Report on the state of play of the deinstitutionalisation process and the development of community-based Care in the European Union

The European Expert Group on Transition from Institutionalisation to Community-based Care

July 2016
The European Expert Group on the Transition from Institutional to Community-based Care (EEG) is a broad coalition gathering stakeholders representing people with care or support needs and their families, including children, people with disabilities, homeless people, people experiencing mental health problems; as well as service providers, public authorities and intergovernmental organisations.

The Group has as its mission the promotion of person-centred, quality and empowering models of services and formal and informal care that fully respect the human rights of all people with care or support needs. The Group supports national efforts to implement the necessary reforms, in compliance with the United Nations Convention on the Rights of Persons with Disabilities (in particular with Article 19), the United Nations Convention on the Rights of the Child and the European Fundamental Rights Charter.

The Group provides expert support on EU policy, legislation and funding. All members of the Group provide a link to operational expertise at national, regional and local level through their direct involvement and the empowerment of their member organisations.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Introduction</th>
<th>P. 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection of country fiches</td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>P. 4</td>
</tr>
<tr>
<td>Bosnia Herzegovina</td>
<td>P.6</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>P.7</td>
</tr>
<tr>
<td>Catalonia</td>
<td>P.9</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>P.11</td>
</tr>
<tr>
<td>Denmark</td>
<td>P.13</td>
</tr>
<tr>
<td>England</td>
<td>P.14</td>
</tr>
<tr>
<td>Estonia</td>
<td>P.16</td>
</tr>
<tr>
<td>Greece</td>
<td>P.18</td>
</tr>
<tr>
<td>Hungary</td>
<td>P.20</td>
</tr>
<tr>
<td>Ireland</td>
<td>P.22</td>
</tr>
<tr>
<td>Lithuania</td>
<td>P.24</td>
</tr>
<tr>
<td>Moldova</td>
<td>P.26</td>
</tr>
<tr>
<td>Poland</td>
<td>P.28</td>
</tr>
<tr>
<td>Serbia</td>
<td>P.30</td>
</tr>
<tr>
<td>Slovakia</td>
<td>P.32</td>
</tr>
<tr>
<td>Slovenia</td>
<td>P.34</td>
</tr>
<tr>
<td>Conclusion</td>
<td>P.40</td>
</tr>
</tbody>
</table>
INTRODUCTION

The European Expert Group on Transition from Institutionalisation to Community-based Care has collected this past year country fiches of the European Union’s member states in order to draw a state of play of the implementation of deinstitutionalisation.

This report reveals the findings and underlines the main challenges encounter by the different country. The analysis is based on the following elements:

- Legal and policy context
- EU structural funds
- Progress toward DI
- Support in the community
- Involvement of users

It appeared to the EEG that a lack of communication and exchanges between grassroots level and national/European level exists leading to a lack of understanding and knowledge. For this reason, we have launched this collection.

The challenges and issues encounter while transitioning from institutional to community-based care are very different from one country to another. For this reason, particular attention must be given to the specific context when assessing the state of play. The data available and the findings differ from one country to another and the results may not always be comparable. However, this report constitutes a good source of information and will keep being updated.

ACKNOWLEDGEMENT

Many organisations participated to the draft of the report and we would like to warmly thanks them for the time and effort they dedicated to it.

Jane Snaith (MTÜ Igale Lapsele Pere), Irina Malanciu (Lumos Moldova), Regina Bisikiewicz (Open Dialogue Foundation), Unicef Bulgaria, Dr Joanna Robaczewska, Pordán Ákos (Hand in Hand), Mencap UK, Maria Holsaee (Danske Handicaporganisationer), Ferran Blanco (Fundacio Tutelar), Mental Health Ireland, COFACE (Confederation of Family Organisations in the EU), EASPD (European Association of Service Providers for People with Disabilities), EDF (European Disability Forum), ENIL/ECCL (European Network on Independent Living/European Coalition for Community Living), ESN (European Social Network), Eurochild, FEANTSA (European Federation of National Organisations Working with the Homeless), Inclusion Europe, Lumos, Mental Health Europe, as well as the United Nations’ Office of the High Commissioner for Human Rights – Regional Office for Europe and UNICEF.

Glossary

Deinstitutionalisation: It is the full process of planning transformation, downsizing and/or closure of residential institutions, while establishing a diversity of other child care services regulated by rights-based and outcomes-oriented standards

Community-based Care: It refers to the spectrum of services that enable individuals to live in the community and, in the case of children, to grow up in a family environment as opposed to an institution. It encompasses mainstream services, such as housing, healthcare, education, employment, culture and leisure, which should be accessible to everyone regardless of the nature of their impairment or the required level of support.
Collection of country fiches

Analysis of the implementation of deinstitutionalisation & the development of community-based Care
Legal & Policy Context

Monitoring bodies

Children

The Federal Ministry for Family and Youth installed a Monitoring Board for Children’s Rights as an independent advisory body. The Monitoring Board for Children’s Rights comprises child and youth advocacies from the states, representatives of the Network for Children’s Rights and renowned experts in their fields of child and adolescent psychiatry, youth surgery, demographics, pedagogues, law and youth welfare. The installation of the Monitoring Board on Children’s Rights has created a permanent mechanism for coordination, drawing on a line of experts from diverse fields (health care, law, new media and more), the child and youth advocacies of the individual states and related NGOs as well as involving ministries and state governments and is not merely a symbolic gesture, but a pragmatic step towards the full implementation of the Convention on the Right of the Child in Austria” (3).

People with disabilities and People with mental health problems

The Federal Disability Act) establishes a Monitoring Committee that monitors the domestic implementation of the Convention on the Rights of Persons with Disabilities. According to the Federal Disability Act the members of the Committee must be independent and may not be bound by any directives and orders. (4) In some of the Länder monitoring committees have been established as well: So in Vienna, Tirol, Lower Austria and Upper Austria. It has been criticised that regional Monitoring Committees as well as the national one don’t adhere to the Paris Principles. (5)

In an amendment to the Federal Disability Act, an Ombudsman for the Equal Opportunity of People with Disabilities (Disability Ombudsman) was created. The Disability Ombudsman is responsible for providing advice and assistance to persons who feel discriminated against according to the prohibition of discrimination in the Disability Equality Act. (6)

EU Structural Funds

The ESF budget for Austria 2014-2020 amounts to 442 Mio. EUR plus co financing through national partners (1). The partnership agreements between the EU and Austria contain horizontal principles amongst them accessibility and non discrimination of people with disabilities. According to ÖAR the main challenges are the lack of controlling/monitoring mechanisms and hence the implementation and enforcement of these principles. The Federal Ministry of Labour, Social Affairs and Consumer Protection (BMASK), Unit VI/9, is responsible for the overall coordination of the ESF in Austria (2).

Progress toward DI

Children

The transition from large institutions to smaller forms of care is not completed. The City of Vienna has set the agenda with its program „Heimreform 2000“ that intended to replace all large residential homes for younger people radically towards decentralised residential groups (still) with a maximum of 8 inhabitants. Also in the other Länder the process is in progress. According to the „principle of Life-Space“ children should be accommodated close to their community of origin. This principle has been adopted in the operative work of the child and youth services. Still not included in this principle are children with disabilities. The City of Vienna has set the agenda also in this matter having closed large residential homes for younger persons with disabilities. In the rest of Austria there is no consensus, that the children and youth services are responsible for all of the children. In Lower Austria for instance the matters of children with disabilities are still handled by 2 divisions.

The federal Ministry for family and youth is responsible for the frame of DI for children and youth. The 9 provinces (Länder) are responsible for the implementation. There is a long and extended culture of residential care.
Lobbying for DI seems a little bit blocked by care providers. On the other hand in each federal country there is an “ombudsman” for children. These ombudsmen could play an important role to provide political exchange and influence towards DI.

Challenges DI for children: Inclusion of children with disabilities and mental health problems, Support of vulnerable children and young persons showing behavioural problems/criminal offenders. Beyond projects there is still not enough collaboration between children and youth services and justice, Support of underage asylum seekers, there are merely no care centres, Promoting and building up a professional system of foster-parenting as an alternative to residential care, Care centres for children with psychosocial disabilities are very rare; Working on unified, national standards for residential care.

