



Independent Living Survey

Summary report, December 2022



ENIL's 1st Independent Living Survey Summary report

1. Introduction

On 30 June 2020, the European Network on Independent Living launched its first Independent Living Survey, with the aim of collecting general information about access to Independent Living of disabled people¹ across Europe, and detailed information about Personal Assistance schemes or systems. The online survey targeted countries within the Council of Europe area and was disseminated to ENIL members, as well as to the general public, through our Newsletter, website and social media.

The Independent Living Survey followed Personal Assistance (PA) tables, published by ENIL in 2013 and 2015, which included a smaller number of questions in relation to the provision of Personal Assistance. This time, a total of 97 questions were included, 22 in **Section I (General section on Independent Living)**, and 75 questions in **Section II (General information about the PA scheme/policy)**. The latter section covered the following areas: a) funding; b) eligibility and needs assessment; c) provision; and d) recruitment and working conditions of PAs. Section II was aimed exclusively at those countries which had some form of PA available. All the questions were available in English, German and French².

A total of 143 responses were received, 116 in English, 7 in French and 20 in German. The majority came from disabled people (including PA users) and organisations of persons with disabilities (see Annex I). In the end, responses from 43 countries were included in the analysis (see below, Table 1). A detailed description of the PA scheme/policy – i.e. the country sheets - is available for 30 countries. A response from the Russian Federation could not be verified, therefore it was not included in the analysis. No responses have been received for Andorra, Liechtenstein, Monaco and Switzerland.

¹ ENIL prefers the term 'disabled people' over 'persons with disabilities' or 'people with disabilities', in order to reflect the fact that people are disabled by the environmental, systemic and attitudinal barriers in society. This is in line with the social model of disability.

² To access the questions included in the survey, please go to: <https://enil.eu/news/enil-launches-independent-living-survey/>

| | | | |
|-------------------------|----------|-----------------|----------------|
| Albania | Denmark | Latvia | Romania |
| Armenia* | Estonia | Lithuania | San Marino* |
| Austria | Finland | Luxembourg* | Serbia |
| Azerbaijan | France | Malta | Slovakia |
| Belarus* | Georgia | Moldova* | Slovenia |
| Belgium | Germany | Montenegro | Spain |
| Bosnia and Herzegovina* | Greece* | Netherlands | Sweden |
| Bulgaria | Hungary* | North Macedonia | Turkey* |
| Croatia | Iceland | Norway | Ukraine* |
| Cyprus | Ireland | Poland | United Kingdom |
| Czech Republic | Italy | Portugal | |

*Countries for which there is no description of the PA scheme/policy (Section II of the survey)

2. Development of the survey

Questions in **Section I of the survey** were based on Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD)³ (see Box 1). Consideration was given to the fact that 46 out of the 47 Council of Europe countries, the European Union and all its 27 EU Member States have ratified the CRPD, therefore were required to provide disabled people with the right to live independently and to be included in the community. Our aim was to establish not just the level of implementation of the article, but also if any progress has been made in the last five years.

The survey focused on the level of choice disabled people have in deciding where and with whom they live, the prevalence of institutionalisation of disabled adults and children, the existence and quality of deinstitutionalisation strategies, availability of PA, and the level of access to mainstream services. An additional question was added to find out whether funds provided by the European Union were being used to support institutions or other segregated services. The reason for this question is the prohibition of investing in institutions under the General Comment 5⁴, and the fact it is an area that ENIL works on. Most of the

³ See: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

⁴ Committee on the Rights of Persons with Disabilities, General Comment No. 5 (2017) on living independently and being included in the community, CRPD/C/GC/5, 27 October 2017, available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/5&Lang=en

questions were multiple choice, with space to provide additional information or comments.

Section II of the survey was based on ENIL's Personal Assistance Checklist⁵, developed by Dr Teodor Mladenov in 2019, as part of a three-year Marie Skłodowska-Curie individual research fellowship. The PA checklist is a tool designed for assessing PA schemes from the perspective of independent living. Its defining features are that it was co-produced with PA users and independent living advocates, it measures the degree to which PA schemes support independent living, and it enables international comparisons. As with Section I, most of the questions were multiple choice, with space to provide additional information or comments.

Box 1: Article 19 – Living independently and being included in the community

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

⁵ European Network on Independent Living (2019), PA Checklist – A Tool for Assessing Personal Assistance Schemes, available at: https://enil.eu/wp-content/uploads/2019/02/Mladenov_Pokern_Bulic-PA_Checklist.pdf

3. Methodology and limitations

The survey targeted disabled people and their representative organisations. Section II of the survey required detailed knowledge of the PA scheme/policy, which is why ENIL strongly suggested that it should be completed by PA users, or in close consultation with PA users. The survey was sent to members of ENIL, and shared in the Newsletter, on the website and via social media. Recognising that English may not be accessible to all, it was translated into French and German, and was available both online and in Word.

Because of the technical nature of the survey (i.e. Section II), and the fact that it required very good knowledge of the PA scheme/policy, ENIL did not aim for a large number of responses per country. Rather, we tried to ensure that only those familiar with the system answered the questions. In some countries, where ENIL does not have members, this was not possible, however.

ENIL's aim was to get more than one response per country, to improve accuracy, and we were mainly successful in achieving this. Where only one response was received, attempts were made to verify it with other members or DPOs. Only one response, for the Russian Federation, submitted by a local authority, could not be verified with a DPO and it was therefore not included in the analysis.

The information gathered was used to complete 43 individual country sheets. In the case of Belgium, United Kingdom and Spain, the country sheets cover different constituent territories/autonomous provinces separately.

The analysis of the data was made difficult by the following limitations, which should be taken into account when reading this summary report and the 43 country sheets.

3.1. Subjectivity of responses

A number of questions ask respondents to rate the level of access, or the quality of policies or provision. Where respondents from the same country provided a different rating, the average value was used. However, it is clear that some respondents were more critical than others, or have higher expectations. Therefore, countries considered as having made considerable progress in Independent Living in the past (such as the Scandinavian countries or the UK), may have fared worse than countries where access to Independent Living is more limited. ENIL is of the view that this is because of the level of expectation and awareness of independent living in some countries. Where people have spent decades

fighting for independent living and other rights, and have achieved these, they expect the situation not to go backwards. With many countries affected by cuts to disability services in the last decade, and more recently COVID-19, it is understandable that many disabled people are disappointed with the direction their countries are heading in.

3.2. Regional differences and postcode lottery

A question was included in the survey whether the responses relate to the entire country or a particular region. In some cases, respondents stated that they were answering for the entire country, whereas their response was in fact limited to their local authority or the region. This was made clear by the fact that another person from the same country provided conflicting information.

It is evident that, in many countries, provision of social care services, which includes PA, is the responsibility of local and/or regional authorities. Therefore, access may vary greatly from one local authority/region to another. In the case of Spain, Belgium and the UK, the constituent territories/autonomous provinces have very different levels of PA provision. Such regional differences, as well as the existence of so-called 'postcode lottery' (where access varies from one local authority to another), make it difficult to present the situation in some countries in a coherent way. We have noted such regional differences in the country sheets, whenever this was clear from the responses provided.

3.3. Misunderstanding of Personal Assistance

There continues to be a lack of awareness about what differentiates Personal Assistance from home care services, even among some disabled people and their representative organisations. In addition, according to the Independent Living movement, a system or a policy that does not have certain characteristics (such as adequate level of funding, being able to hire one's PA etc.) should not even be referred to as Personal Assistance. The full list of criteria is set out in the definition of PA in General Comment 5, and is included in Annex II of this summary report. For the purposes of this survey, we have included all the information about PA schemes/policies provided by respondents. However, it is worth noting that many of the schemes/policies described do not fulfil some or many of the criteria listed in the definition of PA. These issues will be addressed in Chapter II of this report.

To address the limitations outlined above, more research is needed in the countries to identify all characteristics of PA schemes/policies at local, regional and national levels. Such research should encompass interviews

with disabled people, family members, DPOs, providers of PA (such as user-cooperatives and Centers for Independent Living, but also other service providers), and should include research into legislation, policy and funding. It would be important to ensure a cross-disability approach, including people with psychosocial and intellectual disabilities, children, women and girls, and disabled people over the age of 65. Research should be carried out by disabled researchers and led by DPOs, to ensure a user-led approach.

4. Organisation of the report

This summary report is divided into two chapters:

Chapter I: This chapter includes findings from the General section on Independent Living, followed by recommendations. In addition to quantitative data, written comments by the respondents were used to provide more detailed information about deinstitutionalisation strategies and initiatives.

Chapter II: This chapter covers the Section on PA schemes/policies, with the data presented under the following headings: a) PA scheme: general information and corresponding legislation; b) funding of personal assistance; c) eligibility and needs assessment procedures; d) characteristics of PA provision and recruitment; and d) working conditions of assistants. These are followed by recommendations. [To be added in January 2021.]

Annex I: This annex includes a table with the number and type of respondents by country.

Annex II: This annex includes the definitions of key terms.

In addition to the summary report, 43 country sheets will be available from ENIL's website by the end of January 2021: www.enil.eu.

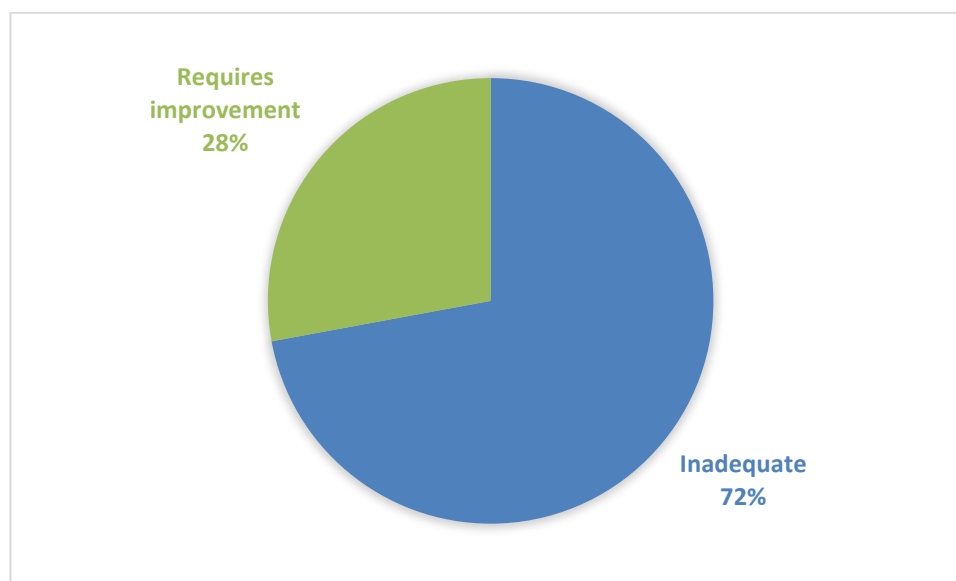
Should you notice any inaccuracies in the summary report or the country sheets, please let us know and we will correct them. Please email us at secretariat@enil.eu, with a subject line 'Independent Living Survey correction'.

Chapter I: General section on Independent Living

The aim of this section is to understand overall access of disabled people to the right to live independently and to be included in the community, as set out in Article 19 CRPD.

1. Transition from institutional care to independent living

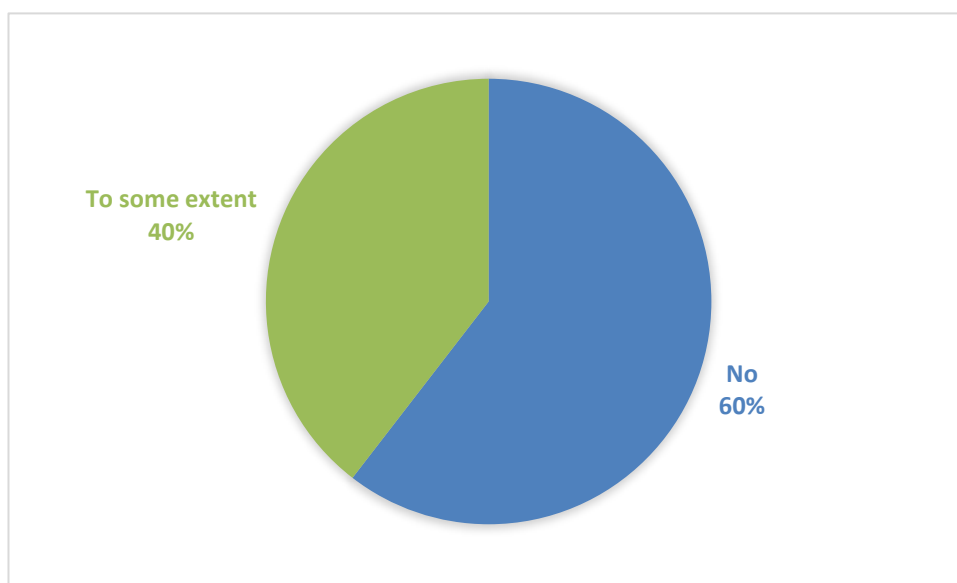
Q1: How would you describe the implementation of Article 19 of the UN CRPD in your country?



Respondents from 31 countries consider implementation of Article 19 to be inadequate, and from 12 countries as requiring improvement. None of the countries are considered to be doing enough to implement the right to live independently and being included in the community.

Q2: Can all disabled adults choose where and with whom to live, without being forced into a particular living arrangement?

In the majority of countries (26), respondents state that disabled people have no choice about their living arrangements, while in some countries (17) they consider that disabled people are able to choose to some extent. There is no country where all disabled people have a real choice about where, with whom and how to live. These responses can be explained by the fact that while some may have choice, others do not. This can be due to their impairment, age, place of residence or other characteristics, and motivated by the prevailing medical model of disability, stigma, inadequate funding for community-based services and other reasons.



For example, the situation in Denmark was explained as follows:

“It is not possible for any person with more demanding/complex or even sometimes minor disabilities to choose where to live and with whom. If you’re dealing with persons with physical impairment, the majority are able to choose where to live and with whom, but if you are in need of more space or particular furnishment/possibilities within your place of living, it can be challenging to get the support for adaptation of your living accommodation. If you are a person with more complex and demanding intellectual, cognitive or even psychosocial disabilities, one can be provided with a single solution/possibility to live together with others, not chosen by oneself and in a place not supported/chosen by oneself.”

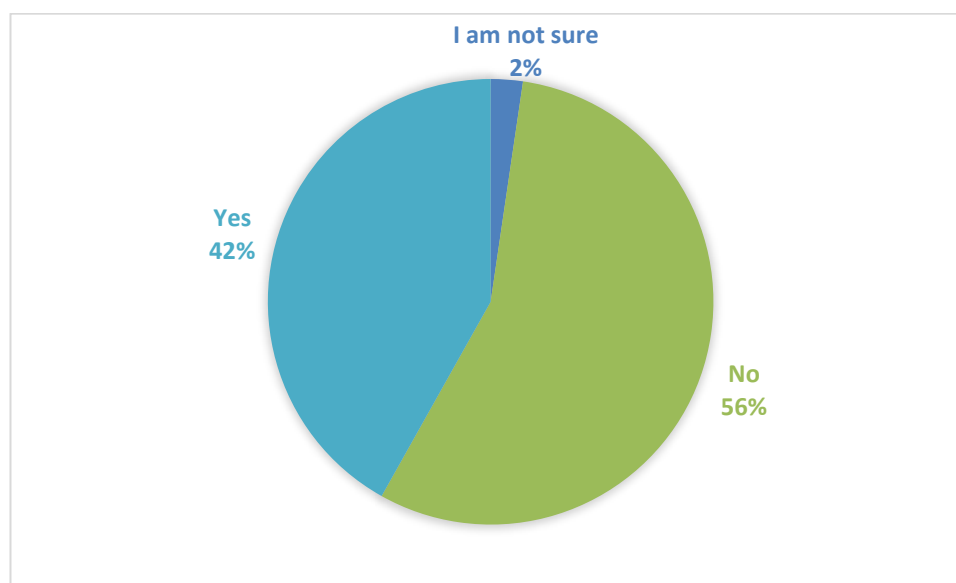
Q3: Are there still segregated settings (social care institutions, psychiatric hospitals, group homes and other) for disabled adults (incl. older people with disabilities).

All 43 countries (100%) still have segregated settings for disabled adults. This includes social care institutions, psychiatric hospitals, group homes, but also sheltered workshops and day care centres for disabled adults.

Q4: Are there still segregated settings (social care institutions, family-type homes, residential schools and other) for disabled children?

The majority of the countries – 42 out of 43 – have segregated settings for disabled children. This includes social care institutions, institutions under the health authorities, family-type homes, residential schools and other. San Marino is the only country, according to the response provided, where all disabled children live with their families or in family-based care, and go to mainstream schools.

Q5: Does your country have a deinstitutionalisation strategy?



A total of 18 countries have a deinstitutionalisation strategy, while 24 are yet to adopt one. There is no information for Azerbaijan.

The countries with a deinstitutionalisation strategy are: Armenia, Bulgaria, Croatia, Cyprus, Estonia, Finland, Hungary, Ireland⁶, Latvia, Lithuania⁷, Moldova, North Macedonia⁸, Norway, Poland, Romania, Slovakia, Slovenia and Ukraine. Parts of the United Kingdom, such as England, Scotland (see Case study) and Northern Ireland⁹ also have a strategy, though the UK as such does not.

Poland has a new strategy, from August 2020. Two countries – Greece and Malta – are in the process of developing a strategy. In Greece, working groups have been established by the Ministry of Labour and Social Affairs, and the process is supported by the EU.

⁶ See: <https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-from-congregated-settings-%E2%80%93-a-strategy-for-community-inclusion.pdf>

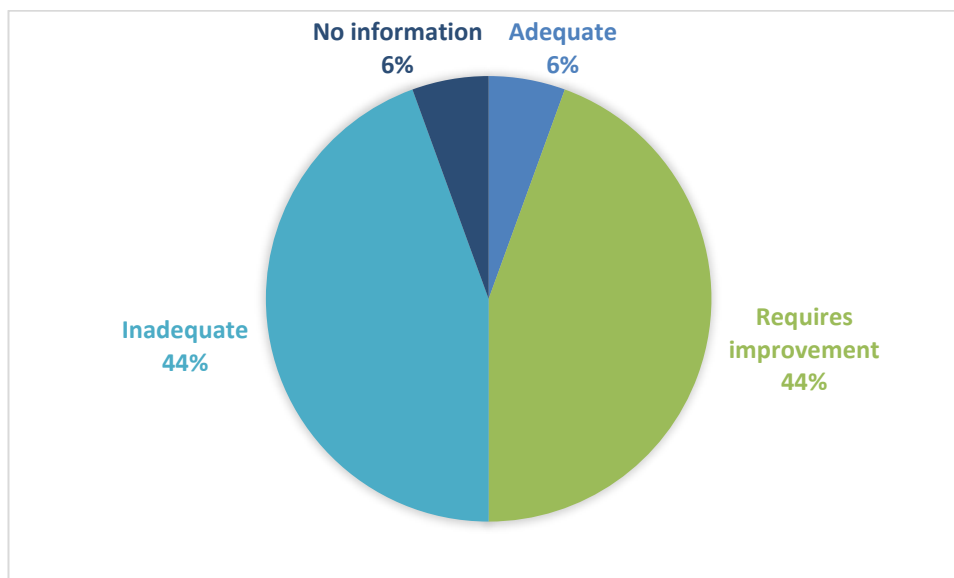
⁷ See: http://perspektyvos.org/images/failai/dei_report_3.pdf

⁸ See: http://www.mtsp.gov.mk/content/pdf/2019pravilnici/23.4_National%20Deinstitutionalisation%20Strategy%20and%20Action%20plan.pdf

⁹ See: <https://www.health-ni.gov.uk/articles/community-care>

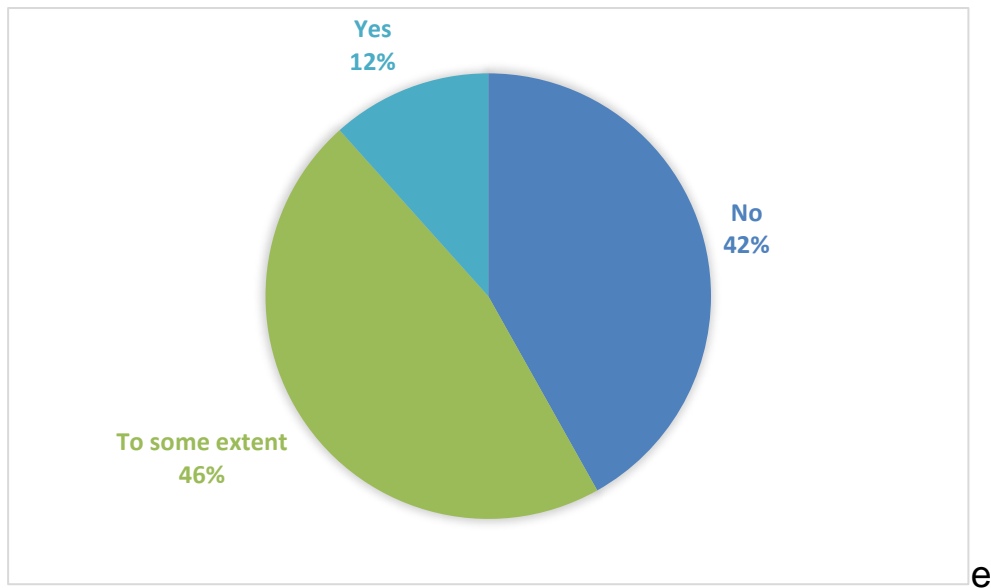
In Belarus, although there is no deinstitutionalisation strategy, the government is taking certain non-systemic measures, aimed at introducing services at one's home. In Serbia, the Strategy on the Improvement of Status of Persons with Disabilities contains a part on deinstitutionalisation.

Q5.1: If yes, how would you describe this deinstitutionalisation strategy?



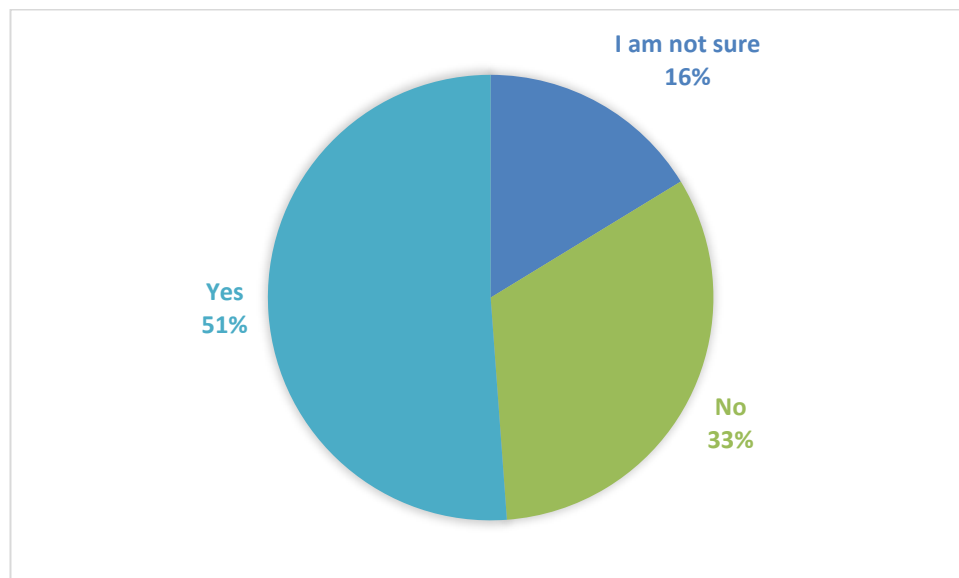
Out of the 18 countries that have a deinstitutionalisation strategy in place, only one country – Moldova – has one that is considered by the respondents as fit for purpose. The majority of countries have a strategy that is either inadequate (8), or requires improvement (8). There is no information for Poland, because the strategy was adopted very recently, in August 2020.

