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Deinstitutionalisation of social services in Slovakia

ANALYSIS OF THE COUNTRY'S SITUATION.

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Introduction

The transition from institutional to community care (deinstitutionalisation, further known as DI) is since 2011 one of the national social policies in Slovakia. The process of social services DI in Slovakia started before this year and has a more extended history. Our organisation Rada pre poradenstvo v sociálnej práci (Social Work Advisory Board – further SWAB) has DI as one of the main goals since the organisation's establishment in 1990.

In the last 33 years, several projects and affords started the DI process. The results of these efforts have been changing the provision of social services and social support in Slovakia. We can divide this time into two main stages – from 1990 – 2010 and 2010 – until now.

From 1990 – 2010, primarily non-governmental organisations tried to start and change Slovakia's institutional provision of social services. The primary triggers were poor quality of institutional services and ethical and humanistic questions about social services. DI became a national social policy in late 2010 when the EU stopped ESIF funding towards Slovakia's institutional services.

Since 2011, on paper, it has been one of the leading social policies in Slovakia. Still, in real life, DI is prolonged, has many “enemies”, especially between institutional social services providers, regional governments and municipalities and has deficient political support on all state levels. On the other hand, many small and significant changes were made, strengthening DI's position as a substantial need and policy in Slovakia.

In this analysis paper, we present a short history of DI in Slovakia, the current state of the DI process, and the provision of support for people with disabilities.

Short history of DI in Slovakia

Social services and support for people with disabilities in Slovakia go back to the Middle Ages and later to the 19th and 20th centuries when municipal and state services were founded for people in need.

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

The communist regime gave room to the promotion of institutional care and culture. But in the 80s, more support and attention was paid towards community services and designing the alternative to traditional, institutional care. At 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 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 for a systemic change, i.e., implicitly a shift from institutional to community-based care, but did not manage to implement it. This can also be seen repeatedly nowadays.

Their capacity can demonstrate the situation in the Slovak social care centres as of 31 December 1989. There were 8,914 places for persons with intellectual disabilities, 5,659 were in institutions for adults, and 386 were in weekly care and daycare centres.[3] In 2021, there were 44.437 places in all-year-round services; 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 a 110% increase in the institutionalisation of people with disabilities in the last 30 years in Slovakia. We need to mention that, since 2014, it is forbidden to place children under 18 years in all-year-round social care homes. If we compare the increase in the number of places in weekly and daycare centres, 1989, there were 386 places, but in 2021 there were 3,162 places. This means a 719% increase in the type of services, but in the absolute number of all places for people with disabilities, it is only 14.4%.[5] All these data indicate 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 the early 90s, after the Velvet Revolution, Slovakia made several changes in social care. In 1990, 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 non—profit organisations rendering social care.

In 1991, in reaction to the long-stated needs of families and young people with intellectual disabilities, 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 about 10,000 people were 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 supporting people with health disabilities. There were no significant systemic changes from the point of transformation and deinstitutionalisation. Still, gradually, cooperation with international stakeholders, mainly from non-governmental institutions, established innovative and community services.

Various day-care facilities with a vital community component for people with disabilities 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. 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 the material need or social needs of an individual with their active participation; provide for primary living conditions of a citizen in their environment; prevent causes of developing, promoting or repeating disorders in the psychological, physical, and social development of a citizen and facilitate their 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 cooperated with the Social Work Advisory Board (SWAB) and monitored quality in six social services institutions under its jurisdiction. As a result, it picked two institutions subject to transition and deinstitutionalisation: the Centre of Social Services in Hodkovce and the Centre of Social Services in Kráľovce. The quality monitoring performed by SWAB in Hodkovce identified multiple institutional problems. At the same time, some of them had resulted in violations of human rights, including placing immobile patients into cage beds, unauthorised fixing of residents to still objects while some of them had their extremities tightened by straps, prioritising care and health services, forced sexual and physical abuse among the residents, depriving residents of their legal capacity. SWAB and Košice's self-governing region prepared the 1999 first deinstitutionalisation project in Slovakia, which was only partially successful – primarily because of political changes and lack of political support from leaders of the self-governing region. However, 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 the transition from institutional to community care. However, a joint initiative of SWAB and SOCIA Foundation led to amending the Act of Social Assistance and defined conditions for providing financial contributions to transforming institutions. This project showed that the critical 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 social services institutions 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 in the 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 organisations have been promoting the need for changes in the social field and the need for transition and deinstitutionalisation. Pilot projects aimed at the transition of social services have clearly demonstrated the critical importance of synergies between soft activities (education, support and preparation of staff, users and the environment) and challenging, 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 Transition of Existing Centres of Social Services project that did not bring about any principal changes. The project was initiated in 2003 when the Slovak government approved a request for a loan from the World Developmental Bank of the Council of Europe to fund infrastructure for social services centres through Resolution No. 430 from 21 May 2003. Despite its title, the project itself did not represent the fundamental transformation of social services; it was instead an investment into the existing infrastructure of institutional social care and its partial humanisation.[3]

One of the critical transition and deinstitutionalisation projects was the EQUAL Community Initiative. This operational programme supported various important civil society projects that focused on the 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 Slovakia's first more systemic transition and deinstitutionalisation project of social services. 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 many users with health disabilities in round-the-clock institutions that were not adequately offered and allowed to participate in work life. In the long run, the region was also committed to enhancing the socialisation of those centres' users, dealing with low qualifications and staff with limited commitment to improving 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 intending to support community-based care.
3. The Agency of Supported Employment project titled Examples of Good Practice – Supporting Deinstitutionalisation in the Social Area is an excellent example of an initiative in transition and deinstitutionalisation. [3]

The programming period 2007-2013 offered support to infrastructure development through the Regional Operational Programme (starting now the “ROP”).[6] One of the goals set in its original version of social services social and legal protection was to increase the quality of rendered services in the social area. The total proposed allocation for this measure was €270 million, representing 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 upgrading information communication technologies as a follow-up to their renovation, scale-up, modernisation and construction.

