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# Deinstitutionalisation of social services in Slovakia

## ANALYSIS OF SITUATION IN THE COUNTRY

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# Introduction

Transition from institutional to community care (deinstitutionalization, further as DI) is since 2011 one of the national social policies in Slovakia. Process of social services DI in Slovakia started before this year and has longer history. Our organisation Rada pre poradenstvo v sociálnej práci (Social Work Advisory Board – further SWAB) has DI as one of main goals since the establishment of organisation in 1990.

In last 33 years there were several projects and affords to start DI process. The results of these affords are changing step–by-step the provision of social services and social support in Slovakia. We can divide this time in to two main stages – from 1990 – 2010 and from 2010 – until now.

From 1990 – 2010 it was mostly non-governmental organisations who tried to start and change institutional provision of social services in Slovakia. The main trigger were poor quality of institutional services and ethical and humanistic questions around social services. DI became national social policy in late of year 2010 when EU stopped funding from ESIF towards institutional services in Slovakia.

Since 2011 is DI on paper one of main social policies in Slovakia, but in real life the process of DI is very slow, has many "enemies" specially between institutional social services providers, regional governments and municipalities and has very low political support on all levels of state. But on other hand there was done many small end also big changes which strengthen position of DI as a major need and policy in Slovakia.

In this analysis paper we are presenting short history of DI in Slovakia, current state of DI process and provision of support of people with disabilities.

## Short history of DI in Slovakia

Social services and support of the people with disabilities in Slovakia goes back to Middle Ages and later to 19th and 20th century when there were founded first municipal and state services for people in need.

First institution for people with intellectual disability was founded in 1898 in Plešivec[1]. In 20th century there were established, by charities, several institutions, and centres for people with disabilities. After foundation of Czechoslovakia in 1918 were several of these institutions transferred under the jurisdiction of state. The care for people with disabilities in Slovakia that time was partially taken by Psychiatric clinic at the Comenius University in Bratislava – where under the lead of prof. Matulay where banished cells, cage beds, strait jackets and there was active therapy and ergotherapy[2]. Between World Wars and specially after Second World War there was institutional care boom in Czechoslovakia as an aftermath of the war. In 50s started government to treat care for people with disabilities systematically under the Act on Social Welfare with focus at medical approach. That lead to centralisation of social care under the state and building of many social care institutions. Most of these institutions can we describe as a total institution with high institutional culture. In 1957, there were already 89 institutions in Slovakia providing care to elderly or to people with health disabilities. Social care fell under the jurisdiction of national committees.

The communist regime gave room to promotion of the institutional care and culture. But in the 80s more support and attention started to be paid towards community services and designing the alternative to the traditional, institutional care. In the beginning of the 80s the national committees intensified their efforts to open day-care centres for people with intellectual disabilities. This effort reacted to the needs and demands of families with children with intellectual disabilities and the aim to render social care in line with the international trends.

The pioneering institutions in Slovakia were mostly those in Bratislava and Žilina. There was a paradox that even then the Ministry of Health and Social Care pointed to the need of a systemic change, i.e., implicitly a shift from institutional to community-based care but did not manage to implement it. This can we see also repeatedly nowadays.

The situation in the Slovak centres of social care can be demonstrated by their capacity as of 31 December 1989: there were 8,914 places for persons with intellectual disability, of those 5,659 places were in institutions for adults and there were 386 places in weekly care and day care centres.[3] In 2021 there were 44.437 places in all-year-round services and from these places there are 18.747[1] places for people with disabilities in all-year-round services – most of them are in institutions[2][4]. So, we can see 110% increase of institutionalization of people with disabilities in last 30 years in Slovakia. We need to mention that, from 2014, it is forbidden to place children under 18 years in all-year-round social care homes. If we compare increase of number of places in weekly and day care centres in 1989 there were 386 places, but in 2021 there were 3,162 places in 2021. This means 719% increase of the type of services, but in absolute number of all places for people with disabilities, it is only 14,4%.[5] All these data indicates that the most common provision of social services in Slovakia for people with disabilities happens in institutional settings.

[1] Presented number of places for people with disabilities is without number of places in institutions for elderly people. Altogether there are 52.062 places in social services institutions in Slovakia, from which there are 44.437 places in all-year-round institutions.

[2] From 18.747 places for people with disabilities in Slovakia only 608 places were in supported housing at community level. But there are several social care homes at community level with less capacity than 6 places in one building.

Since early 90s after the Velvet revolution there were several changes in social care in Slovakia. In 1990 there were 38 institutions for children and youth, and 45 institutions for adults with disabilities. The legislative changes between 1991 and 1992 14 opened the possibility of rendering social care by non—profit organizations.

In 1991, in a reaction to long-stated needs of families and young people with intellectual disability Slavomír Krupa established the first supported housing – Betania Senec with a capacity for eight persons. the first non-governmental organizations fundamentally contributed to drafting Key Challenges of People with Intellectual Disabilities and Their Social Integration – Draft Solutions (Návrh riešenia zásadných problémov ľudí s mentálnym postihnutím a realizácia ich spoločenskej integrácie). Its authors pointed to the fact that there were about 10,000 people living in residential social care and that intellectual disability was a medical, ethical, pedagogical, psychological, social, and economic issue, therefore early diagnostics and intervention were needed. This report underpinned the need for transition and a multi-sectoral approach to issues of supporting people with health disability. There were no major systemic changes from the point of transformation and deinstitutionalisation but gradually cooperation with international stakeholders, mainly from non-governmental institutions, brought about establishment of innovative and community services.

Various day-care facilities with a strong community component for people with disability were established, including Detský klub in Košice, Betánia in Senec, and supported housing in Rusovce, hand in hand with public services – Symbia in Zvolen, Méta in Martin, Domino in Prievidza and others. In 1998, a new Act No 195/1998 on Social Assistance was adopted. Its goal was to regulate legal provisions for rendering social support that was aimed at decreasing or overcoming material need or social need of an individual with his/her active participation; provide for basic living conditions of a citizen in his/her environment; prevent causes of developing, promoting or repeating disorders in psychological, physical, and social development of a citizen and facilitate his/her inclusion into society. The law approached the issue of social assistance from various perspectives, including through social and legal protection (as of 2005) and social services.

In 1999, the Košice self-governing region established cooperation with the Social Work Advisory Board (SWAB) and they did a quality monitoring in six institutions of social services under its jurisdiction. As a result, it picked two institutions that were to be subject of transition and deinstitutionalisation: Centre of Social Services in Hodkovce and Centre of Social Services in Kráľovce. The quality monitoring performed by SWAB in Hodkovce identified multiple institutional problems, while some of them had resulted in violations of human rights, including: placing of immobile patients into cage beds, unauthorized fixing of residents to still objects while some of them had their extremities tightened by straps, prioritizing care and health services, forced sexual and physical abuse among the residents, depriving residents of their legal capacity. SWAB and Košice self-governing region prepared in 1999 first deinstitutionalization project in Slovakia, which was only partially successful – mostly because of political changes and lack of political support from leaders of self-governing region. But one of the main positives of this project was that the original wording of Act of social assistance No. 195/1998 did not create any legal room for transition from institutional to community care. A joint initiative of SWAB and SOCIA Foundation however, led to amending the Act of social assistance and defined conditions for providing financial contributions also to transforming institutions. This project showed that the key factor for good and effective transition and deinstitutionalisation is quality education and training of the staff.

Another lesson learned was that so-called humanisation in the institutions of social services had not been a qualification for successful transition and deinstitutionalisation. The most important thing is to change the attitude towards people with health disability. Between 2000 and 2001, ideas of transition

and deinstitutionalisation of social services were promoted by in first place by SWAB, but also the SOCIA Foundation (for instance in a project Supporting Systemic Changes in Social Services) and Agency for Supported Employment in Bratislava (e.g. its project Supported Employment as a Tool of Systemic Changes in Transition of Social Area and others). Those non-governmental organizations have been promoting the need for changes in the social field and need for transition and deinstitutionalisation. Pilot projects aimed at transition of social services have clearly demonstrated the key importance of synergies between soft activities (education, support and preparation of staff, users and the environment) and hard, i.e. investment activities. These experiences were later taken into account in the preparation of national projects of deinstitutionalisation after 2011. In 2004, the Slovak Republic joined the European Union.

This opened room for introducing systemic changes with the support of structural funds. Between 2004 and 2005, the Ministry of Labour, Social Affairs and Family implemented a project titled Transition of Existing Centres of Social Services that, however, did not bring about any principal changes. The project had been initiated in 2003 when the Slovak government approved a request for a loan from the World Developmental Bank of the Council of Europe for funding infrastructure for centres of social services through its Resolution No. 430 from 21 May 2003. In spite of its title, the project itself did not represent real transformation of social services; it was rather an investment into the existing infrastructure of institutional social care and its partial humanisation.[3]

One of the important transition and deinstitutionalisation projects was the EQUAL Community Initiative. This operational programme supported various important civil society projects that focused on enhancement of community based services and deinstitutionalisation, including:

1. The Project of the SWAB titled Transition of Centres of Social Services with the Aim of Social and Labour Integration of Their Residents. This was the first more systemic transition and deinstitutionalisation project of social services in Slovakia. The Council, in cooperation with the self-governing region of Banská Bystrica, implemented it between 2005 and 2007. The region had decided to participate in this initiative mainly due to a prevailing high number of users with health disability in round-the-clock institutions that had not been adequately offered and given the opportunity to participate in work life. In the long run, the region was also committed to enhance socialisation of the users of those centres, deal with a low qualification, and staff with limited commitment to enhance the labour and social integration of the users.
2. The project of SOCIA Foundation: Increasing Chances for Disadvantaged Groups of Citizens through Working with Municipalities and Civil Society Organizations that prepared and supported 85 municipal social workers with the aim to support community-based care.
3. The project of the Agency of Supported Employment titled Examples of Good Practice – Supporting Deinstitutionalisation in the Social Area is a good example of initiative in the field of transition and deinstitutionalisation. [3]

The programming period 2007-2013 offered support to infrastructure development through the Regional Operational Programme (hereinafter the “ROP”).[6] One of the goals set in its original version in the area of social services, social and legal protection was to increase the quality of rendered services in the social area. The total amount of proposed allocation for this measure was €270 million, which represented about 16 percent of the total ROP allocation. ROP support could be allocated to all regions and locations except the Bratislava region. In the context of NSRR analysis, the following projects were supported in the first round:

- Reconstruction, scale up and modernisation of the existing centres of social services,
- Construction of new centres,

- Procurement of new equipment and refurbishment of the centres, including upgrade of information communication technologies as a follow up to their renovation, scale up, modernisation and construction.

Measurable indicators were set for reconstruction, modernization and scale up of 310 establishments (centres) and construction of 30 new ones that were to form a part of the existing social infrastructure. This measure was not necessarily direct support of institutional care and traditional types of social services, but the eligible interventions approved by ROP included the following problematic specification:

- Priority will be given mainly to the following type of establishments: senior centres, adult centres of social services, child centres of social services (except for children homes), nursing homes with a capacity of 50+ users with minimal space standards (8 m2 per person).

This measure was counter to the new law No. 448/2008 on Social Services. However, nobody suggested its revision during the review process of ROP. SocioForum, an independent platform of organisations, pointed to this discrepancy requesting the ROP monitoring committee members to make appropriate changes in this operational programme. In its request, the platform stated: "For the competition for users to be fair, free access of all types of social service providers to EU funds earmarked for support of social infrastructure, among other things, must be guaranteed. Equally important is that the eligibility requirements for non-returnable funds should not be against the trends in each area.

Hereby we conclude that by adopting the Act on Social Services, such contradiction emerges." After European Commission started to shift its attitude to the use of EU structural funds in the field of social inclusion. The first changes in the Regional Operational Programme started to unfold in 2010. As indicated in the INESS study of Monitoring the Use of Structural Funds in the Social Area between 2007 – 2011,[7] as of the end of September 2010, 136 applications were approved under the ROP – social services in the amount of €209 million of the total allocation for social services of about €234 million. Almost half of the approved amount was geared towards construction of large institutions with a capacity of over 50 users.