Q6: Has there been any progress in the last 5 years when it comes to deinstitutionalisation?



Most of the countries (20) have made limited progress in the last 5 years. A similar number (18) have made no progress at all, while in 5 of the countries - Azerbaijan, Cyprus, Georgia, Moldova and Slovenia - respondents have been positive about the progress made.

Q7: Are you aware of funds provided by the European Union being invested into the renovation or building of new institutions for disabled people in your country?



In most countries (22), respondents are aware of the EU Funds being used to build or renovate institutions (i.e. large institutions or group homes), or other segregating services (i.e. sheltered workshops, residential schools, day care centres and other) for disabled children and adults. The countries for which this information was reported are: Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Italy, Lithuania, Luxembourg, Malta, Moldova, Montenegro, the

Netherlands, North Macedonia, Poland, Portugal, Romania, San Marino, Slovenia, Spain and Turkey.

In 14 countries, EU Funds are not being used for this purpose, while in 7 countries, respondents replied that they were not sure. Considering the difficulty in accessing information about projects co-funded by the EU, such high number is not surprising.

2. Key characteristics of DI strategies and the process of deinstitutionalisation

A number of respondents described the main problems with the implementation of the deinstitutionalisation strategy, or the process of deinstitutionalisation (where it is not based on a strategy) in their country. They can be summarised under the following headings:

2.1. The strategy/process provides for alternatives to institutions that do not support independent living

In several countries, respondents have highlighted the trend of moving disabled people from large into smaller institutions, rather than providing everyone with the opportunity to live independently in the community (also referred to as 're-institutionalisation'). In some countries, disabled people are placed into residential care, when providing support in the community is considered to be 'too expensive'.

In **Bulgaria**, the deinstitutionalisation strategy is focused on the closure of large institutional care facilities, without providing for independent living. Residents are resettled and relocated into group homes, without any change in their ability to make decisions about their lives, their social inclusion and participation. The situation of disabled children who have been moved into so-called family-type homes (i.e. group homes), as part of Bulgaria's closure of large institutions for children, has been well document by NGOs¹⁰ and the media¹¹.

In **Norway**, the deinstitutionalisation strategy dates back to the 1990s, and has led to positive changes in the past. However, the respondents noted that, in the last 10 years, there has once again been a rise in state-funded institutions. These institutions are typically smaller, such as group homes, to avoid negative public opinion, and have just below the

¹⁰ Disability Rights International, 2019. *A Dead End for Children – Bulgaria's Group Homes*, available from: <https://www.driadvocacy.org/wp-content/uploads/Bulgaria-final-web.pdf>

¹¹ BBC, Bulgaria's Hidden Children, see: <https://www.bbc.co.uk/programmes/m000c1ds>

maximum number of residents allowed by law. In theory, every individual should have a right to choose where they live; however, the state has discretion in deciding whether that is possible. Mostly it comes down to costs; if the city council considers it more cost effective to place someone in residential care, they can do so against the person's will.

In **Scotland**, there has been a longstanding process of de-institutionalisation and closure of long stay hospitals, but some group living settings persist, particularly for people who are described as 'challenging' or having more complex needs. There are also still a number of people 'placed' away from their home areas in group settings in other parts of the United Kingdom.

In **Cyprus**, the state operates 'houses' in the community, where disabled adults are transferred from large institutions, and where they live with other adults with disabilities, with support. Adults with more complex needs, as well as disabled children, are still placed in large institutions and in boarding schools.

In **Estonia**, the strategy targets only people with intellectual disabilities, who are being moved into settings with prevailing institutional characteristics.

In **Sweden**, group homes and nursing homes are, in theory, optional and are supposed to provide opportunities for independent living. However, because community-based services are under constant threat, due to attempts to reduce public spending, this leads to people who could have lived with personal assistance being forced to move into group homes or nursing homes. In these facilities, shortages of staff are a problem and constantly subject to regression. Thus, people living there are becoming socially isolated. At the same time, the Government claims that there are no institutional care facilities in Sweden.

Many people in Sweden are denied access to personal assistance by the municipality or the state. It is possible to challenge this in court, but it is a long process. For those unable to go to court, there is no other choice but a group home, nursing home or home care services, which is what is often being offered.

2.2. The strategy is not comprehensive

In **Croatia** and **France**, the process of deinstitutionalisation discriminates on the basis of the type of disability. For example, in Croatia, people with psychosocial disabilities are marginalised in the strategy, the measures aimed at their deinstitutionalisation are heavily delayed or not implemented at all. Similarly, in **England**, the strategy does not require an

end to involuntary treatment in psychiatric hospitals, to involuntary treatment of detained patients, and to community treatment orders under the Mental Health Act.

The **Hungarian** strategy does not contain any guarantees that EU funds will not be used to create solutions that are not CRPD compliant. It continues to maintain the underfunded social system, which is unsuitable for supporting disabled people. Its aim is not real social inclusion. In turn, the strategy contains only generalities and avoids specifying deadlines and appointing those responsible. Thus, although it refers to Articles 12 and 19 of the CRPD as a starting point, its provisions go against the principles and spirit of the CRPD.

In **Turkey**, prevention of institutionalisation is based on a monthly cash payment to a disabled person's family member, who stays at the same home address. Even this, however, is means tested and only provided to those people whose household income does not exceed a certain amount. It is not available to disabled people who are employed, for example.

2.3. There are delays in the implementation of the strategy

In a number of countries, delays have been reported with the implementation of deinstitutionalisation strategies. In **Croatia**, for example, the implementation is considered too slow. In **Ireland**, the strategy was adopted in 2011, but very little has changed for disabled people since then. There are numerous young people living in institutional care with very little prospect of living independently in the community, with the support of a Personal Assistance service.

In **Italy**, the laws are applied differently depending on the region, and on the resources that are available (with significant differences across the country). Respondents from **Serbia** noted that the action plan for implementation of deinstitutionalisation reforms has still not been developed. Similarly, in **Malta** and **Finland**, the process of deinstitutionalisation is not being implemented effectively, despite the strategy in Finland having been adopted 10 years ago. In Malta, the respondents pointed to a lack of involvement of DPOs in discussions and decisions related to disability rights.

In **Moldova**, there is still reportedly a lot of resistance to the changes, which makes the work of those advocating for implementation of the deinstitutionalisation strategy very difficult. In **Slovenia**, despite the strategy, disabled people continue to be placed into psychiatric hospitals and social care institutions, which receive significant funding.

2.4. There is still no deinstitutionalisation strategy

Several respondents provided additional comments, even though their countries do not have a deinstitutionalisation strategy in place.

For example, in the **Czech Republic**, it was pointed out that funds were still going into renovation of institutions. Whether someone lives at home depends very much on the level of support they need and whether they have family to assist them. This is because the budget provided to disabled people for personal assistance is not high enough in many cases and makes it difficult to hire assistance from the open labour market.

In **Azerbaijan**, “the State Programme for the placement of children living in state-owned child institutions in families (Deinstitutionalization) and alternative care” was implemented between 2006 and 2015. A total of 604 children were prevented from entering state-owned special child institutions in the country, including 12 children in 2015. A total of 364 children were reintegrated into their biological families and placed with close relatives by the order of district and city authorities. This process has continued thanks to new legislation, but a new deinstitutionalization strategy has not been adopted after 2015.

In **Denmark**, there is no strategy and the development is going backwards, especially when it comes to persons with intellectual or cognitive disabilities.

In **Germany**, there is officially a commitment to deinstitutionalisation; however, there are significant shortcomings in the implementation. Institutions are not being closed, but rather extended, or new ones created. Residential care homes can accommodate up to 24 individuals, although they are often built in the middle of towns or villages.

One respondent from Germany also noted that there is a move back to institutional care and the medical model, which results in the placement of disabled people into large or smaller institutions. There is insufficient access to personal assistance, in particular outside of the big cities. Also, many people are afraid of losing their current status quo - including PA hours that they have been granted - if they “activate” themselves (i.e. if they start working or form a family).

Case study 1: Ukraine

Ukraine started the process of deinstitutionalisation of the child care system in 2016. At the moment, it is still among the European countries with the highest number of children in institutions, many of which are in boarding schools.

In January 2016, the Government signed a decree “on a working group for reforming the system of institutional care and education of children”, which launched the reform. After that, the National Strategy of Institutional Childcare System Reform, and the National Action Plan for 2017 - 2026 were also adopted. The planned reform consists of three components: a) rapid development and availability of services at community level for children and families, which will contribute to a gradual closure of boarding schools; b) using released funds to create new and expand existing services in the community; and c) transformation of institutions into centers for providing specialized services, educational institutions and other, to help meet the needs of the community.

The reform will span over 10 years. The plan is to reduce the number of children in boarding schools by 90%, and to ensure that in each community, there are affordable and high-quality services to support families with children, according to their individual needs.

In 2020, the second stage of reforming the state-run boarding schools began. Among the key indicators of this process, according to official information, is the development of social work specialists in local communities, increasing the number of foster families, reducing the number of children in boarding schools. In reality, however, the process is not going well. At the end of 2019, a representative of the Office of the Presidential Commissioner for Children's Rights noted that 26 boarding schools have closed down through liquidation or transformation into an educational institution. She added, however: "At the same time, another 47 institutions have changed only the type of institution, without abandoning the boarding school system", concluding that this approach is “a pseudo-reform”.

The worst situation is found in psychiatric institutions (referred to as “psychoneurological dispensaries”) for adults. There are 145 of these institutions in Ukraine, accommodating 27,8 thousand individuals with intellectual and/or psychosocial disabilities (data as of 2018). The state of these institutions in Ukraine is, as in most post-Soviet countries, appalling, as human rights are violated on a daily basis. Psychiatric institutions are recognized as places of detention. However, there is currently no comprehensive policy for reforming the system.

Case study 2: Scotland

In 2013, the Scottish Government, the Scottish Health Service and the Convention of Scottish Local Authorities signed, alongside the Scottish

Coalition for Independent Living, "A Shared Vision for the Future of Independent Living in Scotland"¹². While this is not a distinct deinstitutionalisation strategy, it has as its aim ensuring access of disabled people to independent living.

In the same year, the Social Care (Self-Directed Support) Scotland Act gave disabled people four options to use a direct payment: a) employ their own PA; b) pay a care agency to provide support in their own home; c) give payment back to local authority in exchange for a service; d) a combination of previous options¹³.

In 2019, the Scottish Government gave the Scottish Independent Living Movement (SILM) funding to become actively involved in their Adult Social Care Reform Programme¹⁴. With this funding, SILM set up a virtual group of disabled people who make online comments, or complete online surveys, on the work of the Government's Reform Programme. From this virtual group, the members of which come from urban, rural and island communities, and a range of other demographics, a smaller group comprise the People-Led Policy Panel, and have regular meetings with the other stakeholders. The funding from the Government not only created this structure, but allows the panel sufficient time and resources to make a meaningful contribution to this coproduction process.

Despite optimistic publications by Scottish Government¹⁵, the implementation of this strategy is piecemeal, as it depends on the irregular and unsystematic implementation of the 32 local 'Health and Social Care Partnerships' throughout Scotland. There is also the effect of Michael Lipskey's 'street-level bureaucracies'¹⁶, in which the attitudes of front-line professionals affect public policy. So, there is a tendency to persuade people that a direct payment is too difficult to manage, and that they should just rely on publicly controlled home care services.

Once again, there is a growing tendency to implement an unofficial policy of institutionalising those whose support package exceeds the weekly cost of a care home. As one front-line bureaucrat has, unreported, said: "We can no longer afford your human rights". Therefore, there is a large

¹² See:

<https://www.webarchive.org.uk/wayback/archive/20150220144551/http://www.gov.scot/Publications/2013/04/8699/0>

¹³ See: <https://www.legislation.gov.uk/asp/2013/1/contents/enacted>

¹⁴ See: <https://www.gov.scot/policies/social-care/reforming-adult-social-care/>

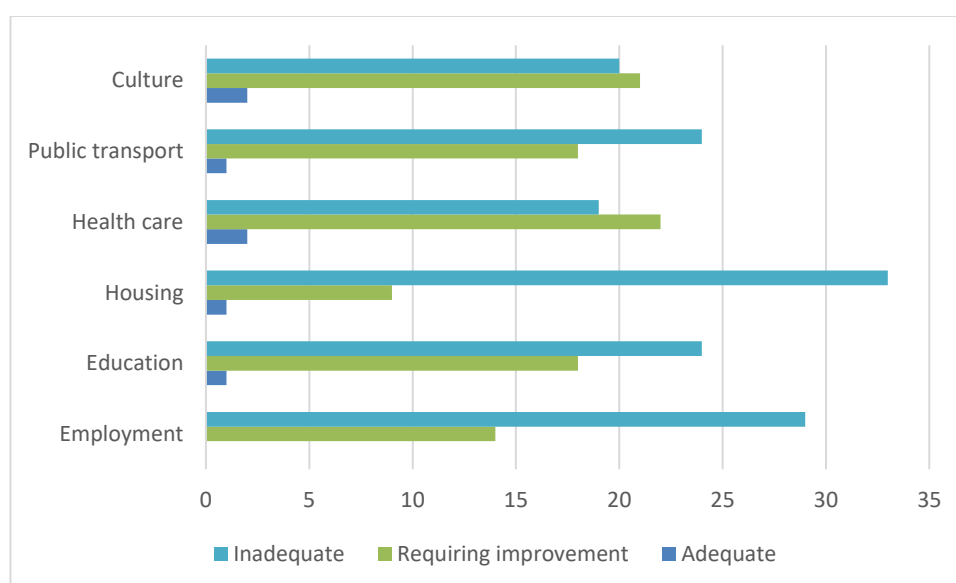
¹⁵ See: <https://www.gov.scot/publications/self-directed-support-strategy-2010-2020-implementation-plan-2019-21/pages/2/>

¹⁶ See: https://en.wikipedia.org/wiki/Street-level_bureaucracy

disconnect between the inclusion of the Scottish Government and the exclusion of local government.

3. Access to mainstream services

Q8: How would you rate disabled people's access to mainstream services? ['Adequate' means that these services are available on an equal basis to disabled people and are responsive to their needs.]



The question on access to mainstream services covered: employment in the open labour market; education (primary, i.e. elementary schools); education (secondary; i.e. high schools); education (higher/tertiary, i.e. universities, colleges, vocational training); housing; health care; public transport and culture.

In the majority of countries (33), access to housing is considered as inadequate, followed by employment (29 countries), public transport and education (24 countries), culture (20 countries) and health care (19 countries).

Access to health care is found to require improvement in 22 countries, followed by culture (21 countries), education and public transport (18 countries), employment (14 countries) and housing (9 countries).

There are no countries where access to employment is considered to be adequate. In San Marino and Cyprus, respondents are satisfied with access to health care, while in Georgia and Luxembourg, access to culture is considered as adequate. In Georgia, access to all levels of education is found to be adequate, and in San Marino that applies to access to

housing and public transport. Overall, access to mainstream services appears to be the best in San Marino and Georgia, which had the highest number of 'adequate' responses in the survey.

Q9: Does your country have legislation that protects disabled people from discrimination in the labour market?

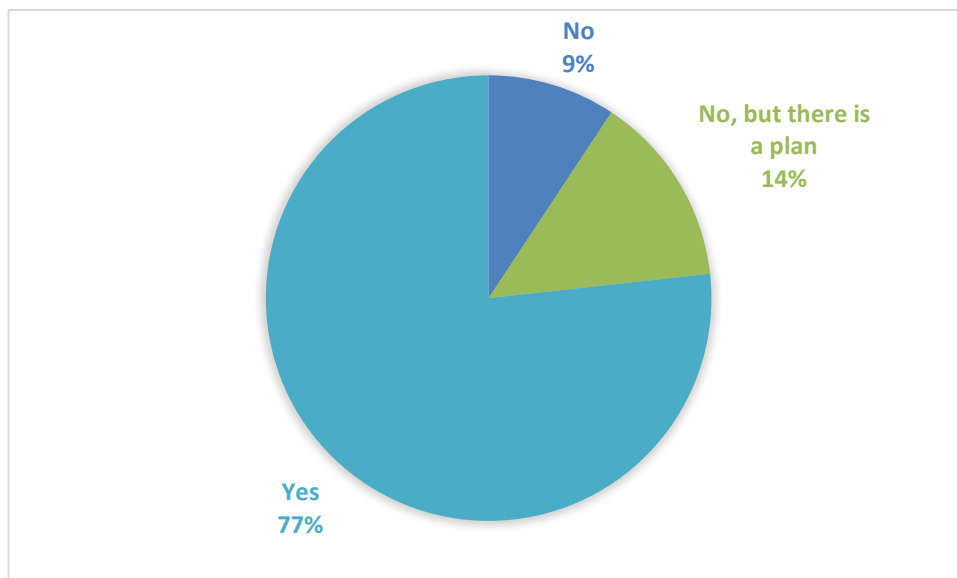


The vast majority of the countries – 40 in total - have legislation that protects disabled people from discrimination in the open labour market. In Austria and Bosnia and Herzegovina, respondents reported no such legislation, while we do not have information for Lithuania.

Q9.1: If yes, how would you describe the impact of this legislation?

In contrast with answers to the previous question, which were largely positive, the majority found this legislation to be inadequate (18 countries) or requiring improvement (23 countries). This means it is not considered to be effective in preventing and tackling discrimination of disabled people in employment. There are no countries where respondents found legislation to protect from discrimination in employment to be sufficiently good.

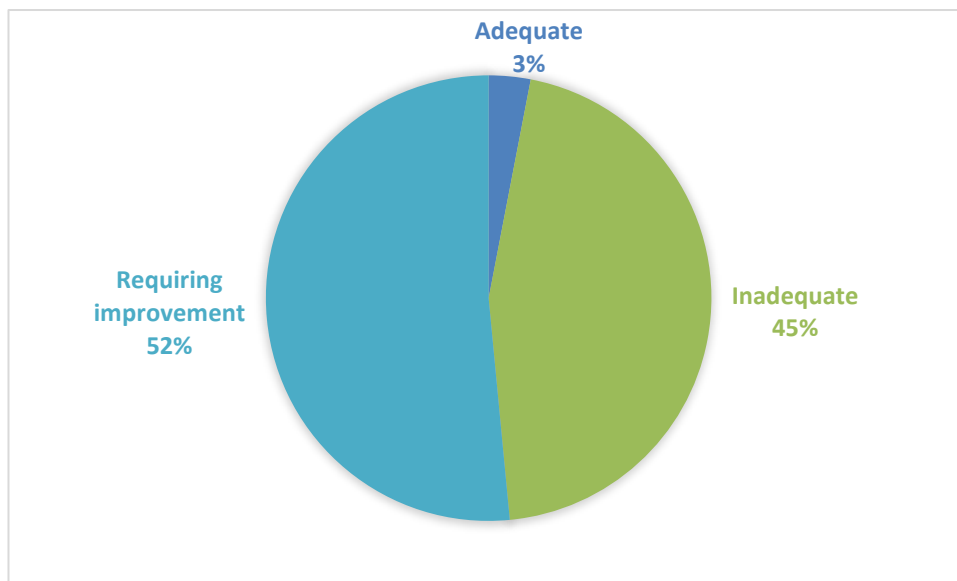
Q10: Can disabled people access personal assistance (PA)?



In most countries – 33 in total – disabled people can access personal assistance to at least some extent. In Bosnia and Herzegovina, Armenia, Greece, San Marino, Albania and Luxembourg, there is no PA scheme/policy, but there is a plan to introduce it in the near future. There are only 4 countries – Hungary, Turkey, Ukraine and Belarus – where there is neither access to personal assistance, nor a plan to introduce it.

This is, overall, a positive result, although the quality of PA schemes varies greatly. This is summarised in Q11 and further analysed in Chapter II of the summary report.

Q11: If yes, how would you describe access to personal assistance (PA) in your country?



Out of the 33 countries that have some form of personal assistance scheme/policy, it is considered adequate in only one country – Slovenia. In the rest of the countries, respondents find PA schemes/policies to be either requiring improvement (17 countries) or inadequate (15 countries). The reasons for such assessment can be found, as noted above, in Chapter II of this summary report, but also in the individual country sheets, where access to PA is described in considerable detail.

4. Recommendations on access to Independent Living

Based on the information provided in the Independent Living survey, ENIL calls on the Governments to take the following actions:

- Ensure that all disabled people are provided with a **genuine choice of where and with whom they live**, regardless of their impairment, the level of support needs or the cost of providing community-based services;
- Ensure that **families of children with disabilities have all the support they need** to raise their child at home, including access to personal assistance if required, peer support, adequate housing and income, as well as inclusive childcare and education;
- Adopt a **comprehensive deinstitutionalisation strategy**, as a matter of priority, based on Article 19 CRPD and the guidance set out in the General Comment 5, and in close consultation with disabled people and their representative organisations;
- Accelerate the **closure of all segregated settings** and a facilitate transition to independent living and being included in the community, through access to personal assistance, peer support and other community-based services, as well as full access to mainstream services and facilities;

- Adopt or review existing **personal assistance legislation**, in line with Article 19 and the General Comment 5, and in close consultation with disabled people and their representative organisations;
- Make sure that **personal assistance is adequately funded** and provided in a way to facilitate choice and control of disabled people over their lives, and in the case of children a right to grow up in a family;
- Support **research initiatives into PA**, led by disabled people and their representative organisations, to identify all characteristics of PA schemes/policies at local, regional and national levels, with the aim of bringing them in line with the CRPD.

We also call on the European Commission to:

- Ensure that **EU funds are used in line with the CRPD, the EU Fundamental Rights Charter and other EU laws**, and prohibit and sanction investments into any form of segregation of disabled children and adults;
- **Investigate reports** of EU funds being used to build or renovate institutions for disabled people in the Member States, as well as other European countries benefiting from EU funding, and put in place an efficient and transparent monitoring and complaints system accessible to non-governmental organisations and the general public.