People with disabilities

“In Austria, human rights of persons with disabilities are neither recognized nor guaranteed in various areas. Thus, the shift of paradigm as stipulated in the CRPD has largely not been realized in Austria (e.g. an indicator for this is that it is still the Ministry for Social Affairs, which is mainly responsible for the Federal Government’s obligations towards persons with disabilities). Comprehensive accessibility (physical, intellectual, social and communicative) is lacking. Inclusion of persons with disabilities in the area of education and work is not ensured. Moreover, measures to realize independent living are lacking.” (7)

It appears that very few development have been made since the last UNCRPD recommendations. “The segregating system continues unabated, reforms towards inclusion, accessibility, self-determination and participation remain limited half-heartedly as before or pilot projects. There are also setbacks (e.g. in education and in the area of accessibility). For people with disabilities directly and existentially important issues such as personal budget, personal assistance, de-institutionalization and supported decision-making are not or not sufficiently regulated by law. (8)

The Austrian National Council of Disabled Persons (ÖAR) criticizes that there is no systematic coordination system of data collection in the field of disability services. The national report instead provides a set of examples of types of services provided across the different provinces. Data on types, size and residents of institutions would be necessary.

The strategy of the Austrian federal government for the implementation of the CRPD is written down in the NAP on disability 2012-2020. The NAP covers DI only in one passage: “In the field of housing, a comprehensive de-institutionalisation programme is necessary in all nine Länder. In this process, large institutions need to be broken down and at the same time support services created which also enable people requiring a high level of support to lead an independent life in their own homes. The principle has to be that those affected can choose the form of housing which suits them and the support services they need.” (9)

Support in the community

In the aspect of DI Austrian NGOs see personal assistance as an important alternative to institutional segregation of people with disabilities. In Austria concepts and programs for the depletion of institutions and for the composition of community based support systems are lacking.

Involvement of Stakeholders

Involvement of persons with disabilities in Austria are organized in numerous groups and organizations, which nonetheless are mostly confined to urban areas. Apart from ÖAR (Austrian National Council of Disabled Persons) there are independent Living Groups and various groups of persons with disabilities. Also, organizations of the church such as Caritas or Diakonia participate in policy discussions regarding persons with disabilities.

Although in Austria persons with disabilities and their representative organizations are invited to comment on reviews of laws or other measures, frequently their comments are not taken into account. This is either due to opposition of the rather influential Austrian commerce sector or for reasons of supposed lack of funds. Therefore, equal participation in all areas of society, as enshrined in the CRPD, has in fact not been realized in Austria.
Legal & Policy Context

The following policies relate to DI. There are no specific legislation as such and there is no coordinating structure at any level.

- Policy for the Protection of Children Deprived of Parental Care and Families at Risk of Separation in FBiH, 2006-2016
- Republika Srpska Strategy for Enhancement of Social Welfare of Children Without Parental Care, 2015-2020
- Strategy for deinstitutionalisation and transformation of institutions in Federation of BiH, 2014

Legal Capacity

Decision to deprive or revert legal capacity may be appealed by any person who participated in the proceedings within three days of receipt of the decision. The person whose legal capacity has been taken away may appeal regardless of their health status. The appeal does not stay the execution of the decision, unless the court for good cause, decides otherwise. Court of First Instance will appeal to the writings without delay to the appellate court, which is obliged to decide within three days after receiving the complaint. (10)

Inclusive education

Inclusive education is foreseen by local education laws. However, implementation is lagging behind, largely due to lack of funds to train and hire sufficient number of individual assistants in schools.

Budget allocation

No mechanisms to re-route funds exist. Allocations for development of community based services are allocated from cantonal, and municipal budgets to a minor extent, and largely supported through international projects.

EU Structural Funds

Progress toward DI

Data

There are approximately 1,000 children without parental care in institutions and approximately 600 children with disabilities in institutions. About 1,700 adults with disabilities are in institutions.

Support in the community

Different types of support in the community exist, such as day centers, assisted living, early intervention programmes, counselling services provided by NGOs – however mainly only present in larger, urban centers. These types of services largely depend on donor funding, only few actually integrated in the system.

Involvement of Stakeholders

Some examples

Family support programme – Hope and Homes for Children: supporting families at risk of separation, involvement of all relevant stakeholders in the community
Young adult support programme – Hope and Homes for Children: supporting young adults leaving public care on their road to independence, involvement of all relevant stakeholders in the community
Assisted living in the community for persons with disabilities – SUMERO Alliance for support to persons with intellectual difficulties, involvement of relevant entity and cantonal ministries of social welfare, centres for social work
Early childhood development centres – UNICEF
Drop-in centers for street-involved children – Save the Children
**BULGARIA**

**Legal & Policy Context**

**UNCRPD**

The coordination for its implementation is delegated to MLSP. Ministry of Labour and Social Policy leads the policy for people with disabilities and the Minister is the Chairman of the National Council for the Integration of Persons with Disabilities (NCIPD). Two Action Plans for implementation of the UNCRPD were approved by the Council of Ministers, i.e. covering the periods 2012-2014 and 2015 – 2020. The plans are focused on art. 12, art. 19 and art. 27. According to local organizations the plan is not ambitious and will not lead to substantial changes. A special body – Agency for people with disabilities is responsible to support the national policies for people with disabilities.

**Legislation**

All social services are regulated by the Social Assistance Act and its Implementing Regulations. In addition, social services for children are also discussed in the Child Protection Act. Both acts stipulate the use of institutional care as a last resort.

In January 2016 the Parliament adopted amendments to the Social Assistance Act with relation to the access to community based services. The amendments include:

- the definition of the objective of social services is improved and they are aimed to support the social inclusion;
- new obligatorily assessment is added to the medical expertise;
- the persons under guardianship receive the right to be hearth about their willingness what service to use.

Still the list of social services in the SAA is too limited as possibilities for independent life and too conservative as approach. Despite the good practices there is no legalization of home based support for elderly people, persons with disabilities and health problems and for persons with mental health problems.

**Strategy**

Relevant strategic documents are:

- National Strategy for Long-term Care adopted by the Government

Currently a new Action Plan for the implementation of the Vision for DI as well as a new Concept and Action Plan for DI in the Ministry of Health are being developed. Ministry of Labour and Social Policy is currently developing a plan for DI of care for elderly and people with disabilities 2016 – 2020. There is idea on strategical level to close institutions for adults but there is no plan to improve substantially the quality of live there in the meantime. The rules for delivering support in specialised institutions are not improved in the line with UNCRPD. Drafts of strategies for implementation of art. 1, 2, 12 and 19 of UNCRPD are under preparation.

**Legal Capacity**

There are good practices in the country piloting new approach - Supported Decision Making which supports people to follow their own decisions and will and to keep their civil rights. Recent monitoring of the conditions in the specialised institutions conducted by Helsinki Committee shows that for the persons placed in institutions there is no difference if they are under guardianship or not, as for all the residents the fundamental and civil rights are not fulfilled. Under preparation is a new act according to the art. 12 of the Convention which is directed to introduce a new form of support for persons with intellectual difficulties and mental health problems regarding their civic participation and civil rights. The new act aims to eliminate the existing full and partial guardianship for people with mental health problems. The new act was elaborated by Ministry of Justice and it is expected that will be adopted.
Inclusive Education

In September 2015 the National Assembly adopted a new Law on pre-school and school education, which reinforces the right of every child with disability to receive education in the mainstream system, and establishes the necessary institutional arrangements to support inclusive education. It also envisages special schools (with the exception of schools for children with visual and hearing impairments) to be closed and transformed within 1 year after the law enters into force into Centers for specialized pedagogical support. At present the country is developing a Standard on inclusive education which will further develop the national framework on inclusive education. (13)

Budget allocation

Social services are funded mainly by: Subsidies from the state budget to the municipalities and local revenues of the municipalities The total planned subsidy from the state to the municipalities for provision of social services (residential and community-based) for 2016 is almost 100 million Euros.

Re-allocation of funds from institutional to community-based services is performed by the Agency for Social Assistance in any case of reducing the capacity or closure of an institution with corrections to the budgets of the municipalities. There is no mechanism for re-allocation of funds in the case of closure of Infant Homes, which are managed by the Ministry of Health.

