents can choose their own support persons, provided they work at the same institution.

- f. Residents can move to less restrictive living arrangements and/or change their place of residence and are given support with doing so e.g. moving from shared accommodation to supervised accommodation or from supervised accommodation to independent living with personal assistance or with other kind of individual support.
- g. Residents can move to less restrictive living arrangements and choose support persons, regardless of the degree of support they require.

**Question 34: Do residents have a say at the institution?**

- a. There are hardly any opportunities to express wishes regarding the development of the institution.
- b. In principle, residents can express their views and are encouraged to do so at the institution.
- c. There are regular get-togethers where all residents are informed about the institution's development.
- d. Residents can help steer the development of the institution; there is genuine participation in decision-making.
- e. The institution management takes the requirements of the UN CRPD on the rights of persons with disabilities very seriously. Together with residents, the institution is developing a plan to dismantle old institutional structures and create new housing options that enable residents to be involved and have autonomy.
- f. Residents have a say in deciding which employees to hire.
- g. There is (independent) representation of interests at the institution and/or the service provider.

**Question 35: Are there any restrictions on freedom?**

- a. Mechanical restraints are used.
- b. Psychopharmacological drugs are administered/dispensed at the institution. Residents' representatives are not informed about the use of chemical restraints.
- c. Measures that restrict freedom are not recognised as such and are not reported.
- d. Staff is not aware of the requirements governing the admissibility of restrictions on freedom.

- e. Training has been provided (for residents and employees) at the institution on the Federal law on the protection of personal liberties during long-term residential care.
- f. Employees are aware of the requirements governing the admissibility of restrictions on freedom.
- g. Employees know which measures constitute (may constitute) restrictions on freedom.
- h. Measures that restrict freedom are discussed with residents before being put in place.
- i. Residents' consent is obtained before a measure is put in place that restricts freedom (AAC is also used).
- j. Milder alternatives are sought and discussed before putting a measure in place that restricts freedom.
- k. Any measures that restrict freedom are documented, including their duration.
- l. Any restrictions on freedom are reported to residents' representatives.
- m. The institution notifies residents' representatives about any mechanical and chemical restraints.
- n. The necessity of restrictive measures triggers internal pedagogical or therapeutic discussions, during which milder measures are explored.
- o. Less restrictive alternatives are developed and discussed with residents.
- p. The use of restrictive measures triggers requests to external parties to provide staff with pedagogical/therapeutic advice and/or training.
- q. The use of restrictions on freedom triggers supervision.
- r. The use of restrictions on freedom triggers consideration of structural changes.
- s. The use of restrictions on freedom triggers consideration of staff changes.
- t. No measures to restrict freedom are put in place.

**Question 36: Are residents able to make complaints?**

- a. There is no possibility for persons with disabilities to complain.
- b. Complaints are not taken seriously or are interpreted as part of the disability/as disruption by the individual.
- c. Complaints can be made to direct caregivers/support persons and are dealt with individually.
- d. Complaints are discussed in the care/support team without the person concerned.

- e. Complaints are discussed in the care/support team with the person concerned.
- f. It is open to residents to contact an independent person and make a complaint.
- g. It is open to residents to contact an independent organisation and make a complaint.
- h. Residents are informed in advance of independent organisations where they can make complaints.
- i. Opportunities to contact an independent person or organisation and to make a complaint with them are easily accessible (for example, the person comes to see residents at the institution at regular intervals).
- j. Residents can make anonymous complaints.
- k. The institution has a body representing residents' interests with which residents can make complaints.
- l. There are selected house spokespersons, who provide support with complaints.
- m. Everybody is adequately informed about the complaints arrangements and can make use of them without fearing that there will be repercussions.