Annex I: Overview of responses

| Country | Responses by individuals (out of which PA users) | Responses on behalf of an organisation | Names of organisations |
|-------------------------------|--------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------|
| Albania | 1 | 1 | Fondacioni “Së Bashku” |
| Armenia | 1 | 1 | Unison NGO |
| Austria | 2 (2) | 1 | Independent Living Austria |
| Azerbaijan | 0 | 1 | Union of Disabled People Organisations of Azerbaijan |
| Belgium | 10 (4) | 4 | GRIP, EVA asbl |
| Belarus | 0 | 1 | Office for the Rights of Persons with Disabilities |
| Bosnia and Herzegovina | 2 | 0 | |
| Bulgaria | 1 | 1 | Centre for Independent Living |
| Croatia | 1 | 1 | SOIH |
| Cyprus | 0 | 1 | Cyprus Paraplegics Organisation |
| Czech Republic | 3 (3) | 0 | |
| Denmark | 2 (1) | 0 | |
| Estonia | 1 | 0 | |
| Finland | 2 (2) | 1 | Threshold Association |
| France | 5 (2) | 2 | CHA, Gré a Gré |
| Georgia | 1 | | |
| Germany | 16 (11) | 3 | Rhein-Main-Inklusiv e.V., ZSL e.V. Erlangen/EUTB North-East Middle Franconia, Phoenix e.V. Tegensburg |
| Greece | 2 (1) | 1 | i-living Independent Living Organisation |
| Hungary | 2 | 1 | MEOSZ |
| Iceland | 1 (1) | 1 | NPA miðstöðin |
| Ireland | 8 (5) | 0 | |
| Italy | 1 | 2 | ENIL Italia onlus, Assoziacione Vita Indipendente |
| Latvia | 0 | 1 | SUSTENTO |
| Lithuania | 0 | 2 | Association of Independent Living, NGO mental Health Perspectives |
| Luxembourg | 1 | 0 | |
| Malta | 5 | 1 | Malta Federation of Organisations of Persons with Disabilities |
| Moldova | 1 | 1 | NGO of people with disabilities Vivere |
| Montenegro | 2 (1) | 0 | |

| | | | |
|------------------------|--------|---|--------------------------------------------------|
| Netherlands | 3 (1) | 0 | |
| North Macedonia | 0 | 1 | Polio Plus |
| Norway | 1 | 1 | ULOBA – Independent Living Norway |
| Poland | 2 (1) | 0 | |
| Portugal | 4 (2) | 0 | |
| Romania | 2 (2) | 0 | |
| San Marino | 0 | 1 | Attiva-Mente |
| Serbia | 3 | 2 | Centre Living Upright, CIL Serbia |
| Slovakia | 2 (1) | 0 | |
| Slovenia | 7 (6) | 1 | YHD |
| Spain | 4 (2) | 3 | FEVI, Vigalicia |
| Sweden | 0 | 2 | STIL/Independent Living Institute, JAG |
| Turkey | 1 | 1 | Engelli Kadin Demegi |
| Ukraine | 1 | 0 | |
| United Kingdom | 18 (4) | 6 | Disability Rights UK, CILNI, In Control Scotland |

Annex II: Definitions of key terms

Independent Living

The right to living independently and being included in the community is set out in Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD) and further defined in the General Comment No 5¹⁷:

“Independent living/living independently means that individuals with disabilities are provided with all necessary means to enable them to exercise choice and control over their lives and make all decisions concerning their lives. Personal autonomy and self-determination are fundamental to independent living, including access to transport, information, communication and personal assistance, place of residence, daily routine, habits, decent employment, personal relationships, clothing, nutrition, hygiene and health care, religious activities, cultural activities and sexual and reproductive rights. These activities are linked to the development of a person’s identity and personality: where we live and with whom, what we eat, whether we like to sleep in or go to bed late at night, be inside or outdoors, have a tablecloth and candles on the table, have pets or listen to music. Such actions and decisions constitute who we are. Independent living is an essential part of the individual’s autonomy and freedom and does not necessarily mean living alone. It should also not be interpreted solely as the ability to carry out daily activities by oneself. Rather, it should be regarded as the freedom to choose and control, in line with the respect for inherent dignity and individual autonomy as enshrined in article 3 (a) of the Convention. Independence as a form of personal autonomy means that the person with disability is not deprived of the opportunity of choice and control regarding personal lifestyle and daily activities.”

Personal assistance

The General Comment 5¹⁸ defines personal assistance as “person-directed/“user”-led human support available to a person with disability” and “a tool for independent living”.

According to the General Comment 5, the following characteristics distinguish PA from other types of assistance:

¹⁷ Committee on the Rights of Persons with Disabilities, General Comment No. 5 (2017) on living independently and being included in the community, CRPD/C/GC/5, 27 October 2017, para 16(a).

¹⁸ *Ibid*, para 16(d).

- Funding for personal assistance must be provided on the basis of personalized criteria and take into account human rights standards for decent employment. The funding is to be controlled by and allocated to the person with disability with the purpose of paying for any assistance required. It is based on an individual needs assessment and upon the individual life circumstances. Individualized services must not result in a reduced budget and/or higher personal payment;
- The service must be controlled by the person with disability, meaning that he or she can either contract the service from a variety of providers or act as an employer. Persons with disabilities have the option to custom design their own service, i.e., design the service and decide by whom, how, when, where and in what way the service is delivered and to instruct and direct service providers;
- Personal assistance is a one-to-one relationship. Personal assistants must be recruited, trained and supervised by the person granted personal assistance. Personal assistants should not be “shared” without the full and free consent of the person granted personal assistance. Sharing of personal assistants will potentially limit and hinder the self-determined and spontaneous participation in the community;
- Self-management of service delivery. Persons with disabilities who require personal assistance can freely choose their degree of personal control over service delivery according to their life circumstances and preferences. Even if the responsibilities of “the employer” are contracted out, the person with disability always remains at the centre of the decisions concerning the assistance, the one to whom any inquiries must be directed and whose individual preferences must be respected. The control of personal assistance can be exercised through supported decision-making.

Group homes/Institutional care

The term ‘group homes’ refers to buildings, houses or apartments where disabled people live together. Some countries will use other terms, such as protected homes, sheltered homes, organised housing or even supported or assisted living.

If group homes have *one or more* of the following ‘institutional care’ characteristics, they can be considered as institutional in character and not compliant with Article 19 CRPD¹⁹:

¹⁹ *Ibid*, para 16(c).

- obligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from;
- isolation and segregation from independent life within the community;
- lack of control over day-to-day decisions;
- lack of choice over whom to live with;
- rigidity of routine irrespective of personal will and preferences;
- identical activities in the same place for a group of persons under a certain authority;
- a paternalistic approach in service provision;
- supervision of living arrangements;
- a disproportion in the number of persons with disabilities living in the same environment.

General Comment 5 goes on to state that institutional settings with these characteristics “may offer disabled people a certain degree of choice and control; however, these choices are limited to specific areas of life and do not change the segregating character of institutions”.

With regard to children, the General Comment 5 states that anything other than a family is considered an institution, as there can be no substitute for growing up with a family.²⁰

Deinstitutionalisation

ENIL defines ‘deinstitutionalisation’ as:

“a political and a social process, which provides for the shift from institutional care and other isolating and segregating settings to independent living. Effective deinstitutionalisation occurs when a person placed in an institution is given the opportunity to become a full citizen and to take control of his/her life (if necessary, with support). Essential to the process of deinstitutionalisation is the provision of affordable and accessible housing in the community, access to public services, personal assistance, and peer support. Deinstitutionalisation is also about preventing institutionalisation in the future; ensuring that children are able to grow up with their families and alongside neighbours and friends in the community, instead of being segregated in institutional care.”

²⁰ *Ibid*, para 16(c).

The Toolkit on the Use of European Union Funds for the Transition from Institutional to Community-based Care²¹ describes 'deinstitutionalisation' as a process which includes:

- the development of high quality, individualised services based in the community, including those aimed at preventing institutionalisation, and the transfer of resources from long-stay residential institutions to the new services in order to ensure long-term sustainability;
- the planned closure of long-stay residential institutions where children, disabled people (including people with mental health problems), homeless people and older people live, segregated from society, with inadequate standards of care and support, and where enjoyment of their human rights is often denied;
- making mainstream services such as education and training, employment, housing, health and transport fully accessible and available to all children and adults with support needs.

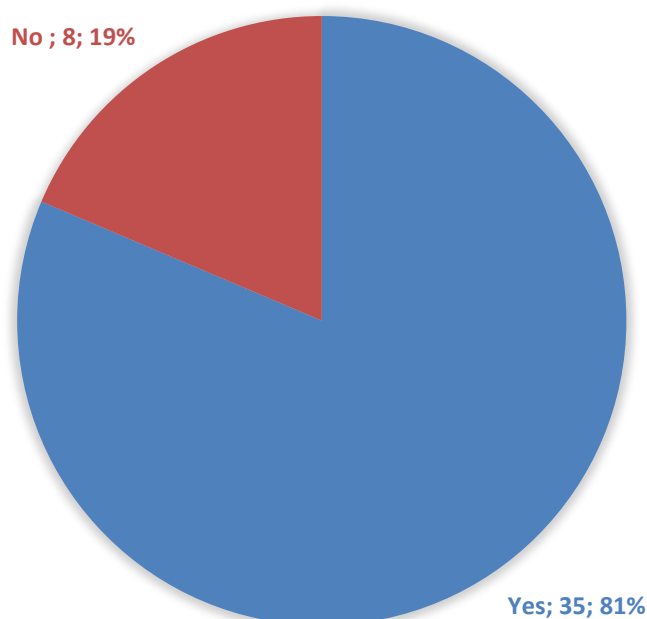
²¹ European Expert Group on the Transition from Institutional to Community-based care, *Toolkit on the Use of European Union Funds for the Transition from Institutional to Community-based care*, 2012, available at: <https://enil.eu/wp-content/uploads/2016/09/Toolkit-10-22-2014-update-WEB.pdf>

Chapter II: Personal assistance schemes in 43 countries

The aim of this section is to provide detailed information on personal assistance schemes in the countries included in the survey. The data is presented under the following headings: 1. PA scheme: general information and corresponding legislation, 2. Funding of personal assistance, 3. Eligibility and needs assessment procedures, 4. Characteristics of PA provisions and recruitment, 5. Working conditions of assistants. The chapter will also include heading 6. on policy recommendations.

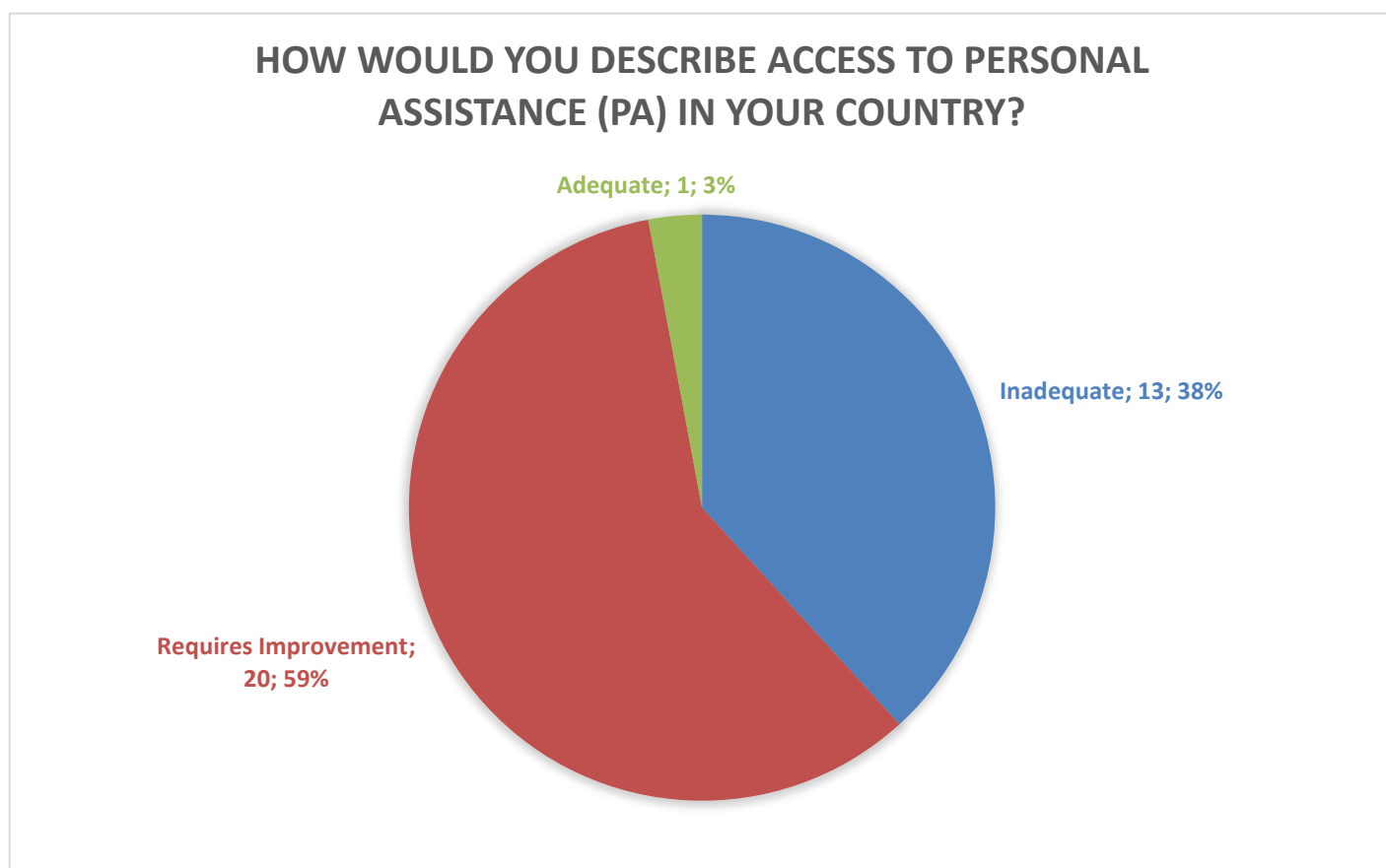
1. PA scheme: General information and corresponding legislation

THE COUNTRY HAS A PUBLICLY FUNDED PERSONAL ASSISTANCE SCHEME



According to our newly updated data, the number of countries which have publicly funded personal assistance schemes has increased. In 2020 33 countries reported to have PA-schemes in place. Now in 2022, this figure increased to 35 countries. Albania and Greece joined the group of countries offering this service. The PA-scheme in Greece is running as a pilot project. It is unclear whether Bosnia and Herzegovina, Armenia, San Marino and Luxembourg still have plans to introduce personal assistance. Hungary, Turkey, Ukraine and Belarus do not have PA-schemes.

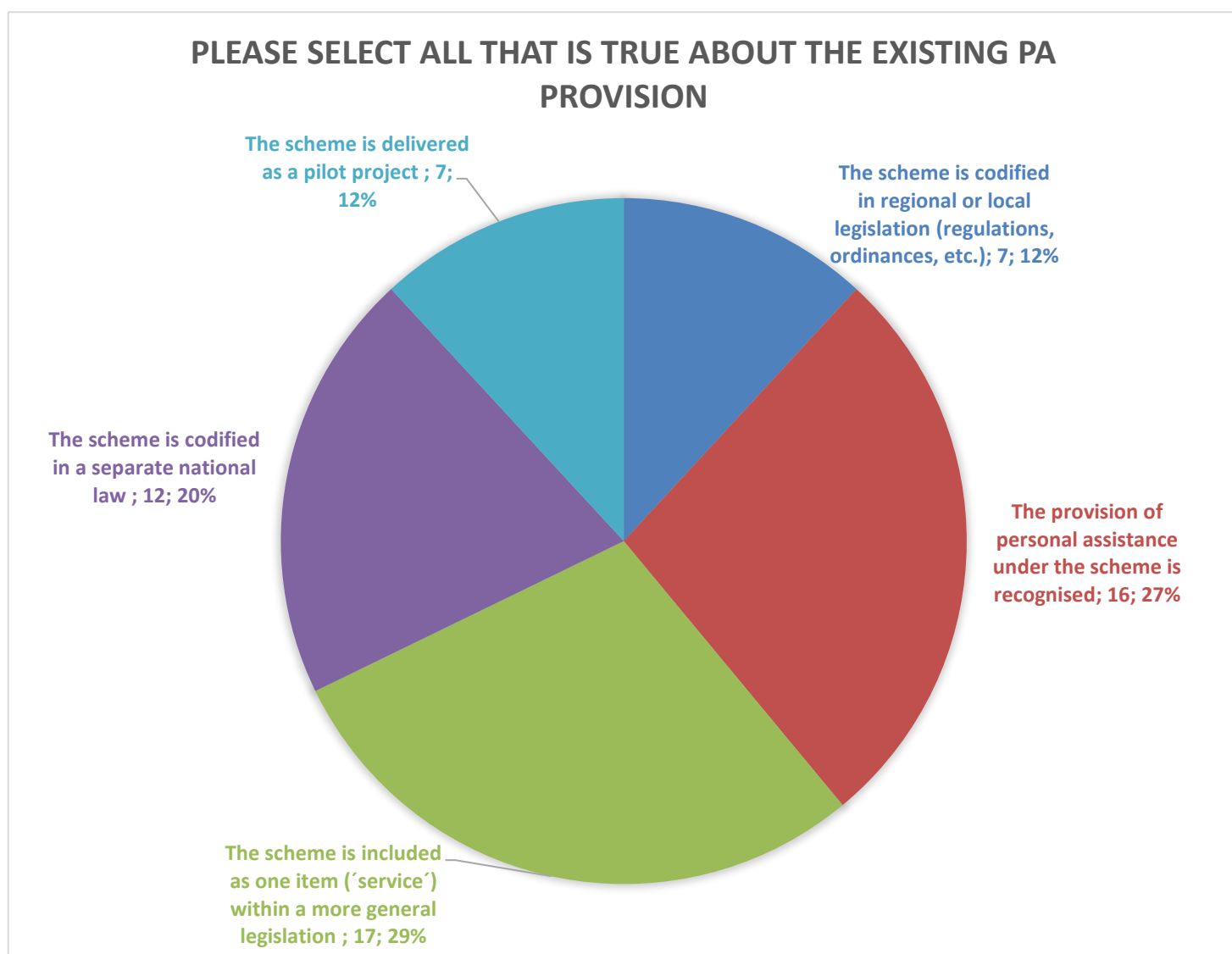
Q 1: How would you describe access to personal assistance (PA) in your country?



Out of 35 countries that offer personal assistance, one country, Slovenia, reports having a PA-scheme of adequate quality. In 2020 respondents indicated PA-schemes are inadequate in 45% of countries. According to our updated information, this figure has decreased to 38%. At the same

time 59% of countries received the rating “requires improvement” for their PA-schemes, compared to 52% in 2020. The low levels of satisfaction concerning access to personal assistance are unacceptable. UNCRPD article 19 (b) requires state parties to provide personal assistance to disabled people with support needs. State parties need to increase the availability and accessibility of personal assistance so that all needs are met.

Q 2: Please select all that is true about the existing PA provision

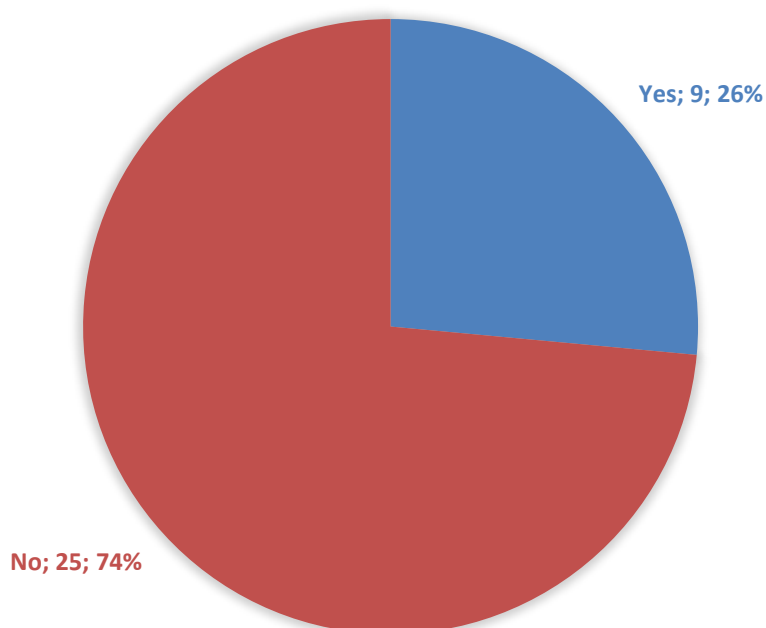


In 7 countries the PA-scheme is delivered as a pilot project. Personal assistance in Ireland has been running as a pilot for 28 years. Personal assistance has been running as a pilot for 10 years in Croatia and since

2019 in Portugal. It is unclear whether the governments of the countries concerned have plans to install permanent PA-schemes. In 7 countries the scheme is codified in regional or local legislation. In countries which place implementation under the sole authority of regional or local authorities, experience significant variations in how the service is provided, depending on where the user lives. Respondents from Denmark and Norway reported significant variations in services provision due to the strong competence of municipalities. PA provision in Scotland is undergoing a complete restructuring of adult social care, following a review recommending the centralisation to secure uniformity of the service. In 16 countries, the provision of PA under the scheme is recognised as a right. In 17 countries the scheme is included as one item within a more general legislation. In 12 countries the scheme is codified in a separate national law.

Q 3: Do disabled people living in residential care settings have the possibility to apply for personal assistance?