Measurable indicators were set for the reconstruction, modernization and scale-up of 310 establishments (centres) and the construction of 30 new ones 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 establishments: senior centres, adult centres of social services, child centres of social services (except for children's homes), and nursing homes with a capacity of 50+ users with minimal space standards (8 m2 per person).

This measure countered 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.

At this moment, we conclude that such contradiction emerges by adopting the Act on Social Services.” After the 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 began 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 for €209 million of the total allocation for social services of about €234 million. Almost half of the approved amount was geared towards constructing 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 budget within ROP for developing new community-based services, approximately €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 corrections in 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 change 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. It showed interest in contacting and cooperating 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, emphasising 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 eligible activities: pilot projects of deinstitutionalising the existing social services centres and social and legal protection centres and support of building community-care centres for marginalized citizens.

The ministry started to draft a Strategy for the 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- 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 the transition from institutional to community-based care became the Strategy of Deinstitutionalising the System of Social Services and Foster Care (starting now the "DI Strategy"), approved by the government on 30 November 2011. This strategy represented primarily a declarative document by which the Slovak Republic pledged to support a transition from institutional to community-based care. In the spring of 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 from preparing the national deinstitutionalisation project (OP EMP SI) without notifying them officially or officially cancelling the public tender through which they had been chosen. Then, the new leadership of the Ministry commissioned a review and redraft of the deinstitutionalisation project, and 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] The pilot NP DI offered training, 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 then, deinstitutionalisation has become a formal part of Slovakia's social policy. After 2015, it took 3 years to start with the second national project. Between 2015 and 2018, several national and international initiatives towards the Slovak government focused on DI support. The implementation agency of the ministry prepared a public tender for partnering with the National DI Plan – Supporting Transition Teams (starting now 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 project launch. The following organizations were selected: 1. Social Work Advisory Board to offer social services support; 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 the following chapters, we will describe detailed information about changes in deinstitutionalisation since 2018.

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

In the first chapter, we described the short history of deinstitutionalisation in Slovakia. This history relates to overall changes in social policies in recent years, especially in long-term care. The support services for people with disabilities in Slovakia are considered part of long-term care.

This means that long-term care in Slovakia is focused on older people and all other user groups who need long-term support, including social and health support. Several social and healthcare system activities and reforms had different results. Despite the multiple attempts and efforts to reform and interconnect social care and health care systems in Slovakia, there is a lack of coordination between these systems and their connection to the Convention on the Rights of Persons with Disabilities (CRPD). Slovakia's health and social care remain separate systems with minimal coordination and interconnection. Each system is governed by its own legislation and standards. This results from a highly complex 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. If we are analysing the support systems for people with disabilities, it is necessary to reflect all complex requirements of the Slovak legislation. Regarding deinstitutionalization, it is essential to remark on 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 the Ministry of Labour, Social Affairs and Family (starting now MLSAF). However, the MLSAF itself is not providing any social services. The social services system in Slovakia is regulated by Act No. 448/2008 Coll. on social services, as amended (now referred to as the Social Services Act). Slovak social legislation defines the conditions for providing formal social care and support. The Social Services Act regulates legal relations in providing social services and their financing, monitoring, and control. At the same time, it defines conditions for assessment activities and quality assessment of social services provision (connected with the Act on Inspection in Social Affairs). The provision of services itself is decentralized towards self-governing regions and municipalities. There are seven primary actors in the social care system in Slovakia:

- **The social service user -** Following the 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 requirements in Section 3 of the Social Services Act.
- **The social services provider -** Per the Social Services Act, a social service provider can be a municipality, a self-governing region, or other legal entities established and financed by the municipality or self-governing region. There are basic types of social services providers – public providers (municipalities 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 compelled to assess the need for services chosen, is bound to plan services in community planning/regional strategy of social services, can control selected services. Self-governing regions are also

responsible for registering all social services and keeping all registration records of all social providers registered in that region.

- **Ministry of Labor, Social Affairs and Family** – is obligated to control and monitor the quality of social services, can pay for selected social services, identify national priorities regarding social services, and prepare social service legislation.
- **Partnership** - is a particular institution within the participants in legal relations within the Social Services Act. A partnership is a group of individuals and other legal entities established to implement projects or programs to prevent or mitigate unfavourable social situations of individuals or to solve these situations and to support community work projects and programs. Partnership members may include municipalities, self-governing regions, labour offices, social affairs and family, community representatives, and other legal entities and individuals. The partnership is established based on a written agreement/contract, which defines the partnership members, the partnership's start date, the partnership's duration, the partnership's purpose, the partners' obligations, 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 dependent on social services and the right to choose them under the conditions stipulated by this law. If an individual is interested in providing social services, they 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 the provision of social services following the citizen's right to choose a social service provider within the scope of its competence.

Suppose an individual obtains a valid decision on the social service provision approved by the municipality. In that case, the municipality shall provide the individual with social services in the scope of the 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, 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, aimed at preventing the emergence of an unfavourable social situation of an individual, family or community and its solution or mitigation. There are several reasons for unfortunate social situations.

An unfavourable 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 the 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 persons with severe disabilities,
- support and care to the person with severe disability, to endanger the behaviour of other individuals or, if a person is the victim of the behaviour of other individuals, e.g., domestic violence, gender-based violence or violent crime,
- persistence in a spatially segregated locality in concentrated and generationally reproduced poverty.

A 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 unfavourable 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 needs, 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 their types. This results in many possibilities for social service providers and complicates the social care system.

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** are 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** include accommodation provided in residential social services facilities. 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 providing social services, which implies that social services should be provided to individuals as long as possible in their natural family or community environment. The social benefits are divided into five primary areas depending on the type. Social services by type are described in attachment 1.

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

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

Social services in Slovakia are decentralized, which means they are financed from different financial sources. As mentioned before, there are many combinations of types and forms of social services. This means there are many possibilities of funding for social services provision in Slovakia.