EU Structural Funds

Progress toward DI

Children

The number of institutions and institutionalized children in the country was significantly reduced since 2010. During 2015 alone 31 institutions for children were closed. The number of institutions and children placed in them since 2010 was reduced. (14)

Adults

The process of elaboration of the first plan for DI for adults has just started. It includes development of new residential services with a capacity for 20 people located more or less in the same localities as the existing institutions (small towns and municipalities with very limited number of population and with explicitly written intention to involve the same personal in the new services). The plan so far does not include measures for training and capacity development and the functional requirements for the new residential services copy the structure of the specialised institutions with the limited personal space, no access to domestic activities and kitchen and with no space for activities by interest and in small groups. The proposal faces a strong opposition from the NGOs.

<table>
<thead>
<tr>
<th>Institution</th>
<th>December 2015</th>
</tr>
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<tbody>
<tr>
<td></td>
<td># of institutions</td>
</tr>
<tr>
<td>Homes for People with Mental Retardation</td>
<td>27</td>
</tr>
<tr>
<td>Homes for People with Mental Disorders</td>
<td>13</td>
</tr>
<tr>
<td>Homes for People with Physical Disabilities</td>
<td>21</td>
</tr>
<tr>
<td>Homes for People with Sensory Impairments</td>
<td>4</td>
</tr>
<tr>
<td>Homes for People with Dementia</td>
<td>14</td>
</tr>
<tr>
<td>Homes for Elderly People</td>
<td>81</td>
</tr>
<tr>
<td>Total # of institutions</td>
<td>160</td>
</tr>
<tr>
<td>Total # of people</td>
<td>10 990</td>
</tr>
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Support in the community

<table>
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<th>Facility</th>
<th>Capacity</th>
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<td>Community Support Centre</td>
<td>4537</td>
</tr>
<tr>
<td>Street Children Centre</td>
<td>291</td>
</tr>
<tr>
<td>Centre for Social Rehabilitation and Integration of Children</td>
<td>1472</td>
</tr>
<tr>
<td>Day Care Centre for Children with Disabilities</td>
<td>1944</td>
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<tr>
<td>Day Care Centre for Children and Adults with Disabilities</td>
<td>411</td>
</tr>
<tr>
<td>Shelter</td>
<td>30</td>
</tr>
<tr>
<td>Crisis Centre</td>
<td>166</td>
</tr>
<tr>
<td>Mother and Baby Unit</td>
<td>67</td>
</tr>
<tr>
<td>Family Type Placement Centre for children and young people without disabilities</td>
<td>1564</td>
</tr>
<tr>
<td>Family Type Placement Centre for children and young people with disabilities</td>
<td>1655</td>
</tr>
<tr>
<td>Transitional Home</td>
<td>148</td>
</tr>
</tbody>
</table>

Training of professionals

Training of professionals was part of national DI projects for children, however it was very limited in terms of duration. 4621 professionals were trained under the DI projects for children in the period 2010 – 2015 (data provided during a seminar organized by UNICEF and the State Agency for Child Protection in January 2015). Training for staff in new services is planned to continue with EU funds. There is no nation wide system for capacity building, training and supervision to professionals.
Legal & Policy Context

There isn’t specific legislation which contemplates a full transition from institutionalised care to community-based services/care. There’s, at best, an approach towards deinstitutionalization in the National Health Strategy and is not fully legally binding and varies depending on the region if the autonomic region has competences on the subject (for example Catalonia have competences in health, social services and the law system) so it focuses to develop a more progressive approach towards the transition from institutionalized to community-based care than the rest of Spain, or at least, it works different.

Two important legislation concern community based care:
- Ley 26/2011 normative adaptation to the Convention on the Rights of Persons with Disabilities). Basically this law, as a general rule, recognises several principles: respect to the dignity, the right to independent living, equality of opportunities, non-discrimination and universal accessibility. It applies to: telecoms, information, public spaces, infrastructures, transportations, goods and services, relations with the public administrations, justice administration, cultural heritage and labour. It was born to ensure protection in all spheres of an individual’s life.
- Real Decreto Legislativo 1/2013 de 29 de noviembre, approves the revised text of the general la won the rights of persons with disabilities and their social inclusion). Its objective is to guarantee the right to equal opportunities and treatment of individuals with disabilities as well as the real and effective exercise of rights of persons with disabilities as the Spanish Constitution and the CRPD recognises. It also establishes a regime of sanctions and penalties in case of infringement.

DI is highly encouraged in national health strategies, especially in our region, which embed in its objectives deinstitutionalization as a strategic line or objective to achieve in subsequent years according to the integral action plan for people with mental health impairments and drug addiction.

Inclusive education

In Catalonia, there are opportunities for people with disabilities to enjoy the right to education in a non-segregated centres (even though segregated centres exists as well as special education centres) in all stages of an individual education: childhood, primary and secondary education (mandatory) and post-obligatory education. Its implementation depends on economic resources of the centre and the form of support the person need previously assessed in an individualised curricular plan elaborated by the CAD (Diversity Attention Commission). The CAD is a special commission inside the school integrated by the management team, teachers specializing in attention to diversity (special education teachers, counsellor of the centre, therapeutic education teachers, psychopedagogues and the studies coordinator).

Budget allocation

Community-based services are publicly underfinanced given that demand of those services exceeds its public offer. Community-based services are offered mainly by the Social Service System through its Portfolio of Services (detailed later) and to a lesser extent by the Health Care System, still highly dependent on hospital settings and institutions to offer attention to its users.

However, in our region, there’s a trend towards decentralizing mental health services from the hospital which in practice translates into mobile teams (mainly psychiatrists) that visit patients in its home. However we can’t provide specific data or asses its effectiveness and impact because it’s in a pilot stage. If you are not eligible to enjoy a publicly concerted service you need to contract it in the private sector; people with complex needs and with complex situations due to disabilities receive welfare benefits, albeit the monthly income proceeding from benefits is generally lower than minimum wage. In that situation, an efficient use of resources alongside with high doses of creativity is required to enable an individual to enjoy independent living or support in the transition to institutionalized care to community integration.
EU Structural Funds

Progress toward DI

Support in the community

In Catalonia, institutions and services available are offered – and subsequently are dependant – either through the Health Care System or through the Social Services System. The Portfolio of Social Services (in form of resources, institutions and services) available is organized by categorizing its user base in different typologies. The following data is extracted from the Specialised Social Services Report and it comprises the entire Catalonian territory (divided by its 4 regions: Barcelona, Girona, Lleida and Tarragona).

**Elderly People**

Assisted-living facilities. (+65 years. 24/7). 997 Equipment & Services
Day-care centre. (+65 years). 880 Equipment & Services
Supported Housing. 50 Equipment & Services
Long-stay socio-sanitary centre. 100 Equipment & Services
Day-care hospital. 73 Equipment & Services
House assistance services. 102 Equipment & Services

**Intellectual Disabilities**

Occupational Centres. 264 Equipment & Services
Specialised day-care centre. 44 Equipment & Services
Residential centres. 91 Equipment & Services
Residential homes. 236 Equipment & Services
PSALL (Autonomy support in an individual's home). 71 Equipment & Services

**Physical Disabilities**

Occupational Centres. 19 Equipment & Services
Specialised day-care centre. 13 Equipment & Services
Residential centres & Residential homes. 27 Equipment & Services
PSALL (Autonomy support in an individual's home). 13 Equipment & Services
Personal Assistant. 8 Equipment & Services

**Psychosocial Disabilities**

Residential centres. 39 Equipment & Services.
Supported Housing. 94 Equipment & Services
Pre-laboral Service (Guidance, formation and training). 39 Equipment & Services
Social Club. 52 Equipment & Services
PSALL (Autonomy support in an individual's home). 35 Equipment & Services
**Legal & Policy Context**

There is a new government from November 2014. All DI plans started by previous governments formally continue, but leadership is not so visible. For example the MoLSA deputy minister responsible for social services is openly supporting idea of refurbishing of institutions as alternative to DI process.

**EU Structural Funds**

OP are in process to be agreed. It is calculated with a special program for transformation of mental health care, special program for continuity of transformation of social care homes and there are special programs for the reform of institutional care for children. All together for DI project is planned about 300-400 million Euro. The partnership agreement targets early-childhood education and care services (by increasing offer and ensuring quality), including integrated approaches combining childcare, education, health and parental support, with a particular focus on the prevention of children’s placement in institutional care. Support the transition from institutional care to community-based care services. Ministry of Regional Development (investments), Ministry of Labour and Social Affairs are the structure managing the funds.