Ďurana pointed to the fact that as of the end of September, the financial value of the approved projects represented 101 percent of the total allocation. The shift at the European level was thus not translated into practice. There was a proposal for a new allocation within ROP for developing new community-based services in the approximate amount of €119 million. A draft ROP revision had been sent to the Commission at the end of October 2010. The Commission reviewed it until February 2011 and required revisions in the area of social infrastructure towards transition and deinstitutionalisation. Mr. Pfeiffer prepared a short Situation Report for the European Commission on social services in the Slovak Republic in the context of transition and deinstitutionalisation, building on civil society expertise. The Commission turned down the requirement to revise the ROP and to support deinstitutionalisation. The Ministry of Labour, Social Affairs and Family dealt with the issue and showed its interest to contact and cooperate with Mr. Pfeiffer and nongovernmental organisations with long-term experience in deinstitutionalisation. As a result, the ministry started to prepare revision criteria for ROP. There was still an allocation of €40 million in ROP that the ministry had wanted to invest into supporting deinstitutionalisation. This process led to a revised version of the ROP that specifically highlighted qualitative shortcomings in the existing social infrastructure and took the principles of deinstitutionalisation into account; emphasised the need to discourage further support of medium to large-sized centres of a boarding type; and to support community-based centres. The ROP acknowledged only two types of eligible activities: pilot projects of deinstitutionalisation of the existing

centres of social services and centres of social and legal protection; and support of building community-care centres for marginalized groups of citizens.

The ministry started to draft a Strategy of Deinstitutionalisation of the System of Social Services and Foster Care in the Slovak Republic. The National Action Plan – Transition from Institutional to Community-based Care and National Project of Supporting Deinstitutionalisation that was to be carried out within the Operational Programme Employment and Social Inclusion. The ministry created a broad working group that was to prepare strategic documents. The baseline material supporting transition from institutional to community-based care became the Strategy of Deinstitutionalising the System of Social Services and Foster Care (hereinafter the "DI Strategy"), approved by the government on 30 November 2011. This strategy represented primarily a declarative document by which the Slovak Republic pledged itself to support transition from institutional to community-based care. In spring 2012, a new government was appointed.

As a result, deinstitutionalisation and transition of social services was significantly slowed down. The new leadership of the Ministry of Labour, Social Affairs and the Family stopped the selected partners in their preparation of the national deinstitutionalisation project (OP EMP SI) without notifying them officially or officially cancelling the public tender through which they had been selected. Then, the new leadership of the Ministry commissioned a review and redraft the deinstitutionalisation project in a way that the final beneficiary was the Social Development Fund. The redesign of the project lasted until the end of 2012. The project counted only with involving natural persons as experts supporting the DI process and it also decreased the number of involved entities (institutions). The national project implementation was delayed until March 2013. In May 2014 there were personnel changes in the project methodological team and the implementation was extended to December 2015. As a result a three-year project had to be squeezed into one and one-half years. [3] Among other things, the pilot NP DI offered: trainings, supervision, dissemination of information, support to involved institutions, and study trips for their staff and service beneficiaries to transformed institutions in the Czech Republic; an international conference and several methodological and expert publications on the transition process and deinstitutionalisation. A Final Evaluation Report was prepared that offered project evaluation and presented legislative and non-legislative recommendations for further implementation of the transition process and systemic deinstitutionalisation in Slovakia.[8]

Since this time deinstitutionalisation became as formal part of social policy in Slovakia. After 2015 it took 3 years to start with the second national project. Between 2015 – 2018 there were several national and international initiatives towards Slovak government with focus on DI support. The implementation agency of ministry prepared a public tender for partnering with the National DI Plan – Supporting Transition Teams (hereinafter the "NP DI PTT"). The eligibility criteria were similar to those in 2011: partners were to assist in drafting and implementing the process of transition and deinstitutionalisation. There was no project requirement for the partner(s) to co-fund the activities, which later complicated the whole project launch. The following organizations were selected: 1. Social Work Advisory Board that was to offer support in social services; 2. Slovak Union of Supported Employment that should support mobilisation and employability; and 3. Research and Training Centre of Design for All (Výskumné a školiace centrum bezbariérového navrhovania - CEDA STU) to support universal design. Until 2023 there were 90 institutions which got support in preparing transition plans towards community services. In next chapters we will describe detailed information about actual changes in deinstitutionalisation area since 2018.

# Social care system for people with disabilities in Slovakia – basic information and statistics

In first chapter we described short history of deinstitutionalisation in Slovakia. This history relates to overall changes in social policies in late years especially in sa called long-term care. The support services for people with disabilities in Slovakia are seen as a part of long-term care.

This means that long-term care in Slovakia is not only focused on elderly people, but also to all other user's groups with need for long-term support including social and health support. As we mentioned there were several activities and reforms of social and health care systems with different results. Despite the multiple attempts and efforts to reform and interconnect social care and health care systems in Slovakia, there is lack of coordination between these systems and their connection to Convention on the Rights of Persons with Disabilities (CRPD). Health care and social care in Slovakia remain two separate systems with minimal coordination and interconnection. Each system is governed by its own legislation and standards. This altogether results a very complicated system regulated by more than 3 different legal acts – Social Services Act, Health Care Act, and Act on Financial Benefits to compensate for severe disabilities. To analyse support systems for people with disabilities, it is necessary to reflect all complex requirements of the Slovak legislation. In relation to deinstitutionalization, it is essential to remark two basic legislative standards that can affect it:

- Act no. 448/2008 on Social Services
- Act no. 447/2008 on financial benefits to compensate for severe disabilities.

## Social services system in Slovakia

### Basic information

Responsibility for legal framework in social services is at Ministry of Labour, Social Affairs and Family (hereinafter MLSAF). But the MLSAF itself is not providing any social services. The system of social services in Slovakia is regulated by the Act No. 448/2008 Coll. on social services, as amended (hereinafter referred to as the Social Services Act). Slovak social legislation defines the conditions for provision of formal social care and support. The Social Services Act itself regulates legal relations in the provision of social services, but also their financing, monitoring, and control of their provision. At the same time, it defines conditions for assessment activities and quality assessment of social services provision (connected with Act on Inspection in social affairs). The provision of services itself is decentralized towards self-governing regions and municipalities. There are seven basic actors in the social care system in Slovakia:

- **The social service user -** In accordance with Social Service Act is an individual who meets the various conditions laid down by this act and a citizen of the Slovak Republic, but also EU citizens and foreigners, who meet the strictly defined conditions in Section 3 of the Social Services Act.
- **The social services provider -** In accordance with the Social Services Act, a social service provider can be a municipality, a self-governing region, or other legal entities that are established and financed by the municipality or self-governing region. There to basic types of social services providers – public providers (municipalities and established by a municipality or self-governing region) and non-governmental/private providers (mostly non-profit organizations).
- **Municipality and self-governing region** – can establish or find social providers, can provide social services, is obligated, and can pay for selected social services, is obligated to assess

need for selected services, is obligated to plan services in community planning/regional strategy of social services, can control selected services. Self-governing regions are also responsible for registration of all social services and keeps all registration records of all social providers registered in that region.

- **Ministry of Labor, Social Affairs and Family** – is obligated to control, monitor quality of social services, can pay for selected social services, is obligated to identify national priorities with regards to social services, and prepares the legislation in area of social services.
- **Partnership** - is a special institution within the participants in legal relations within the Social Services Act. Partnership is a group of individuals and other legal entities established for the purpose of implementing projects or programs to prevent or mitigate unfavorable social situations of individuals or to solve these situations and to support community work projects and programs. Members of the partnership may include municipalities, self-governing regions, offices of labor, social affairs and family, community representatives, but also other legal entities and individuals. The partnership is established based on a written agreement/contract, which defines the partnership members, the start date of the partnership, the duration of the partnership, the purpose of the partnership along with the obligations of the partners, and the way of financing the project or program.

Municipalities and self-governing regions within the scope of their competence ensure the availability of social services for individuals who are dependent on social services and ensure the right to choose social services under the conditions stipulated by this law. If an individual is interested in providing social services, he/she must formally request the municipality or self-governing region to do so. The municipality may provide the social service directly if it is a registered provider or ensure that the service is provided by another registered social service provider. The self-governing region ensures, within the scope of its competence, the provision of social services in accordance with the right to choose a social service provider by the citizen.

If an individual obtains a valid decision on the social service provision approved by the municipality, the municipality shall provide the individual with social services in the scope of individual's degree of dependence confirmed in the pre-determined contract and its conditions. The Social Services Act defines the obligation to provide social services without delay, if the life or health of the individual is seriously endangered or if the individual does not have the necessary conditions to meet basic life needs, or in other specific situations defined by this law.

Slovak legislation perceives social services as professional activities, care activities and other activities, or a set of them, which are aimed at preventing the emergence of an unfavorable social situation of an individual, family or community and its solution or mitigation. There are several reasons for unfavorable social situation.

The unfavorable social situation can arise according to the law for several reasons:

- individual does not have the essential conditions to satisfy the necessities of life,
- life habits and way of life of individual, substance abuse or gambling,
- threats to development due to disability in children under seven years of age,
- severe disability or ill-health,
- retirement age,
- support and care to person with severe disability,
- support and care to person with severe disability, to endanger the behavior of other individuals or, if a person is the victim of the behavior of other individuals, e.g., domestic violence, gender-based violence or violent crime,

- persistence in a spatially segregated locality in the presence of concentrated and generationally reproduced poverty.

Spatially segregated locality is perceived as persistence in the space defined by an apartment building, street, city district, municipality, or locality outside the municipality without basic civic amenities. Concentrated and generationally reproduced poverty is perceived as a long-term unfavorable social situation of a group of individuals due to the occurrence of several negative phenomena at the same time, such as high long-term unemployment rate, material need, low level of education, poor hygiene habits, unavailability of goods and services and the occurrence of socio-pathological phenomena with a high tolerance to them.

The legislation in Slovakia creates a broad spectrum of various social services and its types. This results many possibilities for social service providers and makes the system of social care more complicated.

Social Services can be divided based on three options:

1. Period/Time of social service provision (concrete period or indefinite time)
2. Form of social service
3. Type of social service

Social services according to the form of social service provision, namely:

- **Outpatient Social Services** provided to an individual who is coming alone or is accompanied or transported to the place of supply of social services.
- **Field/Home Social Services** are provided to an individual through field/home programs designed to prevent the social exclusion of that person, family, or community in an unfavourable social situation.
- **Residential Social Services** are services provided in residential social services facilities and include accommodation. Residential social services can be weekly or year-round.

The provision of social services in outpatient and field/home forms takes precedence over the provision of social services in a residential form. This focus is on the condition and the need for standardization and subsidiarity in the provision of social services, which implies that social services should be provided to an individual as long as possible in their natural family or community environment. Depending on the type, the social services are divided into five basic areas. Social services by type are described in attachment 1.

In terms of content, almost each social service consists of three core activities:

a) Professional activities
b) Service activities
c) Other activities

Social services in Slovakia are decentralized and this means that they are financed from different financial sources. As mentioned before, there are many combinations of types and forms of social services. This means that there is lot of possibilities on how to finance social services provision in Slovakia.

There are 3 basic types of organization that can provide social services from a financial point of view:

- Budgetary organizations (mostly self-governing regions and municipalities providers) – is a legal entity of the state, municipality, or self-governing region, which is involved in the state budget, the budget of the municipality or the budget of the self-governing region with its

revenues and expenditures. It manages independently according to the approved budget with funds determined by the founder within its budget.

- Contributory organizations (mostly municipalities providers) - is a legal entity of the state, municipalities, and self-governing region, of which less than 50% of production costs are covered by sales and that is the state budget, municipal budget, or the budget of the self-governing region contributions. The financial relations determined by the founder within its budget apply to it.
- Non-governmental organizations (mostly private providers) - legal entity which provides services of general interest under pre-determined conditions and for all users on equal terms, and whose profit may not be used for the benefit of founders, members of bodies or its employees, but must be used in its entirety to provide services of general interest.

This division is very important in terms of financial sources which can be used to fund social services provision, but also the rules and obligations which different providers have. This also leads to hidden discrimination of private providers of several types of services, who are not guaranteed stable funding from state budget, self-governing region, or municipalities (our and their users' syndrome). Not all types of social services guarantee funding. The actors, who are responsible for funding different types of social services, are the self-governing regions and municipalities. As a result of decentralization of social services, they have legal responsibility for provision or ensuring the provision of selected types of social services in the municipality or region. Because of the lack of funding on regional and municipal level there is also funding from state budgets (through the Ministry of labour, social affairs, and family) to selected services. In selected services, there is also an obligation for users to pay for social services. Although some of the services don't have any guarantee of financing (especially community-based services of crisis intervention or support services). This situation leads to low capacities of these social services in practice.

Main funding sources of social services in Slovakia are:

- Budgets of self-governing regions,
- Budgets of municipalities,
- Financial support of selected private and municipal services from state budgets,
- Users' payments,
- Payments from public health insurance (minimal amount of all funds),
- EU funds (selected services through national projects – non-systematic and time limited funding of services),
- Donation from different foundations and ministries (non-systematic and time limited funding of services mostly for projects).