3 basic types of organizations can provide social services from a financial point of view:

- Budgetary organizations (mostly self-governing regions and municipalities providers) –a legal entity of the state, city, or self-governing territory, 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) - 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) - the 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 fundamental regarding financial sources to fund social services provision and different providers' rules and obligations. This also leads to hidden discrimination against private providers of several services, who are not guaranteed stable funding from the state budget, self-governing region, or municipalities (our and their users' syndrome). Not all types of social services secure financing. The self-governing regions and municipalities are responsible for funding different social services. As a result of the decentralization of social services, they have legal responsibility for the 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 levels, there is also funding from state budgets (through the Ministry of Labour, Social Affairs, and Family) for selected services. In selected services, users also must pay for social services. Although some of the services don't guarantee financing (primarily community-based services of crisis intervention or support services). This situation leads to low capacities of these social services in practice.

Primary 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),
- Donations from different foundations and ministries (non-systematic and time-limited funding of services primarily for projects).

A possible funding stream for different types of services is presented in Attachment 2. Funding schemes are regulated by the Social Services Act and are often complicated by other 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), a financial contribution for the provision of social services based on an assessment of dependence for non-public/private providers and selected municipalities providers (from the state budget) and financial contribution for providing overnight shelters. The 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 to 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 kind 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 services 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 Slovakia's most significant problems in social care provision is the lack of capacity of the professional workforce. Almost all social providers in Slovakia report the lack of professional care workers as nurses, caregivers, and social workers. There are several reasons for this situation. The main reason is the financial base – low wages of social services employees in Slovakia and better economic conditions for caregivers in other countries are leading to work migration from Slovakia to countries like Austria, Germany, Netherlands, Switzerland, and Scandinavian countries.

According to the Slovak Chamber of Caregivers, around 35,000 caregivers from Slovakia work in Austria and thousands in other countries. Moreover, the Slovak Chamber of Caregivers claims that in Slovakia, there is a lack of 7,000 caregivers in social care facilities and 7,000 caregivers in home care.

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

Social services act and deinstitutionalization

Several parts of the Social Services Act are composed to support community services and deinstitutionalization. The Social Services Act in Slovakia is complicated, and there are disproportions between the act's primary purpose – to help the independence of service users and the system of financing social services – most resources are going towards institutional care. This disproportion is one of the main reasons for the slow progress of deinstitutionalization in Slovakia.

Paragraph 6 of the Social Services Act states that a person has the right to social service provision, which, by its scope, form and type of provision, enables them to realise their fundamental human rights and freedoms, preserves their human dignity, activates them to strengthen their self-sufficiency, prevents their social exclusion and promotes inclusion to society. The legislation also defines other rights as the right to ensure the availability of information in a form comprehensible to them and different sets of fundamental human rights and freedoms. There are also obligations towards social service providers focused on fundamental human rights and liberties as:

- consider the individual needs of the social service user,
- activate the social service user according to their abilities and possibilities,
- to provide the social service at a professional level,
- to cooperate with the family, the municipality, and the community in the 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 their personal goals, needs, abilities and health status,
- to cooperate with social care providers in alternative children's care to support the transition for young adults from the Centre for Children and Families to social services.[9]

These are the mainframes which are the background for the implementation of CRDP and deinstitutionalization in the social services system in Slovakia. However, other parts of the legislation partially support the transition from institutional to community care. The most important are regulations about the maximum capacity of buildings and housing units where social services are

provided. This regulation of capacity was taken into the legislation in 2014. The theoretical basis for this proposal came from The “small group” principle.[10] This means there was a maximum capacity of 6 users in one housing unit and 12 persons in one building. The final version in law is not what was proposed in 2014. The reason for this was that three members of Parliament made the amendment proposal in the last quotation in the legislation process in parliament and increased the maximum capacity of social care homes, elderly care homes and specialized facilities up to 40 beds. This was done without a professional discussion or theoretical basis on human rights. The final regulation on the capacity of selected types of year-round services is for Supported housing – a maximum of 6 persons in one housing unit and 12 persons in one building. For specialized facilities, elderly care home and social services home – 40 beds in one separate building. From 2014 until now, this regulation of capacity became accepted in the social services system, and there were several amendments to the 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 the social services act).

These regulations were partially used for regulating capital investments from ESIF in Slovakia in the programming period 2014 – 2021 (the rule for Supported housing was used for all capital investments) and in the 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]. There are no possible capital investments from ESIF or RRP in Slovakia to institutions or year-round services with a capacity higher than 6 people in one housing unit and more than 12 people in separate buildings. The only exception is services with intensive long-term social and health care in RPP with a maximum capacity of 30 beds in one separate building. However, 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 state investments to reconstruct existing institutions. Therefore, the provincial governments invest around 10 million EURO annually to rebuild their large-scale institutions. However, there is good prevention for capital investments from ESIF to institutional care in Slovakia.

Another essential part of the 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 need social services. Support 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, help 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 a kind of personal assistance service within social services. This service user must live in their own or rented accommodation in the community. The user doesn’t need to have any assessment for this service, and there are no requirements for age. There needs to be only a written agreement between the user and social provider with a defined support scale. According to the Social Services Act, these social services can be provided to all people in need. The financing of these services is the responsibility of the regional government, and it’s paid to social services providers, not persons. Most service providers in the deinstitutionalization process register and provide these services. We will mention it closely in good practice examples.

[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.

Social services quality standards are the last essential part of the Social Services Act, which supports independent life and deinstitutionalization in Slovakia. Since 2022, there has been a new act on inspection in social care. This act defines new quality standards focusing on fundamental human rights and freedoms in providing services. The background of the new standards is the WHO Quality Rights Toolkit.[12] Quality standards describe how to provide social services according 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 primary groups – operational standards, personal standards, and procedural standards.

Some minor parts of the Social Services Act provide operational benefits to providers actively transitioning from institutional to community-based care.

Social services statistics

The latest public statistical information about Slovakia's social services system is from 2021[4]. The data set used in this analysis was from MoLSAaF of the Slovak Republic. This analysis will focus on social services provided in institutional facilities with long-term care. We will also look at selected outpatient services and field services.

Social services providing year-round, long-term care in Slovakia are social care homes, elderly care homes, specialized facilities, daily centres, rehabilitation centres, Supported housing and retirement homes, halfway houses and emergency housing facilities. We are not counting on our statistics places from shelters for people without accommodation.