Currently there are a considerable number of projects and measures which are financed through ESF and ERDF. We have on-going projects and a new call for proposals for regions and social service providers for:
- support of new community-based social services;
- community planning;
- process of de-institutionalisation etc.

**Progress toward DI**

Although in recent years can be seen various positive efforts, the deinstitutionalisation process in the Czech Republic has been slow and unsatisfactory. The number of people with disabilities in residential care has only slightly decreased. Most of policy documents and pilot programs do not have a clear plan for continuation.

**Data**

In a year of 2013 there were 418 residential care homes for people with disabilities (18 beds and more), with total capacity 16,000 beds, of whom 1,045 are children with disability. In recent years, there is significant growth in number of care homes with “special regime” – these are mainly used for people with dementia and for people with challenging behaviour (incl. people with autism, mental health issues etc.). Number of people in these institutions is about 8,000. There are about 38,000 older people living in residential care homes as well.

In 2012 there were under the health resort 33 institutes for infants and homes for children up to 3 ye. Capacity of these institutes was 1,700 places and at the end of year there were placed 1,397 children. Under the education resort there were 6,941 children in children homes. There is 9,300 beds in psychiatric hospitals. About 3,000 beds are for long stay clients, rest of this capacity is for acute admission and short stay clients.

**Project**

Ministry of Labour and Social Affairs has begun in 2010 implementing a project of deinstitutionalisation (called “Support for the transformation of social services”) in the framework of the EU Integrated Operational Programme with a budget of EUR 56 million. The aim of the project was to support the transformation process of residential social care, by validating pilot transformation of social care based on individual users’ needs for social services. Individual projects have received 100% funding of the total cost.

32 institutional facilities across Czech Republic have been involved in this project. They provide services for approximately 3,800 persons with disabilities. Again no further plans are proposed or designed with those institutions. The project’s goal was to conduct a pilot test of deinstitutionalisation, including comprehensive plans, staff training, and assessment of service users’ needs. By creating networks of group homes in the community, these initiatives should reduce the capacity of large institutions and lead to deinstitutionalisation.
This programme was focused on the entire territory of the country with the exception of the capital city of Prague. There is no interim report available on the progress of the project so far.

In March 2013, the project Support of the Transformation of Social Services ends. However, evidence suggests worries regarding the shortage of national resources for the new residential social services after the completion of the EU project.

As of end of 2013, thanks to this project 544 people with disabilities left institutions to live in new conditions: 130 went on to live with their families, friends. 414 lives in community based social services.

Main issues following DI of social services for people with disabilities:
- in some of those 32 institutions, the transformation process will not be finished by end of 2015 due to lack of finances (e.g. Pata Hazlov) or troubles within the administrative process and/or resistance from local communities (Domov Sluneční dvůr, Jestřebí)
- part of ESF money which is being used for “transformation” creates new or rebuilds existing institutions – esp. regional operation programmes which lack clear guidelines on DI (see Domov Beruška, Ostrava)
- transformation activities lead mostly to the creation of group homes (with up to 18 people), while individual solutions are limited
- no clear guidelines for new ESF programming period regarding the type of services that may get funding – MoLSA states preparation of new criteria; so far, there are no documents and Integrated operational programme states it is possible to finance “humanization” of existing institutions.

Children
On 19 January 2009, the Government adopted the document “Draft of transform of the system of care for vulnerable children - the basic principles. Interagency coordination was established. Later on in 2009 Nationla Action Plane of Transform and Unify the System of Care for Vulnerable Children was adopted.
There is certain progres and number of capacities in institutional care for children is slidelly reducing. But the current system of care for vulnerable children i s still very complicated and confusing. The topic of vulnerable children directly addresses five ministries. Children institutions are in charge of three different ministries. Coordination of activities of all these departments and agencies under these ministries operating is insufficient.

Persons with psychosocial disabilities
In 2013; the Ministry of Health accepted a document “Strategy of the reform of psychiatric care”. Although this document have main aim to improve quality of life of people with psycho-social disability, the document is rather general and transformation of institution to community based care is not mentioned. The process of detailing a strategy and preparation of pilot project are in progress.
Although there is a plan of transformation of institutional care Norwegian funds are actually used for refurbishing institution to create better condition for “rehabilitation” and preparation of clients for discharge. In some hospitals this funds are used for building up “ training housing” within hospital premises.

Homelessness
In relation to the homeless people, the housing-led approach is not well developed. It is very difficult for people to progress from shelter use into an apartment. There is no comprehensive system of social housing, or housing assistance. Some cities provide some form of housing according, but other cities have sold almost all apartments into private ownership or cooperatives during the transition from communism. A comprehensive strategy document for combating social exclusion for the period 2011-15 refers to social housing (emergency housing/shelters, temporary accommodation, training housing, and long-term social housing/housing).

Support in the community
Several legislative proposals on Social Services. have been submitted, aiming to introduce:
- new principles of using social services: firstly by referring to mainstream services and resources in community, secondly to field and ambulant social services and at last to residential community-based services;
- new measures, i.e., in community planning and referring to the obligations of the social services providers, If accepted, the proposals should be incorporated as amendments to the Act of Social Services. One proposal has been accepted so far – sheltered housing cannot be attached to/take place in institution or on its grounds.

Involvement of users
DENMARK

Legal & Policy Context

The law on Social Service was changed in 1998 where the concept ‘Institution’ was taken out of the law. That meant that Housing under the Social law is by law separated from the personal support given by Social law. However, even though institution is formally not a part of the law, in practise some Municipalities connect support with housing and thereby we do see some institution-like constellations on the practical level. Housing under the Social law is primarily for people with LD or intellectual disability.

There is no National strategy for DI. In relation to children it has been a tradition for many years that children live at home if at all possible and legislation gives different possibilities for the parents to get support at home.

Inclusive education

A new law was implemented in xx with the goal of including 96 % of children with disability in primary school. Due to how this was done in practise, the Government has just decided to abandon that goal. However 95,2 % of children with disability is now included due to the former legislation and 4,8 % is in special schools.

Budget allocation

Since Institutions is formally nonexistence in law, there are no mechanisms to re-route money.

EU Structural Funds

Progress toward DI

Data

There are no data on how many people living in large institutions. The latest data on how many people living in housing under the Social law is from 2012. These data shows that approximately 14.000 adults from 18 and up lives in housing under the Social law. However the size of these residencies varies from about 6 people living together to more than 200 living together.

Since 2012 there has been a change in national data-collection and there is only data from 32 out of 98 Municipalities. An un-published rapport (will be published later on in the fall) from the Danish Institute For Human Rights show that around 1/7 of all new-build residence for people with disability has room for 60 people or more.

Support in the community

Almost all services for people with disability except certain healthcare services are based at Municipality level. The residencies under the Social law can be either private or public, but it is the Municipalities that have the authority to refer people with disability to housing under the Social law. There are 98 Municipalities in Denmark. A few percentages of residencies are based at Regional level. These are mostly specialised residencies with specialised services, but it is still the Municipalities that have the authority to refer to these residencies.

Involvement of users
Although we have seen the closure of long-stay institutions, we still have a long way to go to achieve full independence for people with a learning disability in the community. Government policy formulated in the wake of the Winterbourne View scandal reinforces both the policy on independent living and the personalisation agenda. It is clear that people should be getting personalised support in their community. It is recognised that too many people have ended up in inpatient settings because of a lack of the right support and services in local communities.

There is now an NHS England led closure programme to develop the right support and services for people with a learning disability and behaviour that challenges in the community and close inpatient units.

The few following legislative act impact the development of community based care:

- The Care Act 2014 is a new piece of legislation covering adult social care. It has a focus on wellbeing, prevention and personalisation. It refers to the UNCRPD and the guidance says that ‘supporting people to live as independently as possible is a guiding principle in the Act’.

- The Mental Capacity Act is the law designed to protect and empower people who may lack capacity to make decisions. It says that adults have the right to make their own decisions wherever possible. If they are unable to make their own decision (because they lack the ‘mental capacity’ to do so) then others may make a best interest decision for them but the person must still remain at the centre of any decisions made.