Possible funding stream for different types of services is presented in Attachment 2. Schemes of funding are regulated by the social services act and are often very complicated by different patterns. These patterns are changing almost every year. Social services have different regulations defined by the Social Services Act as financial support to non-public/private providers (from self-governing regions and municipalities), financial contribution for provision of social services based on assessment of dependence for non-public/private providers and selected municipalities providers (from state budget) and financial contribution for providing overnight shelters. Basic structure of funding social services based on assessment of dependence is divided between two streams:

1. Financial contribution in dependence of person.
2. Financial contribution for operation/provision of social services.

Most of these expenditures are for retirement homes, specialized facilities, social home services and home care services. According to the Report on the Social Situation of the Population of the Slovak Republic for 2021, yearly trends of expenditure on these types of social services clearly show that there is an upward trend, regardless of the type of social service, which only confirms the high financial demands for the provision of this type of social services. Just as in the number of employees, the highest increase was recorded for nursing service and specialized facilities, namely of more than 21 % of expenditure. The highest co-financing was provided to retirement homes, specialized facilities, homes of social services and nursing homes.

One of the biggest problems in social care provision in Slovakia is the lack of capacity of professional workforce. Almost all social providers in Slovakia are reporting the lack of professional care workers as nurses, caregivers, and social workers. There are several reasons for this situation. The main reason has financial base – low wages of social services employees in Slovakia and better financial conditions for caregivers in other countries are leading to work migration from Slovakia to counties like Austria, Germany, Netherlands, Switzerland, and Scandinavian countries.

According to Slovak chamber of caregivers there is around 35.000 caregivers from Slovakia working in Austria and thousands in other countries. Moreover, Slovak chamber of caregivers is claiming that in Slovakia, there is a lack of 7.000 caregivers in social care facilities and other 7.000 caregivers in home care.

The current situation with COVID-19 is showing this lack of caregivers and other employees in social services. However, this can be a game changer in this area because there is prediction that work migration will slow down this year and next as well.

## Social services act and deinstitutionalization

There are several parts of social services act which are composed with goal to support community services and deinstitutionalization. Social services act in Slovakia is complicated and there are disproportions between main goal of the act – to support independence of service users and system of financing social services – most resources are going towards institutional care. This disproportion is one of the main reasons for slow progress of deinstitutionalization in Slovakia.

Paragraph 6 of the social services act states that person has right for social service provision, which by its scope, form and type of provision enables to realise her/his fundamental human rights and freedoms, preserves her/his human dignity, activates her/him to strengthen her/his self-sufficiency, prevents her/his social exclusion and promotes inclusion to society. The legislation is defining also other rights as right to ensure the availability of information in a form which is comprehensible to him or her and other sets of fundamental human rights and freedoms. There are also obligations towards social service providers focused at fundamental human rights and freedoms as:

- consider the individual needs of the social service user,
- activate the social service user according to his/her abilities and possibilities,
- to provide the social service at a professional level,
- to cooperate with the family, the municipality, and the community in development of conditions for the transition of the social service user in a year-round residential facility to the ordinary family environment or community, with the preferential provision of the social service in field form, outpatient form or weekly residential form, with the consent of the social service user and respecting his/her personal goals, needs, abilities and health status,

- to cooperate with social care providers in alternative children care to support transition for young adults from centre for children and families to social services.[9]

These are the main frames which are background for implementation of CRDP and deinstitutionalization in social services system in Slovakia. But there are also other parts of legislation which are partially supporting transition from institutional to community care. The most important are regulation about maximum capacity of buildings and housing units where are social services provided. This regulation of capacity was taken into the legislation in 2014. The theoretical bases for this proposal came from The "small group" principle.[10] This means that there was set up maximum capacity of 6 users in one housing unit and maximum 12 persons in one building. Final version in law is not that what was proposed in 2014. The reason for this was that three members of Parliament did the amendment proposal in the last quotation in legislation process in parliament ang increased the maximum capacity of social care homes, elderly care homes and specialized facilities up to 40 beds. This was done without and professional discussion or theoretical bases on human rights. The final regulation on the capacity of selected types of year-round services are for Supported housing – maximum 6 persons in one housing unit and maximum 12 persons in one building. For specialized facility, elderly care home and social services home – 40 beds in one separate building. From 2014 until now this regulation of capacity became to be accepted in social services system and there were several amendments of social services act, but without any proposal to change this either way (to go down with the capacity 40 or to erase this regulation from social services act).

**Okomentoval(a): [MC1]:** We should have discussion about group homes...

These regulations were partially used for regulating capital investments from ESIF in Slovakia in programming period 2014 – 2021 (regulation for Supported housing was used for all capital investments) and in Recovery and Resilience Plan (regulation for Supported housing is used for all capital investments in year-round services without health care, in year-round services with direct health care is capacity regulated to maximum 30 beds in one separate building[3]. Simply said there are no possible capital investments from ESIF or RRP in Slovakia to institutions or year-round services with capacity higher than 6 people in one housing unit and more than 12 people in separate building. The only exception are services with intensive long-term social and health care in RPP with maximum capacity of 30 beds in one separate building. But there are still possible private capital investments and investments from state and regional budgets until the capacity restriction in social services act. There is no restriction for private or states investments for reconstruction of existing institutions. Therefor are the regional governments investing to reconstructions of own large-scale institutions around 10 million EURO per year. But there is good prevention for capital investments from ESIF to institutional care in Slovakia.

Another important part of social services act regarding deinstitutionalization is one concrete type of social service – support of independent housing. This type of service was introduced in 2014 as a new type of support for people who needs social services. Support of independent housing is a social service to support the autonomy, independence, and self-sufficiency of a natural person, aimed at assistance in the operation of the household, assistance in money management, support in the organization of time, support in participating in social and working life, support for the development of personal interests, prevention and resolution of crisis situations, support for socially appropriate behaviour. This service is kind of personal assistance service within social services. Its requires that user of this services is living either in own or rented accommodation in community. User doesn't need to have any

[3] The limit of maximum capacity to 30 beds was connected to capacity definition in 11. Mansell, J., et al., *Deinstitutionalisation and community living–outcomes and costs: report of a European Study. Volume 2: Main Report.* 2007. s. 4.

assessment for this service and there are no requirements for age. There need to be only written agreement between user and social provider where is defined scale of support. These social services can be provided to all people who are in need situation according to social services act. The financing of this services is in responsibility of regional government, and it's paid to social services provider not to person. Most of the services providers in deinstitutionalization process are registering and providing these services. We will mention it closely in good practice examples.

The last very important part of social services act which is supporting independent life and deinstitutionalization in Slovakia are social services quality standards. Since 2022 there is a new act on inspection in social care. This act defines new quality standards with focus at fundamental human rights and freedoms in provision of services. The background of the new standards is WHO Quality Rights Toolkit.[12] Quality standards are describing how to provide social services with accordance to CRPD and fundamental human rights and freedom. The main goal is to understand that good quality of social services can be achieved only in community-based settings. The quality standards are defined in three basic groups – operational standards, personal standards, and procedural standards.

There are also some minor parts of social services act which gives operational benefits to social services providers who are actively doing transition from institutional to community-based care.

## Social services statistics

The latest public statistical information about social services system in Slovakia are from year 2021[4]. The data set used in this analysis were provided to us from MoLSAaF of Slovak republic. In this analysis we will be focused on social services provided in institutional facilities with long-term care. We will look also at selected out-patient services and field services.

The types of social services where is provided year-round long-term care in Slovakia are: social care homes, elderly care homes, specialized facilities, daily centres, rehabilitations centres, Supported housing and retirement homes, half-way houses and emergency housing facilities. We are not counting to our statistics places from shelters for people without accommodation.

All-together there is 48.206 places in 1.221 social care facilities in Slovakia. Most of the places you can find in year-round services (mostly with institutional culture) – 41.820 places (87%). Outpatient services are the second largest number 5.849 places (12%) and there are 537 places (1%) in weekly services[4].


*Figure 1- Social care services in Slovakia – facilities.[4]*

As one can see from the diagram the most of places in social services are in institutional year-round care. Some of these places are place in community-based settings like Supported housing (608 places) and homes for social services and specialized facilities with capacity towards 12 places with several house units. In 2021 at national level there was lack of data about exact capacities in concrete buildings, therefor we can't provide deeper analysis of this numbers. The new social services information system will also provide these data, but there are not collected yet. In table below we are presenting number of places for different types and forms of social services.

| 2021 | Number of services providers | Number of places to 31.12.2021 | Year-round services | Weekly services | Outpatient services |
|---|---|---|---|---|---|
| **Slovakia** | **1.371** | **52.062** | **45.582** | **537** | **5.943** |
| Social care home | 273 | 11.797 | 9.543 | 445 | 1.809 |
| Elderly care homes | 406 | 19.748 | 19.614 | 21 | 123 |
| Specialized facility | 190 | 8.934 | 8.596 | 46 | 292 |
| Daily centres | 156 | 3.050 | - | - | 3.040 |
| Rehabilitation centres | 26 | 614 | 44 | 1 | 569 |

| | | | | | |
|---|---|---|---|---|---|
| Retirement homes people | 94 | 2.536 | 2.496 | 24 | 16 |
| Supported housing | 47 | 608 | 608 | - | - |
| Emergency housing facilities | 29 | 674 | 674 | - | - |
| Half-way house | 15 | 245 | 245 | - | - |

*Table 1 Types and forms of social services facilities in Slovakia and number of facilities and places.[4]*

Most of the places are places in facilities for elderly people - almost 31.000 places. The rest of the places are places for people with disabilities or people in need. This numbers are confirmed also by numbers of people who are receiving social services in different types of facilities. There were 46.577 users of social services in social care facilities from which there were 31.780 (67,23%) elderly people. If we will look at social services users in three basic age groups: 0-18 years (pre-productive age), 19-64 years (productive age) and 62+ (post-productive age), it will confirm data about high number of elderly people in social services. In Slovakia there is 1.607 (3,45%) social services users in pre-productive age and 13.665 (29,32%) in productive age. Social services users in pre-productive age are mostly in weekly or outpatients social care facilities.[4]

In annex 3 we are presenting different indicators about social services users in social care facilities in Slovakia in 2021. Social services statics show us that the most of social services users are women (28.128) and there is 10.000 less men in social care facilities. But if we are analysing the number of men and women in social care homes, which are most typical institutions for people with intellectual disabilities there is higher number of men (6.186) than women (4.808) and in Supported housing men (352) and women (216).[4] This difference between total number of women and men in all social care facilities and number of men and women in social care homes and Supported housing is because of the high number of elderly people in social services in Slovakia. In general demography of Slovakia, we can see that there are more women than men in age group 65+. This information about higher percentage of men than women in institutional care for people with intellectual disabilities is important especially because of strategies to deal with challenging behaviour of users and ill treatment in institutions. We need to have this in mind when we will prepare strategies and action in transition from institutional to community-based care.

In context with this information there is also important number of people who are receiving psychiatric treatment 15.859 people (34%) in all social care facilities. But when we will look closer towards institution for people with intellectual disabilities (social care homes) we will see that 52,57% of social care home users are receiving psychiatric treatment.[4] This high percentage can only confirm negative aspects of institutional care. This also shows that there is lack of community-based care for people who are dealing with mental health problems. The most of these users are also at antidepressant treatment.

The statistics show us also that around half part of social care users (24.817) in facilities are people who have problems with mobility and need more intensive support in daily activities.[4] This information is important in context of needed number of supporting personal in new community services and in context of the knowledge, education, and skills of personal. That need to be taken in account in strategy and planning new community-based services in transition and deinstitutionalization process.

The last important data from statistic are about legal capacity. 18,4% of all social services users in social care facilities are fully or partially deprived in legal capacity. This number can be seen as not so hight in overall numbers, but when we are analysing institutional types of social care facilities for people with intellectual disabilities, we will see that there is this number much higher (50,45%).[4] The cause for this is the same as we mentioned when we were writing about sex and age differences. The most

people in social care facilities are elderly people without intellectual disabilities, therefor there is not common to deprive them in legal capacity. But in social care homes we can find mostly people with intellectual disabilities who lives for long time in institutions, and they were historically and systematically deprived in legal capacity until 2000. From 2016 there is no legal possibility to deprive a person fully in his/her legal capacity[13]. And from 2021 there social care services provider can't be intended as a guardian for social service user who is deprived in legal capacity[9].