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

2021	Number of service 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 the number of facilities and places.[4]

Most of the places are facilities for older people - almost 31,000 places. The rest are places for people with disabilities or in need. These numbers are confirmed by the number of people receiving social services in different facilities. There were 46,577 users of social services in social care facilities, of which there were 31,780 (67,23%) older people. Suppose we will look at social services users in three primary age groups: 0-18 years (pre-productive age), 19-64 years (productive age) and 62+ (post-productive age). In that case, it will confirm data about many older people in social services. In Slovakia, there are 1.607 (3,45%) social services users in pre-productive age and 13.665 (29,32%) in productive age. Social services users in the pre-productive age are mostly in weekly or outpatient social care facilities.[4]

In annexe 3, we present different indicators about social services users in social care facilities in Slovakia in 2021. Social services statistics show that most social services users are women (28.128), and there are 10,000 fewer men in social care facilities. But let's analyse the number of men and women in social care homes, the most typical institutions for people with intellectual disabilities. There is a higher number of men (6.186) than women (4.808), and in Supported housing, men (352) and women (216).[4] This difference between the total number of women and men in all social care facilities and the number of men and women in social care homes and Supported housing is because of the high number of older people in social services in Slovakia. In the general demography of Slovakia, we can see more women than men in the age group 65+. This information about a higher percentage of men than women in institutional care for people with intellectual disabilities is essential primarily because of strategies to deal with the challenging behaviour of users and ill-treatment in institutions. We must consider this when preparing strategy and actions in transitioning from institutional to community-based care.

In context with this information, there is also an essential number of people receiving psychiatric treatment: 15.859 people (34%) in all social care facilities. But when we look closer towards institutions for people with intellectual disabilities (social care homes), we will see that 52.57% of social care home users receive psychiatric treatment.[4] This high percentage can only confirm the negative aspects of institutional care. This also shows a lack of community-based care for people with mental health problems. Most of these users are also at antidepressant treatment.

The statistics also show that around half of social care users (24.817) in facilities have mobility problems and need more intensive support in daily activities.[4] This information is vital in the required number of supporting personnel in new community services and in the context of the individual's knowledge, education, and skills. That needs to be considered in strategy and planning new community-based services in the transition and deinstitutionalization process.

The last essential data from statistic are about legal capacity. 18,4% of all social services users in social care facilities are fully or partially deprived in a legal capacity. This number can be seen as not so high in overall numbers. Still, when analysing institutional types of social care facilities for people with intellectual disabilities, we will see that this number is much higher (50,45%).[4] The cause for this is the same as when we were writing about sex and age differences. Most people in social care facilities are older people without intellectual disabilities; therefore, it is not expected to deprive them of legal capacity. But in social care homes, we can find primarily people with intellectual disabilities who lived in institutions for a long time, and they were historically and systematically deprived in legal capacity

until 2000. From 2016, there is no legal possibility to deprive a person entirely in their legal capacity[13]. From 2021, the social care services provider can't be intended as a guardian for a social service user who is deprived in a legal capacity[9].

Most of the types of social care facilities require complex social and health assessments of social service needs. Assessment is provided by municipalities and regional governments. The result of the assessment is the level of social service needs. There are 6 levels, where level 6 means the highest need with 24-hour support[9]. Altogether, 43.166 social services users are assessed for need of social service in social care facilities. The following table shows an overview of social services users with valid social service facility assessments.

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 a medical background and focus. The assessment system in social care is fragmented, and there is a goal to reform in this area. It is a crucial part of the Recovery and resilience plan in Slovakia. As one can see in statistics, most social services users are at the highest level. There are several reasons for this situation – the most common is financial support from the state to service where social services providers can get higher support for users with the highest level. The second problematic reason in the assessment system was "appropriate supervision" vs "constant supervision." It means that when the officer writes in assessment, the person needs constant supervision. Hence, they reached level 6 regardless of whether they have good active day-living skills and can live independently. This assessment problem often leads to the very paternalistic provision of social services in institutions, where the "safety" of the social service user is often used as an excuse for violating and depriving their fundamental rights.

All these data about institutional social care in Slovakia confirm a strong institutional culture in social care facilities and a high need for transition from institutional to community-based care. Other statistical data support this thesis – for example, there are only 26.669 employees in social care facilities, but 48.206 places. This shows a massive lack of personnel in institutional care, leading to low-quality services and a more paternalistic and institutional approach. The total cost for social services provided in facilities in Slovakia was 668.314.516, - EUR. More than half part of these resources were

used for personal wages. But there were also capital investments into the reconstruction of institutions, mostly from regional and municipal budgets – altogether 13.889.897, - EUR.[4] As one can see, a massive amount of resources still goes into Slovakia's institutional care provision. Therefore, there is a need to reform social services financing towards personal budgets. One crucial issue is the number of people on the waiting list for a place in a social care facility. In 2021, there were 8,525 persons on a waiting list for a place in a social service facility. This number has decreased (around 23.32%) compared to the last 4 – 5 years.[4] The main reason was the COVID-19 pandemic. The strict rules in social services in Slovakia during the COVID-19 pandemic resulted in a situation where people don't want to go to social services facilities but want to have social services provision in their homes. This thesis is supported by the latest research about people's opinions about the type of support and social services they would choose if needed. 93% of people in Slovakia would choose community-based services and services provided in their homes, and only 7% would choose institutional social care[14]. These results are significant for supporting the transition from institutional to community-based care.

On the other hand, there are also community-based services in Slovakia. These services are provided mainly as outpatient services or in-person 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 for these community-based services for people with disabilities is 76.270.740, - EUR per year in 2021. 7.482 employees are providing community-based services in Slovakia.[4] From these numbers, there is minimal support towards community-based services in Slovakia.

In the chapter Deinstitutionalization conceptualisation in Slovakia, we will closely analyse reasons and current situation in social services facilities which were and are participating in the 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 for severe disabilities. This area, in general, abroad, is also an integral part of integrated care for people with disabilities. Payment for the social consequences of severe disability is, in the legislative sense, mainly seen as alleviating or overcoming the social effects of severe disability through the provision of cash allowances for compensation or social services. Under the legislation, special care under Act 305/2005 Coll. on Social Protection of Children and Social Guardianship is also considered compensation. This section 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 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 - compensate 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.
    - Associated with the care of a dog with special training.