The Deprivation of Liberty Safeguards (DoLS) 2007: These are part of the MCA and are intended to provide safeguards for people who lack capacity to consent to the arrangements for their care and where their support arrangements are so restrictive that they are considered to be ‘deprived of their liberty’. The idea is that there are safeguards in place to ensure such a level of restriction is in their best interests, properly authorised and monitored.

- Mental Health Act (1983) is the law which sets out when someone can be admitted, detained and treated in hospital (inpatient setting) against their wishes.

In February 2015 Simon Stevens, CEO of NHS England, committed to a closure programme in front of Parliament’s Public Accounts Committee. This closure plan was published in October 2015: ‘Building the right support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition’ (NHS England, Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS)).

The key target in the closure plan: Overall, 35-50% of inpatient beds will close nationally in the next 3 years, with alternative care provided in the community. To accompany the closure programme, NHS England, LGA and ADASS have published a national service model: ‘Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.’ This sets out the range of support that should be in place no later than March 2019.

**Budget allocation**

There is some funding attached to the NHS England led closure programme of in-patient beds. It has been recognised that there are financial disincentives in the system (for example, if someone is sent to an inpatient unit, Health will fund the placement whereas in the community they may be funded through social care or a joint package of social care and health. In addition, if someone is in a secure unit rather than a non-secure unit then local Health funding doesn’t pay, NHS England specialist commissioning does). This agenda straddles health and social care and there are real concerns that the adult social care system is chronically underfunded. It is important to be aware of this context.
Recent announcements (November 2015) by the
government to give local councils more scope for increasing
local taxes (Council Tax) specifically to fund social care, are
not expected to raise anything like the amount of money
claimed.

**EU Structural Funds**

**Progress toward DI**

There was a failure over the following 2 years to meet the
target to move people with a learning disability and
behaviour that challenges out of inpatient settings and back
to their local communities by June 2014.

To date little has changed for individuals and their families
(see data on inpatient numbers below). Many families have
been campaigning for a number of years to get their loved
ones out of in-patient settings and supported in the
community, nearer to home. New families continue to
contact support organisations, new petitions are being
launched by families calling on the NHS and local areas to
deliver the changes promised. Their stories are regularly
features in the media. In short, families are still having to
battle to get loved ones out of units.

The Learning Disability Census 2013, 2014 and 2015 have
shown the number of people with a learning disability in
inpatient units and information about their experience in
these settings. This has been a yearly snapshot looking at
data from providers of inpatient care.

Figures from the Learning Disability Census 2015 include:
- the estimated total number of people with a learning
disability in inpatient units is 3,480.
- there are 165 children in inpatient units.
- Of patients receiving inpatient care who were included in
  the Census:
  - 72% had received antipsychotic medication, yet only
    28.5% were recorded as having a psychotic disorder.
  - 1,670 had experienced one or more incidents (self-harm,
    accidents, physical assault, restraint or seclusion) in the 3
    months prior to census.
  - Average length of stay in an institution is 4.9 years.
  - 670 people are 100km or more from home.

**Support in the community**

**Involvement of users**
**ESTONIA**

**Legal & Policy Context**

Estonia is about to begin the working ability reform, which will create a new performance of the working ability support system. (15) The aim of the amendments is to change attitudes towards people with reduced working ability and to help them find and keep a job.

Each person with reduced working ability will be approached individually, assessed on its ability to be active in the society, and, consequently, helped to find opportunities in the labour market. Also, a future employer of the person is dealt with separately, in order to find labour relationship solutions necessary for both parties.

People with reduced working ability are paid are working ability allowance. (16) The Reform started from 01.01.16. By 2020, the public sector will have employed at least 1,000 people with decreased working ability.

The main objective of the new Work Ability Allowance Act is to preserve a person’s work capacity, activate people with lowered work capacity, prevent unemployment and return people to work. (17) The purpose of this Act is to support employment and access to employment of persons with reduced work ability caused by long-term health damage and to ensure an income for them under the conditions and to the extent provided by law. This Act establishes the bases for assessment of work ability and the conditions of and procedure for grant and payment of work ability allowance.

**Strategy**

The following general goal has been established for the Special Care and Welfare Development Plan: ensuring adult persons with special mental needs with equal opportunities for self-realisation and high-quality special care and welfare services that are in line with the principles of de-institutionalisation.

Three sub-goals have been established to reach the general goal:
1) adults with special mental needs are ensured with equal opportunities for self-realisation;
2) special care and welfare services comply with the principles of de-institutionalisation;
3) special care and welfare services are of high quality and offered by qualified and professional service providers.

The Strategy of Children and Families for 2012-2020 (hereinafter named as Strategy) and its Action Plan for 2012-2015 constitute an integrated multi-dimensional policy framework for tackling child poverty and social exclusion and for promoting child well-being in Estonia. The objectives of the Strategy together with the implementation measures and activities focusing primarily on prevention enable to increase effectiveness of the work in the area of child and family policy.

The Strategy is also in conformity with the government’s family policy objectives as well as with development plans and strategy documents of the Ministry of Social Affairs and of other government agencies. Synergies between relevant policy areas and players are guaranteed by involving more than one hundred experts in the area of children and families as well as decision-makers at different levels already in an early stage of the strategy-making process. However, the success of the Strategy depends on the provision with resources and improved capabilities at all levels.

**Inclusive education**

Special education needs are managed under Ministry of Education and Research. The state runs schools with visual, hearing or speech impairment, mobility disability (coupled with an educational special need), multiple disabilities, intellectual disability, emotional and behavioral disorders as well as for students with chronic somatic illness who need special educational attention. (18)

**EU Structural Funds**

The DI coordinating structure is the Ministry of Social welfare.
Progress toward DI

There are two types of data collection and public information sources available (unfortunately in Estonian) about care services and statistics: collected social welfare data from local authorities and aggregates social welfare statistics and reports, presented by social welfare institutions. (19) Regarding the types of institutions that exist, information and data are also available on these above stated sources.

Support in the community

Estonia is currently in process preparations to create community based services also for other bigger institutions for adults, to close large institutions by 2023.

Training

Professionals working with children in residential care institutions - their qualifications are indicated by Social Welfare Act. Foster carers providing home-based care currently will have to pass only required PRIDE (the only training program accepted by Estonian government currently) pre-training. No follow up training is required. Its performed by voluntary and charitable organizations by project based means. Training needs and systems for foster care is currently under re-assessment by government.

Involvement of users
Legal & Policy Context

In Greece, one can speak of a “no model” / “no answer” paradigm. There is a complete absence of a systematic public approach to mental disability area, to persons with intellectual disabilities, to persons with autism, to persons with physical disabilities etc. In Greece there is no de-institutionalisation strategy in place.

Nevertheless, actions regarding the Psychiatric reform are included in the Greek Operational Program “Development of Human Resource 2007 – 2013” (Ministry of Labour, Social Security and Welfare – Axis 5). The Supported Living Housing is co-financed both by the Regional Operational Programs 2007 – 2013 (Greek Prefectures) and Operational Program “Development of Human Resource 2007 – 2013”. This is a very positive element.

In Greece, the Ministry of Labour, Social Insurance and Welfare (Directorate Welfare) is responsible for the Supported Living Housing and the Ministry of Health (Directorate of Mental Health) is responsible for the Psychiatric Reform.

According to the texts of the new Operational Programs for the programmatic 2014 - 2020, which has recently been approved by the European Commission, only the Regional Operational Programs (13, one per Region) will be responsible for the implementation of actions under the Thematic Goal 9 “promoting social inclusion, combating poverty and any discrimination” of the Regulation (EU) 1303/2013 (please refer to article 9 of the above-mentioned Regulation).

Since February 2014, the role both of the focal point and the coordination mechanism of the UNCRPD article 33.1 has been assigned to the Directorate of International Relations/General Directorate of Administrative Support and e-governance /Ministry of Labour, Social Security and Welfare. Thus, this Directorate is also responsible for the monitoring of the implementation of the Article 19 “Living independently and being included in the community”.