Most of the types of social care facilities requires complex social and health assessment of social service need. Assessment is provided by municipalities and regional governments. Result of assessment is level of social service need. There are 6 levels, where the level 6 means the highest need with 24 hours support[9]. Altogether there is 43.166 social services users who are assessed for need of social service in social care facilities. In next table you can see overview about number of social services users with valid assessment for social services facilities.

| 2021 | Level 1. | LEVEL 2. | LEVEL 3. | LEVEL 4. | LEVEL 5. | LEVEL 6. | TOGETHER |
|---|---|---|---|---|---|---|---|
| **SLOVAKIA** | **148** | **797** | **1.420** | **5.332** | **6.751** | **28.718** | **43.166** |
| **Social care home** | 3 | 58 | 38 | 51 | 966 | 9.868 | 10.984 |
| **Elderly care homes** | 140 | 326 | 120 | 3.996 | 4.037 | 9.216 | 17.835 |
| **Specialized facility** | 4 | 0 | 1 | 32 | 849 | 7.323 | 8.209 |
| **Daily centre** | 0 | 23 | 1.035 | 818 | 394 | 594 | 2.864 |
| **Supported housing** | 1 | 172 | 87 | 59 | 11 | 238 | 568 |
| **Rehabilitation centres** | 0 | 169 | 66 | 70 | 41 | 254 | 600 |
| **Retirement homes people** | 0 | 49 | 73 | 306 | 450 | 1.163 | 2.041 |

*Table 2 Assessment for social service need – number of social service users in Slovakia.[4]*

We need to mention that the assessment system for social services has medical background and focus. Assessment system in social care is fragmented and there is a goal to do reform in this area. It is a crucial part of Recovery and resilience plan in Slovakia. As one can see in statistics it looks like most of the social services users are in the highest level. There are several reasons for this situation – the most common is financial support from state to service where social services providers can get higher support for users with highest level. The second problematic reason in assessment system was and is so called "appropriate supervison" vs. "constant supervision." It means that when the assessment officer wrote in assessment that the person needs constant supervision so they got level 6 regardless they have good active day living skills and can live independent life. This assessment problem leads often to very paternalistic provision of social services in institutions, where "safety" of social service user is often used as an excuse for violating and depriving his/her fundamental rights.

All these data about institutional social care in Slovakia are confirming that there is strong institutional culture in social care facilities and there is high need for transition from institutional to community-based care. Other statistical data are only supporting this thesis – for example there is only

26.669 employees in social care facilities, but 48.206 places. This shows huge lack of personal in institutional care what leads to low quality of services and more paternalistic and institutional approach. The total coast for social services provided in facilities in Slovakia was 668.314.516, - EUR. More than half part of these resources were used for personal's wages. But there were also capital investments into reconstruction of institutions mostly from regional and municipal budgets – altogether 13.889.897, - EUR.[4] As one can see there is huge amount of resources still going into the institutional provision of care in Slovakia. Therefor there is need to do reform of social services financing towards personal budgets. There is also one important issue to present, and it is number of people who are in waiting list for place in social care facility. In 2021 there were 8.525 persons in waiting list for place in social service facility. This number has decreased (around 23,32%) in comparison to last 4 – 5 years.[4] The main reason was COVID-pandemic. The strong rules in social services in Slovakia during COVID-pandemic resulted to situation where people don't want to go to social services facilities but want to have social services provision in own home. This thesis is also supported by latest research about people's opinions about type of support and social services they would choose if they needed it. 93% of people in Slovakia would choose community-based services and services provided in their home and only 7% people would choose institutional social care[14]. These results are very important for support of the need of transition from institutional to community-based care.

On the other hand there are also community-based services in Slovakia. These services are provided mostly as an outpatient's services or services provided in persons homes (field services). The most common community-based care service is home care. There are 14.678 users of home care in Slovakia. Most of them are elderly persons. Other community-based services to support people with disabilities are:

- Early intervention service for children with disabilities (2.2023 users/families).
- Services for people with hearing impairments (768 users).
- Integration centre (296 users).
- Support of independent living/housing (400 users)
- Social advisory and social rehabilitation (67.052 users)[4]

The financial support to these community-based services for people with disabilities is 76.270.740, - EUR per year 2021. There are 7.482 employees providing community-based services in Slovakia.[4] From these number it is clear that there is minimal support towards community-based services in Slovakia.

In chapter deinstitutionalization conceptualisation in Slovakia, we will closely analyse reasons and current situation in social services facilities which were and are participating in national project – support of transformation teams of social services.

## Compensation for severe disability

A second important area of social care and support for people with disabilities is the compensation of severe disabilities. This area in general, abroad, is also an integral part of integrated care for people with disabilities. Compensation for the social consequences of severe disability is, in the legislative sense, mainly seen as the alleviation or overcoming of the social consequences of severe disability, through the provision of cash allowances for compensation or the provision of social services. Under the legislation in force, special care under Act 305/2005 Coll. on Social Protection of Children and Social Guardianship is also considered as compensation. In this section, we will focus on cash allowances to compensate for severe disabilities.

Compensation is legislatively defined by Act No. 447/2008 Coll. on cash benefits for the compensation of severe disabilities and on amendments and supplements to this act. The social consequences of severe disability are compensated in the following areas under the legislation in force:

- Mobility and orientation - compensates for reduced mobility or orientation.
- Communication - the impaired ability to communicate is compensated for.
- Self-care - compensates for limited self-care ability or loss of self-care ability.
- Increased expenditure - to compensate for increased expenditure:
    - for dietary catering
    - related to hygiene or wear and tear of clothing, linen, footwear, or furnishings.
    - related to ensuring the operation of a passenger motor vehicle.
    - related to the care of a dog with special training.

The basic aim of providing compensation in accordance with the legislation is promoting the social inclusion of persons with severe disabilities in society, with their active participation and preserving their human dignity. A person with a disability can obtains a card of a natural person with a severe disability, a card of a natural person with a severe disability with a guide and a parking card for a natural person with a disability. The production of these cards and the granting and payment of the cash allowance for compensation shall be preceded by an individual assessment. Assessment activities in this area represent the second partial part of the assessment activities affecting persons with disabilities. The social consequences of a severe disability are compensated for in the form of the following one-off or recurrent allowances:

- One-off cash contributions:
    - a cash allowance for the purchase of aids
    - a cash allowance for training in the use of the aid
    - a cash allowance for adapting the aid.
    - a cash allowance for the repair of the aid
    - a cash grant for the purchase of lifting equipment
    - a cash contribution towards the purchase of a personal motor vehicle
    - a cash allowance for the modification of a personal motor vehicle
    - a cash allowance for home adaptations
    - a cash grant for the adaptation of the family home
    - a cash contribution for the adaptation of a garage
- Recurring cash contributions
    - A cash allowance for personal assistance
    - A cash allowance for transport
    - A cash allowance to compensate for increased expenses.

- A cash allowance for care

Allowances for compensation which enable to compensate social consequences of severe disabilities are divided into recurring and lump-sum allowances. The Allowances Act lays down the calculation of their amounts in three forms. Lump-sum allowances are determined as fixed amounts. Transport allowance and allowances for compensation of extra costs belonging to recurring allowances are determined as MSA percentage. The amount of the care allowance and the rate for one hour of personal assistance (belonging to recurring allowances) are determined as fixed amounts.[15]

To receive compensation benefits, citizens must go through a comprehensive assessment process. The assessment activity in this area is distinguished into medical assessment activity and social assessment activity, as opposed to assessment activity for social insurance purposes. The medical assessment activity is carried out by the medical assessors of the Labour, Social Affairs and Family Offices. This part of the assessment activity assesses and evaluates the state of health, its changes, disorders that affect the disability of a natural person, determines the degree of functional impairment, and assesses the social consequences in terms of compensation that a person has because of severe disability with a person without disability.

Of the above-mentioned financial contributions, we will take a closer look at two of them, which are directly related to deinstitutionalisation and community-based services of citizens with disabilities, from the point of view of our topic. These are the cash allowance for personal assistance and the cash allowance for informal care.

Personal assistance is very important part of this legal act. In the Slovak Republic, it is provided through the monetary contribution for personal assistance in accordance with Act No 447/2008 Coll. on monetary contributions for the compensation of severe disabilities. This Act states that the purpose of personal assistance is to activate and support the social inclusion of a person with severe disabilities, to support independence and the possibility of making decisions and influencing the performance of family roles, and to carry out work, education, and leisure-time activities. The scope of personal assistance is determined according to a set list of activities that a person with a disability cannot carry out on his or her own and the number of hours needed to carry them out. At the same time, the maximum number of hours of personal assistance for one person is set at 7,300 hours per year. Personal assistance may only be provided based on a comprehensive assessment. Personal assistance is carried out based on a contract for personal assistance and the personal assistant may be insured for a pension. The person with disability chooses his/her own personal assistant – except for family members and may also have several assistants based on the scope of the personal assistance granted. Moreover, contrary to the cash allowance to informal care, which is paid to care-givers, allowance for personal assistance is directly paid to persons with disabilities. Besides that, based on the decision of the Constitutional Court (which came into force on 20 May 2020), the discriminatory (based on age) provisions in the legislation on personal assistance have been prohibited. Furthermore, since the amendment of the Act No. 447/2008 Coll. L. in 2018, the means-test for personal assistance was cancelled. On the other hand, a person living in an institution is allowed for personal assistance only for guidance of a person to school or to working activities, i.e. only few people living in institutions have access to personal assistance. This restriction has been in place to prevent duplicate funding for the same support. The rate per hour of personal assistance was in 2021 at €4.82. The rate per hour of personal assistance serves for calculation of the amount of the allowance for personal assistance.

In 2021 there were 11.515 people with disabilities who had personal assistance. Average sum per month was 613,29, - EUR and total expenses for personal assistance in Slovakia in year 2021 were 86.233.232, - EUR.[15]

The second area of support, which we will briefly discuss, is the cash allowance for informal care, which serves to provide daily assistance to a person with severe disabilities in self-care, household care and social activities to remain in a natural home. This care allowance is granted to a person who cares for a person with severe disabilities if he/she is dependent on the help of another person for at least 8 hours a day. The legislation states that the basic activities of care include eating and drinking, emptying the bladder and colon, personal hygiene, general bathing, dressing, undressing, changing position, sitting, and standing, walking upstairs, walking on housing unit ground, orientation in the environment, compliance with the medical regime, and the need for supervision. We see this form of contribution as one of the basic forms of support in informal long-term care for people with disabilities.

Cash allowance for informal care provided to a carer who does not receive any of the statutory pension benefits (of working age) has in 2021 following lump-sum per recipient:

- cares for one natural person with a disability 508,44, - EUR,
- cares for two or more disabled natural persons 676,22, - EUR,

Cash allowance for informal care provided to a career receiving one of the statutory pension benefits has in 2021 following lump-sum per recipient:

a) cares for one natural person with a disability 254.22, - EUR
b) cares for two or more disabled natural persons 338,11, - EUR
c) cares for one natural person with a disability to whom an outpatient form of social service is provided for more than 20 hours per week 223,71, - EUR,
d) cares for two or more natural persons with a disability who receive more than 20 hours of social care per week outpatient form of social service 314,44, - EUR,
e) cares for one natural person with a disability who receives more than 20 hours per week of outpatient form of social service and at the same time cares for a natural person with a disability who is not provided with or provided for no more than 20 hours per week with an outpatient form of social service 327,97, - EUR.[15]

Only informal carers have right to get respite services according to the social services act. On the cash allowance for informal care, provided on monthly average to 62.917 natural persons (caregivers) caring for natural persons with disabilities, a total of 318.377.800, - EUR was spent.[15] Around half-part of people who are getting informal care are people with disabilities, the second part are elderly people.

As one can see this system of benefits is very important part of support for people with disabilities and helps them to live independently in their own homes. But on other hand there are more resources going into institutional care than to support of community-based care and informal care in Slovakia. Therefor there is need to reform the social care system and support transition from institutional to community—based care.

## Deinstitutionalisation conceptualisation in Slovakia

### Strategic national documents about deinstitutionalisation in Slovakia

Since 2011 is deinstitutionalisation formal social policy in Slovakia. The main document which has conceptualised transition from institutional to community care in Slovakia is Deinstitutionalisation strategy of social services system and foster care from 2011. This document was approved by the government. The goal of the strategy was to create and realized national DI project (see chapter 1) and national action plan. Deinstitutionalisation strategy formally approved that Slovakia joined the global trend of systematically eliminating the consequences of the model of institutional isolation and segregation of people requiring long-term care in institutions.

With the DI Strategy of 2011, the Slovakia formally named the need to change the system of institutional care prevailing in the conditions of the Slovak Republic - to deinstitutionalise and transform it into a system with a predominance of services and measures provided in the community, organisationally and culturally as similar as possible to a normal family. After ten years of validity of the first DI Strategy, the Ministry proceeded to the preparation of a new material reflecting the current challenges - the National Strategy for the Deinstitutionalisation of the System of Social Services and Foster Care, which was approved by Government Resolution No. 222/2021 on 28 April 2021[16]. One of the basic tasks of the DI Strategy was the development of the National Action Plan for the Transition from Institutional to Community Care in the System of Social Services for the years 2022-2026[17], which was developed and approved by the Ministry of Labour, Social Affairs and Family of the Slovak Republic in June 2022.