The primary aim of providing compensation following 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 obtain a card for a natural person with a severe disability, a card for a natural person with a severe disability with a guide and a parking card for a genuine 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 help.
    - 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 private 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 compensation of 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 percentages. The amount of the care allowance and the rate for one hour of personal assistance (belonging to recurring allowances) are defined 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, and 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 a 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 an essential part of this legal act. The Slovak Republic provides it through the monetary contribution for personal assistance following Act No 447/2008 Coll. on financial contributions to compensate for 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 independently 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 a disability chooses their 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 for informal care, which is paid to caregivers, 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 personal assistance only for guidance of a person to school or to working activities, i.e. only a 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 calculates the allowance amount for personal assistance.

In 2021, 11,515 people with disabilities had personal assistance. The average monthly sum was 613,29, - EUR, and total expenses for personal assistance in Slovakia in 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 provides 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 they depend on another person's help 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 primary 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) 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 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 the outpatient form of social service and at the same time cares for a genuine 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]

According to the Social Services Act, only informal carers have the right to get respite services. On the cash allowance for informal care, provided on 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 of the people getting informal care are people with disabilities; the second part is older people.

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

Deinstitutionalisation conceptualisation in Slovakia

Strategic national documents about deinstitutionalisation in Slovakia

Since 2011, the deinstitutionalisation of formal social policy in Slovakia. The main document conceptualising the transition from institutional to community care in Slovakia is the Deinstitutionalisation strategy of the social services system and foster care from 2011. This document was approved by the government. The goal of the strategy was to create and realise a national DI project (see Chapter 1) and national action plan. The 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, 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 typical family. After ten years of validity of the first DI Strategy, the Ministry proceeded to the preparation of 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 primary 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 supporting deinstitutionalisation that are approved by the government or the MLSAF. It's especially *National priorities for developing social services 2021 – 2030*[18]*.* This document identifies four main priorities in the development of social services until 2023:

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

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

The national programme on improving the living conditions of persons with disabilities for 2021 – 2030[19] is a general national document approved by the Slovak government with tasks and actions that must be done to fulfil CRPD. The goals and activities are extensive in this document, but there are several recommendations towards the DI process and independent living of persons with disabilities. Other national documents approved by the Slovak government and directly and formally supporting DI are the *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 reflect the human rights approach and CRPD. The new national DI strategy is deinstitutionalization, defined as 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 influential network of new or existing alternative community-based services for the inhabitants of

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

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

Values and human rights approach challenges

The theme of deinstitutionalisation is not a new one in Slovakia. The Social Work Advisory Board has been working in this area since 90ties. The transition from institutional to community-based care has been a part of national policy since 2011. But still, there is a lot of opposition against the deinstitutionalisation process in Slovakia. CRPD and human rights approach is affecting the EU funds and national policies. Still, on the regional and municipal level and in self-social care provision, many people and organisations are actively against it. The history and culture of a post-communistic country with huge paternalism thinking in daily life is a great challenge to accept individual freedoms and choices. The idea that the state, region, municipality or professionals know 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 their own decisions. The lack of respect between professionals, academics, politicians, providers, and policymakers towards people with disabilities, especially those living in institutions, leads to plodding progress in this area. The people who should be examples for the population often present that deinstitutionalisation is not worth doing. They present the human rights of people with disabilities not as a base ground but as something extra. There is quite "schizophrenia" in this process in Slovakia – on paper, 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 to reshape the institutional culture and thinking of the whole nation and country. It can be done, but it is a challenging process where you need to start with the small communities and change them by showing them good examples and teaching them to accept otherness. Therefore, there is a need to focus more on the quality of the transition process from community-based care rather than quantity. This is one of the main lessons which we learned in Slovakia.

The lack of education and support for inclusion in the daily lives of all people and the lack of knowledge about fundamental rights is what we need to overcome on the way to an inclusive society.

Practical and legislative challenges

Slovakia has signed (2007) and ratified (2010) CRPD and its optional protocol but didn't make any significant changes or reforms connected to CRPD commitments. In 2016, the United Nations Committee on the Rights of Persons with Disabilities (hereafter CRPD Committee) gave Slovakia 83 different recommendations and concerns 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 that Slovakia fasten up DI and be more specific in supporting people with disabilities. But since then, progress in this area at the practical and legislative levels has been slow. Some outstanding actions were done to support DI and community-based care, but on the other hand, there is a lack of systematic reform of social services and social care in Slovakia. According to several strategic documents, let's look at Slovakia's practical problems of social services and support. There is a lack of formal community-based care in Slovakia as a supported living service, respite services, and outpatient services.

This situation causes difficulties for persons with disabilities and their families to get adequate support and care. As one can see in social care statistics, most social service users live in institutions (mostly large-scale institutions) or are getting meagre 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 a human rights approach and community-based services as a fundamental type of support. Still, on the other side, the model of financing social services likes and supports institutional primary services.

The CRPD committee also reflect on this situation when it recommends that 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 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 national budget to institutions and reallocate these resources into community-based care. These recommendations were partially made in the last few years. Since 2011, there have been no investments in institutional care from ESIF and no plan to invest in institutions from the Recovery and resilience plan and actual programming period of ESIF. Despite strong opposition from mostly regional governments, municipalities, and institutions, non-governmental organisations and European committees strongly influenced this. What has not changed are resources and investments from state budgets or regional governments and municipalities' budgets. State funds for accommodation development still support investments in large-scale institutions, and state regional governments and municipalities financially support the provision of institutional social services.

A game changer in this situation can be the Recovery and Resilience Plan (hereafter RRP) from the European Union. The logic and structure of this fund are based on investments depending on the need for structural changes in the country. This means that if Slovakia wants to use investments from RRP, some concrete structural changes must be made. Component 13 – Long-term care of Slovakian RPP presents these fundamental structural social care and support changes. Three fundamental reforms need to be done in Slovakia by 2026 if Slovakia wants to use 250 million. EUR in investments in social care infrastructure. RRP proposed these reforms – *social care and support inspection with a focus on CRPD (was taken into force in November 2022), reform of disability assessment system (2024) and reform of financing of social care with an emphasis on introducing personal budgets (2025).*[23] RRP will invest in developing outpatients 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 a planned investment in 16 social-health care facilities with a maximum capacity of 30 persons in one building. All buildings need to be part of the community, and it is forbidden to segregate and group these buildings in a common area. The goal is to create around 1440 new community-based places, far

below the need in the country. Therefore, there is a plan to use the same kind of investments in the actual programming period.