## Implementation

### **Community-based or local services to prevent segregation and the implementation of deinstitutionalisation:**

“Often, individuals with disabilities cannot exercise choice because there is a lack of options for them to choose from. This is the case, for instance, where informal support by the family is the only option, where support is unavailable outside of institutions, where housing is inaccessible or support is not provided in the community and where support is provided only within specified forms of residence such as group homes or institutions.” (CRPD 2017, paragraph 25)<sup>4</sup>

Community-based/regionally accessible support services, social services and medical services are structural prerequisites for successful deinstitutionalisation and can be deployed on a preventive basis to prevent institutionalisation/segregation.

Regional development plans must include support for people with disabilities, the elderly and people with psychosocial disabilities (e.g. for persons with psychiatric disorders), taking a holistic approach that is designed to ensure an inclusive day-to-day experience.<sup>5</sup>

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<sup>4</sup> Committee on the Rights of Persons with Disabilities (CRPD) (2017): [General comment No. 5 \(2017\) on living independently and being included in the community](#); \_

<sup>5</sup> In 1993, Austria made attempts to set standards and put structural measures in place to provide for community-based services, through a Federal-Federal State Agreement (15a Contract) “on joint measures by the Federation and the Federal States for persons requiring care” ([15a-Agreement](#): <http://bidok.uibk.ac.at/projekte/behindertenbewegung/docs/15a-vereinbarung-1993-pflegebeduerftige-personen.pdf>). This initiative was based on a report prepared by the Ministry of Social Affairs in 1990. However, the 15a-Contract was never implemented. [Link to report: Report by the working group on support for persons requiring care](#)

## Quality criteria

### Questions on quality criteria (indicators) for community-based services or services that are at least available in the district:

1. Are persons who are requiring support guaranteed the freedom to choose organisations and support persons?
2. Is the necessary support available around the clock, if required (including at weekends and on public holidays)?
3. Is there a holistic approach to the provision of support, and is such support not spread too thinly across a range of service providers (support is therefore geared to everyday life and a holistic view of need)? <sup>6</sup>
4. Can support be accessed quickly (mobile phone, emergency call system, email etc.)?

## Conclusions

The greater the availability of the services listed below, in a region where they meet actual needs and the better, they correspond to the four quality criteria outlined above, the better the chances are of successfully introducing measures to encourage deinstitutionalisation and prevent segregation in institutions for disabled people, older people and psychiatric patients. The key is to ensure that these services are developed on a community basis and meet actual needs. Reallocating the financial resources and personnel associated with institutions to community-based services aims to ensure that this happens. Under no circumstances should community-based services be viewed as merely an add-on to large, unchanged, centralised facilities or be reduced to a solely preventative function.

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<sup>6</sup> A holistic approach means: In personal assistance, for example, one person provides assistance on one day (or for a selected period of time) with shopping, cooking, accommodation cleaning and personal care. In this example, if no personal assistance is available, independent services would be needed to provide support with going out (to go shopping), as would delivery services, meals on wheels, home help/cleaning services and personal care services. To manage everyday life, then, a person requiring support not only needs many different services but must usually also accept that they will not be able to choose the people providing such support.

## List of community-based services

These can support deinstitutionalisation and strengthen community-based inclusion. This is not an exhaustive list.

- Centre for Independent Living – advice and assistance when claiming personal assistance<sup>7</sup>
- Open community day centre; professionally supported meeting place for recreation, self-help, advice, social engagement, and education (adult education)
- Counselling centre providing support with applying for and using a personal budget (support with hiring personal assistant(s), wages accounting service)
- Mobile services; holistic, professional support services and assistance
- Family support services and child assistance (see for example: [YouTube-Video](#))
- School assistance
- Personal assistance at school
- Personal assistance at work
- Special help with running households (meals on wheels, laundry care, cleaning and repair service = rapid service to repair technical devices, etc.)
- Reading aloud service
- Contact centre for sign language interpretation
- Accessible, usable public transport
- Accessible, usable taxis

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<sup>7</sup> Advice and support in accordance with the “peer counselling” principle; a range of holistic personal assistance services provided by suitable laypersons on the instructions of the individuals concerned. This includes assistance at work and support from mentors for people with learning difficulties (example: the [Swedish Service Guarantor System](#)).