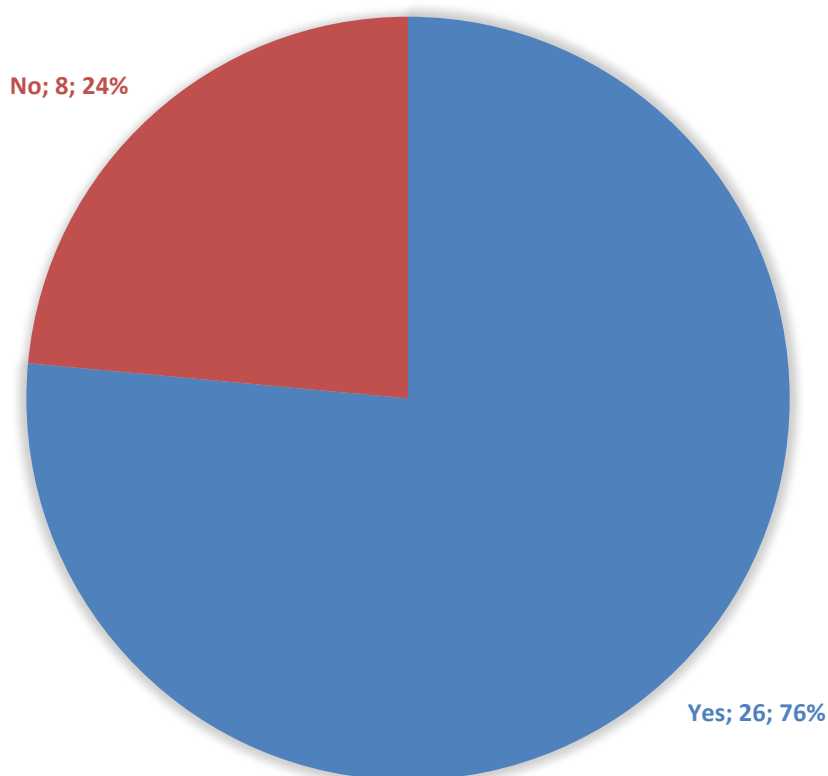
**DO DISABLED PEOPLE LIVING IN RESIDENTIAL CARE SETTINGS
HAVE THE POSSIBILITY TO APPLY FOR PERSONAL ASSISTANCE?**



The overwhelming majority of countries, 74%, do not allow disabled people living in residential settings to apply for personal assistance under the publicly funded scheme. According to article 19 of the UNCRPD, General comment no 5 and the Guidelines on Deinstitutionalisation, including in emergencies, personal assistance is a key service required by disabled people with support needs to avoid institutionalisation or to leave institutions. If disabled people confined to institutions cannot even apply for personal assistance under the scheme, it does not provide for an alternative to institutionalisation. According to the CRPD Guidelines on Deinstitutionalisation, institutionalising disabled people is discrimination in line with article 5 of the UNCRPD. Not providing the support services required to leave an institution has the effect of continuing this discrimination. State parties to the UNCRPD need to give disabled people living in institutions or at risk of institutionalisation preferential access to the countries' PA-scheme.

Q 4: Are there restrictions on what PA can be used for?

ARE THERE RESTRICTIONS ON WHAT PA CAN BE USED FOR?

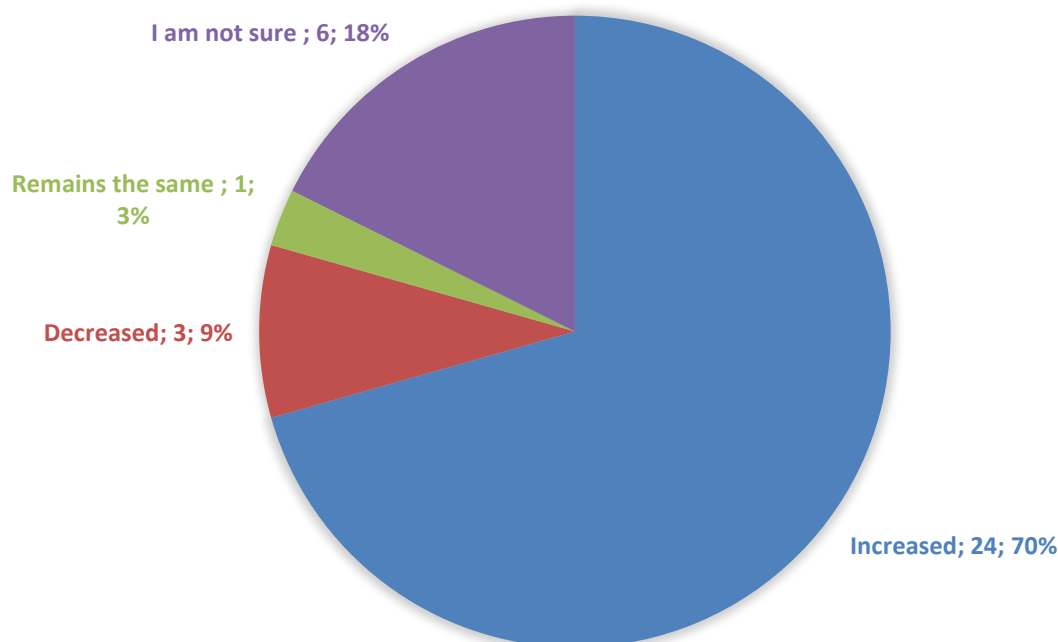


In the overwhelming majority of countries, 26 out of 35 or 76%, authorities place restrictions on what PA can be used for. This might for example entail that assistants are not allowed to perform tasks related to health care, even after delegation or approval by medical professionals, that assistants can only provide support inside the person's home, not outside or that there is a pre-defined list of tasks that the assistants can perform. In Norway municipalities establish such restrictions. Restrictions are different from one municipality to the other and are decided by the local administration. For example, restrictions on the ability to travel are possible. General Comment no 5 defines personal assistance as "person directed, or "user led human support" and "a tool for independent living". Independent living "means that individuals with disabilities are provided with all necessary means to enable them to exercise choice and control over their lives and make all decisions". which must include the option to custom design to decide "how, when, there and in what way the service is

provided.” Placing restrictions on what PA can be used for is therefore not in line with the UNCRPD since it limits choice and control of the disabled person and restricts the ability to take decisions.

Q 5: Has the number of PA users number increased, decreased or remained the same (e.g. due to waiting lists) in the last 5 years?

HAS THE NUMBER OF PA USERS NUMBER INCREASED, DECREASED OR REMAINS THE SAME (E.G. DUE TO WAITING LISTS) IN THE LAST 5 YEARS?



Respondents stated that in a large majority of countries, 24 out of 34 or 70%, the number of PA users has increased in the last five years. In one country, Greece, the number of PA users has remained the same which is most likely due to the fact that the pilot project has just started. These figures imply that across Europe the number of PA users is one the rise which is good news. A respondent from Slovenia reported that the number of PA users in the country increased from 2 472 in 2021 to 3560 in 2022 which represents a 44% increase. In Belgium, there is a waiting list of up to 23 years to receive the personal budget needed to hire Personal

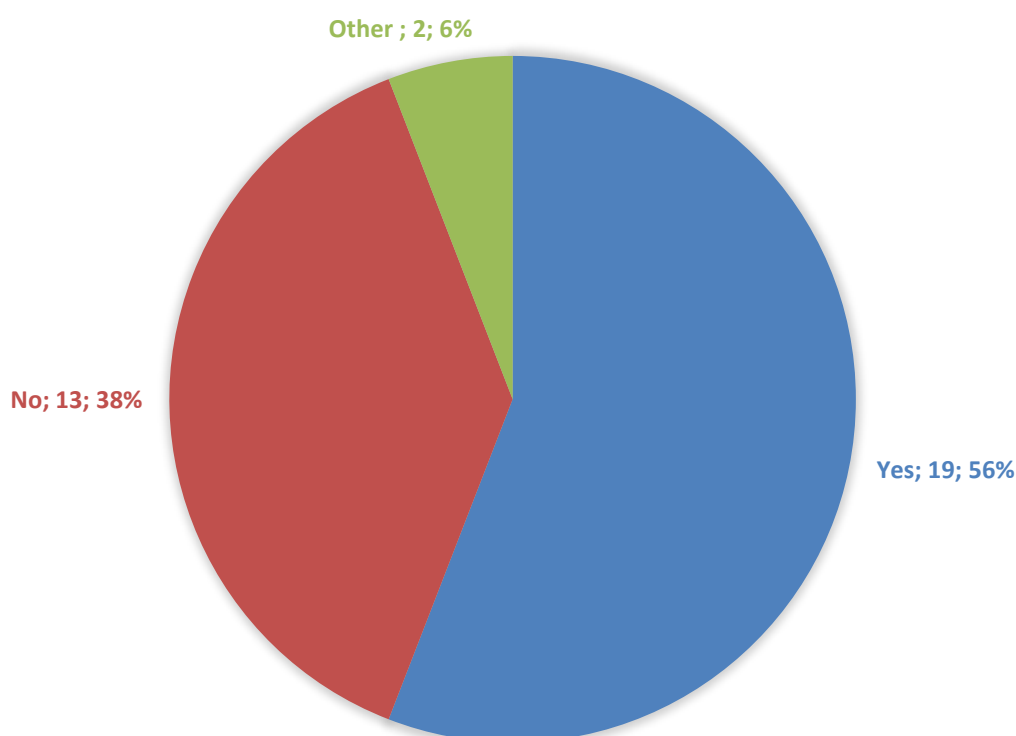
Assistants. These figures show that personal assistance is perceived as a highly attractive service by disabled people. State parties should respect this preference and continue the expansion.

According to our information, the number of PA users has decreased in Denmark, Sweden and England. The decrease in England is a direct result of the closure of the UK Independent Living Fund, an austerity measure implemented by the government of former prime minister David Cameron.

2. Funding of personal assistance

Q 6: Is PA paid through direct payments, such as personal budgets?

IS PA PAID THROUGH DIRECT PAYMENTS, SUCH AS PERSONAL BUDGETS?

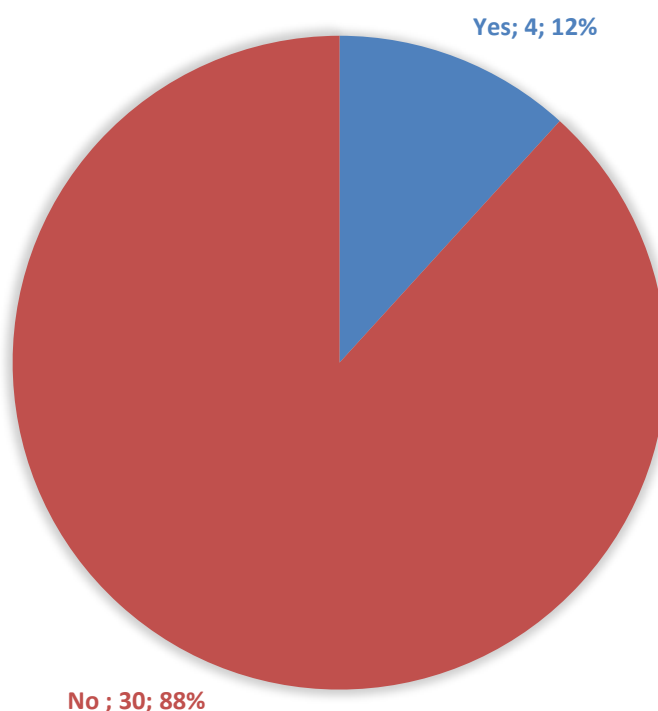


In 19 or 56% of countries the financial resources required to purchase personal assistance are allocated directly to the user in the form of personal budgets. This procedure is very much in line with General Comment no 5 which states that “the funding is to be controlled by and allocated to the person with disability with the purpose of paying for any assistance required.” According to the seminal article on the question “what is good personal assistance made off” by Teodor Mladenov being organised in the form of direct payments represents the most empowering form to organise PA (Mladenov 2019). Disability activist highlights the how direct payments enable full control over the purchasing of assistance

(Ratzka 2004a). Thus, it is good that a high number of countries has chosen personal budgets and direct payments. On the other hand, a sizeable number of countries, 13 or 38%, does not allow direct payments. Instead, funds are usually allocated to service providers directly which reduces choice and control for the disabled person. Those countries are Poland, Slovenia... All state parties to the UNCRPD, should adopt direct payments as the main form to provide funding for the purchasing of PA.

Q 7: Does the PA funding allow users to cover all their needs in practice?

DOES THE PA FUNDING ALLOW USERS TO COVER ALL THEIR NEEDS IN PRACTICE?

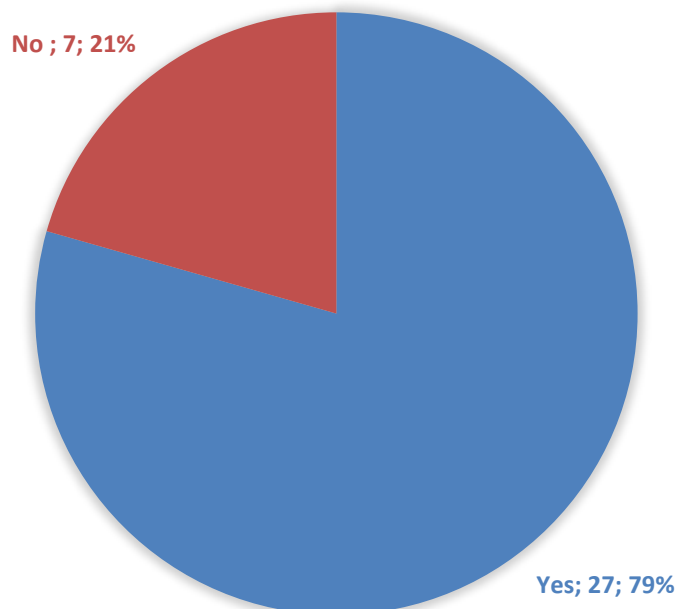


In an overwhelming majority of 30 or 88% of countries, the funding provided to purchase PA is not sufficient to cover all the users needs in practice. Users whose needs surpass the number of hours of PA granted per week, might depend on family members to support them or have to resort to living in an institution. According to the Independent Living

philosophy, personal assistance is supposed to enable the user to live like a non-disabled person, to have an ordinary live. If users have to pay a share of the costs of their personal assistance out of pocket, this might lead to financial constraints and thus reduces self-determination. In some countries there is a divide between the rules in the book, the national laws on PA, and how authorities apply in the law in practice. For example, in Germany legislation provides coverage of all expenditures but in practice people have to engage in long discussions with authorities to be able to actually receive what they are legally entitled to. State parties should provide funding that covers all the user's needs de jure and de facto.

Q 8: Is the scheme limited by a 'cost ceiling' (maximum amount of money) per user?

IS THE SCHEME LIMITED BY A 'COST CEILING' (MAXIMUM AMOUNT OF MONEY) PER USER?

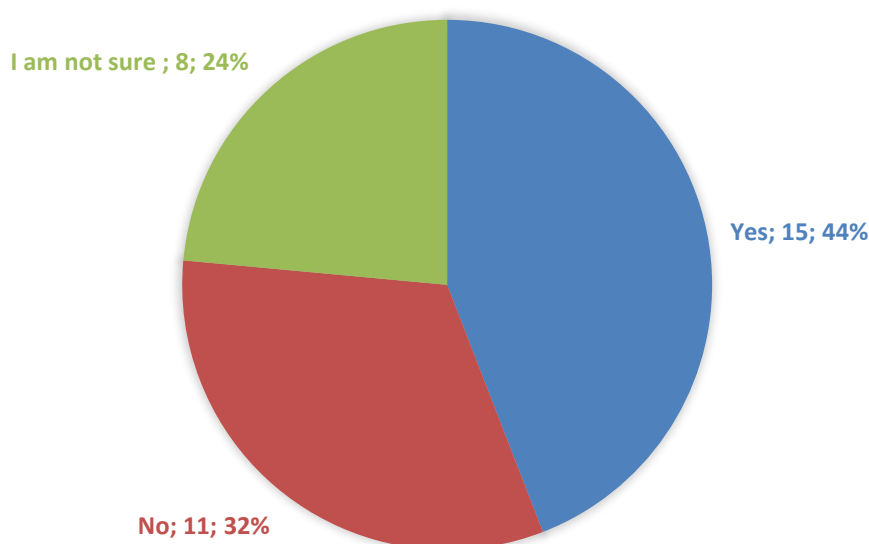


Question 7 and 8 are closely connected. The fact that authorities very often establish cost ceilings which are too low, is the logical reason for the inability of funding to cover all the users needs in practice. In Denmark

municipalities possess the authority to establish cost ceilings per user, which may result in lack of funding to pay for employer's contributions, payroll work, tickets, events or PA trainings. If no funding is provided for these expenses, it might lead to significant out of pocket expenditures for the user which might lead to financial constraints. If a user is unable to pay this might lead to substandard quality of PA service, compared to other users. State parties should lift fixed cost ceilings and instead allow dynamic cost adaptations.

Q 9: If yes, are users whose support needs exceed the cost ceiling directed towards residential care (e.g., social care institutions, group homes, nursing homes etc.)?

IF YES, ARE USERS WHOSE SUPPORT NEEDS EXCEED THE COST CEILING DIRECTED TOWARDS RESIDENTIAL CARE (E.G., SOCIAL CARE INSTITUTIONS, GROUP HOMES, NURSING HOMES ETC.)?

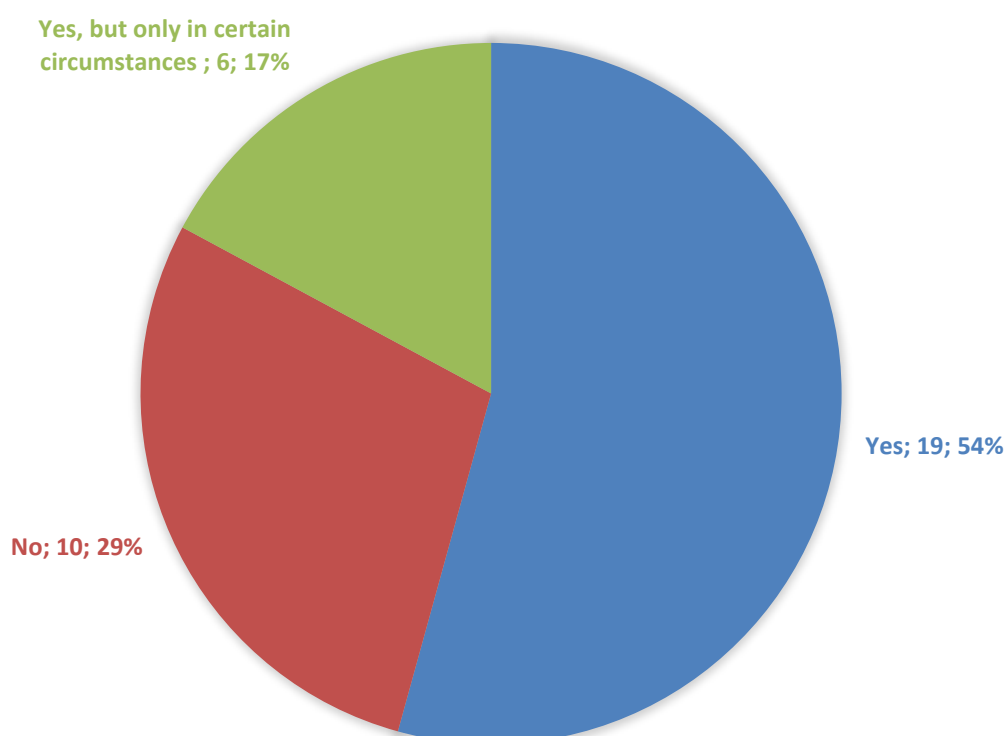


15 or 44% of countries direct users whose support needs exceed the cost ceilings, towards residential care. Although it is not a majority of countries, this figure is too high as it defeats the purpose of personal assistance.

According to General Comment no 5 and the Guidelines on Deinstitutionalisation, including in emergencies, personal assistance is supposed to free disabled people with support needs from the need to live in institutions. Personal assistance is supposed to be based on “individual needs”, covering all the needs in practice. Withholding a cost adaptation to the individual needs and instead institutionalising a persons can be seen as discrimination. State parties must discontinue this practice. A large amount of respondents, was not willing to commit to a decisive answer to question 9. It will be an objective to provide a higher amount of yes or no replies in future updates of our survey.

Q 10: Are family members allowed to be paid as PAs?

ARE FAMILY MEMBERS ALLOWED TO BE PAID AS PAS?

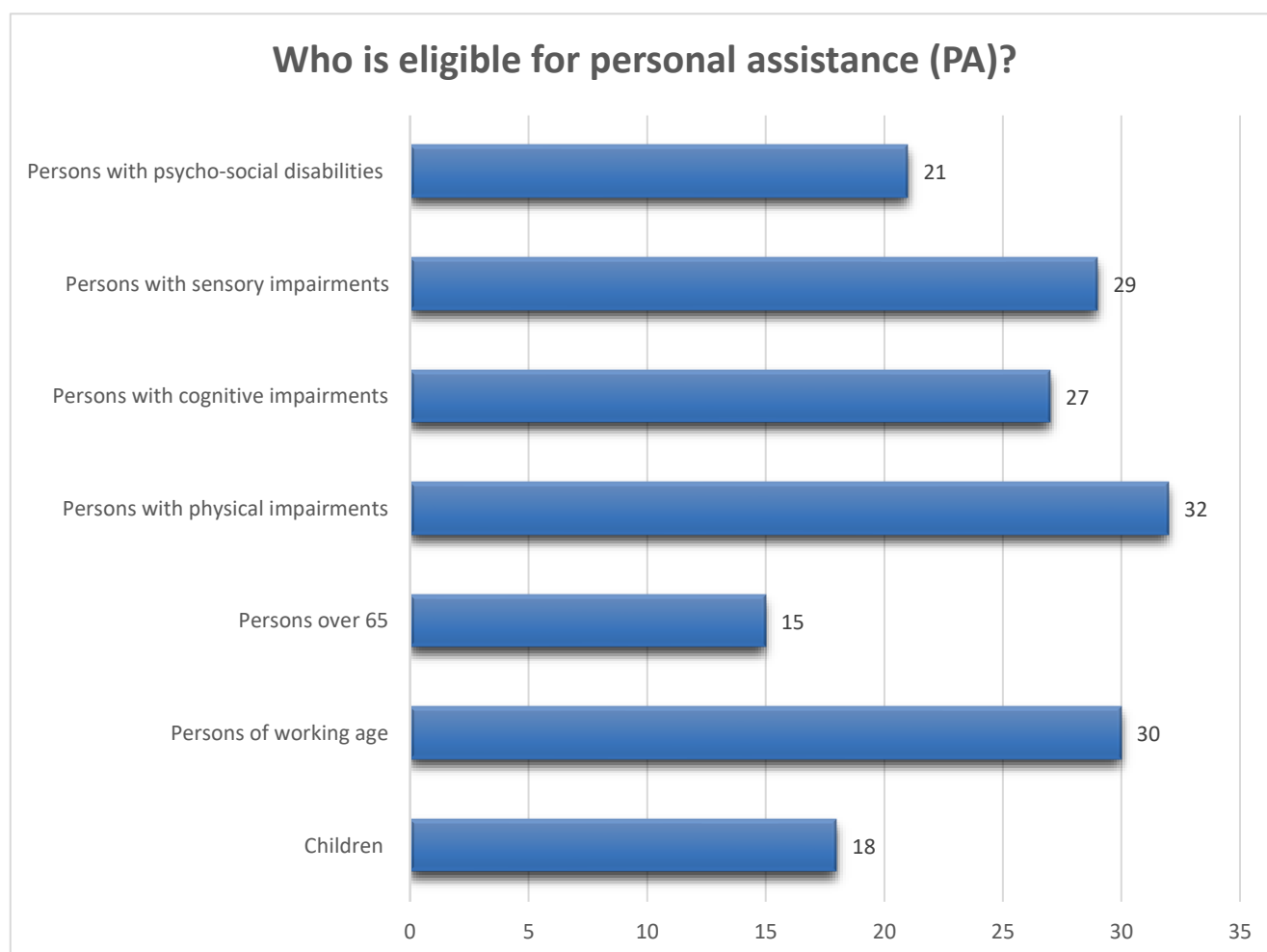


19 countries allow family members to be paid as personal assistants. 10 countries do not allow this option. 6 countries only allow for this possibility in certain circumstances. In Norway it is up to the discretion of local

authorities to permit family members to be paid as PAs. On the question on whether it should be allowed to pay family members as PAs General Comment no 5 and the Guidelines on DI do not provide guidance. Within the Independent Living Movement there is no consensus on this question (Mladenov 2019). Voices in favour point to the fact that it makes it easier for the disabled person to assign tasks if they can provide a monetary compensation to a relative or neighbour for helping. Also it can make it possible to avoid having a non-family member in the house at night (comp. Stainton & Boyce 2004, Ratzka 2004).