EU Structural Funds

Partnership Framework

In the framework of the obligations derived from the Memorandum which was signed by the Greek Minister of Health and the Commissioner of Employment, Social Affairs and Inclusion Mr. Laszlo Andor, the Thematic Goal 9 “promoting social inclusion, combating poverty and any discrimination” of the Greek Partnership Agreement states (on p. 104) that interventions for the finalization of mental health services and the sensitization and upgrade of skills of the staff in health area will be promoted as well.

Progress toward DI

People with mental health problems

The Greek Psychiatric reforms began in the early 1980s with the introduction of the National Health System and the financial support of the then European Community. Result: The de-institutionalization of patients from psychiatric hospitals has almost been achieved. Psychiatric hospital beds have been reduced, psychiatric units in general hospitals have been developed, a basic number of community mental health services has been established.

New legislation has been introduced. However, psychiatric units in general hospitals and Community Mental Health Centres have not yet fulfilled their role as principal providers of psychiatric care, while decentralization, sectorization and completion of the network of mental health services has not been completed.

The reform of mental health services in Greece has been evaluated by various groups of experts over the last decade. Despite their many positive remarks underlining the progress accomplished both in policy and in public attitudes towards mental illness, these reports have systematically identified a series of structural problems that were already obvious long before the current economic crisis. Needless to say, that during the economic crisis the financing of the bodies of the Psychiatric Reform program “Psychargos” has decreased significantly.
These problems include: a) lack of specific data regarding the budget for mental health within the total health expenditure, b) the Mental Health Law (1999) and Policy decisions are not implemented, c) two systems (old asylums & new community services) are operating in parallel, d) the services system is fragmented, inconsistent and lacks coordination d) there are major gaps in service provision for children and adolescents, e) There is inequality regarding access to services, with different types of services in different areas and few areas with a full range of services, f) The Greek Government is not respecting its commitments to the European Union that instigated a large part of the mental health reform policy: this is particularly true for the “Spidla Agreement” that was signed in 2009 by the Ministry of Health and the European Commission regarding: i) continuing to reform the system (closing down psychiatric hospitals and building networks of services in the community), ii) providing sufficient funding, iii) putting into place monitoring and evaluation mechanisms.

In May 2012, a memorandum was signed by the Greek Minister of Health and the Commissioner of Employment, Social Affairs and Inclusion Mr. Laszlo Andor, which has been so far implemented. The following important issues were foreseen: i) the abolition of psychiatric hospitals until the 31st of December 2015, ii) the establishment of a viable new system of providing mental health services also by the end of 2015, iii) the support and extension of the Social Created Limited Liability Partnerships (KOISPE) and the continuation of their funding, iv) the continuation of the funding of new mental health units in hospitals and of the not for profit organizations of the private sector until the 31st of December 2015, v) the finding of a definite and permanent way to finance all these from the 1st of January 2016. These reforms are supported by the Operational Programme “Development of Human Resources “, Axis 5, until the end of 2015.

Support in the community

Involvement of users
Legal & Policy Context


Following the decree, the Coordinating Board for Deinstitutionalization was formed. The priority task of the Board is to evaluate the incoming implementation studies for the tender advancing the implementation of the Strategy, to formulate professional advice on the tenders based on the aims and principles of the Strategy, to assess the utilisation concept of the remaining infrastructure after the changes drawn up in the tenders, to monitor the developments, to assess the plans of professional trainings following the process and to oversee their implementation, to review the capacities of basic services, to ensure full transparency and to prepare the Action Plan for Institutional Transformation. Persons with disabilities, the organizations representing them, social support institutions, institutions of higher education specialising in social care and special education, as well as the service managers participate in the activities of the Board.

Inclusive education

Children with special educational needs are entitled to receive special educational and pedagogical care appropriate to their condition within the framework of special treatment from the date their entitlement was established. The special care must be provided in accordance with the opinion of the expert committee. The parent selects the educational institution appropriate for the child with special needs based on the opinion, taking into account the opportunities and needs of both the parent and the child.

Budget allocation

The subsidy for housing and the budget support for basic services will be recorded in the budget law: The state contributions to the operational costs of the particular social services are included in the subsidies for social services provided in the budget law. It is significant in terms of defining the subsidies that which manager is obliged to perform the specialised task or finance the particular fund, as well as which manager is entitled to finance it voluntarily as defined by the law (see Table 1.) The amount of subsidies depends on the particular target group the manager provides the particular service to. The amount of budget subsidies also depends on the type of the manager that provides the particular social care.

EU Structural Funds

Progress toward DI

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Type of care</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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Collection of country fiches: Analysis of the implementation of deinstitutionalisation

### Capacity of boarding social care institutions

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### Type of care

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### More Tables

#### Support in the Community

#### Involvement of Users
Legal & Policy Context

The Government launched the National Disability Strategy in 2004 and looked to tie together law and policy in the area of disability. This was to include existing and future legislation. (20) The elements of the strategy are:

- **The Disability Act 2005**: is a law brought in by the Department of Justice. The Act aimed to: Allow for an assessment of the needs of people with disabilities and a service statement; Improve access to public buildings, services and information; Ensure that certain Government Departments brought out Sectoral Plans outlining what improvements that department would take; Place an obligation on public bodies to be pro-active in employing people with disabilities; Restrict the use of information from genetic testing for employment, mortgage and insurance purposes; Establish a Centre for Excellence in Universal Design. The Centre would be charged with developing best practice guidance on how to design, build and manage buildings and spaces so that they can be readily accessed and used by everyone, regardless of age, size, ability or disability.

- **The Citizens Information Act 2007**: The primary purpose of the Citizens Information Act 2007 is to provide for a legal right to advocacy and the establishment of a statutory advocacy service called the Personal Advocacy Service. The Personal Advocacy Service would have legal powers to enter premises and make enquiries on behalf of persons in residential and day services. Service providers would be legally obliged to co-operate with the service. Personal Advocates would have the power to pursue any right of review or appeal on behalf of the person with a disability. However, this statutory advocacy service is not yet in place, and there is no date for its commencement. A National Advocacy Service was introduced by the CIB in 2011. This service replaced the 46 pilot advocacy projects, which were funded by the CIB between 2005 and 2010. The National Advocacy Service does not have statutory powers and service providers and other agencies have no legal obligation to co-operate with it.

- **The Education for Persons with Special Educational Needs Act 2004**: The EPSEN Act is currently on hold and the key sections that gave statutory rights to assessment, education plans and appeals processes for children with special educational needs have been deferred indefinitely. EPSEN defines “Special educational need” as a “restriction in the capacity of the person to participate in and benefit from education on account of an enduring physical, sensory, mental health or learning disability, or any other condition which results in a person learning differently from a person without that condition”. Under EPSEN, the following was envisioned as the system to assess children. However, this system is not yet in place, and there is no date for its commencement. There are three types of education provision for children with special educational needs, mainstream, special classes within mainstream and special schools. EPSEN says that children should be educated in an inclusive setting unless this would not be in the best interests of the child or the effective provision of education for other children in mainstream education.

The National Housing Strategy for People with a Disability 2011-2016 examines the area of housing and people with disabilities, including mental health disabilities. It looks at establishing a framework for the delivery of housing for people with disabilities through mainstream housing policy. The Strategy was developed by the Department of Environment, Community and Local Government, and launched in October 2011. The stated vision of the strategy is: To facilitate access, for people with disabilities, to the appropriate range of housing and related support services, delivered in an integrated and sustainable manner, which promotes equality of opportunity, individual choice and independent living.

EU Structural Funds
Support in the community
Involvement of users
Progress toward DI
People with disabilities

The New Directions report was published in February 2012 and set out a proposed new approach to adult day services for people with disabilities. This new approach involves delivering 12 supports, which are collectively called New Directions. A National Working Group was established to look at day services. In addition to looking at Irish and international practices, they conducted a census of day service users and a consultation with stakeholders. The review concluded that there was some confusion around what constituted a day service, and that what was happening on the ground was diverse and varied.