- Nursing care
- All forms of outpatient and mobility support for older people
- Mobile, activity-based medical/therapeutic support and advice
- Advice on accessibility/accessible construction
- Supported multi-generational shared accommodation
- Multi-generational and inclusive living housing facilities
- Home visits by general practitioners
- Home visits by specialist doctors
- Home visits by social education workers and psychotherapists
- Group practice with general practitioners, specialist doctors and psychotherapists working as a team
- Outpatient and mobile treatment services
- Outpatient and mobile psychosocial services
- Outreach crisis intervention teams and emergency services
- “Establishment of multidisciplinary teams: including social workers, psychologists, medical and technical services, social care, specialist care workers (advanced nurse practitioners), stationary and mobile mediators e.g. mobile outpatient departments and (specialist) medical buses for diagnosis and treatment.”<sup>8</sup>
- Palliative medical care and mobile hospice service
- Short-term care “holiday dialysis”, etc.
- Advice: Legal advice, advice on financial and residential matters
- Advice on assistive devices and resources (linked to a pool of resources and assistive devices)
- Regional social advisory boards to provide advice in the community, and a supervisory and appeals body, periodically selected by secret ballot of the persons concerned.

Mag.<sup>a</sup> Isolde Kafka

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<sup>8</sup>Quote from: Care Taskforce Supporting the Process of Drawing Up Targets, Measures and Structures. Findings. Vienna, January 2021, Commissioned by the Federal Ministry for Social Affairs, Health, Care and Consumer Protection, page 12.

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Picture © Lebenshilfe für Menschen mit geistiger Behinderung Bremen eingetragener Verein  
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## Appendix/Endnotes

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**1 Notes on Question 1:** Two quotes on size: “In one of the largest comparative studies ever undertaken in Europe on the topic of de-institutionalisation (DECLOC), the authors expressly pointed out that there is a proportional relationship between the size of an institution and the likelihood of low service quality and potential for violence against residents. It must be noted, however, that smaller accommodation does not in itself guarantee that a facility will not have an institutional culture. There are a number of other factors, such as the extent of choice exercised by service users, the level and quality of support provided, participation in the community and quality assurance systems used which impact on the quality of the service.” (European Expert Group [2012]: Common European Guidelines on the Transition from Institutional to Community-based Care. Brussels, page 27)

**2 Notes on Question 2:** Merging residential and daily structures, where housemates and workmates are largely the same people, with hardly any alternatives, represents a particular structural stress factor for people with disabilities. This can create a variety of psychosocial frictions and lead to forms of bullying or even violence. On violence prevention grounds alone, living and working areas should be separate and inclusive forms of work and supported employment should be systematically promoted.

**3 Notes on Question 3:** Children and young people are often overlooked when considering the subject of accommodation. The absence of effective family support/respite services means that children with disabilities live away from home for certain periods or have to live at an institution all year round. Due to a lack of acceptable alternatives, 18-year-olds with disabilities often have to move into a setting with many considerably older people with disabilities. For older people, this can be a benefit, but it is questionable whether these settings are an appropriate environment for young people’s development. The freedom to choose acceptable alternatives in line with the UN Convention standards must be guaranteed. This is at the heart of Art. 19 of the UN Convention on the Rights of Persons with Disabilities, which enshrines the right to choose your own place of residence on an equal basis with others, and to decide where and with whom children, young people, adults and older people with disabilities live. However, the right for children and young people to live with their parents with appropriate support is not negotiable. In order to avoid being compelled to have predetermined, special residential arrangements, appropriate community-based services that meet the UN-CRPD

aims must be created by public authorities. Please see the list and quality criteria for community-based services at the end of these Questions.

**4 Notes on Question 5:** Residential groups are part of a (larger) institution, shared accommodation is an independent facility without further subdivisions. Supervised or supported living are apartments for 1-3 people with external/mobile support. Supported living with autonomy and the freedom to choose acceptable support providers or use a personal budget in the context of employment are the acceptable housing models envisaged by the UN-CRPD and should be put in place.