3. Eligibility and needs assessment procedures

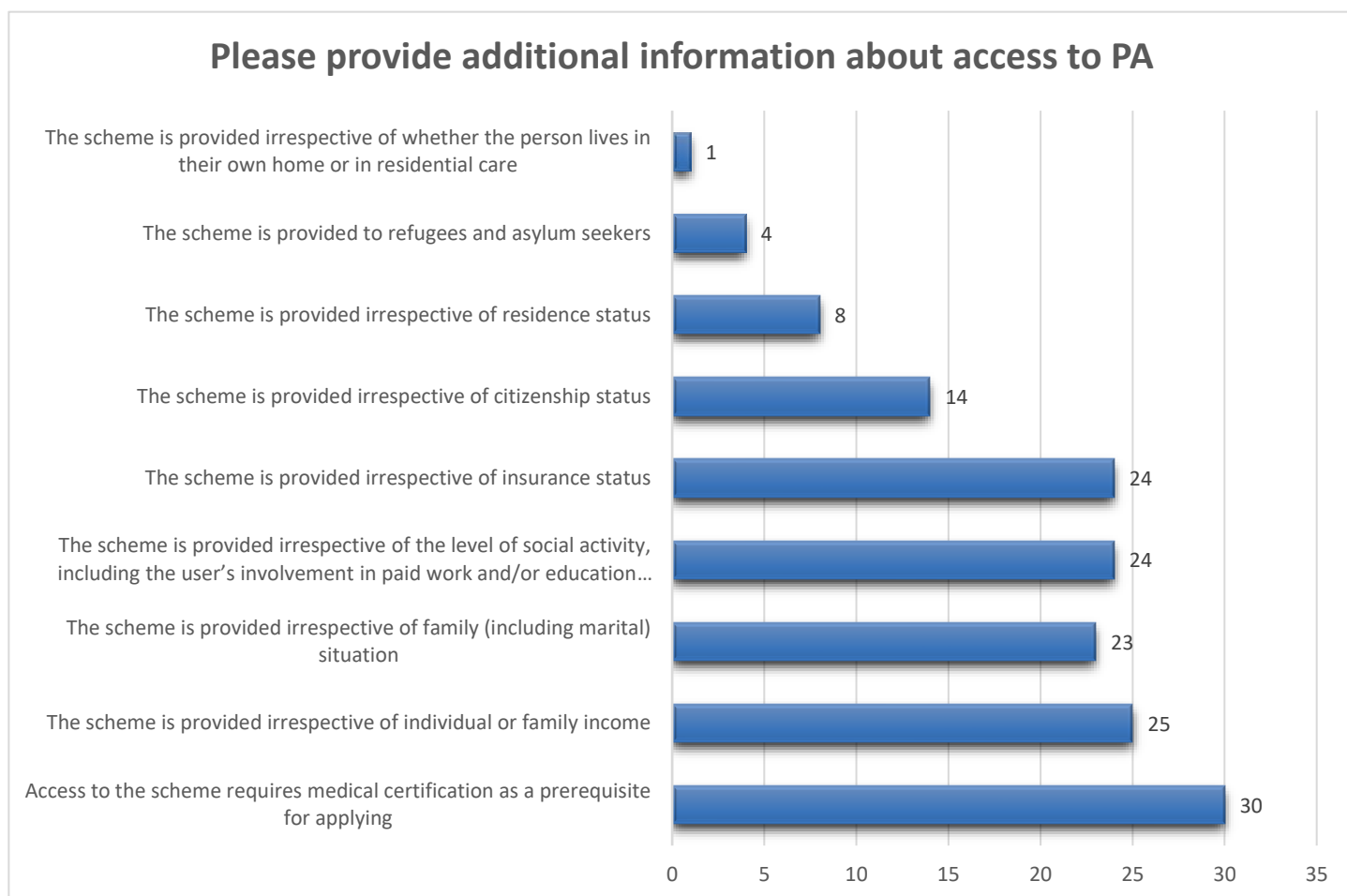
Q 11: Who is eligible for personal assistance (PA)?



Persons with physical impairments are eligible for personal assistance in almost all countries included in the survey, that have publicly funded

personal assistance schemes (32). 29 countries offer personal assistance to people with sensory impairments and 27 countries to people with cognitive impairments. Having access to personal assistance is the most difficult for people with psycho-social impairments as only 21 countries offer this service. Personal assistance schemes are typically directed at persons of working age (18-65), who have access to PA in 30 countries. Children are permitted access in 18 countries. Persons over 65 have a hard time accessing PA. Only 15 countries allow this type of service. Discriminating between different impairments and age groups is not in line with the UNCRPD. General Comment no 5 and the Guidelines on DI state clearly that all disabled people, regardless of impairment, age or other factors like race, gender or sexual orientation have the right to personal assistance. State parties need to follow these interpretations and adjust their PA policies accordingly. In some countries access to personal assistance for persons over 65 is permitted according to the law but authorities rarely approve in practice.

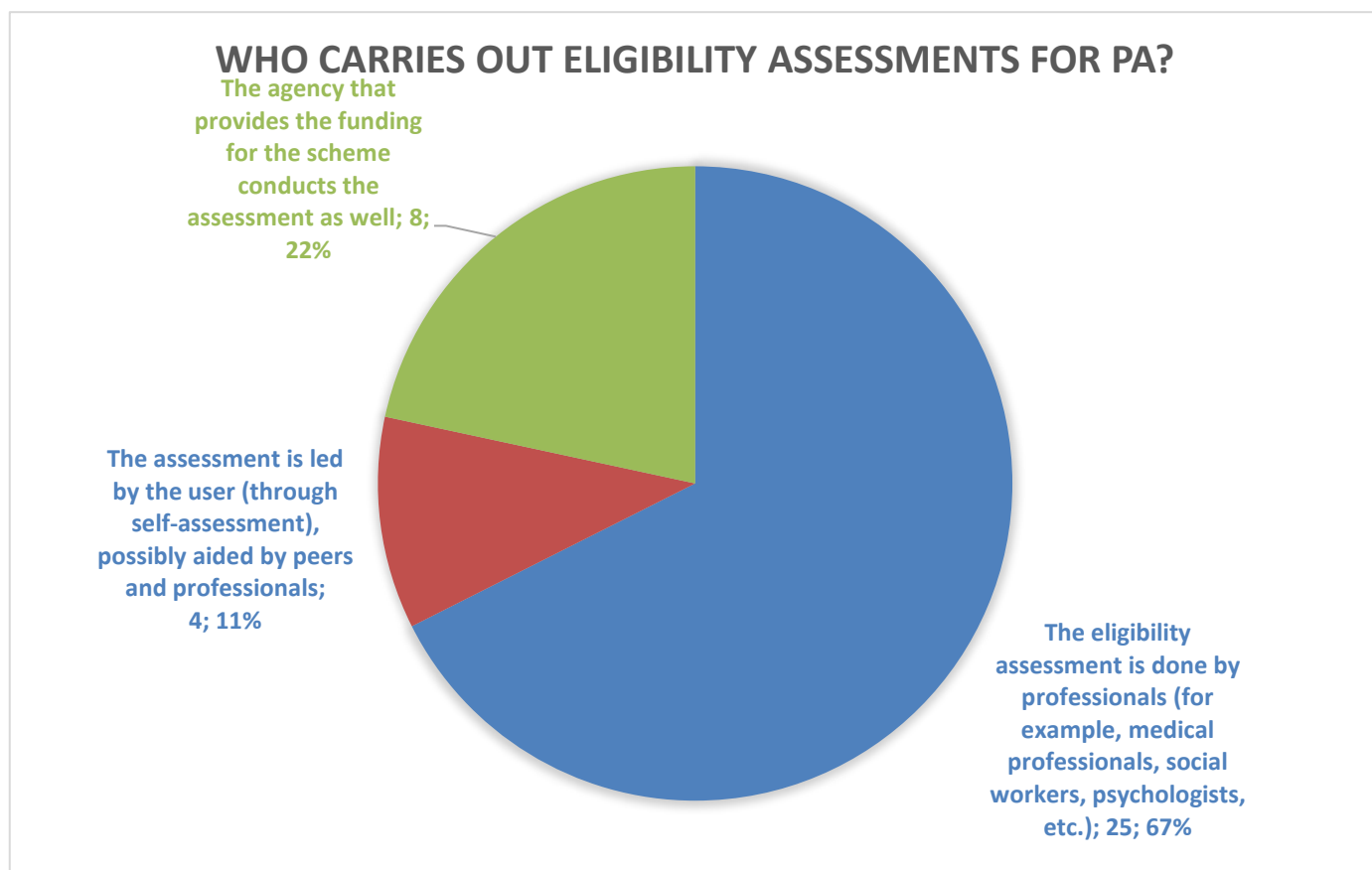
Q 12: Please provide additional information about access to PA.



A large majority of countries included in the survey, 30, require medical certification as a prerequisite for applying for personal assistance. On the one hand medical certification might place undue power in the hand of medical professionals. On the other hand, there might be the need for some objective criteria a person must to receive access to PA to ensure that this service is reserved for people who need it. Among the Independent Living Movement there is no consensus on this question (Mladenov 2019). 25 countries allow access irrespective of individual or family income. 24 countries provide PA irrespective of the level of social activity, like the involvement in work or education or insurance status. In 23 countries the scheme is provided irrespective of family (including marital) situation. Only 14 countries allow access to PA irrespective of citizenship status. When it comes to residence status the number of countries that permits access is even lower. Only 8 countries permit foreign nationals residing in their territory this service. This is particularly

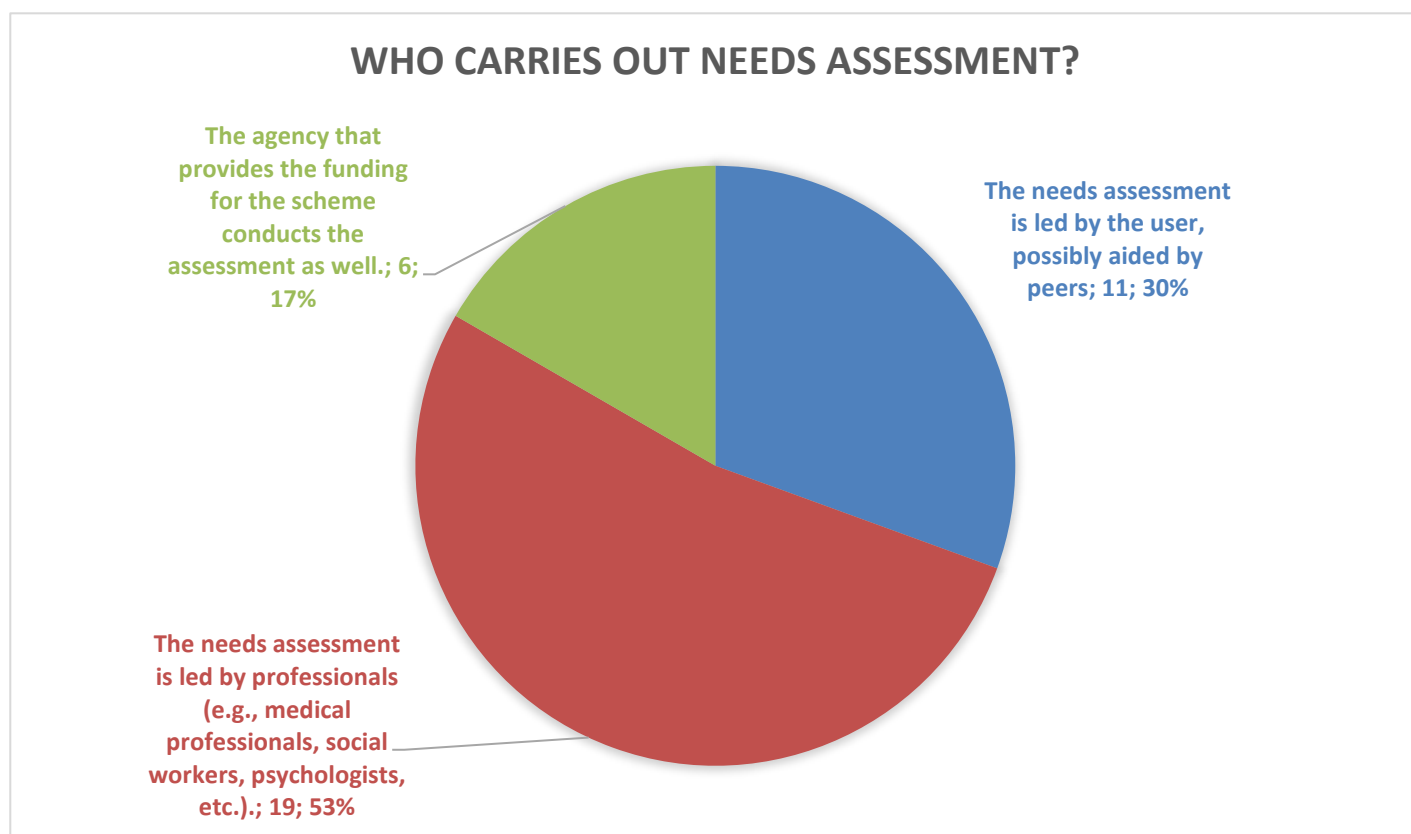
problematic for countries belonging to the EU. EU citizens are allowed to work and reside anywhere within the Union. The right to mobility involves access to social security such as employment benefits, public healthcare and pension insurance. Disabled people in need of PA who want to leave their country of origin and work in another member state, do not enjoy the same privilege since they can not get access to the host countries personal assistance scheme without receiving citizenship first. In order to be able to acquire citizenship, one needs to be able to live in a country for a while. In order to reside in a foreign country, a disabled person with support needs might need personal assistance. Before moving to another country to acquire a residence status a disabled person might need to have access to PA from day one in the new country. To be able to do that it is necessary to be allowed access before moving to the new country. Countries should not discriminate between disabled people. All disabled people in need, need to have the right to access PA.

Q 13: Who carries out the eligibility assessments for PA?



According to respondents, in the majority of countries, 25 or 67%, the eligibility assessment is done by professionals, for example medical professionals or social workers, psychologists. In 8 or 22% of countries the agency that provides the funding for the scheme does the assessment. In 4 countries the eligibility assessment is led by the user through self-assessment. Q 13 is among the questions on which there is no guidance from CRPD documents. There is also no consensus within the Independent Living Movement.

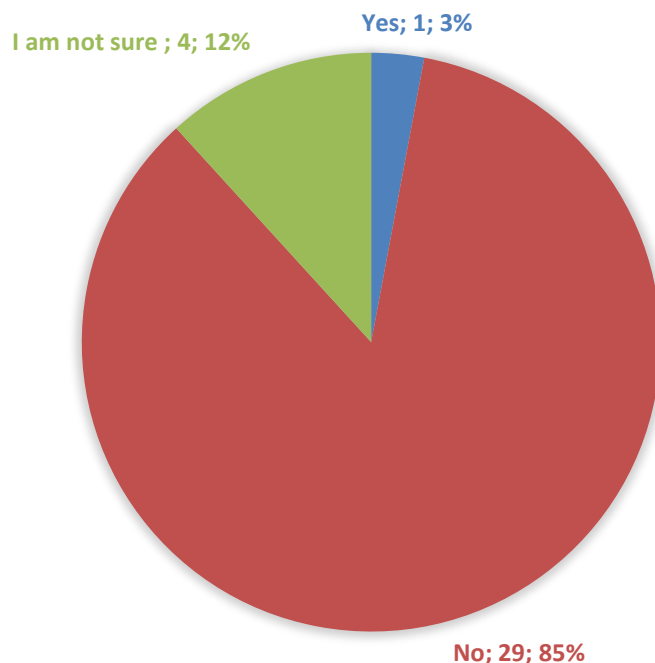
Q 14: Who carries out eligibility assessments for PA?



Q 14 and Q 13 are closely related. Surprisingly, countries seem to place more competence in the hands of users when it comes to the needs assessment. 11 countries allow users to led the needs assessment, while it is only 4 countries who do that when it comes to the eligibility assessment. Thus, the share of countries which place the competence for the needs assessment into the hand of professionals is smaller. 19 or 53% of countries allow for that.

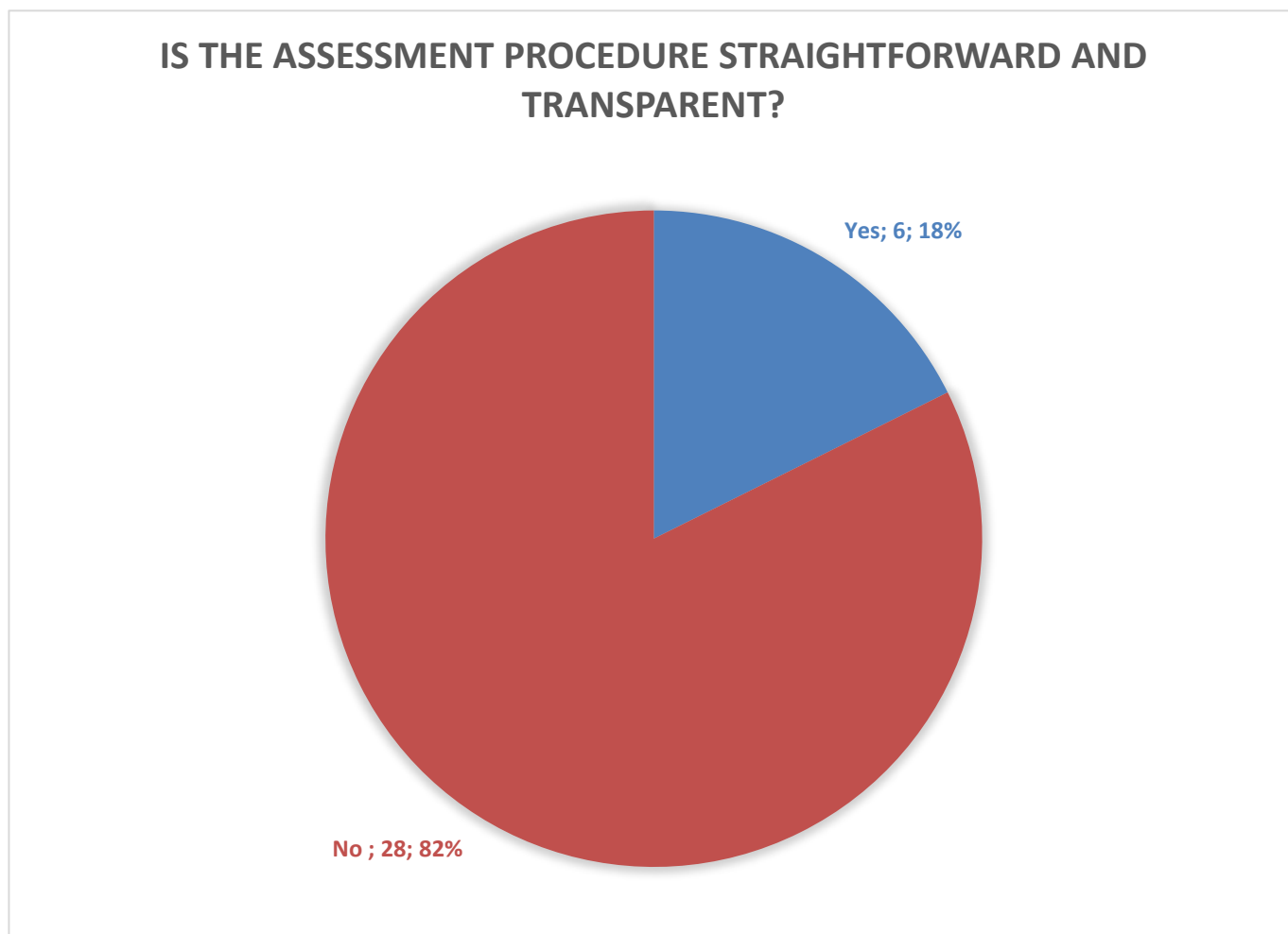
Q 15: Do the assessors, who carry out the needs assessment, receive training on Independent Living and the social model of disability?

DO THE ASSESSORS, WHO CARRY OUT THE NEEDS ASSESSMENT, RECEIVE TRAINING ON INDEPENDENT LIVING AND THE SOCIAL MODEL OF DISABILITY?



In an overwhelming majority of 85% (25) of countries, the assessors conducting the needs assessment do not receive training on Independent Living and the Social Model of disability. Since the assessors are to a large extent medical professionals, this entails the risk that assessments are being conducted according to the medical model of disability which sees impairments as a great personal tragedy (ENIL 2022). Under the medical model, disabled people are being subordinated to the authority of medical professionals who often presume that disability inevitably leads to a miserable quality of life. In surveys disabled people often report to have a better quality of life than non-disabled people (Special Rapporteur 2019). The only country which, according to our respondents, provides this kind of training on a routine basis is Cyprus. All state parties should make it a precondition for assessors to have a firm knowledge on Independent Living and the social model of disability.

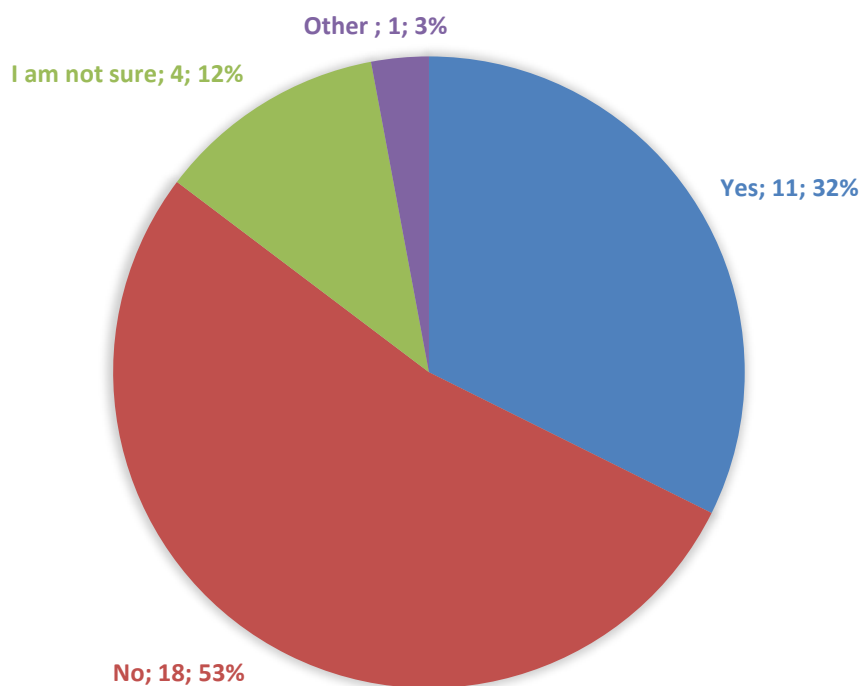
Q 16: Is the assessment procedure straightforward and transparent?