Children

8 standards were developed and defined differently for children and adults with disabilities: Child Centered Services, Effective Services, Safe Services, Health and Development, Leadership, Governance and Management, Use of Resources, Workforce, Use of Information. To ensure a more equitable access to disability services for children, a national program has been set up to reconfigure how disability services are delivered in Ireland. This program takes its lead from the Report of the National Reference Group on Multidisciplinary Services for Children aged 5-18, which was published in 2009. It is envisaged each child will undergo an assessment by a multidisciplinary team to determine the level of support they may need. There is acknowledgement that we are now living in a time of limited financial resources but that services must live within budget, and use their resources to achieve maximum benefit for children and families. (21)

It is envisaged that the majority of children with less complex needs will have their needs met by their local primary care team. A typical primary care team may include the following professionals: general practitioners, nurses, physiotherapists, occupational therapists, social workers, speech and language therapists and clinical psychologists.

Under the new model, network disability teams will have the experience and skills to deal with a range of disabilities including intellectual disability, sensory disability, physical disability and autism. A typical network disability team should include professionals such as physiotherapists, speech and language therapists, occupational therapists, social workers, clinical psychologists, paediatrician (sessional), key worker, family support workers and therapy assistants. These teams may also have the support of a dietician and orthotist when needed.

Specialist disability team will be provided at a regional level and specialise in each of sensory disability, intellectual disability, physical disability and autism as required. These teams will provide direct service to children with complex needs on a short term basis, and consultancy to clinicians in primary and network disability teams. Parents are to be consulted during the change process. Although, an assessment is envisaged for each child to determine the level of service they require, as yet no access criteria exist.

People with mental health problems

Both the Green Paper on Mental Health (Department of Health June 1992) and the White Paper: A New Mental Health Act (Department of Health July 1995), which preceded the Mental Health Act 2001, called for the new Act to address the obligations of Health Boards (since replaced by the HSE) to provide access to comprehensive community-based services. However, the new law mainly focused on the issues of involuntary detention and treatment.9 While it also established the Mental Health Commission and the Inspectorate of Mental Health Services, the 2001 Act did not contain a framework for the delivery of mental health services needed to reflect a community-based, comprehensive and integrated service as recommended in successive mental health policy documents and as contemplated by the Green and White Papers. Although the 2001 Act was a welcome improvement on the Mental Treatment Acts 1945-61,10 the omission of provisions for community-based services was criticised by all the main political parties during the Dáil and Seanad debates. (22) At the end of 2013 there were five remaining public psychiatric hospitals in service. These have been replaced with acute psychiatric units in general hospitals as recommended in A Vision for Change. Until the remaining psychiatric hospitals are closed, the staff resource cannot be redeployed to CMHTs.

People experiencing homelessness

The Way Home, the new strategy to address adult homelessness in Ireland, 2008 to 2013, marks a very important departure in Government policy on homelessness. It sets out a vision for the next 5 years, underpinned by a detailed programme of action, with 3 core objectives:
- eliminating long-term occupation of emergency homeless facilities;
- eliminating the need to sleep rough; and
- preventing the occurrence of homelessness as far as possible. (23)

Data: There are more than 4,000 people living in a congregated setting at present in Ireland.
**Legal & Policy Context**

In 2012 a working group was established by the Ministry of Social Security and Labour. This working group, which involves various representatives from NGOs and the Ministries, prepared de-institutionalisation guidelines, which were approved and adopted by the Order of the Ministry of Social Security and Labour in November 2012.

In 2013 there was working group formed for preparing the Transition Plan from Institutional Care to Community Based Services for Disabled, Children without Appropriate Parental Care and Disabled Adults 2014-2020 in Lithuania, which was approved by an Order of the Minister of Social Security and Labour on February 14, 2014.

By an Order of the Minister of Social security and Labour of May 8, 2014 there was interinstitutional monitoring committee on DeI established for assessment and monitoring of the process of Transition Plan. It includes 15 members, 9 of those are representatives of NGOs.

Monitoring Committee on DE-I, initiated by the Minister of Social Security and Labour in May, 2014, has not started operating yet, although the first De-I pilot project proposals have been submitted to the ministry by the Regions (10 Regions in Lithuania uniting several municipalities) on 1st of October, 2014. On 23th October, 2014, on behalf of the Informal NGO Coalition “For the Children’s Rights”, the Ministry of Social Affairs and Labour was addressed with official letter in order to urge this process, but received no relevant initiative was received yet.

The Transition Bureau under the Ministry of Social Affairs and Labour will be responsible for the implementation of the Transition Plan from Institutional Care to Community Based Services for Disabled, Children without Appropriate Parental Care and Disabled Adults 2014-2020

**EU Structural Funds**

Lithuania has already provided plans for using SF funding within the Draft of the Lithuanian Strategy for the use of European Union Structural Assistance for 2014-2020. Currently this Draft strategy as well as Partnership Agreement is being considered by the European Commission. Nongovernmental organizations has not been involved in the SF planning process, nor consulted on the Draft. Ministry of Social security and labour is responsible for planning the use of SF for the deinstitutionalization process and activities according the Transition Plan from Institutional Care to Community Based Services for Disabled, Children without Appropriate Parental Care and Disabled Adults 2014-2020 in Lithuania.

While welcoming the objective of using EU funds to promote the transition from institution to community-based care, in particular for children and persons with disabilities, applying NGOs expressed their concern of the lack of ambition and commitment of the Lithuania government. The targets set and the indicators used in their proposal are not considered sufficient in order to achieve a real change nor a positive progress in promoting deinstitutionalization in Lithuania. The response was received that “Commissioner agree that the Lithuanian authorities have not set their sights sufficiently high as regards the de-institutionalisation objectives in the draft operational programm and wishes to reassure you that the Commission will raise this important point in the negotiations with them. And suggestions provided for indicators and targets will be taken into consideration when discussing the final version of the operational programme with Lithuanian authorities”.

Lithuania is using EU Structural Funds to support the development of mental health services, in particular the establishment of five crisis intervention centres, five psychiatric centres for children and family and 27 day care centres.

Despite the Del processes, that started at the end of 2012-2013, Lithuania still has plans for using money from the previous Structural fund period for the renovation, construction of the institutional social care settings. According to the financing programs („Development of social services within the care and other institutions; „Development of infrastructure of social services“) of Ministry of Social security and labour, there are number of projects foreseen to be funded throughout the years 2014-2015.
The main changes regarded decrease of share of children and persons with disabilities that should be still placed in institutions in the future and increase of community based care alternatives developed. Only measures supporting the transition from institutional to community-based care should be financed.

There is still no coordinating structure foreseen. Nevertheless, it is the Ministry of Social Security and Labour which is taking initiative, since this Ministry is responsible for all the national institutions of social care (for children, persons with disabilities, elderly).

Overall responsibility for the administration of the SF funding is attributed to the Ministry of Finances.

**Progress toward DI**

Deinstitutionalisation guidelines were approved and adopted by the Order of the Ministry of Social security and Labour in November 2012. Subsequently, the Transition Plan from Institutional Care to Community Based Services for Disabled, Children without Appropriate Parental Care and Disabled Adults 2014-2020 in Lithuania was approved by the Order No. A1-696 of the Minister of Social Security and Labour on December 18, 2013. Working group for preparing both of those documents was established by the Ministry of Social Security and Labour that involved various representatives from NGOs and the Ministries.

In general, deinstitutionalisation process has been very slow in Lithuania. Although Lithuanian Government has declared that they are creating alternatives for the care in institutions, still institutional form of care prevails in Lithuania.

Social care services for adults with disabilities in 2012 were provided by 38 state social care institutions. At the end of 2012, care institutions for persons with disabilities accommodated 6.1 thousand people, 51.6 percent of those having mental health problems, and 35.4 percent – persons with intellectual disabilities, others having complex disability. On July 2013, there were four social care institutions providing social care services for disabled children and disabled young people, the total number of the accommodated being 654 children. As well there are 5 infant homes in Lithuania that accommodate children from 0 to 3 years old, 327 infants. Historically, state-owned social care homes (especially for adults with disabilities) accommodate between 100 and 500 residents.

Lithuanian municipalities are responsible mainly for development of community based services for people with psychosocial disabilities, but there are humble signs of services developed, especially concerning the quality. New independent living homes in Vilnius and Kaunas cities were opened recently having a lot of signs of institutional culture and segregation.

According to the data of Seimas Ombudsmen’s office there are more than 250 social care institutions for children and adults in Lithuania, with more than 16 thousand residents. In total there are 160 residential care institutions for persons with disabilities, providing long term/ short term care, covering all age groups (children, adults and elderly).