The subdivision of institutions into residential groups, currently a widespread practice in Austria, does not change the assessment of overall institution size as outlined in Question 1. The Austrian Federal Monitoring Committee argues: "... the Committee has observed a particular strategy adopted by funding organisations in order to conceal the actual size of facilities. For example, when a residential group of six people is discussed, there is no mention of the fact that it is one of four residential groups in a single building. Parcelling the institution up into residential groups conceals the real number of residents." (Federal Monitoring Committee [2016]: Position Statement on De-institutionalisation, pages 9-10).

In its general comments, the UN Committee is very clear that independent living with autonomy and freedom of choice is the correct interpretation of the UN CRPD and rejects any form of control and supervision. This also applies to supported living: "Eliminate all forms of control and surveillance of residents in 'supported housing', and ensure their autonomy, freedom of choice and privacy; Ensure that implementation of the service ring is not any longer linked to institutions but promotes living independently and full inclusion and participation in the community" (CRPD 2019: Committee on the Rights of Persons with Disabilities; Inquiry concerning Hungary under article 6 of the Optional Protocol to the Convention, paragraph 114 b, iv and v; [Convention on the Rights of Persons with Disabilities](#)).

Important analysis and suggestions on "Ensuring the right to choose your residence freely" is provided by Ilse Zapletal (Ilse Zapletal [2020]: Freie Wahl von Aufenthalt und Wohnsitz. [Choosing your own residence] Vienna: Linde-Verlag). A summary (page 147 ff) mentions the following: "Separation of living and support/care"; "Accessible construction"; "Eliminating the separation between care for older persons and care for people with

disabilities”; standardised federal regulation of personal budgets on the basis of “care allowance sector” responsibilities; and reducing the concentration of wealth to increase opportunities for participation.

**5 Notes on Question 25:** Non-verbal forms of communication include, for example: breathing, muscle tension/posture, body movement facial expression/gestures/sounds, spoken language/pointing, eye movements/sign language/finger alphabet/individual systems (e.g. drawing letters in the air with the nose, tapping out coded letters).

**6 Notes on Question 26:** Validation is a well-known form of support for people with learning difficulties or (progressive) memory loss.

In conversation, for example, the person is not endlessly corrected. The focus is on what is meant.

The important aspect here is “unconditional appreciation”.

This promotes well-being and self-determination in the person with disabilities. It involves accepting people in their own reality.

Validation is a necessary fundamental attitude, not a technique or a therapy.

Read more about it here:

[Validation Therapy](#)

**7 Comments on Question 27:** Support for persons with so-called severe disabilities, whose reactions do not appear comprehensible at any level, and people in comas, poses the biggest challenges. Care often does not extend beyond basic medical and nursing care.

As a result of non-communication or the incomprehensibility of different reactions and non-verbal forms of communication, no relationship is established, as if there were no communication at all. However, as long as people live and are cared for, this does of course constitute a relationship and communication, even if it is not reciprocated. It is important here to develop an “as-if” attitude in day-to-day life and communication. This entails treating and communicating with the person as if they understand everything. Furthermore the person is included in everyday activities.

Coma research has shown that this kind of professional and everyday attitude (on the part of relatives and friends, too) is likely to lead to forms of communication and changes in alertness, enabling others to understand what is being expressed.

**8. Comments on Question 33:** For person-centred planning meetings, future planning and circles of support, please see international publications.

**9. Comments on Question 35:** Measures that restrict freedom include a variety of forms of physical force and medication. Signs of communication are often difficult to understand from staff members. Especially, if the person has a very severe disability. Nevertheless, restrictions on freedom do not constitute a professionally acceptable reaction. Restrictions on freedom intensify symptoms and do not resolve them, even if they are sometimes understandable as an emergency response. The desire to restrict freedom is always a warning sign that the institutional environment requires scrutiny and requires staff to have the capacity to understand and act appropriately.