An overwhelming majority of 82% (28) of countries report that assessment procedures are not straightforward and transparent. The 6 countries which do report straightforward and transparent assessments are Serbia, Greece, Denmark, Slovenia, Cyprus and Lithuania. Without reliable assessment procedures there is a risk that some disabled people who might need personal assistance do not obtain it. State parties need to ensure straightforward and transparent assessment procedures.

Q 17: Do people have access to adequate information and/or peer support before and during their assessment?

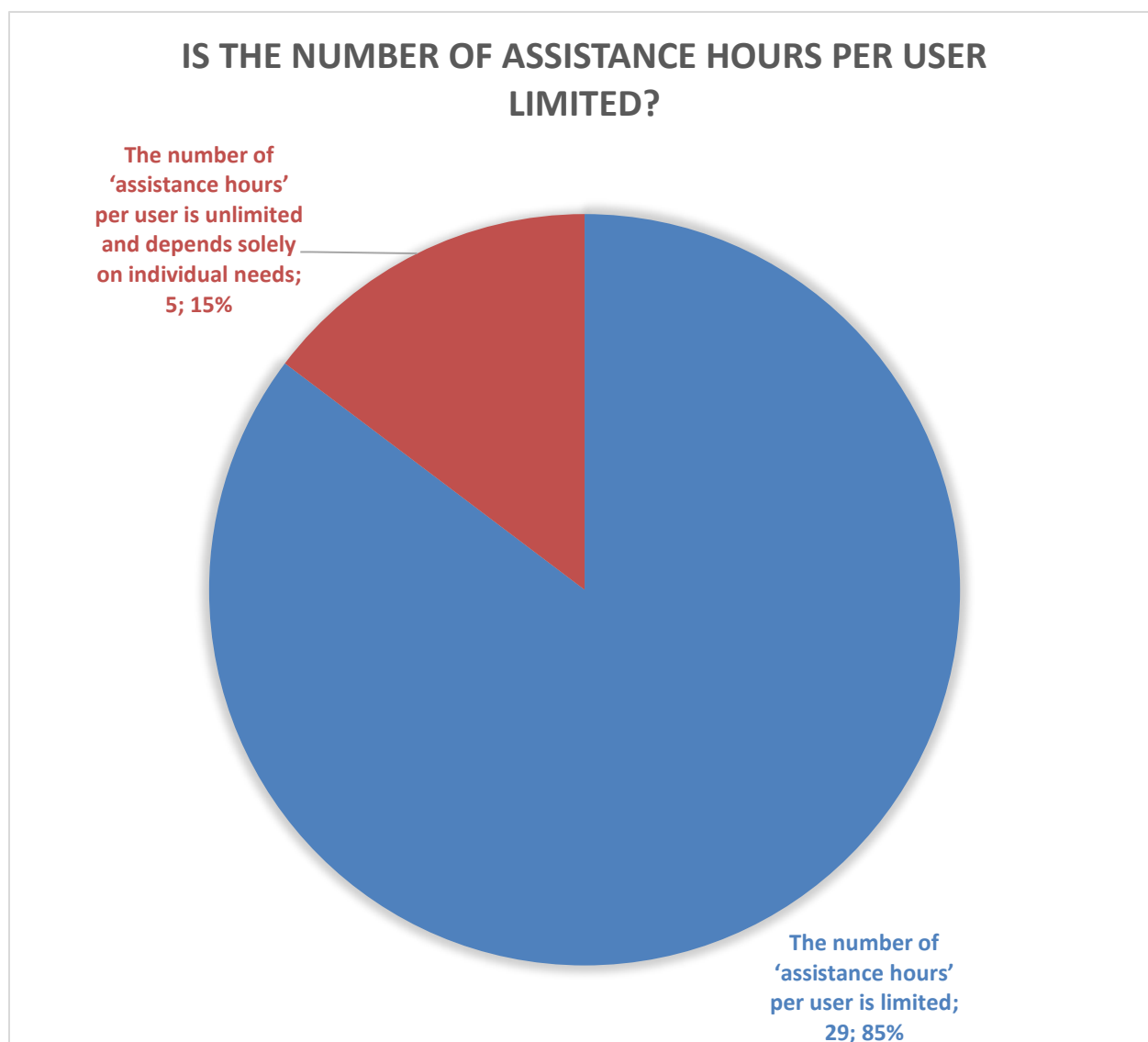
**DO PEOPLE HAVE ACCESS TO ADEQUATE INFORMATION
AND/OR PEER SUPPORT BEFORE AND DURING THEIR
ASSESSMENT?**



Responses indicate that 53% of countries (18) do not offer peer support before and during their assessment. The 11 countries (32%) that do offer peer support are Cyprus, Austria, Azerbaijan, Croatia, Estonia, Malta and Sweden. Studies show that peer support increases the satisfaction of PA users with the services they receive (Stainton & Boyce 2004).

4. Characteristics of PA provisions and recruitment

Q 18: Is the number of assistance hours per user limited?

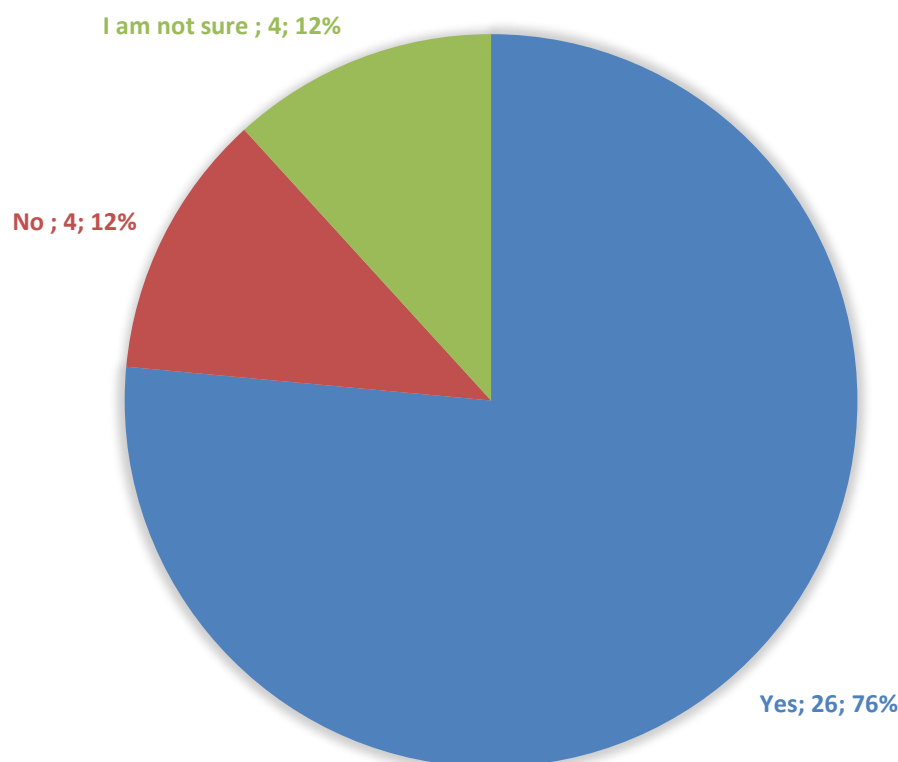


A huge majority of 85% (29) of countries limits the number of assistance hours per user. A limited number of assistance hours can be seen as a result of the cost ceilings that are frequently established, as was revealed in question 8. These types of limitations are not in line with General Comment no 5 and the Guidelines on DI which state that personal

assistance has to be needs based. Some disabled people might need PA support 24 for hours a day for 7 days a week. If the number of assistance hours is limited this type of support is not possible. For example, in Slovenia, PA support is limited to 30 hours per day, leaving disabled people with higher support needs with no resort than to rely on family members or to confine themselves to institutions. Some disabled people might need to be supported by more than one assistant at any given time. In such cases the number of assistance hours has to be higher than one required for 24/7 support which is 168 hours per week. 5 countries award assistance hours solely based on individual needs and thus offer an unlimited number of assistance hours per week. These countries are Albania, Germany, Slovenia, Scotland, Iceland and Sweden. This practice is in line with the UNCRPD. All state parties should adopt this approach.

Q 19: Do disabled people have an opportunity to appeal (file a complaint against) the outcome of their assessments?

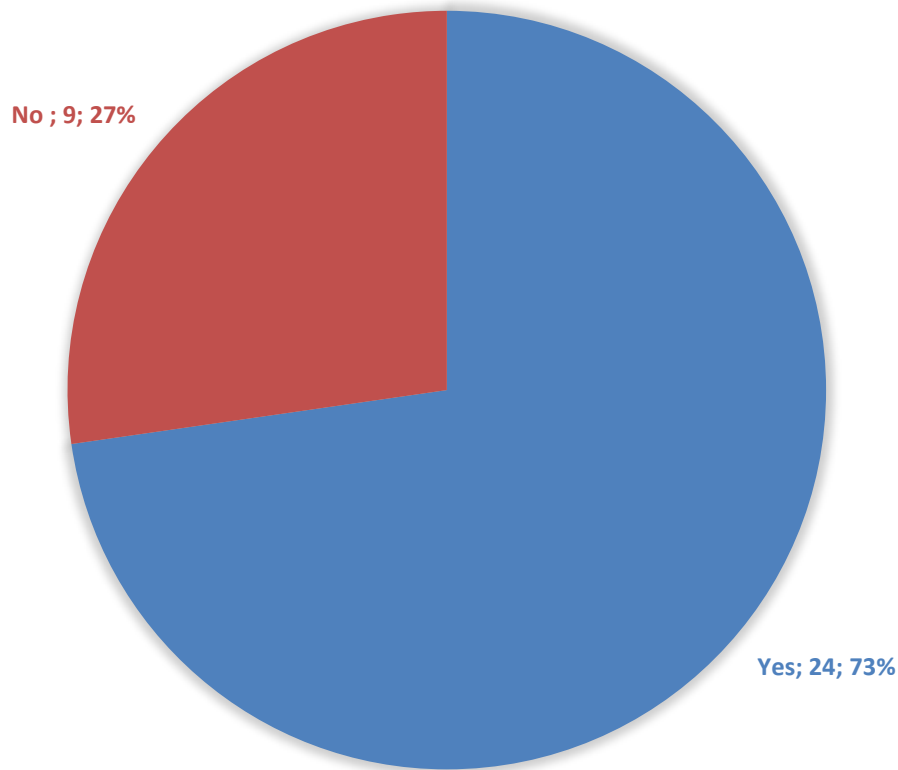
**DO DISABLED PEOPLE HAVE AN OPPORTUNITY TO APPEAL
(FILE A COMPLAINT AGAINST) THE OUTCOME OF THEIR
ASSESSMENTS?**



A large majority of 76% (26) of countries do allow to appeal (file a complaint) against the outcome of their assessment. Within the Independent Living Movement an appeal procedure is rated as an important criterion for the quality of a PA-scheme (Mladenov 2019). Thus it is positive that so many countries offer this opportunity. As can be seen in the 43 country sheets, available under <https://enil.eu/il-map/>, these procedures are usually not reliable. Often it is the assessors that rendered the original verdict who decide about the appeal. To be fair, appeal procedures need to be conducted by staff which is different from the assessors. Ideally assessors for the needs assessment and the appeal procedure need to be structurally insulated from each other.

Q 20: Can users choose who provides the PA services?

CAN USERS CHOOSE WHO PROVIDES THE PA SERVICES?

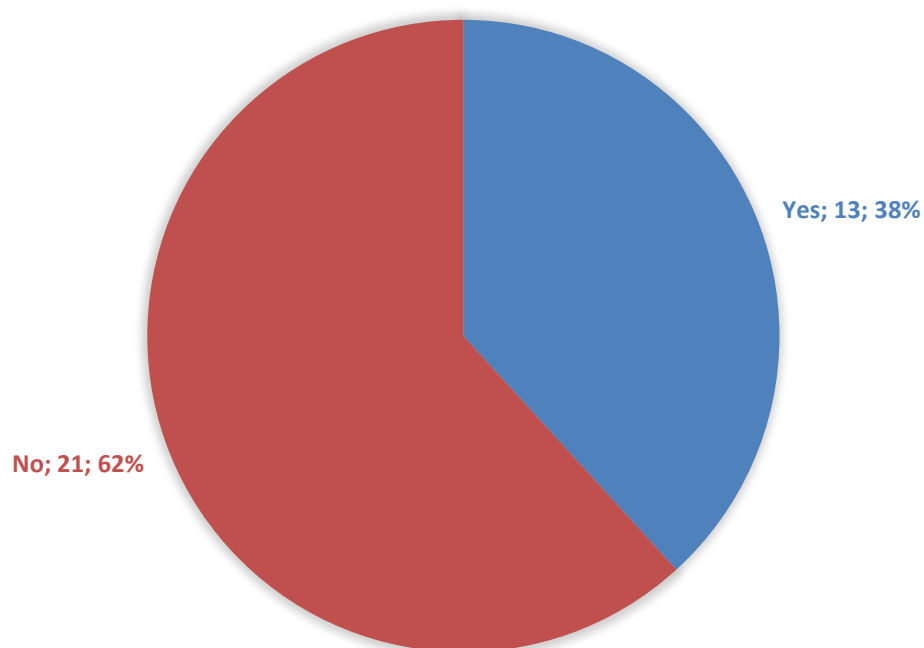


A large majority of 75% (27) of countries allow users to choose who provides the PA service. This feature is very much in line with the UNCRPD. General Comment no 5 states that “persons with disabilities have the option to custom design their service...decide by whom...the service is delivered”. The ability to choose the personal assistance is rated as the number one feature of good personal assistance within the Independent Living Movement since it enables choice and control (Comp. Mladenov 2019; Ratzka 2004). The cooperation between a PA user and the assistant can become fraught with problems (Shakespeare et al.). When such issues, for example personal conflicts or problematic behaviours, occur within institutions or home care services the disabled person often has no choice but to endure. With a PA-scheme that allows free choice of assistants, the disabled person can choose a different assistant. On the other hand, 9 countries do not allow this option. Those countries are Serbia, Montenegro, Norway, Austria, Bulgaria, Croatia,

Estonia, Ireland and Portugal. All state parties to the UNCPRD should allow PA users full choice and control over who provides the assistance.

Q 21: Can PA users keep their assistance when moving to another region or local authority within the country?

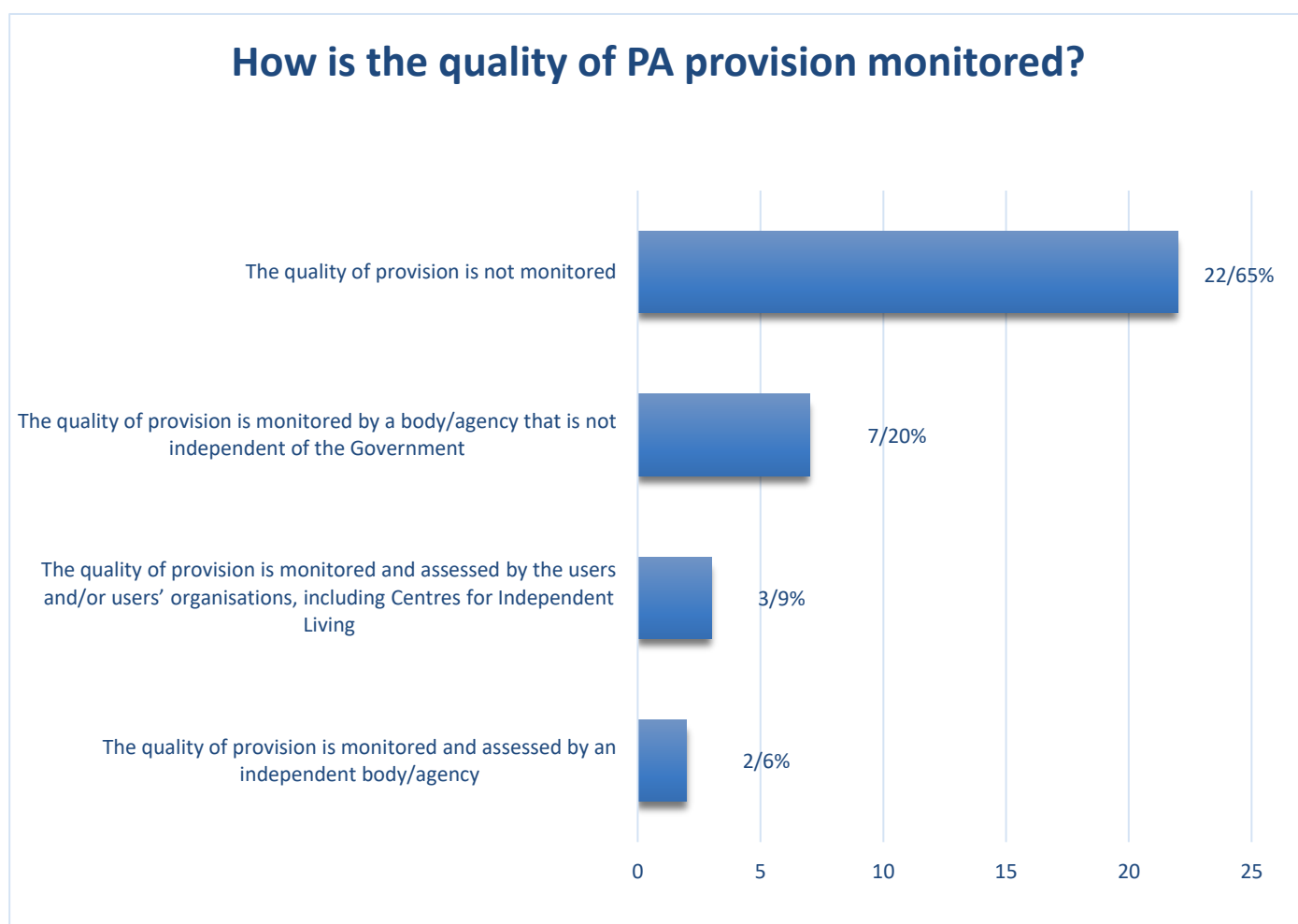
CAN PA USERS KEEP THEIR ASSISTANCE WHEN MOVING TO ANOTHER REGION OR LOCAL AUTHORITY WITHIN THE COUNTRY?



62% (21) of countries do not allow PA users to keep their assistance when moving to another region or local authority within the country. The purpose of the UNCRPD and the provision of personal assistance is to allow disabled people with support needs to live with opportunities and choices identical to non-disabled people. Non-disabled people are able to move around freely within and between countries. A driving license, an educational degree or pension entitlements stay valid if a non-disabled person moves from town to town or EU country to EU country. If PA entitlements are not transferable, this puts disabled people at a significant disadvantage to non-disabled persons since without it they are unable to move to another region, town or country. In countries that do not offer transferable PA entitlements, disabled people have to manage to somehow move without assistance and subsequently apply again at their

place of residence. New PA entitlements can only be granted after passing through the eligibility and needs assessment all over. According to our respondents the countries that offer transferable PA entitlements are Denmark, Albania, Montenegro, the Netherlands, Slovenia, Cyprus, Azerbaijan, Croatia, England, Latvia, Lithuania, Malta, Slovakia and Sweden. All UNCRPD state parties should offer transferable PA. Transferable PA entitlements also need to become available for cross-border mobility.

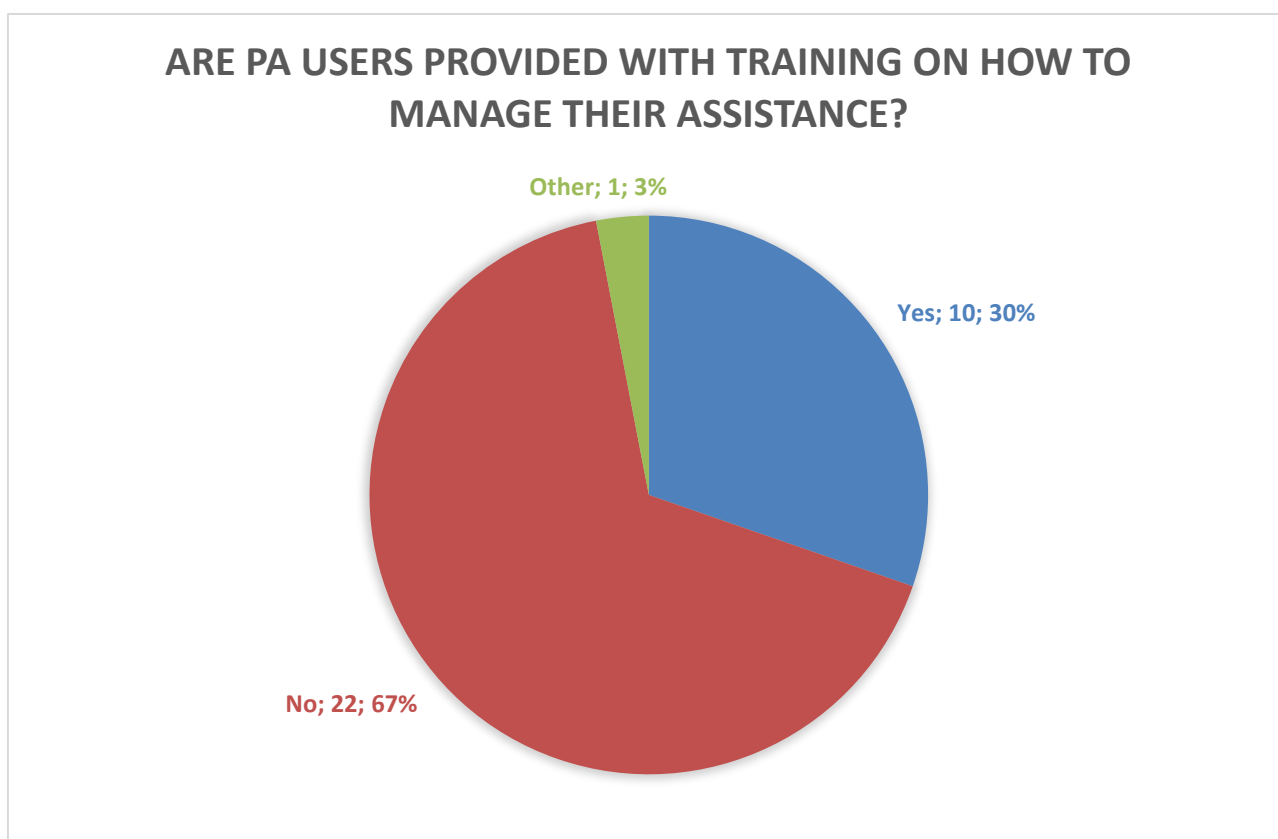
Q 22: How is the quality of PA provision monitored?