New Act No. 345/2022 Coll. on Inspection in Social Affairs, adopted in 2022, has introduced the revised quality standards of the social services, focusing on CRPD and human rights approach. Its Annex 2 sets the quality standards and criteria defining the quality of social services provision from a 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 the background is that only in community-based services can one achieve good service and quality of life.

Nowadays, a working group at MLSAF is preparing to reform social services financing to introduce a 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 (starting now referred to as NPDI PTT) implements support to institutions wishing to engage in the process of deinstitutionalisation. The project aims 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 (now 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 training for involved social care institutions.
4. Consultation and advisory in the development process of transformation plans.
5. Dissemination activities about deinstitutionalisation in Slovakia.

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

- To evaluate 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 options 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 primary 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 severe deficiencies in this area that must be addressed urgently. In this topic, these are mainly deficiencies in the physical environment, often unfit for purpose and unsuitable for providing quality social services. Only 3% of the assessed facilities fully met this criterion - in all cases, these were mainly supported living facilities in the community. Only 2% of the assessed facilities had premises and buildings that provided social services satisfactorily. 23% of the facilities could be evaluated 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 this area's legal requirements. 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 crucial. Only 19% of the assessed social care facilities fully meet this criterion. 29% of the facilities are partially debarrierised. 41% of the assessed facilities have significant deficiencies in debarring, and up to 11% do not meet this criterion at all, i.e. they are violating the Social Services Act.[25] Safety and fire protection are related to several 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 focuses explicitly on fire protection, it appears that 15% of the assessed facilities do not meet this criterion, and 59% meet it at a minimal level. These high figures show the enormous risk in large-capacity institutions during a fire outbreak. Only 10% of the providers assessed fully meet all fire protection requirements.[25] In 2021, there was a fire in one of the institutions involved in NPDI PTT where six social services users and, afterwards, the institution director committed suicide[4]. NPDI PTT assessed this institution in 2019 and urged the director and regional government to rapidly deinstitutionalise these institutions because of fire risk. After this tragedy, there was an open letter to the national government to speed up deinstitutionalisation in Slovakia[5]. This letter was written without any special feedback from the government.

The size of the facility and the proclaimed cost-effectiveness of large-scale facilities often 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, 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 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 increased risk in respect for fundamental rights and freedoms. In other words, humanising large-capacity social services cannot be effective regarding value for money. Most facilities do not meet the required hygiene standards. The most significant deficiency is the shared bathrooms

[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

and toilets for many beneficiaries (all 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 in 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 older adults. 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 (bodily) and mental health. A separate chapter within this theme is the assessment of staff preparedness and skills. Only 7% of the service providers have the right to the highest level of physical and mental health being fully met. In 43% of service 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 organisation's needs over the individual needs of social service users. Concerning the number of social service users, it is essential to highlight that almost all facilities were understaffed - especially regarding 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 to 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 with their quality.

In other words, value for money in these cases would be meagre and insufficient. The result of this situation is that in most social services evaluated, only primary nursing care for physical health was provided. Social work and social rehabilitation on an individual level were provided only sporadically, and even then, mainly in community-based establishments. 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, following the staff's lack of experience 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 for 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 older people).

52% of the evaluated social care facilities have significant reserves in this area, especially supporting 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 follows 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 deprived of their legal capacity, while only some 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 to fulfil 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. Still, it 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 through regularly organised community meetings. Formally, social service users have access to their personal social and health records. Still, 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 rarely included in the records.

It should be noted that evaluating the right to exercise legal capacity, equality before the law and personal freedom for older people 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 always prioritised.
- Social service users receive information, but not exhaustive, in an understandable form; the choice is narrowed down to the service offers proposed by the facility staff.
- Social service users cannot decide 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 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 directly on the Slovak Republic's Constitution in addition to the Convention. 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. Protection from ill-treatment is therefore closely linked to all

the themes assessed and the 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 fully comply 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 substantial shortcomings, which may lead to criminal liability for 5% of them in case of their inaction.[25] The most common deficiencies 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 in working with risk
- Use 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 older people 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 before the NPDI-PTT were focused on essential building and exterior maintenance at a considerable financial cost. There was minimal or no awareness of community housing and service options for social service recipients. School-age social service recipients receive education 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 municipality community, 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. Beneficiaries' participation in the local community's public life (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 occur mainly outside the facility's walls. Actions towards the local community are mainly group-organised.

Assessment done as a part of NPDI PTT shows concrete details of Slovakia's institutional solid culture. An assessment was done in 93 large-scale institutions across all of Slovakia, and it brought very valid information about the current situation in social services in Slovakia.

All reflected data and information show a primary 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 the community.

Good practice examples – Slovakia

Slatinka -the first deinstitutionalised social services home in Slovakia

The Slatinka Social Services Home was 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 was a typical institution in a neo-Gothic manor house in Dolna Slatinka near Lučenec, about 3 kilometres from Lučenec. It is the first large-capacity home in Slovakia where the transformation process, 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 provide care for older adults. 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 older people. Manor house, of course, had to be renovated. In 1955, it was left by the older 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 the reason for establishing 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 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 or 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, and their motor skills and memory should be developed. So, two educational groups were created. ... They tried to develop speech in the children through poems, repetitive movements, and short performances. There were exhibitions of handicrafts performances, and the institutes competed. The children from Slatinka often won first place...*"[26] The sisters worked there until 1988 when they left for the Charity House in Vrícke".