There are also other national documents which are supporting deinstitutionalisation and are approved by government or the MLSAF. It's especially *National priorities for development of social services 2021 – 2030*[18]. This document identifies four main priorities in development of social services until 2023:

*a)* Transition from institutional to community-based care
*b)* Introduction of an integrated social and health care system
*c)* Support of the interconnection of social services and informal care
*d)* Improving the quality of social services.

National priorities are the main planning document for social services policies. Self-governing regions and municipalities need to take consideration them in own community plans and strategic documents on local level.

*National programme on improving the living conditions of persons with disabilities for 2021 – 2030[19]* is general national document approved by Slovak government with tasks and actions which need to be done to fulfil CRPD. The goals and action are very general in this document, but there are several recommendations towards DI process and independent living of persons with disabilities.
Other national documents which were approved by Slovak government and are directly and formally supporting DI are: *Long-term Care Strategy[20], National Strategy for Further Development of Co-ordinated Early Intervention Services and Early Childhood Care[21].*

All these governmental documents are reflecting human rights approach and CRPD. In the new national DI strategy is deinstitutionalization defined as a one of the fundamental instruments of transition from institutional to community-based care, which in several linked processes implies the closing of institutional care services and, at the same time the development, establishment, and promotion of an effective network of new or existing alternative community-based services for the

inhabitants of a given territorial community. Deinstitutionalisation is a process of transition from institutional care to community-based services that provide individuals within their personal needs and external conditions to live independently, activity and social participation. All these strategies identify also challenges and problems in support and provision of care. We can divide these challenges into two basic areas:

- Values and human rights approach challenges
- Practical and legislative challenges

## Values and human rights approach challenges

The theme of deinstitutionalisation is not new one in Slovakia. Social Work Advisory Board is working in this area since 90ties. Transition from institutional to community-based care is a part of national policy since 2011. But still there is lot of opposition against the deinstitutionalisation process in Slovakia. CRPD and human rights approach is affecting the EU funds and national policies, but on regional and municipal level and in self social care provision there are many people and organisations actively against it. The history and culture of post communistic country with huge paternalism thinking in daily life is great challenge to accept individual freedoms and choices. The ideas that state, region, municipality or professionals knowns the best what is needed and how it should be done is opposite to CRPD's ideas and vision that every person is unique and can make own decisions. The lack of respect between professionals, academic, politics, provider, and policymakers towards people with disabilities and especially them who are living in institutions lead to very slow progress in this area. The persons who should be examples for the population are often presenting that deinstitutionalisation is not worth to do. They are presenting human rights of people with disabilities not as a base ground, but as a something extra. There is quite "schizophrenia" in this process in Slovakia – on papers the country is presenting the need and obligations for deinstitutionalisation, but in daily life and provision are regions and municipalities supporting institutions.

So, the biggest challenge is the reshape institutional culture and thinking of whole nation and country. It can be done, but it is challenging process where you need to start with the small communities and change them by showing them good examples and learn them to accept otherness. Therefor there is need to focus more on quality of the process of transition from community-base care rather then on quantity. This is one of the mail lessons which we learned in Slovakia.

The lack of education and support of inclusion in daily life of all people and the lack of knowledge about fundamentals rights is what we need to do overcome on the way to inclusive society.

## Practical and legislative challenges

Slovakia has signed (2007) and ratified (2010) CRPD and its optional protocol but didn't do any major changes or reforms connected to CRPD commitments. In 2016 United Nations Committee on the Rights of Persons with Disabilities (hereafter CRPD Committee) gave to Slovakia 83 different recommendations and concern regarding CRPD The main concern of CRPD Committee was: " *is deeply concerned by the high number of institutionalized persons with disabilities, in particular women with disabilities; that progress on the deinstitutionalization process is too slow and partial; about the ongoing investments from government budgets in institutions; and the lack of provision of full support for persons with disabilities to live independently in their communities*."[22]

CRPD Committee has recommended Slovakia to fasten up DI and be more specific in support of people with disabilities. But since then, was the progress in this area at practical and legislative level slow. There were done some very good actions to support DI and community-based care and support, but on other hand there is lack of systematic reform of social services and social care in Slovakia. If we will look at the practical problems of social services and support in Slovakia according to the several mentioned strategic documents there is lack of formal community-based care in Slovakia as a supported living service, respite services, outpatients' services.

This situation causes difficulties to persons with disabilities and their family to get adequate support and care. As one can see in social care statistics most of the people who are users of social services are living in institutions (mostly large-scale institutions) or are getting very low financial benefits for informal care. The main reason for this situation is social services legislation and its financing. On one side the social services act prefers human rights approach and community-based services as a fundamental type of support, but on other side the model of financing social services prefers and support mostly institutional services.

The CRPD committee also reflect at this situation when it recommends to Slovakia: "*…is concerned at the geographic variation and unequal financial support of community-based social services and home-care services for persons with disabilities, including older persons…, ensure the equal distribution of resources for social care, with emphasis on community-based services. The Committee also recommends that the State party ensure that community-based social services and home-care services are available in all geographic regions and rural areas, and that funds are allocated to persons with disabilities who require them, especially those who are unemployed or in low-wage employment."[22]*

CRPD Committee also recommended Slovakia that there should not be any other investments from European structural and investment funds (hereafter ESIF) towards institutional care and no longer allocate resources from the nation budget to institutions and reallocate these resources into community-based care. These recommendations were partially done in last years. Since 2011 there were no investments to institutional care from ESIF and there in no plan to invest to institutions also from Recovery and resilience plan and actual programming period of ESIF. Regardless strong opposition from mostly regional governments, municipalities, and institution this was very strongly influenced by non-governmental organisations and European committee. What has been not changed are resources and investments from state budget or regional governments and municipalities budgets. State fund for accommodation development still support investments in large-scale institutions and state, regional governments and municipalities are financially supporting provision of institutional social services.

Game changer in this situation can be Recovery and resilience plan (hereafter RRP) from European union. The logic and structure of this fund is based at investments depend at need of structural changes in country. This means that if Slovakia want to use investments from RRP it needs to be done some concrete structural changes. Component 13 – Long-term care of Slovakian RPP is presenting these fundamental structural changes in social care and support. There are three basic reforms which need to be done in Slovakia until 2026 if Slovakia wants to use 250 mil. EUR in investments to social care infrastructure. RRP proposed these reforms – *social care and support inspection with focus at CRPD (was take in force in November 2022), reform of disability assessment system (2024) and reform of financing of social care with focus at introducing personal budgets (2025).*[23] RRP will invest in development of outpatients services and community-based services (maximum capacity of 6 users in one home unit and maximum capacity of 12 persons in several home units in one building). There is also planned investment to 16 social-health care facilities with maximum capacity of 30 persons in one building. All buildings need to be part of community and there is forbidden to segregate and group

these building in common areal. Goal is to create around 1440 new community-based places, which is far below the need in the country. Therefor there is planning to use same kind of investments in actual programming period.

New Act No. 345/2022 Coll. on Inspection in Social Affairs which was adopted in 2022, has introduced the revised quality standards of the social services with focus on CRPD and human rights approach. In its Annex 2 it sets the quality standards and criteria defining the quality of social services provision from procedural, personal and operational perspective to promote user's human rights as defined in the Constitution of the Slovak Republic and the UN and European human rights conventions[24]. The main idea in background is that only in community-based services one can achieve good quality of service and quality of life.

Nowadays there is a working group at MLSAF preparing reform of financing of social services with goal to introduce personal budget scheme for social services and social support.

## The National Project: Deinstitutionalisation of Social Services Institutions - Support to Transition Teams

The National Project: Deinstitutionalisation of Social Services Institutions - Support to Transition Teams (hereinafter referred to as NPDI PTT) implements support to institutions wishing to engage in the process of deinstitutionalisation. The aim of the project is to prepare facilities to implement changes towards the transition from institutional to community-based care by supporting them with soft activities such as consultations, training, readiness assessments, dissemination activities, workshops, foreign and domestic study tours, and conferences. One of the first sub-activities of the NPDI PTT is the implementation of readiness assessments of the involved social service institutions (hereinafter referred to as SSIs) for the deinstitutionalisation process. NPDI PTT has five main activities:

1. Information about DI and recruitment of the social care institutions.
2. Assessment of the quality rights in involved social care institutions.
3. Accredited trainings for involved social care institutions.
4. Consultation and advisory in development process of transformation plans.
5. Dissemination activities about deinstitutionalisation in Slovakia.

The main important activity for this analysis is Assessment of the quality rights in involved social care institutions. The assessment process has following objectives:

- to assess and describe the current state of social service provision in the social service facility and its compliance with selected articles of the Convention on the Rights of Persons with Disabilities through the World Health Organization's WHO QualityRights Toolkit (https://www.who.int/mental_health/publications/QualityRights_toolkit/en/),
- to identify the attitudes of the management, its readiness for the possibilities of self-realization, activation, and participation of social service recipients in the community, their active inclusion,
- to identify readiness for change in the possibilities of communication and cooperation with the labour market and placement of citizens with disabilities in the labour market in the place of operation of the social services facility with employers,
- identify and evaluate the current physical environment of the social service provided.

The assessment of the readiness of the social services is an input document which, in the context of the Convention on the Rights of Persons with Disabilities, will form the basic basis for the preparation of transformation plans for specific social service facilities in three areas:

- Social services,
- Activation and employment,
- Changes to the physical environment

The assessment findings show that 7% of the facilities involved do not fully meet the requirements for fulfilling the right to an adequate standard of living. 58% of the facilities have serious deficiencies in this area that need to be addressed urgently. In this topic, these are mainly deficiencies in the physical environment, which is often unfit for purpose and unsuitable for the provision of quality social services. Only 3% of the assessed facilities fully met this criterion - in all cases, these were mainly facilities of supported living facilities that were in the community. Only 2% of the assessed facilities had premises and buildings where they provided social services in a fully satisfactory condition. 23% of the facilities could be assessed as sufficient and suitable for the provision of social services. However, it is alarming that 64% of the assessed establishments have significant deficiencies in the physical environment. 11% of the assessed social welfare establishments do not meet the legal requirements in this area at all. Overall, 75% of the establishments need to make substantial changes in the physical environment.[25] The obligation to debarrierise social service facilities is imposed by the Social Services Act. From the point of view of safety and fire protection, this criterion is very important. Only 19% of the assessed social care facilities meet this criterion in full. 29% of the facilities are partially debarrierised. 41% of the assessed facilities have significant deficiencies in the area of debarring and up to 11% do not meet this criterion at all, i.e. they are in violation of the Social Services Act.[25] Safety and fire protection is related to several of the topics, standards and criteria assessed.

The overall condition of the buildings and their debarring enter significantly into the assessment of this area. In this self-assessed criterion, which specifically focuses on fire protection, it appears that 15% of the assessed facilities do not meet this criterion at all and 59% of the facilities meet it at a minimal level. These high figures show the enormous risk in large-capacity institutions in the event of a fire outbreak. Only 10% of the providers assessed fully meet all fire protection requirements.[25] In 2021 there was fire in one of the institutions involved in NPDI PTT where died 6 social services user and afterwards director of institution committed suicide[4]. NPDI PTT did assessment in this institution in 2019 and urged director and regional government in rapid deinstitutionalisation of this institutions also because of fire risk. After this tragedy there was made open letter to national government to rapid and speed up deinstitutionalisation in Slovakia[5]. This letter was meet without any special feedback from government.

The size of the facility and the proclaimed cost-effectiveness of large-scale facilities is often fundamentally at conflict with the right to privacy. Only 7% of the assessed facilities of the ZSS meet the conditions and requirements for privacy. 20% of the assessed facilities do not meet this criterion at all and 36% have significant deficiencies[25].This shows that more than half of the assessed facilities are not fit for purpose in terms of the right to privacy, which is mainly reflected in the number of social service recipients per room, or the obligation to respect the specified square metres of living space per social service recipient. In this context, it should be noted that the process of humanisation, i.e., the

[4] https://www.ta3.com/clanok/222445/tragedia-v-osadnom-ma-dalsie-obete-na-nasledky-poziaru-zomreli-traja-klienti
[5] https://www.peticie.com/otvoreny_list_k_situacii_v_socialnych_slubach

reduction in the number of social service recipients per room, will result in a proportionate increase in the amount of costs and reimbursement per social service recipient.

This will ultimately lead to the humanisation process creating economically inefficient facilities with higher capacity but with a high risk in terms of respect for fundamental rights and freedoms. In other words, the process of humanising large-capacity social services cannot be effective in terms of value for money. Most of the facilities do not meet the required hygiene standards, the biggest deficiency is the shared bathrooms and toilets for many beneficiaries (all beneficiaries from one floor), where they do not have enough privacy. It is often not possible to build wheelchair-accessible bathrooms next to each room due to the small span of the load-bearing walls - it is not possible to create enough space to manoeuvre the wheelchair in front of the bathroom door or directly in the bathroom. The investment to build new bathrooms at each room of a large facility requires very high costs that are disproportionate given the other negatives associated with institutional culture. Often the shared bathrooms were also dysfunctional; in addition to technical failures, this was due to poorly designed bathroom space, where there was insufficient room to manoeuvre a wheelchair or to use lifting equipment.