In a significant majority of 65% (22) of countries the quality of PA provision is not monitored. The ability to choose and dismiss the personal assistant allows users to resolve some problems on their own. Quality monitoring offers the chance to not only support the good working relationships between PAs and their users but supervise other aspects, for example the

eligibility and needs assessments and appeal procedures. Only 2 countries have independent agencies conducting quality monitoring and only 3 countries allow quality monitoring by users and/or centres for Independent Living. All state parties should install independent public authorities or Independent Living Centres to conduct regular quality monitoring. In both cases PA users should have a decisive role in leading the process.

Q 23: Are PA users provided with training on how to manage their assistance?

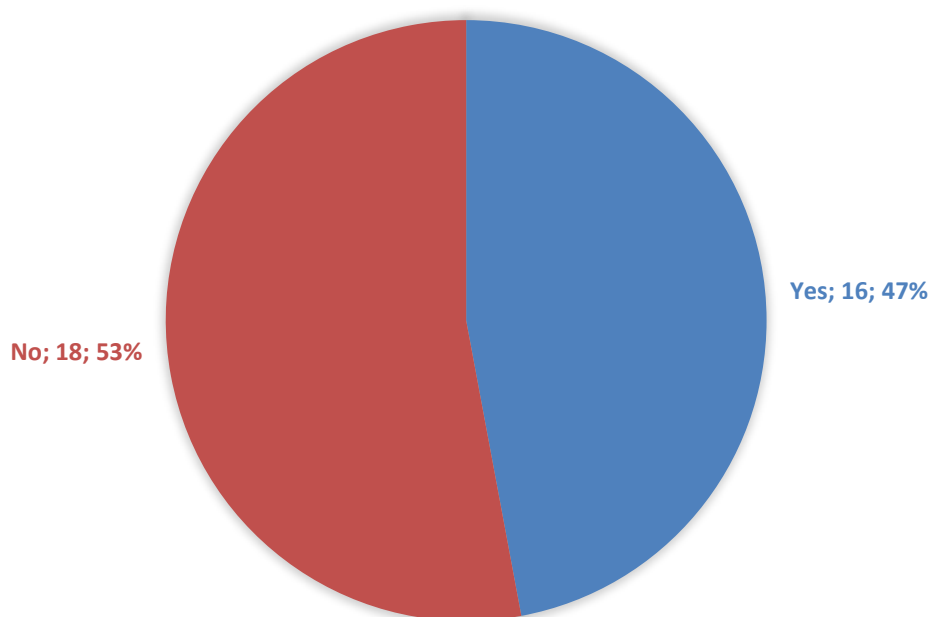


61% of countries (22) do not provide training on how to manage their assistance to users. While some PA users prefer to train and manage their assistants on their own, other might want support with this task. At the moment PA users in for example Slovakia have no access to such trainings. Having to handle this task alone is perceived as a burden by some. General Comment no 5 states that personal assistants need to be trained and supervised by the users but offers no guidance on how to

support users in this task. To make PA accessible to all disabled people state parties should provide various options: 1. Allow the PA user to train and manage the assistant completely independently, 2. Provide various degrees of support. The countries providing training to users on how to manage their assistance are Serbia, Finland, Norway, Slovenia, Austria, Belgium, Croatia, Iceland, Northern Ireland, Portugal, Romania, Slovakia and Sweden.

Q 24: Do PA users have access to peer support, i.e., support provided by other users of personal assistance?

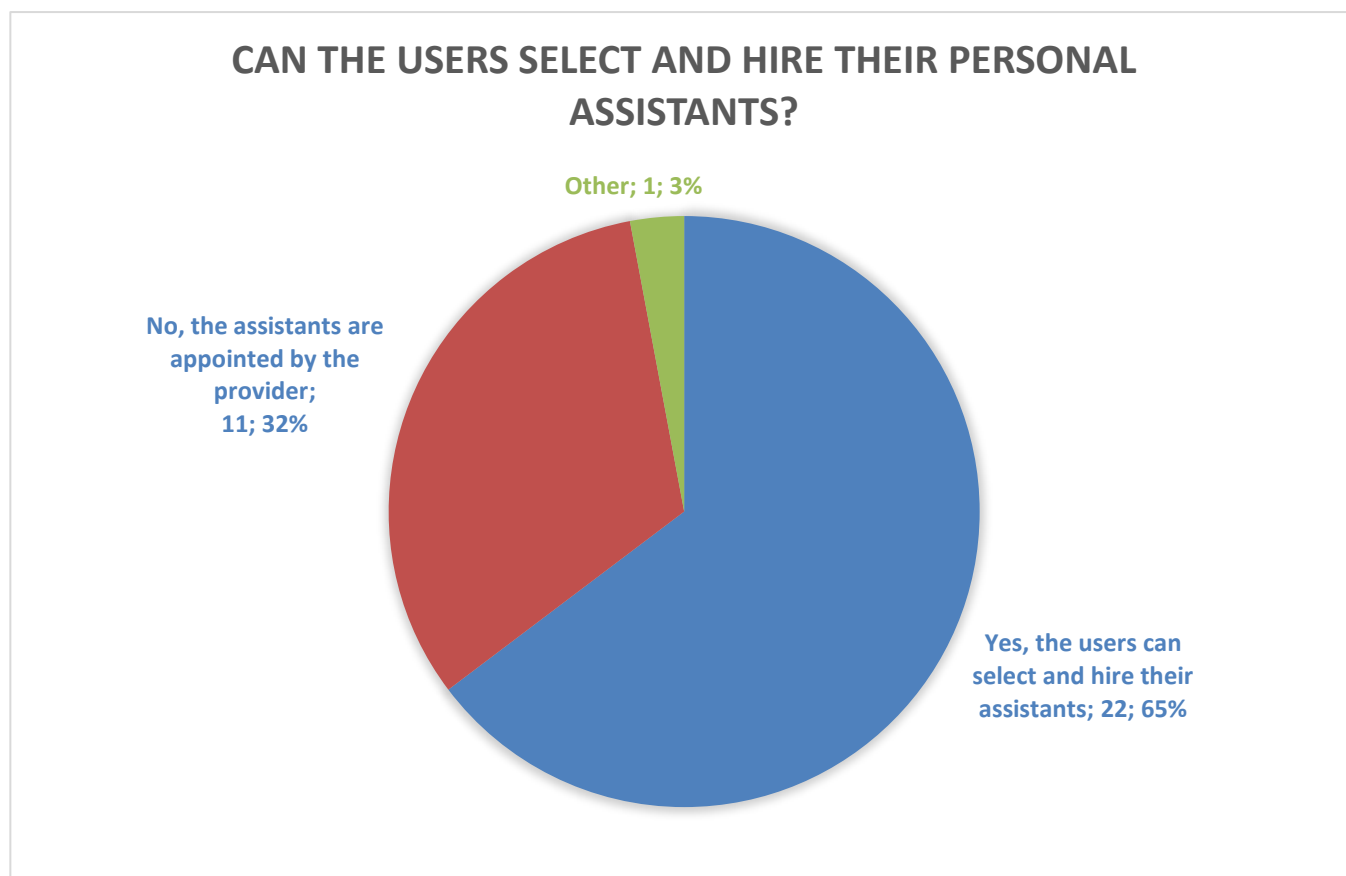
DO PA USERS HAVE ACCESS TO PEER SUPPORT, I.E., SUPPORT PROVIDED BY OTHER USERS OF PERSONAL ASSISTANCE?



When it comes to providing peer support, countries are almost evenly divided. In 53% (18) of countries peer support is not available, while in 47% (16) it is. The availability of peer support is not only crucial for the assessment process (Q 17) but for the complete duration of the working relationship between assistant and user (Stainton & Boyce 2004). State

parties should ensure the availability of peer support and provide the necessary funding for it.

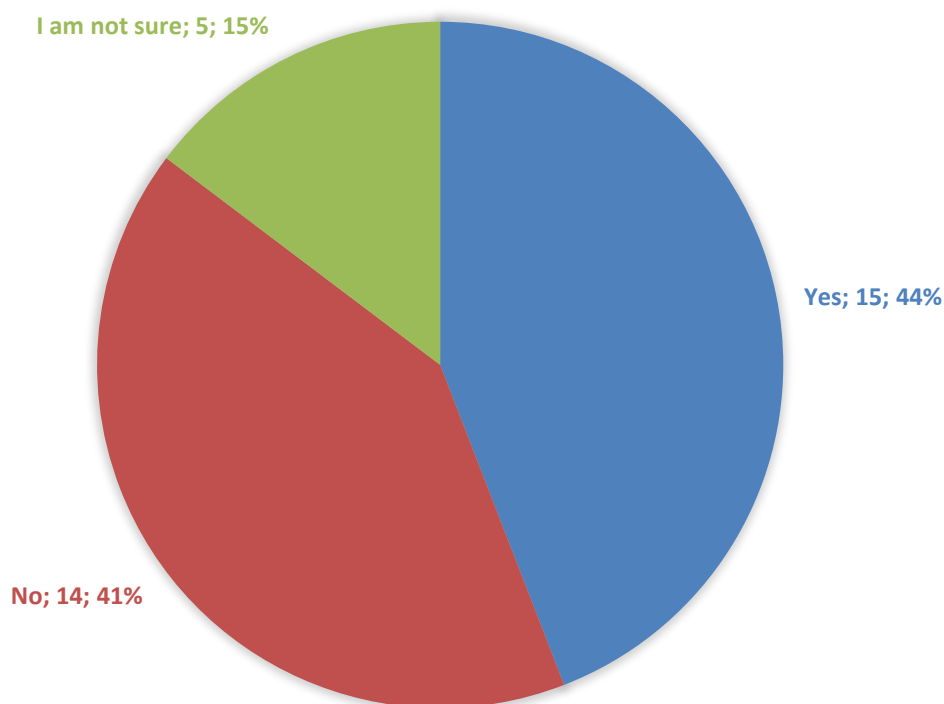
Q 25: Can the users select and hire their personal assistants?



In 22 (65%) of countries PA users can select and hire their assistants while 11 (32%) cannot. The ability to select and hire the assistant is one of the most important features of good personal assistance since it enables choice and control (Mladenov 2019, Ratzka 2004). According to General Comment no 5. “persons with disabilities have the option...to decide by whom...the service is delivered. ... Personal assistants must be recruited...by the persons granted personal assistance.” The question is closely related to Q 20. The discrepancies might be explained by an ability to choose between providers under certain PA-schemes but not to select the individual assistant. Nevertheless, the question to which extent users can select the provider and the individual assistants warrants closer investigation. Users should always have the option of hiring an individual PA directly, without having to go through an organisation, authority or company first. In cases such as these the individual assistant would be the provider. All state parties should allow users to select and hire their assistants.

Q 26: Are people with cognitive impairments allowed to manage their own personal assistance?

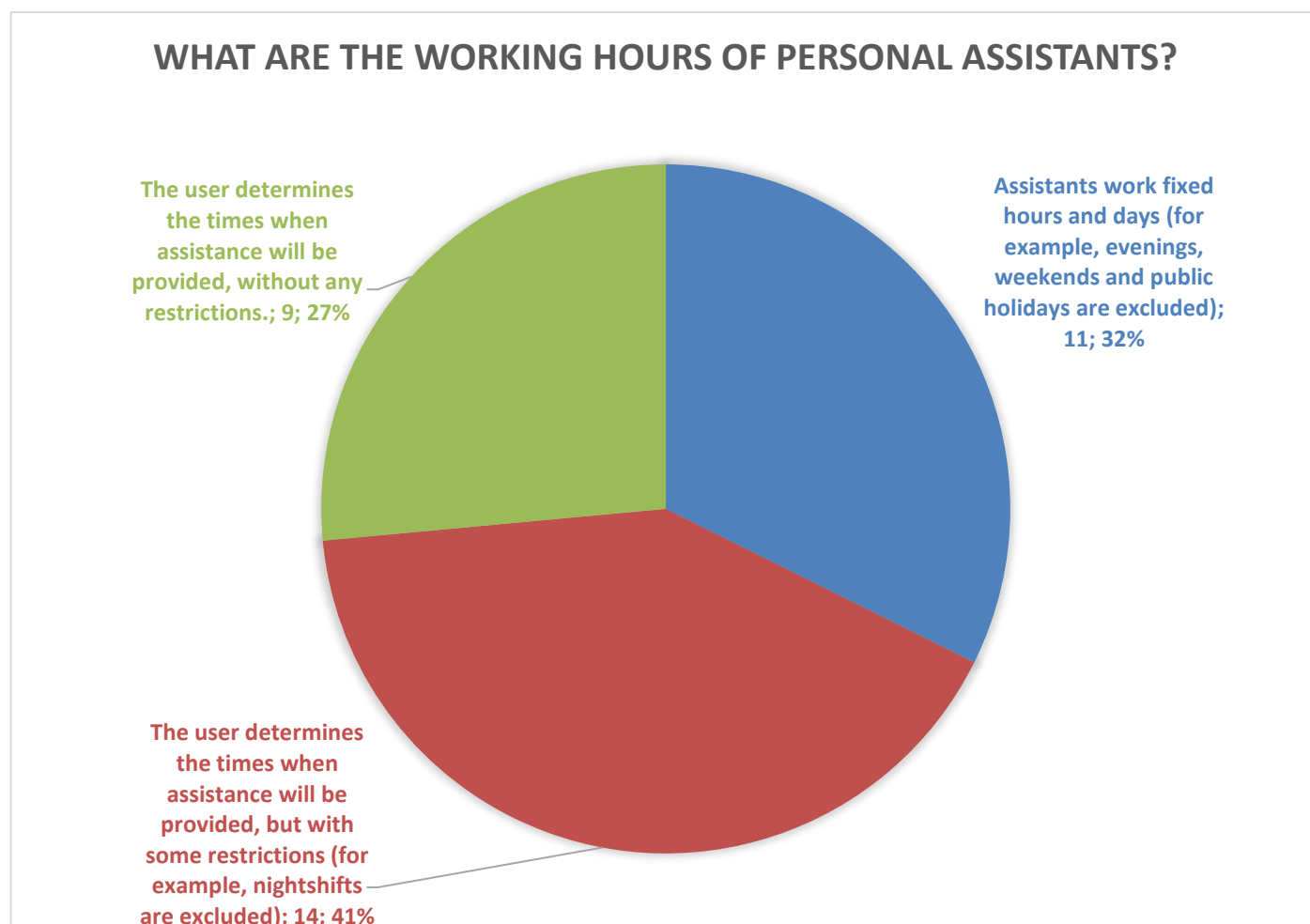
**ARE PEOPLE WITH COGNITIVE IMPAIRMENTS ALLOWED TO
MANAGE THEIR OWN PERSONAL ASSISTANCE?**



On the question whether people with cognitive impairments are allowed to manage their own personal assistants, countries are once again almost evenly split. 44% of countries (14) allow this feature, 41% (15) do not. The comparatively high number of “I am not sure” responses adds some inaccuracy. In future updates of this survey a higher number of clear yes-no responses should be obtained. General Comment no 5 and the CRPD Guidelines on DI unanimously state that discrimination between different types of impairments are not allowed. All disabled people must have the access to personal assistance according to the same rules.

5. Working conditions of assistants

Q 27: What are the working hours of personal assistants?

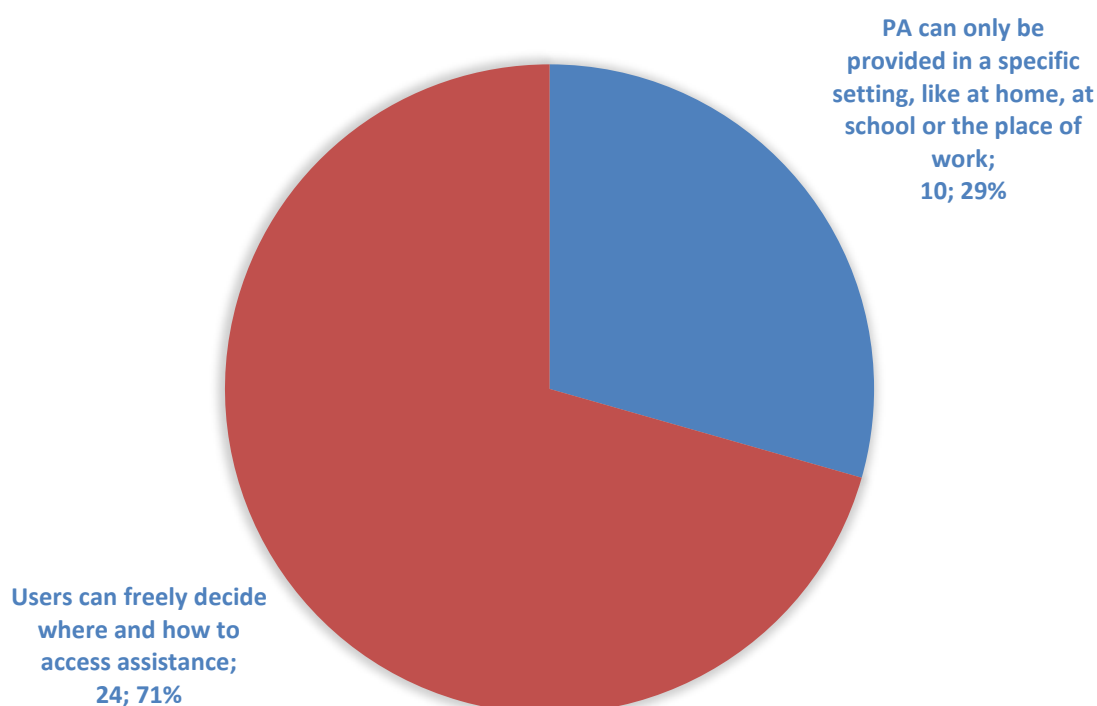


Only a small share of 9 countries (27%) permit users to freely determine when assistance is provided. 41% of countries (14) permit users to determine the times when assistance will be provided but with some restrictions and 32% (11) establish fixed working hours and days and do not allow the users any freedom in setting times at all. General Comment no 5 states “persons with disabilities have the option to decide...when...the service is delivered”. The ability to determine when assistance is provided is key in creating choice and control for the disabled person. The objective of providing personal assistance is to enable the user to have opportunities equal to a non-disabled person. This involves accepting a job where you have to leave the house at 5:00 in the morning

or to go to meet people at the pub at 21:00 in the evening. Also, a spontaneous midnight walk in the forest must be possible. If there are times which are pre-determined exercising such choice is impossible. In addition, some disabled people might need 24 hours support. Excluding night shifts leaves people unattended for a considerable amount of time. For certain impairments, this can put ones live in danger and thus makes PA unsuitable for living outside an institution. Personal assistance is supposed to provide an alternative from having to resort to institutional confinement which it is not when 24 hrs support is not possible. All state parties need to permit users to freely determine when assistance will be provided without any restrictions.

Q 28: Is the provision of Personal Assistance bound to a specific setting or can the user decide where and how to access PA?

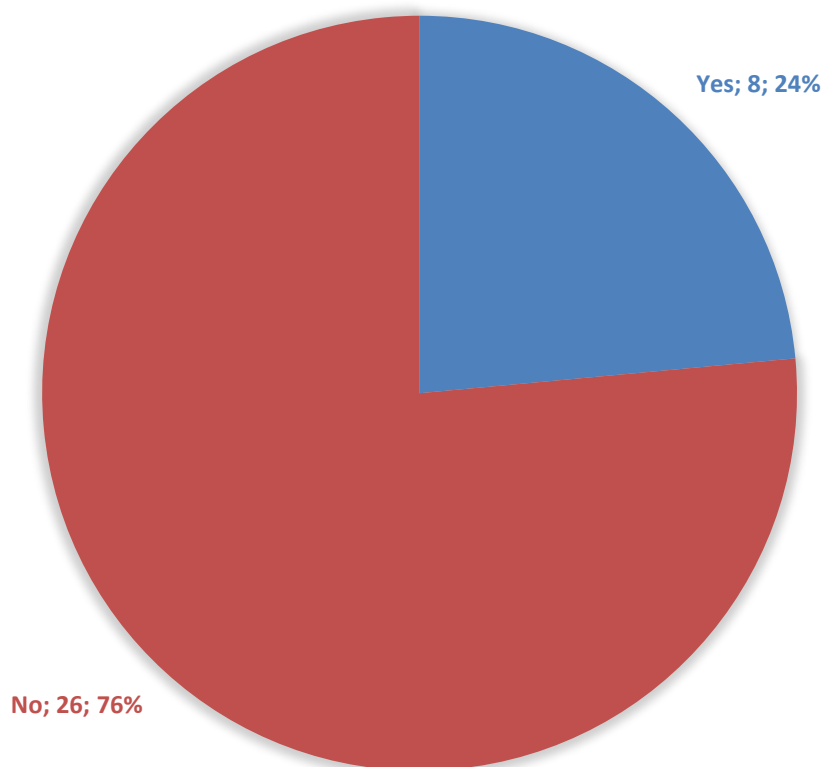
IS THE PROVISION OF PERSONAL ASSISTANCE BOUND TO A SPECIFIC SETTING OR CAN THE USER DECIDE WHERE AND HOW TO ACCESS PA?



Although a large majority of countries does not allow users to freely decide the times when PA is provided, they at least permit user to determine where and how assistance is accessed. In 24 countries (71%) users can freely decide where and how to access assistance. According to General Comment no 5 “persons with disabilities...decide how...where...the service is delivered”, Thus the prevalent practice is in line with the UNCRPD. To have a level of choice in their daily lives as non-disabled people do, a disabled people with support need have to be able to take their personal assistants with when going to work, participating in education, enjoying activities of leisure or when accessing all other areas of life. If this is not possible, normal areas of life risk becoming inaccessible and thus the freedom of choice is restricted. 10 countries (29%) do not permit PA users this freedom by providing personal assistance only in specific settings like at home, at school or at work. State parties need to lift all restrictions and allow full freedom in deciding when, where and how PA is provided.