Until 1989, the institution provided care for children with intellectual disabilities, who, following 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 offers social services for children and adult users with intellectual disabilities. Historically, 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 one providing services from 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 facility's capacity gradually decreased; in 1999, the capacity was 69 places.[27] Between 1989 and 2005, some humanization processes occurred in the facility, but the institution had no fundamental change. By 2005, the facility operated as a typical large-capacity facility, serving 60 users aged 4 to 41. 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. The educational house has day rooms where educators carry out user group activities. The floor of the Educational House was renovated in 2004 to provide accommodation for 12 users. The manor house is not wheelchair accessible; the building layout 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 to Work and social inclusion of their residents". SWAB focused its project on long-term training of social work employees in an individual approach to 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 most significant deficiencies that the institution criticised were the restriction of the personal freedom of its residents and the suppression of freedom of expression and choice concerning 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, and 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. It was not easy to listen to the management or staff then. The facility had a good reputation in the region, and they were convinced they were providing good service. Even more, there needs to be more appreciation for the determination of the then director, Alena Kelemenova, to see the perspective of the facility's residents. 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 transforming 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 implementation phase. Thus 2006, they developed the first transformation project, which had three stages. There are probably several facilities in the following SWOT analysis table, so we will present it in full. The first phase was planned to be completed by the summer of 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 to be more adapted to the needs of the users of Slatinka, but at the same time, they could cover the region's current needs. Therefore, they wanted to provide a family house for Supported housing services for 9 users. They wanted to continue using the training house in the manor house grounds to prepare for more independent living for 12 residents. They planned to renovate the manor house to reduce the number of people in the rooms, obtain suitable space for rehabilitation and educational activities, and add new services to the facility's service offerings - day and weekly respite services. The preparation of individual plans, supervision and staff training were also planned. They also wanted to start working with families and eventually placed 7 children back with their families. Only in the second phase, not defined in time, did they plan to gradually move all the users to the town of Lučenec and leave the manor house altogether. However, due to the planned investments in the loft, the second phase was not envisaged immediately. This is why the opponents criticized establishing the professional defence of the transformation project... Based on the objections, the project was changed. Investments in the repair of the manor house were abandoned;

therefore, it was planned from the outset to gradually leave the house with all the users. The idea was to create a facility that would meet the needs of 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 population composition at that time, the last facility was to serve persons with severe and profound mental disabilities (10 people). After the second's successful completion, the third phase was to use 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, mainly because the inhabitants had no other alternative in both communities - neither Supported housing nor any form of relief service. Changes in the staffing structure were also planned. These included strengthening direct contact staff and reducing the number of nurses. The intention was to create multi-disciplinary teams working on individual development plans. This was to be facilitated by merging the education and health departments, which 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 transitioning 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 brought a surprisingly rapid acquisition of shared skills and, in the long-term, physical, psychological and intellectual changes. The treating psychiatrist himself was surprised by the increase in IQ in adult humans, which he had no longer anticipated. 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]

In 2011, the talk about deinstitutionalisation also started nationally; the Banská Bystrica self-governing region counted on using structural funds to complete the transformation process in Slatinka. Nevertheless, they continued to abandon the manor house, considering 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 higher 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 of technical and political problems, Slatinka realised the final deinstitutionalisation project with investments in community-based services in 2022. Since 2022, no users have lived in the old premises of the Slatinka manor house.

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

Nowadays, Slatinka is the first fully deinstitutionalised social services institution in Slovakia. They are providing several types of social services in the Lučenec area. All provided services are community-

based –residential, outpatient or field services. The main reason for providing residential services is Slovakia's low degree of household funds.

Slatinka is providing these types of services in several:

1. Support 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 buildings are in community settings and integrated into ordinary housing in Lučenec. Support for independent living/housing is provided in typical households and flats rented by social service users from private persons or municipalities. All service users getting this type of service in Slatinka has lived all their life in social care institutions.

There were made several films about the 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 users 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 of 90 institutions which are supported in soft activities to start and provide deinstitutionalisation. The management and employees of this institution made in the 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 a good example of how to not give up even when there are too many struggles to achieve the central vision – the independent lives 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 to establish 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 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 on 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 to the Osvald and later Nemes families. After the social changes 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 attended by the institution's residents. In the institution's registry book, 17 names were noted in 1953, but the capacity gradually reached 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 institution's name 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 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 the surrounding area. Gradually, both the medical and 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 legal subjectivity was granted, 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 is concerned, it acquired its modern form by completing 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 facility's functioning was the fire on 2 May 2007. The fire destroyed the manor house. All the inhabitants evacuated safely, but the building was no longer fit for use. This event significantly impacts the quality of the services provided and the facilities. Since then, the social services have been in a state of emergency. The management had to quickly address

the village's alternative premises- particularly 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 ending. The inheritors were successful. The complicated process of negotiating with the landowners for repairs began. In addition to all these "office" debates, several dozen residents had no roof over their heads. The municipality came to the facility's rescue by leasing an unused part of the kindergarten, where they could move the 24 clients with the highest level of support. The other users had to squeeze into a building on the grounds of the manor house, on-premises not initially intended for housing. They had to accommodate 42 people in a building initially built for 21 people. The state of emergency evokes in many of us the feeling that this situation needs to be addressed urgently because it is incompatible with normal life. 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 near the enclosed fenced mansion and the small common rooms. Therefore, everyone tried to take advantage of every opportunity to go on trips, for culture, for visits and especially for sports. The residents and staff's programme of activities filled the facility in such numbers that it may seem excessive from a layperson's point of view.[29]

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

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 mansion's owners on a lease and a chance to obtain financial support from the Structural Funds for the reconstruction or construction of a large-capacity facility. "*We are doing our best in our conditions but want to do better*." These were the words used by the facility's management 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 residents' environment and working conditions or housing. However, according to them, the ideal was still renovating or constructing an institutional-type facility. The terms of the EU funds call in 2012, which say the maximum of 6 residents per household and 3 households per building, were perceived as threatening 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. The goal was 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 building establishment. After agreeing and joining the pilot process of deinstitutionalisation, there were many problems with public procurement, which was done by the regional government as a founder and owner of the social care home. The regional government cancelled twice finished public procurement, which made it impossible 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. However, the management of the social care home didn't give up, and they began to rent houses in the village, where some of the other social services users moved. They open a daily activities centre where they provide activities for social services users. They began to focus more on community users' support and less on capital investments.