The right to the highest attainable standard of physical and mental health for social service users is an issue that directly affects the individual support of people with disabilities and the elderly. Primarily, this theme assesses the availability of services themselves, but also subsequently the fulfilment and support of the individual needs of users both in terms of physical (somatic) health and mental health. A separate chapter within this theme is the assessment of staff preparedness and skills. In only 7% of the service providers is the right to the highest level of physical and mental health being fully met. In 43% of services providers this right is fulfilled to a relatively high degree. However, in 50% of service providers this right is not fulfilled at all or there are significant gaps in the fulfilment of this right. [25]

The most frequent problem is the large number of social service users in one facility, where in these cases a high degree of institutional culture is introduced, which prefers and promotes the fulfilment of the needs of the organisation over the individual needs of social service users. In relation to the number of social service users, it is important to highlight the fact that almost all facilities were understaffed - especially in relation to the need to fill shifts. The requirement to save and thus make large-scale facilities economically viable is addressed primarily through the ratio of the number of staff to the number of users, where most founders push social service providers into meeting only the minimum staffing standard defined by the law (often considered optimal, but which is not in line with the purpose of the law and its Annex 1). If the number of staff were to be increased so that they could provide safe and quality services, this would have to be multiplied in large-scale facilities, which, combined with the shortcomings in the physical environment, would lead to a significant economic inefficiency of these services in relation to their quality.

In other words, value for money in these cases would be very low and insufficient. The result of this situation is that in most of the social services evaluated, only basic nursing care for physical health was provided. Social work and social rehabilitation on an individual level was provided only sporadically, and even then, mainly in establishments that were community-based. Social work was often of an administrative nature.

The right to the legal capacity and the right to liberty and security of the person and the results of its evaluation show the impact of the long-standing and historically conditioned violation of these rights, especially for persons with disabilities. A paternalistic approach towards the users of social services continues to prevail today, resulting in frequent violations in this area, also following the lack of experience of staff in dealing with crisis situations and risk, in line with the application of the need for

appropriate supervision. There is a misconception among social service providers that they are 'criminally responsible' for all the actions of social service users.

Consequently, they then prefer "lighter" restrictive solutions. This also has implications in maltreatment. Only 4% of the facilities assessed fully ensure the right to exercise legal capacity and the right to liberty and security of the person. Legislative changes in legal capacity, but also because more than half of the users of social services are seniors, this situation is gradually changing and 44% of the social care facilities ensure this right at a high level (mainly social care facilities for the elderly). 52% of the evaluated social care facilities have significant reserves in this area, especially in the support of people with disabilities.[25]

The overload and tiredness of the social network (family, relatives) in providing care in the home environment for people with disabilities and the lack of community-based social services is a frequent cause that the wishes and preferences of the recipient are not always a priority when deciding when and whether to receive social services. Once admitted to a social services facility, the preferences of social services recipients are only partially a priority. The social service provider generally expects the social service user to accept the set conditions of the facility.

The admission and provision of care in a social service facility is, in accordance with Section 74 of the Social Services Act 448/2008, conditional upon the conclusion of a social service contract between the user and the social service provider. Informed consent of the social service user is often not part of the conclusion of the social service contract. Informed consent is applied by the social service provider or the health care facility when providing health care. Social service providers keep records of the number of social service users who are deprived of their legal capacity, while only some social service providers are actively working to restore the legal capacity of the users partially or fully. Supported decision-making is not established in practice due to the lack of opportunities for the fulfilment of preferences and wishes that go beyond the boundaries of the institutional setting.

Communication between staff and users of social services is conducted with respect and deference but is marked by stereotyping, routine, and social isolation of the institution from the local community of the village, town. The key personnel are not selected by the users of social services but by the employees of the social services facility. We positively assess the providers' efforts to open the space for communication with social service users in the form of regularly organised community meetings. Formally, social service users have access to their personal social and health records, but this possibility is not part of the daily offer by the social service provider's staff, which is also the reason why their personal comments are only rarely included in the records.

It should be noted that the evaluation in the right to exercise legal capacity, equality before the law and personal freedom for the elderly in social service institutions shows differences in lower rates of deprivation of legal capacity, freedom of decision-making in hospitalisation, personal, legal and financial matters. The most frequent deficiencies in this topic:

- Social service users can only make choices based on the options offered, which creates the perception that their preferences and wishes are not in all cases prioritised.
- Social service users receive information, but not exhaustive, in a comprehensible form, the choice is narrowed down to the service offers proposed by the staff of the facility.
- Social service users do not have the possibility to decide for themselves whether the service will be provided to them.
- Most social service users with disabilities are fully or partially restricted in their legal transactions.

- Social services staff do not have sufficient experience and knowledge in dealing with risk and liability in social services.
- A paternalistic approach and institutional culture prevail in the Social Services, where the needs of the organisation take precedence over the needs of social service recipients

Protection against torture and other cruel, inhuman, or degrading treatment is based, in addition to the Convention, also directly on the Constitution of the Slovak Republic. In assessing this topic, the focus is not only on the targeted and direct ill-treatment of other persons towards social service users, but mainly on the protection against ill-treatment as such. Protection from ill-treatment is therefore closely linked to all the themes assessed and to theme of living condition standards, namely the right to an adequate standard of living and the right to liberty and security of person.

Only 6% of the assessed social services are fully complying with the protection from ill-treatment. 43% of the social services have made significant steps in this area, but 51% of the assessed social services have significant shortcomings in this area, which may lead to criminal liability for 5% of them in case of their inaction.[25] The most common shortcomings in this area are:

- A paternalistic approach that leads to more restriction than support for the recipients of social services
- The environment where services are provided creates significant limits to respect for human rights and can lead to systemic mistreatment.
- Inadequate records of restraint and insufficient staff experience of working with risk
- Use of unlawful physical and non-corporeal restraints, mainly due to staff shortages (locking and restraining recipients, bed netting, etc.)

The right to independent living and participation in the community is based on Article 19 of the Convention and directly points out that States Parties to the Convention should build a system of community-based services, because only within this framework can the fundamental rights and freedoms of people with disabilities and the elderly be respected. Only 9% of the assessed social service facilities were providing services at the community level. 65% of the assessed social service facilities had started to take the first steps in this area, which is often the reason why they were involved in the NPDI PTT. 15% of the assessed facilities had not taken any steps in this area.

The focus of the evaluation in this area was on how social service recipients are supported towards community involvement, i.e. activities and support outwards from the social services.[25] In previous years, social service providers have only exceptionally and on their own initiative set up community housing and services.

Most social service facilities prior to the NPDI-PTT were focused on essential building and exterior maintenance at considerable financial cost. There was minimal or no awareness of community housing and service options for social service recipients. Education for school-age social service recipients is provided in collaboration with special elementary schools. Most social service recipients tend to be involved in work activities as part of the operation of the social service facility. Opportunities for employment of social service recipients in the community of the municipality, where the local government is interested in cooperation. Staff provide information about public life to social service recipients in the facility on an ongoing basis. Active participation of beneficiaries in the public life of the local community (leisure, sports, cultural, religious, political activities) is minimal. The staff assists the social service recipients in exercising their right to vote. The life and activities of the social beneficiaries take place mainly outside the walls of the facility. Activities towards the local community are mainly group-organised.

Assessment which was done as a part of NPDI PTT show very concrete and in details how strong is institutional culture in Slovakia. There was assessment done in 93 large-scale institutions across all Slovakia and it bring very valid information about current situation in social services in Slovakia.

All reflected data and information show as major need for transition from institutional to community-based care in Slovakia and the need for coordinated and broad support to social services users and staff working in these institutions to move from them to community.

## Good practice examples – Slovakia

### Slatinka -first deinstitutionalised social services home in Slovakia

The Slatinka Social Services Home is established by the Banská Bystrica Self-Governing Region. The facility provides social services to children and adult users with mental and combined disabilities without age limitation.

Social services have been provided in the Slatinka Social Services Home since 1951. From 1951 to 2012, the home is a typical institution located in a neo-Gothic manor house in Dolna Slatinka near Lučenec, about 3 kilometres away from the town of Lučenec. It is the first large-capacity home in Slovakia where the process of transformation, i.e., the transition from institutional to community-based social services, has been fully implemented.

In 1950 it was decided that the manor house, which had been confiscated by the state from the Hungarian bourgeois family, would be provided care for elderly people. Slatinka thus became one of the oldest institutions of its kind in Slovakia. The services provision began in 1951. Initially, the institution was set up for the elderly people. Manor house of course had to be renovated. In 1955 it was left by the elderly people because it was decided that the isolated location away from the town was not suitable for them. A new retirement home was built in Lučenec, where they moved to. The manor house at Slatinka then started providing services to the first children with intellectual disabilities. The children gradually came and went from all over Slovakia. In the written sources we can read what was the reason for the establishment of the institution for children with intellectual disabilities. "*The large rooms in the manor house were not suitable for the elderly, so they moved them to Lučenec and there they established a social welfare institution for children with intellectual disabilities aged from 3 to 12 years*".[26] The children were provided with social care by the nuns of the Satmarky order of St. Vincent. Sister Sapiencia recalls that when I came to Slatinka at the end of 1955 there were already 95 children in the institution. "*At first there was no special educational activity. The nurses looked after the children and supervised them. In the summer, the children were outdoors all day long in the designated areas, adapted for them. There they played and ate ... The beginnings were difficult. There was no central heating, no hot water in the institution. There were 7 nurses for every 95 children in the institution. Later the idea came that healthier children should be brought up, their motor skills and memory should be developed. So, two educational groups were created. ... They tried to develop speech in the children by poems, repetitive movements, short performances. There were exhibitions of handicrafts, performances, the institutes competed. Often it was the children from Slatinka who won the first place...*"[26] The sisters worked there until 1988 when they left for the Charity House in Vrícк".

Until 1989, the institution provided care for children with intellectual disabilities, who, in accordance with the legislation in force at that time, were transferred at the age of 15 to institutions that provided care for adult citizens with intellectual disabilities, separately women and separately men. In 1989, the children were no longer transferred, and the facility now provides social services to children and adult users with intellectual disabilities. In the past, social services in the facilities were provided separately for men and women. The only exception was services for children. The Slatinka Social Services Home has been transformed from a children's facility into a facility providing services from the time of birth with no upper age limit. As a natural development, it became one of the few facilities in the country where social services are provided in a co-educational environment. After 1989, the capacity of the facility gradually began to decrease, and in 1999 the capacity was 69 places.[27] Between 1989 and 2005, some humanization processes took place in the facility, but there was no fundamental change

in the institution. By 2005, the facility was operating as a typical large-capacity facility, serving 60 users, aged from 4 to 41 years. Services are provided in two buildings - a manor house, where most services are provided, and a family house, located on the premises of the facility, which the staff familiarly refer to as the 'educational house' because it serves the needs of users with milder disabilities who are enrolled in the educational group. In the educational house there are day rooms where educators carry out group activities for the users. The floor of the Educational House was renovated in 2004 to provide accommodation for 12 users. The manor house is not wheelchair accessible; the layout of the building is totally unsuitable for everyday life. It is a single-storey building, which cannot be adapted for wheelchair access due to its historical value.