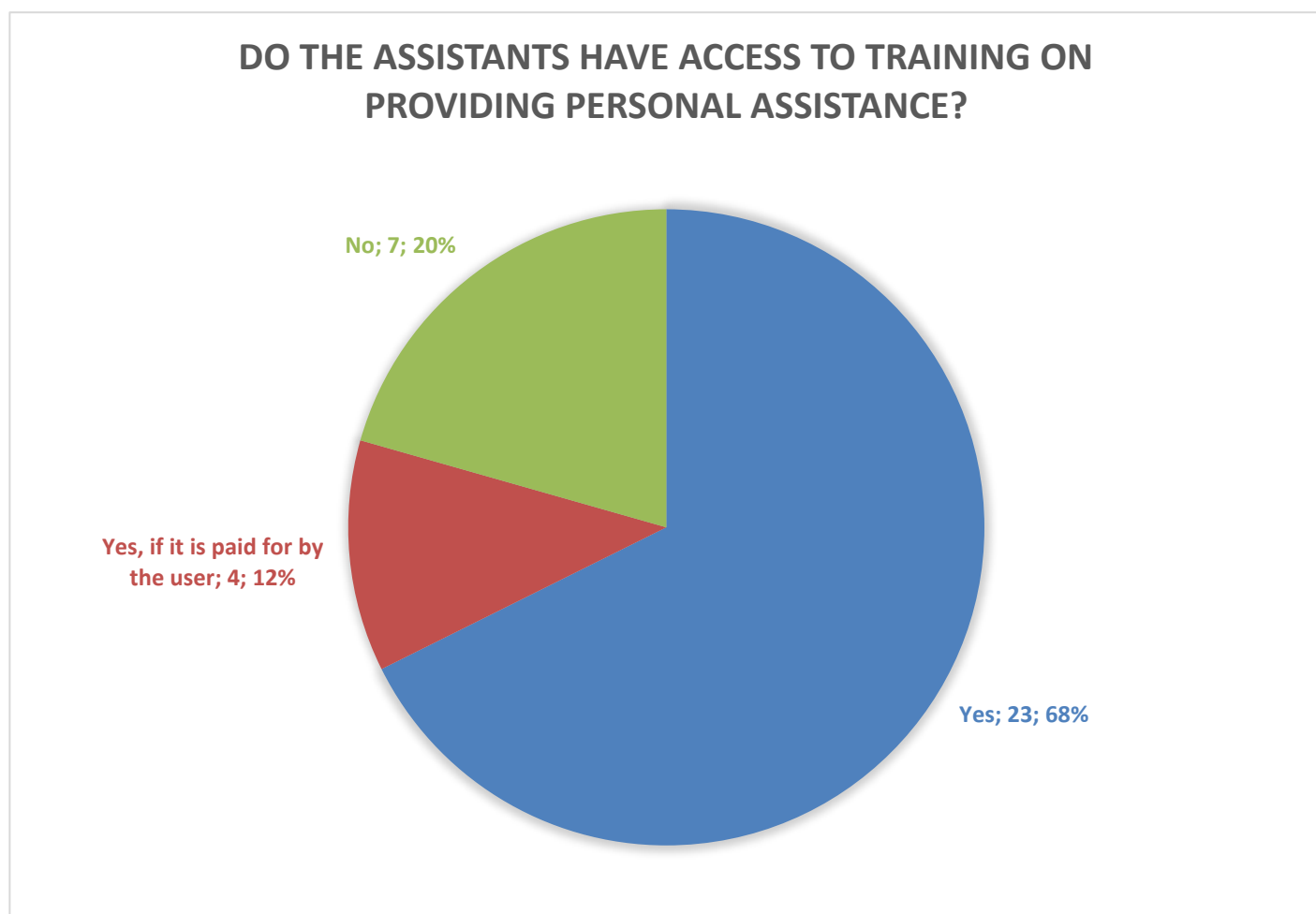
Q 29: Are specific qualifications required for people to work as PAs?

ARE SPECIFIC QUALIFICATIONS REQUIRED FOR PEOPLE TO WORK AS PAS?



An overwhelming majority of 76% of countries (26) does not foresee specific qualifications required for people to work as PAs. As previously mentioned, General Comment no 5 grants disabled PA users the right to train assistants themselves. Requiring specific qualifications might restrict this right. Thus, the practice applied by a large share of countries included in this survey, is in line with the UNCPRD. The countries that have established specific qualification requirements are Greece, Spain, Azerbaijan, Croatia, Estonia, Ireland, Lithuania and North Macedonia.

Q 30: Do the assistants have access to training on providing personal assistance?



A significant majority of 68% of countries (23) grants personal assistants trainings on how to provide assistants. To be in line with the UNCPRD, such trainings must be voluntarily and placed under the control of the PA user to the extent this is desired. A PA user must be allowed to conduct all necessary training herself or himself or if support is desired to design all trainings provided by for example an agency. State parties should provide various degrees of support in training PAs as desired by the user.

6. Policy recommendations

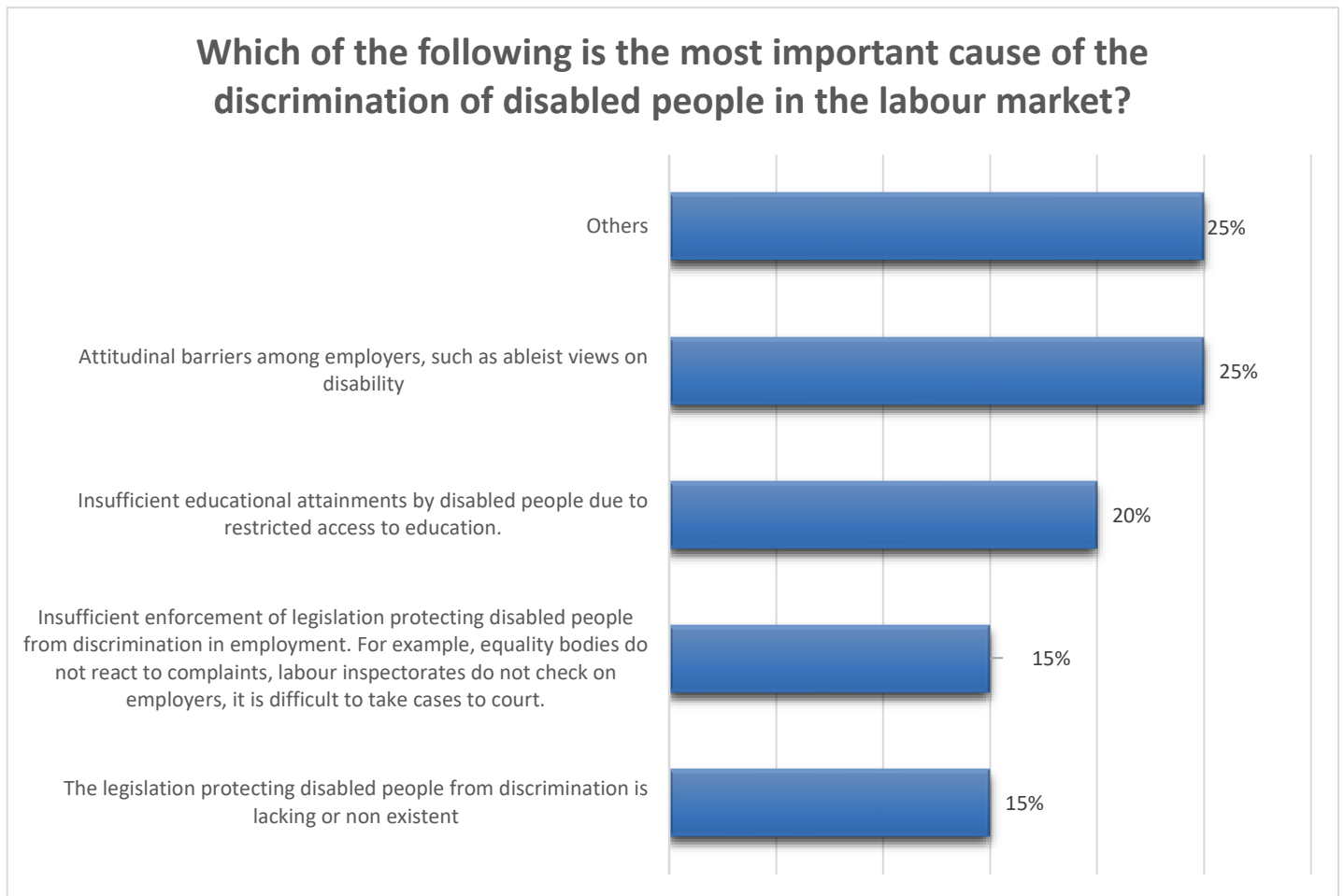
1. All state parties to the UNCRPD need to adopt publicly funded PA-schemes.
2. State parties need to increase the availability and accessibility of personal assistance so that all disabled people in need can benefit from this service.
3. Disabled people confined to residential settings needs to obtain access to their countries PA-schemes.
4. State parties need to lift all restrictions on what PA can be used for.
5. State parties should introduce direct payments such as personal budgets to allow users to purchase their assistance themselves.
6. State parties need to ensure the funding provided is sufficient to cover all users needs in practice.
7. State parties need to abolish cost ceilings (maximum amounts of money) per user and allow dynamic costs adjustments.
8. State parties need to ban the practice of redirecting users towards residential settings.
9. State parties need to ensure users can freely decide where and how to access assistance.
10. State parties need to ensure all disabled people, regardless of impairment, personal situation and other defining features have access to personal assistance.
11. State parties need to ensure eligibility procedures and straightforward and transparent.
12. State parties need to ensure assessors are trained in the Independent Living philosophy and the social model of disability.
13. State parties should ensure that applicants have access to adequate information and/or peer support before and during their assessment
14. State parties need to provide for an unlimited number of 'assistance hours' per user, depending solely on individual needs
15. State parties need to ensure PA applicants have access to fair and effective appeal procedures.
16. State parties need to ensure users can choose who provides the PA services.
17. Users need to be permitted to keep their PA when moving within and between countries.

18. State parties should install independent public agencies or Independent Living Centres to conduct quality monitoring of the countries' PA-scheme.
19. State parties need to ensure users are provided with training of how to manage their PA should they wish so.
20. State parties need to ensure users have access to peer support on all aspects of personal assistance.
21. State parties need to allow users to select and hire their personal assistants.
22. State parties need to allow people with cognitive impairments to manage their personal assistance themselves.
23. The user determines the times when assistance will be provided, without any restrictions.
24. State parties should ensure personal assistants are not required to have specific qualifications.
25. State parties should provide users with the support desired in training personal assistants.

Chapter III: Access to employment

The following chapter presents answers to a small number of complementary questions that were asked in the course of a call for feedback among survey respondents. To live independently, disabled people require access to mainstream services on an equal level with non-disabled people. In the last Independent Living Survey (2020), question 8 asked to rate access to mainstream services. Access to employment stood out as being exceptionally negative. All respondents from all 43 countries rated access to employment as being either inadequate or requiring improvement. The CRPD Guidelines on Deinstitutionalisation, including in emergencies state that poverty among disabled people is a leading cause of institutionalisation. Consequently, the complementary questions to respondents inquired about access to employment.

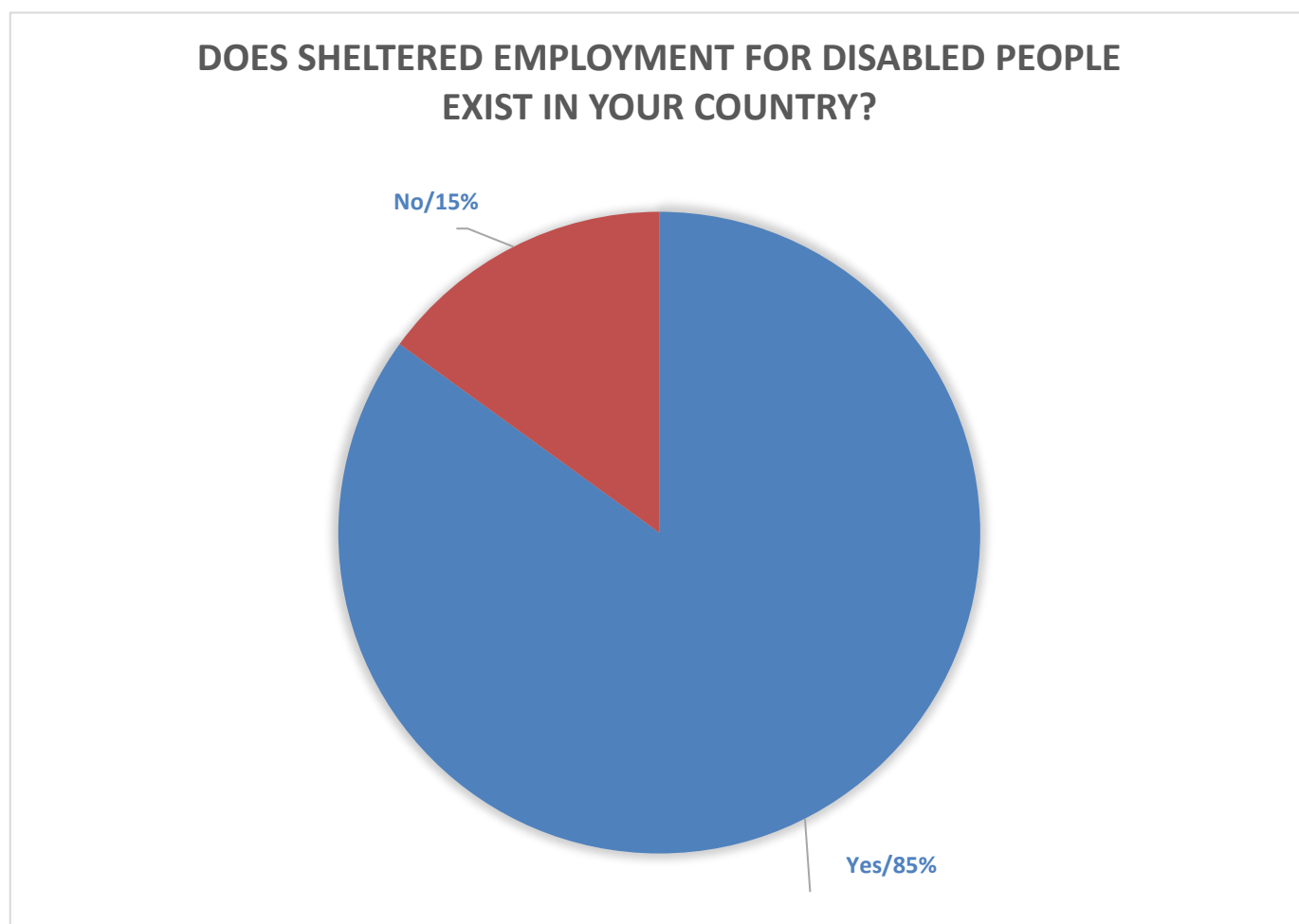
Q 1: Which of the following is the most important cause for the discrimination of disabled people in the labour market?



According to an empirical study, effective anti-discrimination legislation is the most effective tool to improve labour market outcomes of disabled people (van der Zwan & de Beer 2021). When asked to choose among four probable barriers to access employment, most respondents (25%) selected attitudinal barriers among employers such as ableist views on disability. 20% of respondents pointed towards insufficient educational attainments by disabled people due to restricted access to education. 15% selected insufficient enforcement of anti-discrimination legislation and 15% answered that anti-discrimination legislation is not strong enough to make a difference or does not exist. A high number of respondents (25%) explained that barriers to employment result from an interplay between the various factors mentioned. Inaccessible buildings, lack of knowledge on disability among employers and unavailability of PA were mentioned as

further barriers. The mention of PA links back to Chapter II and question 28. In Hungary, Luxembourg, Bosnia and Herzegovina, Armenia, San Marino, Turkey, Belarus and Ukraine there are no publicly funded PA-schemes. In 33 out of 35 countries that do have PA-schemes access is insufficient or inadequate. Consequently, many disabled people in need of personal assistance can not access this service, resulting in an inability to pursue employment.

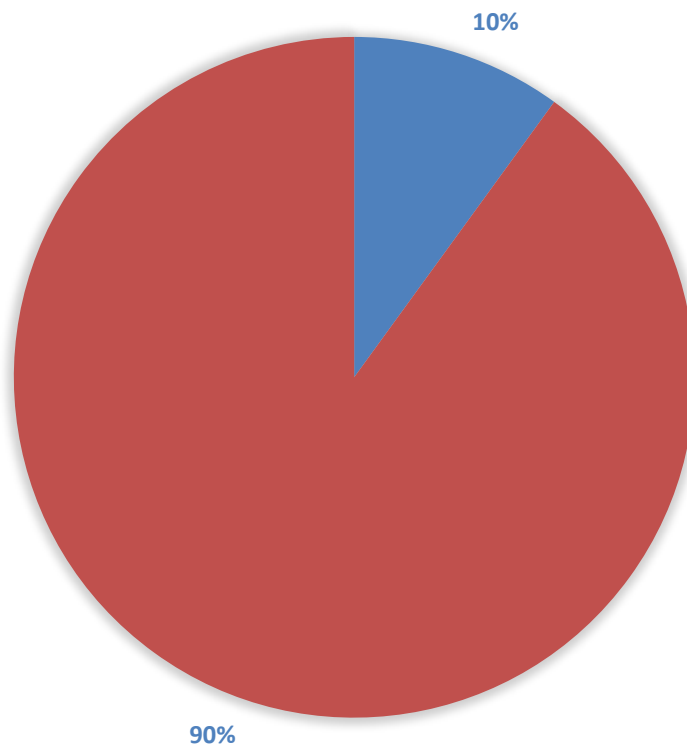
Q 2: Does sheltered employment for disabled people exist in your country?



According to Zwan and Beer (2019) sheltered employment is an ineffective tool for the integration of disabled people into the regular labour market. Still 85% of respondents stated that their countries pursue sheltered employment as a policy. For example in Germany, 330.000 disabled people work in sheltered workshops.

Q 3: In your opinion, do we need sheltered employment to make sure disabled people have access to work?

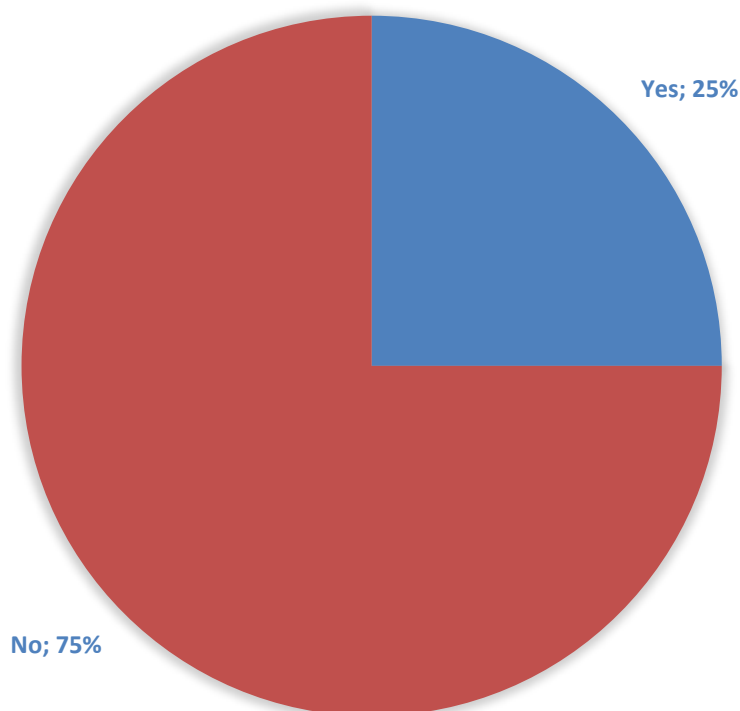
IN YOUR OPINION, DO WE NEED SHELTERED EMPLOYMENT TO MAKE SURE DISABLED PEOPLE HAVE ACCESS TO WORK?



Responding to the question whether we need sheltered employment to make sure disabled people have access to work, 90% of respondents replied with no. 10% of respondents replied saying yes. The fact that the response is not unanimous is surprising. This survey was conducted exclusively within the Independent Living Movement where one would expect consensus on this question. Perhaps barriers to regular employment are perceived as insurmountable by some respondents.

Q 4: Are you aware of projects using EU Funds to maintain, renovate, expand or build sheltered workshops?

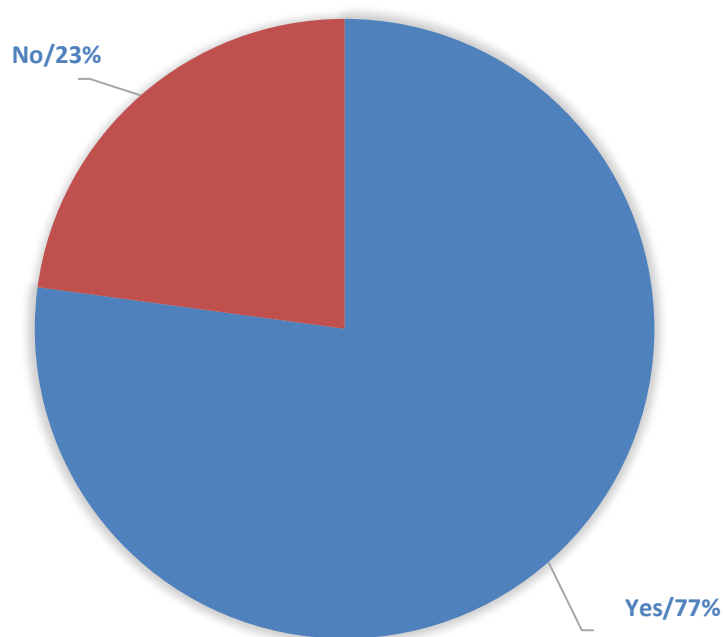
ARE YOU AWARE OF PROJECTS USING EU FUNDS TO MAINTAIN, RENOVATE, EXPAND OR BUILD SHELTERED WORKSHOPS?



75% of respondents stated they are aware EU funds were being used to maintain, renovate, expand or build sheltered workshops in their country. 25% of respondents were not aware of such projects.

Q 5: Are you aware of EU funded projects that support the integration of disabled people into the open labour market?

ARE YOU AWARE OF EU FUNDED PROJECTS THAT SUPPORT THE INTEGRATION OF DISABLED PEOPLE INTO THE OPEN LABOUR MARKET?



77% of respondents are aware of EU funds being used to support the integration of disabled people into the open labour market. 23% of respondents replied there were not aware of EU funds being used for such projects.

Acknowledgements

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We would particularly like to acknowledge the work done by Florian Sanden, Policy Coordinator at ENIL and Nina Portolan (Serbia), a European Solidarity Corps volunteer at ENIL from March – December 2020. Both Florian and Nina completed the survey in cooperation.

We also wish to thank everyone who completed the survey and provided feedback on the draft country sheets, as well as to respondents from Ukraine and Scotland for providing additional information used to write the two case studies. We appreciate everyone's time and commitment.

About the European Network on Independent Living

The European Network on Independent Living (ENIL) is a Europe-wide network of disabled people. It represents a forum intended for all disabled people, Independent Living organisations and their non-disabled allies on the issues of independent living. ENIL's mission is to advocate and lobby for Independent Living values, principles and practices, namely for a barrier-free environment, deinstitutionalisation, provision of personal assistance support and adequate technical aids, together making full citizenship of disabled people possible.

ENIL has Participatory Status with the Council of Europe, Consultative Status with ECOSOC, is represented on the Advisory Panel to the EU Fundamental Rights Agency's Fundamental Rights Platform, and on the Advisory Council on Youth at the Council of Europe.

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