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

In 2018, they successfully applied again for EU funds for capital investments. They are currently building and reconstructing 6 buildings for community-based services in residential and outpatient form. All facilities are made in a universal design and have a passive energy level. The project will be finished this year (2023). Following capital investments, they are improving the support of social services users through international cooperation with Hungary and the Czech Republic, educational activities, and supervision for employees and social services users. From 2018-2021, they were part of a national deinstitutionalisation project, and since 2022, they have continued their soft support project for deinstitutionalisation founded by the EU.

The video about supporting 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 APS) is one of the best community-based providers in Slovakia. APS was founded and directed by Soňa Holubková, one of Slovakia's most important social care innovators and worked on the Social Work Advisory Board. The Support Services Agency is a non-profit organization providing community-based services for citizens with disabilities (primarily intellectual disabilities) in Žilina since 2003. APS aims to provide support in 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 and independence and enhances their quality of life in 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 others. Until then, these people have lived either at home with their relatives (which has 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 longer than initially planned. As we did not want the training flats to become permanent residences, we needed to strengthen the planning phase, find natural support, and implement the plan. We were looking for new methods that would also more intensively support residents who have been with us for extended periods.

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 family, 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 strengthen natural social ties (with parents, relatives, neighbours, and friends) and create a natural support network (neighbourhood help, help within the extended family, etc.). Person-centred approach methods have helped intensify cooperation with families and the city of Žilina; our services have developed into a support system in our flats.

They are providing services to 12 people with disabilities. Few of them now live 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 can come and arrange it. Some 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 decision-making freedom, strengthening relationships with family, and promoting the use of services offered in a person's broader social environment.

The main objectives of APS, n.o.:

- To provide citizens with disabilities with support that helps their development and 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 climate 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, following their needs and abilities, to provide supervision following the legislation in force on the provision of social services

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

The 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 mainly include field social crisis intervention services and the provision of social services in facilities. This social services group aims 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

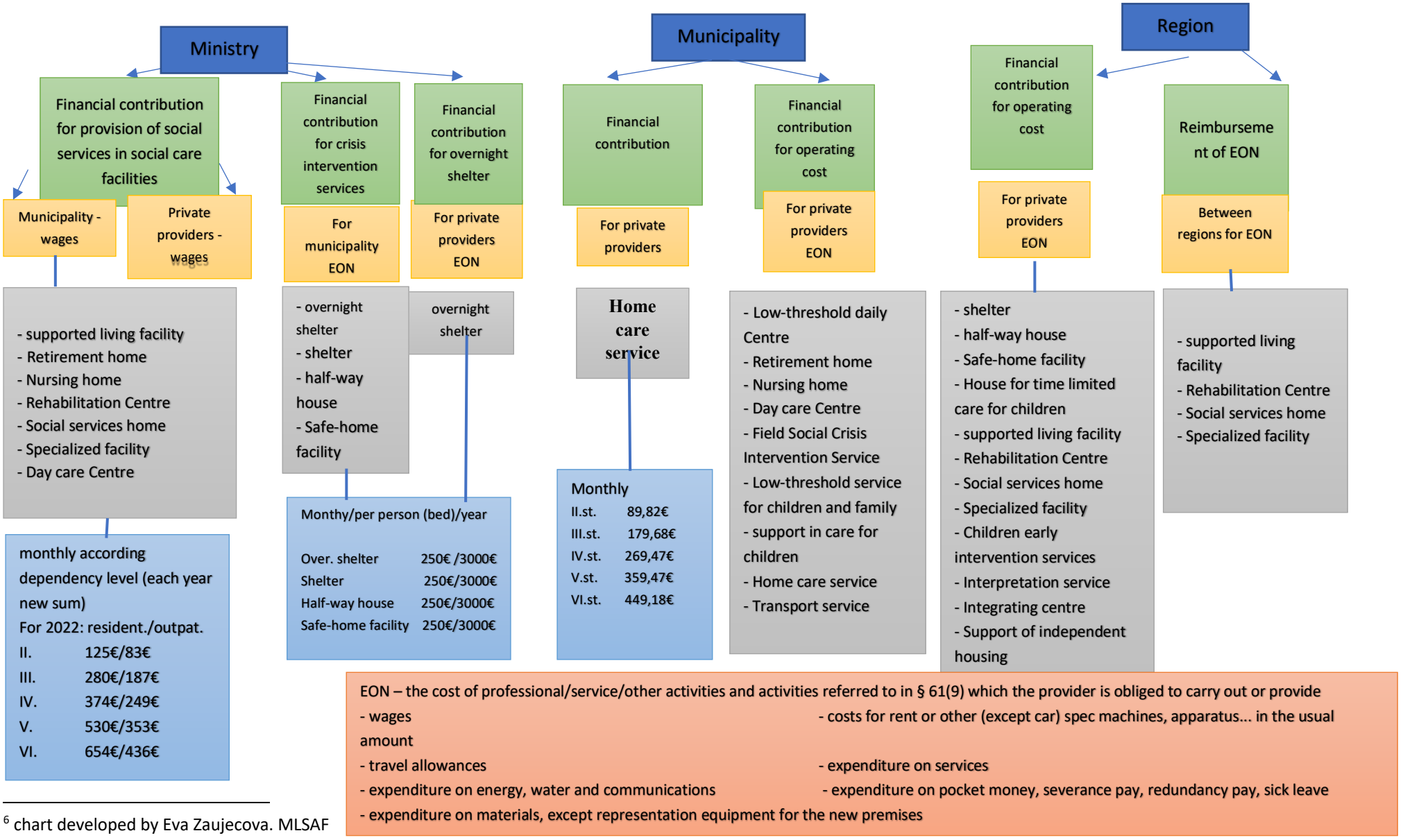
c) Social services for dealing with an unfavourable social situation due to a severe disability, unfavourable health condition or retirement age, where the central part consists of residential and outpatient services provided in facilities for natural persons dependent on the assistance of another individual 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 for assistance
   - Crisis assistance is 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]



[6] chart developed by Eva Zaujecova. MLSAF

Annexe 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