A significant milestone in the transformation of the institution was the period of years 2004-2007, when the Social Work Advisory Board ("SWAB") implemented a project in cooperation with the Banská Bystrica Self-Governing Region entitled "Transformation of social service homes with the aim of working and social inclusion of their residents". SWAB focused its project on long-term training of social work employees in an individual approach in the personal development of citizens with disabilities. Retrieved from the assumption that it is the training of the staff of institutions that can lead to increased readiness for its transformation, to change the quality of life of service users. During 2005, quality monitoring was carried out in the facility, which provided the then management with an independent 'outside' view of the quality and level of service provided in the institution. Among the biggest deficiencies that the institution was criticised were the restriction of the personal freedom of its residents and the suppression of freedom of expression and choice in relation to the organisation of residents' lives in groups. Slatinka at that time severely restricted the right to privacy - there were large bedrooms or walk-through bedrooms, more privacy had only a few users in the training housing had more privacy. All adult users were deprived of legal capacity. The staffing structure reflected a strong preference for nursing and caregiving over social work and rehabilitation. Such an assessment was not easy to listen to for the management or staff at the time. The facility had a good reputation in the region and they themselves were convinced that they were providing a good level of service. Even more there need to be more appreciation for the determination of the then director, Alena Kelemenova, to see perspective of the residents of the facility. As she later admits monitoring quality monitoring helped her to open new perspectives on the lives of people with disabilities and to open up new perspectives for the work of all the facility's staff.[28]

The quality monitoring was followed by training for management and social workers focused on the transformation of the institutions. The output of the training was transformation projects that were subjected to peer review. The Slatinka project was one of the three selected for the next phase of implementation. Thus, in 2006, they developed the first transformation project, which had three stages. In the following SWOT analysis table, there are probably several facilities, so we take the liberty of presenting it in full. The first phase was planned to be completed by summer 2008. The main goal of the first phase was to improve the quality of life of the users who lived in the institution. They were to expand the range of social services so that they could be more adapted to the needs of the users of Slatinka, but at the same time they could cover the current needs of the region. Therefore, they wanted to provide a family house for Supported housing services for 9 users, to continue the use of the training house in the manor house grounds to prepare for more independent living for 12 residents of the manor house. They planned to renovate the manor house to address the reduction in the number of people in the rooms, to obtain suitable space for rehabilitation and educational activities, but also to add new services to the facility's service offerings - day and weekly stays, respite services. The preparation of individual plans, supervision and staff training were also planned. They also wanted to start working with families and eventually managed to place 7 children back with their families. Only in the second phase, not defined in time, they planned to gradually move all the users to the town of

Lučenec and to leave the manor house completely. However, due to the planned investments in the loft, the second phase was not envisaged immediately. And this is what the opponents criticized the establishment of the professional defense of the transformation project... Based on the objections, the project was changed. Investments in the repair of the manor house were abandoned and therefore it was planned from the outset to gradually abandon the manor house with all the users. The idea was to create a facility that would meet the needs for the disabled residents with a high level of support (15 people). They wanted to repeat the experience with the training house and to create this type in Lučenec (10 people). As there were still children in the facility who had been ordered to be institutionalized, they wanted to create a special family-type facility with a link to the school system. According to the composition of the population at that time, the last facility was to serve persons with severe and profound mental disabilities (10 people). After the successful completion of the second the third phase was to follow - the use of the manor house for business purposes or its sale. The transformation project also included an analysis of the need for social services in the districts of Lučenec and Poltár. The demand for the social service provided in the social services home was naturally increasing, especially because in both districts the inhabitants had no other alternative - neither Supported housing nor any form of relief service. Changes in the staffing structure were also planned. These included strengthening direct contact staff, reducing the number of nurses. The intention was to create multi-disciplinary teams working to individual development plans. This was to be facilitated by the merging of the education and health departments was also to help. [28]

Once the Slatinka management had formulated a transformation plan, the facility began intensive training of all facility staff, with a greater emphasis on direct contact staff. Gradually, they were introduced to person-centred work methods. They materialized their new knowledge in their work with specific people. They accurately mapped their abilities, skills and needs. Together, they developed an Individual plan, including realistic measures and responsibilities for its implementation. They drew inspiration not only in Slovakia, but especially abroad - in the Czech Republic and Germany. Thus began an intensive preparation of several residents for the transition from training housing to a family home in Lučenec. In November 2008, the first residents left the manor house. Six people became new residents of Lučenec in the first supported housing facility. This change was crucial. And vital for the people themselves. It not only brought a surprisingly rapid acquisition of common skills, but also, in the long-term physical, psychological and intellectual changes. The treating psychiatrist himself was surprised by the increase in IQ in adult humans, where he had no longer anticipated it. The community accepted their new neighbours without much comment and gradually they found their social connections, contacts or even their first job. All these positive results only encouraged them to continue. With the support of the founder and without increasing the budget, it was possible to open another housing for 9 people in the city centre in September 2010 (it was a service of a social services home). A year later, the attic in the first building was renovated, increasing the capacity to 10 people.[28]

As in 2011 the talk about deinstitutionalisation also started in the national context, the Banská Bystrica self-governing region counted on the use of structural funds to complete the transformation process in Slatinka. Nevertheless, they continued to abandon the manor house, counting on the fact that the current solution is only a step towards small households. In April 2012, 15 people left Slatinka for a family villa in Lučenec with a higher level of support. The last fifteen immobile residents moved out of the mansion to a family house on the grounds of the former institution in September 2012. When, a month later, the administration, the mansion was finally closed and put up for sale.[28] After several years with the technical and political problems Slatinka realised final deinstitutionalisation project with investments to community-based services in 2022. Since 2022 there are no users living in old premises of Slatinka manor house.

Currently, the facility provides various types of services to 79 users in the form of residential, outpatient and outreach services in several separate small-capacity facilities. The facility strives to consider the needs and wishes of the users.

Nowadays is Slatinka first fully deinstitutionalised social services institution in Slovakia. They are providing several types of social services in Lučenec area. All provided services are community-based – either they are residential, outpatient or field services. The may reason to provide also residential services is the low degree of household fund in Slovakia.

Slatinka is providing these types of services in several:

1. Support of independent living/housing in district Lučenec 13 users (currently).
2. Social care home, Haličská cesta 2138/9A, Lučenec 4 users.
3. Social care home, Ulica Dekr. Matejovie 1623/7, Lučenec 12 users (2 households).
4. Supported housing, Hviezdoslavova 1081/5, Lučenec 12 users (2 households).
5. Specialized facility, Martina Rázusa 138/18, Lučenec 12 users
6. Supported housing, Sládkovičova 136/8, Lučenec 11 users.
7. Shelter for women with children in need, Lučenec 17 users.
8. Weekly social care home, Zvolenská 486/9, Vidina 10 users.

All these households and building are in community settings and integrated in ordinary housing in the city of Lučenec. Services support of independent living/housing is provided in ordinary households and flats which are rented by social service users either from private persons or from municipality. All service users who are getting this type of service in Slatinka has lived all the life in social care institutions.

There were made several films about deinstitutionalisation process in Slantika and they are accessible here:

1. Support of independent living/housing - https://vimeo.com/277942600
2. Independent living - https://vimeo.com/275803281
3. Simple happiness II. https://vimeo.com/184652357
4. Slatinka 65 years - https://vimeo.com/187381818
5. Cesty istoty about social service user from Slatinka - https://youtu.be/z0hnCJ2e7Rc.
6. Newspaper article about deinstitutionalisation in Slatinka: https://mynovohrad.sme.sk/c/23032182/casom-ked-spali-v-miestnosti-aj-styridsiati-su-davno-prec-desiatky-mentalne-postihnutych-mieria-do-noveho.html-

## Social services home – Okoč – Opatovský Sokolec

Social care home in Okoč – Opatovský Sokolec is one of the good examples between 90 institutions which are supported in soft activities to start and provide deinstitutionalisation. The managment and employees of this institution did in last 15 years lot of changes to increase the quality and independent life of its social services residents. The life story of this institution can be good example how to not give up even there are to many struggles to achieve the main vision – independent live of people with disabilities.

The social services home was founded in 1953. The Czechoslovak State assigned a late-classical manor house from the second half of the 19th century for the purpose of establishing the Children's Nursing Institute. The manor house is in the village of Okoč-Opatovský Sokolec in the district of Dunajská Streda, 5 km from Veľký Meder. Around the manor there is a forest park, which has an area of 6.8 ha, of which there is approximately 1 ha of arable land, 1 ha of garden and 1 ha of orchard. This area has been landscaped in the past and has also been used for occupational therapy in the adjacent farm. The manor house was built by Leó Loránd, a former merchant from Budapest. Another owner was the Viennese court lady Rozália Behle. After her death, the property passed into the hands of the Osvald and later Nemes families. After the social changes in 1989, the manor was the subject of a long court case (1995-2007). Eventually, in restitution proceedings, it was returned together with the land to the original owners. After the establishment of the institution, the care of children with mental disabilities was carried out by nuns. The congregation also had its own priest, and regular masses were also attended by the residents of the institution. In the institution's registry book, 17 names are noted with the date 1953, but the capacity gradually reached an official 78 places. There were periods, however, when the institution operated beyond capacity. As the capacity increased, people from the village also joined the staff. The age limit of the co-educational institution was gradually raised from 15, 18 and 26 years. Therefore, the name of the institution was also changed to the Institute of Social Welfare for Mentally Handicapped Youth. After the age limit was reached, the girls were transferred to Medveďov, the boys to the Social Welfare Institute Lapagóš (later DSS Topoľníky, today DSS Jahodná).[29]

In the 1980s, construction work began on the premises, a so-called playroom was built, a new building (with a capacity of 21 places) was built on the site of the old outbuildings, and landscaping work was also carried out. Accommodation for girls was created in the loft of the manor house. In 1984 the nuns had to leave the institute. Since then, the care of the residents has been carried out by staff from the village and from the surrounding area. Gradually, both the medical and the educational departments have been expanded to improve the quality of the services provided as well as the standard of living of the residents. Capacity has been reduced to the current 66 residents. The name of the facility was changed twice more. In 1991, after the granting of legal subjectivity, the name was changed to the Social Services Home for Children and Adults Okoč. The last name change was made in 2004, when it was delimited to the Regional Government, to the current Social Services Home for Children and Adults in Okoč-Opatovský Sokolec. At present, the Trnava Self-Governing Region is the founder. As far as the complex itself is concerned, it acquired its today's form with the completion of a new building in 1993. The mansion housed a ward for immobile residents, dining rooms for residents, rooms for girls, a so-called "ward" for people with a high level of support, and premises for administration. The new building houses a laundry, accommodation for boys and rooms for education.[29]

A very unfortunate but significant event for the functioning of the facility was the fire on 2 May 2007. The fire destroyed the manor house. All the inhabitants managed to evacuate to safety, but the building was no longer fit for use. This event has a significant impact on the quality of the services provided and the facilities. Since then, the social services have been provided in a state of emergency.

The management had to quickly address alternative premises in the village - in particular housing for the most supported residents and catering services. The standard routine of a typical institution in Opatovský Sokolec changed radically. At the time, a lawsuit with the inheritors over the manor house was just coming to an end. The inheritors were successful. The difficult process of negotiating with the landowners for repairs began. In addition to all these "office" debates, there were several dozen residents who had no roof over their heads. The municipality came to the facility's rescue by leasing them an unused part of the kindergarten, where they were able to move the 24 clients with the highest level of support. The other users had to squeeze into a building in the grounds of the manor house, in premises that were not originally intended for housing. They had to accommodate 42 people in a building that was originally built for 21 people. The state of emergency evokes in many of us the feeling that this is a situation that needs to be addressed urgently, because it is a condition incompatible with normal life. The truth is that the state of emergency in the DSS Okoč-Opatovský Sokolec has become "normal" for many years. The survival strategy was to spend as little time as possible in the vicinity of the enclosed fenced mansion and in the small common rooms. Therefore, everyone tried to take advantage of every opportunity to go on trips, for culture, for visits and especially for sport. The residents' and staff's programme of activities filled the facility in such numbers that from a lay person's point of view it may seem excessive.[29]

In 2012, talk of deinstitutionalisation began. All self-governing regions were approached to participate in the pilot project together with one nominated facility. In the Trnava Region, they decided social care home Okoč-Opatovsky Sokolec.

The reason? State of emergency.

After years, even the management of the facility admits it. The first impulse was mainly the necessary solution of the physical premises. At that time, there was a definite possibility to agree with the owners of the mansion on a lease, as well as a chance to obtain financial support from the Structural Funds for the reconstruction or for the construction of a large-capacity facility. "*We are doing the best we can in the conditions we have, but we want to do better*." These were the words used by the management of the facility to assess the situation in the summer of 2012. It was a period when they gradually started to learn more about the whole process, not only the management, but also the staff and the clients. From the interviews conducted within the NPDI, it was clear that all staff wanted to change the environment and working conditions or housing for the residents. However, the ideal, according to them, was still the renovation or construction of an institutional-type facility. The terms of the EU funds call in 2012, however, which say the maximum 6 residents per household and a maximum of 3 households per building, were perceived as a threat to the established way of working. However, the 'threat' of continuing to operate in a state of disrepair was a strong argument. The fact that the EU funds clearly articulated support for deinstitutionalisation was a first step. Then followed a lot of work and preparation - finding suitable land, buying it, preparing construction documentation, drawing up a project, applying. There was goal to build 11 new households in 4 different localities until 2015. The project application was approved, and the regional government started with public procurements for establishment of building. After approving and the joining pilot process o deinstitutionalisation there were many problems with public procurement which was done by regional government as a founder and owner of social care home. The regional government cancelled twice finished public procurement and this led to situation where it was not possible to finish and use EU resources until the end of 2015.[29] The capital investments into the new community-based services failed because of the founders' attitudes and steps in this process. The state of emergency continued. But management of the social care home didn't give up and they began to rent houses in the village where they moved some of other social services users. They open a daily activities centre where they provide activities

for social services users. They began focus more at support of users in community and less at capital investments.

Regardless these problems management and employees of social care home continued to improve quality of life and support of independent living in their bad conditions and did lot of activities in the community. The basic idea is that they strictly divided accommodation support from other daily, work and leisure activities. They were also worked a lot with the attitudes in community. The community attitudes were in the start of deinstitutionalisation against the transition of people with disabilities to villages. There was also petition against this process. But the support of daily activities of social services users in the ordinary settings in community changed step-by-step attitudes of community members in villages.

In 2018 they applied again for EU funds to capital investments and were successful. They are currently building and reconstructing 6 buildings for community-based services in residential and outpatient form. All buildings are built in universal design and have passive energy level. The project will be finished this year (2023). In accordance with capital investments, they are improving the support of social services user through the international cooperation with Hungary, Czech republic and educational activities, supervision for employees and social services users. Since 2018-2021 they were part of national deinstitutionalisation project and since 2022, they are continuing own soft support project for deinstitutionalisation founded by EU.

The video about support one of the users: https://youtu.be/PXd6W7p2ocQ

Architecture study for residential community-based services used in Okoč-Opatovsky Sokolec: https://www.employment.gov.sk/files/slovensky/esf/plan-obnovy/katalog-rod/typ-i_rodinne-byvanie.pdf.

Website of social services provider: https://www.dssokoc.sk/.

## Support services agency – Žilina

Support services agency Žilina (hereafter as APS) is one of the best community-based providers in Slovakia. APS was founded and is directed by Soňa Holubková who is one of the most important innovators in social care in Slovakia and worked and works also in Social Work Advisory Board. The Support Services Agency is a non-profit organization that has been providing community-based services for citizens with disabilities (mostly intellectual disabilities) in the city of Žilina since 2003. The aim of APS is to provide support in the ordinary settings (home, workplace, school, etc.), in a targeted manner according to the needs of individual citizens and after communication with them and their families.

APS, n.o. operates a Supported Housing Facility for citizens with disabilities, providing them with support that helps their development, independence and enhances their quality of life in the areas of housing, education, employment, and leisure time interests.

The foundation of the Support Services Agency was in response to the need of young people with disabilities (mainly intellectual disabilities) who expressed an interest in becoming independent. They have shown that they have the desire and the will to learn to fend for themselves and thus reduce their dependence on other people. Until then, these people have lived either at home with their relatives (which has its advantages but can be limiting for independence) or in social institutions (social care homes, day centres, weekly care, year-round care).

APS operates two "training" apartments. The capacity of the apartments is limited to six people. The aim is to develop independence, according to abilities and possibilities to move to a less intensive support network, ideally to independent living. Residents sign a fixed-term contract. However, some residents have stayed in housing for longer than the original planned period. As we did not want the training flats to become permanent residences, we needed to strengthen the planning phase, finding natural support, and implementing the plan. We were looking for new methods that would also more intensively support residents who have been with us for a longer period.

They started to use the PCP method, where the central figure of the planning is the person with a disability. An important starting point for planning is defining the desired changes in a person's life. This is a set of conversations and meetings in a logical sequence, recorded in a way that is easy to understand, which helps us to identify what support we should provide and what opportunities we should collectively seek so that our residents can be seen as contributing citizens. Planning involves not only family but also friends and volunteers who often broaden the range of possible opportunities. We try to build plans so that people with disabilities benefit from the same services as regular citizens. In this way we try to strengthen natural social ties (with parents, relatives, neighbours, friends) and create a natural support network (neighbourhood help, help within the extended family, etc.). Person-centred approach methods, which have helped to intensify cooperation with families and the city of Žilina, our services have developed into a system of providing support in our own flats.

They are providing services to 12 people with disabilities. Few of them are now living independently in flats provided by the city based on a lease agreement with the residents, they have a job and a circle of friends, they only need support in certain areas, and they are able to come and arrange it. Some of the former residents have returned home with a new status, a new perspective on the future, and a new parental view of their child's capabilities and abilities. They believe that a community-based service can respond more flexibly to service users' needs, providing a wider choice of activities and

freedom of decision making, strengthening relationships with family, and promoting the use of services provided in a person's wider social environment.

The main objectives of APS, n.o.:

- To provide citizens with disabilities with support that helps their development, independence and enhances their quality of life, especially in the areas of housing, education, employment, and leisure interests,
- provide support in the natural environment - at home, at work, at school and other places of contact with the social environment in the community,
- use a person-centred approach and work closely with relatives, friends, and the community,
- provide support services in a targeted and targeted manner according to the needs of individual citizens, in communication with them and their families based on individual development plans.
- in two flats, to prepare disabled citizens for independent living in ordinary settings, in accordance with their needs and abilities, to provide supervision in accordance with the legislation in force on the provision of social services

Website: http://aps.nkh.sk/.

Film about their work: https://vimeo.com/118728133.

Film about Soňa's Holubkova work: https://www.youtube.com/watch?v=4UMjOEwCni8.

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## Annex 1. – Social services by type

a) Social crisis intervention services, which mainly include field social crisis intervention service, provision of social services in facilities. The aim of this group of social services is primarily to address the unfavourable social situation of a natural person, which we perceive as a crisis and must be addressed acutely.
   - Field Social Crisis Intervention Service
   - Provision of Social Services in Facilities:
   - Low-threshold Daily Centre
   - Integration Centre
   - Community Centre
   - Overnight Shelter
   - Shelter
   - Halfway House
   - Low-threshold Social Service for Children and Family
   - Safe-home Facility

b) Social services to support families with children.
   - Assistance in the personal care of the child
   - Assistance in the personal care of a child in a temporary childcare facility
   - Service to promote reconciliation of family and working life.
   - Service to promote reconciliation of family life and working life at the institution care for children under three years of age.
   - Early intervention service

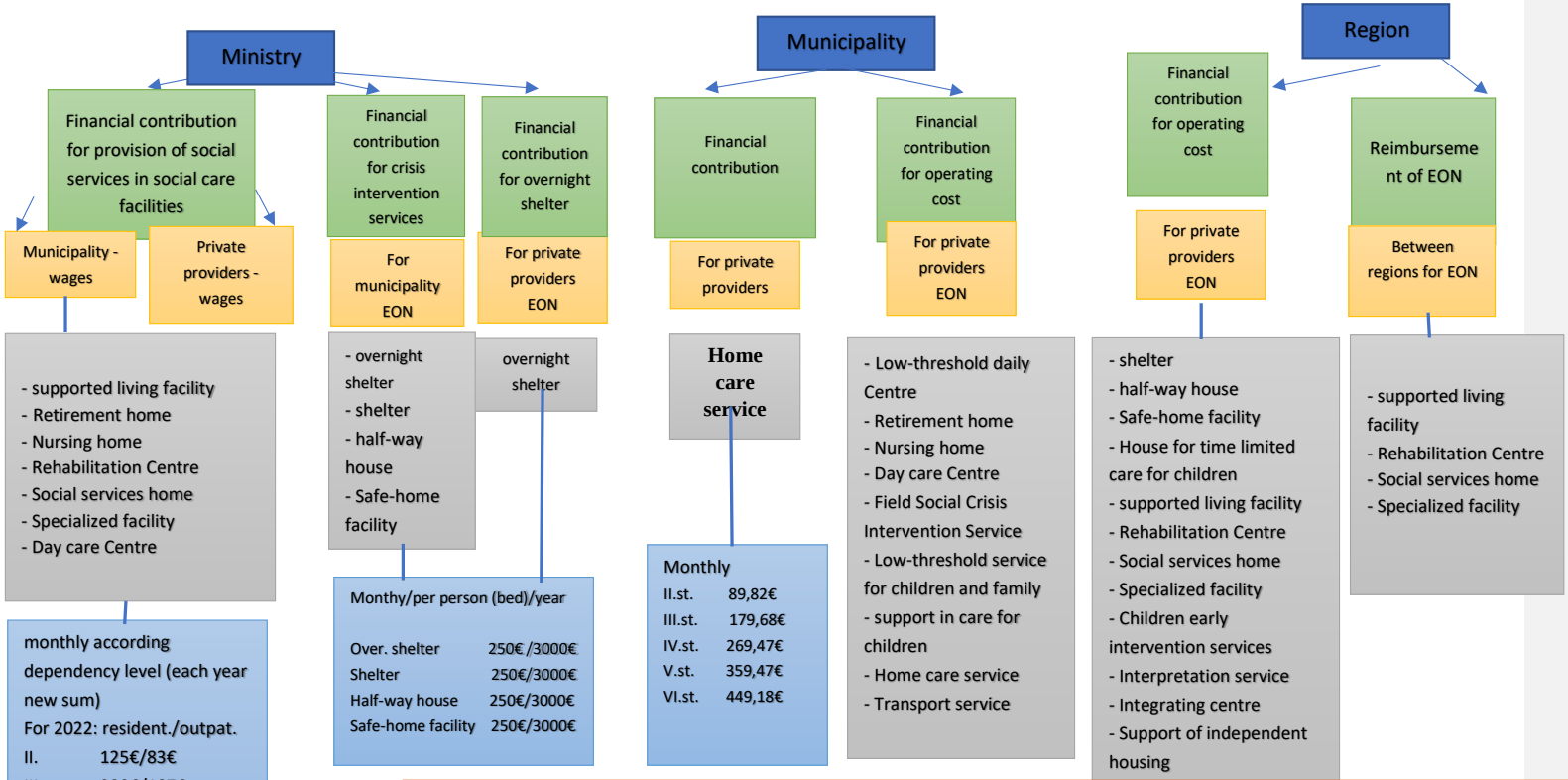
c) Social services for dealing with an unfavourable social situation due to a severe disability, unfavourable health condition or retirement age, where the main part consists of residential and outpatient services provided in facilities for natural persons dependent on the assistance of another individual and for people who have reached retirement age.
   - Provision of social services in facilities for natural individuals who are dependent on the help of another natural person and for natural persons who have reached retirement age, which are:
   - Supported Housing Facility
   - Retirement Home
   - Nursing Home
   - Rehabilitation Centre
   - Social Services Home
   - Specialized Facility
   - Day Care Centre
   - Mediation of personal assistance
   - Home care service
   - Transport service
   - Guide service and reading service.
   - Interpretation service
   - Mediation of the interpretation service
   - Rental equipment

d) Social services using telecommunications technology.
   - Monitoring and alarm for the need of assistance
   - Crisis assistance provided through telecommunications technologies.

e) Support services
   - Respite Service
   - Assistance in safeguarding custody rights and obligations
   - Daily Centre
   - Support of independent housing
   - Canteen
   - Launderettes
   - Personal hygiene Centre

Social services can be combined to best address the unfavourable social situation of citizens.

## Annex 2. - FINANCING OF SOCIAL SERVICES (financial contributions)[6]




EON – the cost of professional/service/other activities and activities referred to in § 61(9) which the provider is obliged to carry out or provide

- wages
- travel allowances
- expenditure on energy, water and communications
- expenditure on materials, except representation equipment for the new premises
- costs for rent or other (except car) spec machines, apparatus... in the usual amount
- expenditure on services
- expenditure on pocket money, severance pay, redundancy pay, sick leave

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## Annex 3 – Different indicators about social services users in social care facilities in 2021 in Slovakia

| | Social services users to 31.12.2021 | Elderly people | Persons with psychiatric treatment | Persons with dementia or with neuroleptic treatment | Persons with antidepressant treatment | Immobile persons | Persons with fully deprived legal capacity | Persons with partially deprived legal capacity | Men | Women |
|---|---|---|---|---|---|---|---|---|---|---|
| **Slovakia** | **46.577** | **31.780** | **15.859** | **11.730** | **11.915** | **24.817** | **6.956** | **1.640** | **18.449** | **28.128** |
| Social care home | 10.994 | 2.723 | 5.780 | 2.027 | 2.712 | 6.970 | 4.756 | 791 | 6.186 | 4.808 |
| Elderly care homes | 17.874 | 17.820 | 4.855 | 5.192 | 5.187 | 10.609 | 275 | 251 | 4.856 | 13.018 |
| Specialized facility | 8.294 | 6.529 | 4.078 | 3.524 | 2.838 | 5.904 | 1.530 | 421 | 3.202 | 5.092 |
| Daily centres | 2.889 | 2.234 | 143 | 187 | 188 | 110 | 173 | 52 | 958 | 1.931 |
| Rehabilitation centres | 638 | 140 | 102 | 27 | 32 | 33 | 33 | 21 | 327 | 311 |
| Retirement homes | 2.045 | 1.878 | 457 | 646 | 547 | 1 047 | 39 | 36 | 703 | 1.342 |
| Supported housing | 568 | 72 | 296 | 89 | 162 | 85 | 138 | 60 | 352 | 216 |
| Emergency housing facilities | 633 | 11 | 9 | - | 15 | - | 1 | 3 | 214 | 419 |
| Half-way house | 190 | 3 | 5 | - | 16 | 1 | - | - | 126 | 64 |