Whereas according the Statistics department, in 2012 there were 57 445 thousand persons (elderly and disabled) receiving social care services, including services at home. This constituted 22 percent of all disabled persons.

In 2007, Lithuania adopted a National Mental Health strategy that covers a wide range of principles, priorities and recommendations. One of the objectives is “De-institutionalisation and modern services that meet the needs of the patients.” In 2007 – 2014, no particular steps were taken towards the implementation of the Mental Health Strategy, though two Strategy implementation plans were approved for the period 2007-2010 and 2011-2013.

In 2013 after the suicide of famous Lithuanian actor, the task force group including 35 members was approved by the Order of the Minister of Health for the preparation of the Action Plan for 2014-2017. Organisation of the task force group was criticized by experts and NGO activists as it lacked transparency, clear operations, terms of reference and even constructive dialogues. The Minister of Health was contacted number of times with particular proposals formulated by the experts and NGO activists, which were neglected. The Action Plan was adopted, but no strategic changes were promoted in Mental Health care system.

The current Mental Health Care Act is valid since 1995. Throughout the period from 1995 to 2014 it was amended only once. In 2008 there was provision on obligatory legal representation included in the law in processes of involuntary hospitalisation of persons with mental health problems. No other amendments or changes of legal framework were in place, which show major reluctance of the government to apply the modern human rights standards to the mental health system in Lithuania.

The Mental Health Care Act is under revision in the task force group established by the Ministry of Health in the beginning of 2014. No NGO representatives were included into the task force group initially.

The NGOs express substantial critics regarding crisis intervention centres, which are established at mental hospitals, but not in the communities. 20 psychiatric day care centres were established in the primary health care level, but services provided there do not include important psychosocial rehabilitation component.
**Legal & Policy Context**

The National Strategy on Child Protection for 2014-2020 (2014) provides a framework of reforms through: ensuring the necessary conditions for raising children in the family with a focus on prevention of child-family separation, the cessation of institutionalisation of children under 3 years of age; closure of residential institutions; reducing negative effects of migration of parents on children; supporting families to ensure optimum development of children. The Strategy for Social Inclusion of Persons with Disabilities 2010-2013 (approved by Law, 2010) ensures the creation and functioning of a coherent system for the protection of children and persons with disabilities, including mental disabilities, through the provision of a model and methods for determining the degree of disability, the development of early intervention services and procedures for the provision of technical and financial support, as well as specialised social services.

The Steering Committee on reforming the residential child care system and developing inclusive education coordinates the DI process at central level. The district-level Education Departments and Social Assistance and Family Protection Departments coordinate the DI process at local level.

**Inclusive education**


The Program is the national policy on inclusive education and declares commitment of the state for development and promotion of inclusive education and for ensuring equal opportunity and access to quality education for every child. It highlights the main responsibilities of all stakeholders involved in development of inclusive education: national and local authorities, support services, schools, professionals etc. and designs the inclusive education management, support/inclusive education services which have to be created at all levels: national, local, school. Following, an action plan was adopted.

**EU Structural Funds**

**Progress toward DI**

**Children**

According to a report prepared for UNICEF and the Ministry of Education, in 2007 there were 11,544 children living in 67 residential institutions in Moldova. In 2013, the Strategic review coordinated by the Ministry of Labour, Social Protection and Family, Ministry of Education and Ministry of Health, with Lumos’ support, showed that the number of institutions and number of children placed in residential care had reduced – there were 3,909 children living in 43 residential institutions in Moldova.

Figures for 2015 regarding children placed in residential institutions, though unpublished, are available at the Ministry of Education.

The proportion of children with special educational needs (SEN) included in mainstream education has increased during the last years. Thus, in 2010, only 28.5% of children with SEN were included in mainstream schools, compared to 71.5% of children with SEN attending special schools for children with intellectual or physical disabilities. In 2014, already 83.3% of children with SEN were included in mainstream schools, while 16.7% of children with SEN were still attending special schools. In the school year 2014-2015, the total number of children with SEN included in mainstream schools was 7,660 children nationally. (24)

**Adults**

The Ministry of Labour, Social Protection and Family (MLSPF) is the coordinator and ensures the proper functioning of 6 residential social institutions for adults: 2 institutions for elderly and adults with physical disabilities (somatic profile), and 4 institutions for adults with psychosocial disabilities (psycho-neurological profile).v

According to data from the Ministry of Labour, Social Protection and Family, the dynamics of beneficiaries in residential social institutions subordinated to MLSPF, for adults, 2009 – 2014, has been the following:
Types of support

Support in the community

At different stages of implementation of the DI and inclusive education reforms in the Republic of Moldova, international organisations and NGOs have supported the local public authorities (LPA) to assess the availability of community-based services and facilities within their respective districts, by mapping of social and educational services at local level.

The staff working in the social assistance domain are trained, according to provisions of legal and normative framework, by the social services providers – the district-level Social Assistance and Family Protection Departments – with support from NGOs.

Involvement of users

<table>
<thead>
<tr>
<th>Primary social services</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Social Assistance Service</td>
<td>1,123</td>
<td>1,124</td>
<td>1,125</td>
<td>1,126</td>
<td>1,127</td>
<td>1,128</td>
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<tr>
<td>In-home Care Service</td>
<td>2,407</td>
<td>2,408</td>
<td>2,409</td>
<td>2,410</td>
<td>2,411</td>
<td>2,412</td>
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<tr>
<td>Social Canteen Service</td>
<td>64</td>
<td>64</td>
<td>64</td>
<td>64</td>
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<table>
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<tr>
<th>Specialized social services</th>
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<tbody>
<tr>
<td>40 Multifunctional Community Centres</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
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<tr>
<td>29 Long-term Placement Centres</td>
<td>3,000</td>
<td>3,000</td>
<td>3,000</td>
<td>3,000</td>
<td>3,000</td>
<td>3,000</td>
</tr>
<tr>
<td>15 Day Care Centres</td>
<td>2,500</td>
<td>2,500</td>
<td>2,500</td>
<td>2,500</td>
<td>2,500</td>
<td>2,500</td>
</tr>
<tr>
<td>Joint Information and Services Bureaus</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
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<td>50</td>
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<tr>
<td>Rehabilitation/recovery services provided to elderly and people with disabilities by 2 Centres under MLSPF</td>
<td>2,000</td>
<td>2,000</td>
<td>2,000</td>
<td>2,000</td>
<td>2,000</td>
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</tr>
<tr>
<td>Social services addressed to households with children:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78 Community Social Assistance (Multifunctional) Centres</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>6 Family and Child Social Assistance Centres</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
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</table>

<table>
<thead>
<tr>
<th>Categories of beneficiaries</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly and physically disabled persons</td>
<td>416</td>
<td>392</td>
<td>364</td>
<td>335</td>
<td>322</td>
<td>347</td>
</tr>
<tr>
<td>Compared to previous year, %</td>
<td>-3.3</td>
<td>-5.8</td>
<td>-7.1</td>
<td>-8</td>
<td>-9.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Mentally disabled adult persons</td>
<td>1690</td>
<td>1700</td>
<td>1688</td>
<td>1687</td>
<td>1677</td>
<td>1712</td>
</tr>
<tr>
<td>Compared to previous year, %</td>
<td>-0.65</td>
<td>0.6</td>
<td>-0.7</td>
<td>-0.1</td>
<td>-0.6</td>
<td>2.04</td>
</tr>
<tr>
<td>Total, persons</td>
<td>2106</td>
<td>2092</td>
<td>2052</td>
<td>2022</td>
<td>1999</td>
<td>2059</td>
</tr>
<tr>
<td>Dynamics of beneficiary numbers compared to previous year, %</td>
<td>-1.17</td>
<td>-0.66</td>
<td>-1.9</td>
<td>-1.5</td>
<td>-1.2</td>
<td>2.91</td>
</tr>
</tbody>
</table>

Source: Residential Institution reports
**Legal & Policy Context**

Polish legislation (ex. Law on Social Assistance) expresses an obligation for local government units to provide places in ex. residential homes and only a possibility to provide community based alternatives. Lack of clear legislation reinforcing transition allows for stagnation or very slow progress in the field. Both the legislation and the system of social assistance are assessed extremely critically by non-governmental organisations and persons with disabilities and their families themselves. (26)

**Children**

The “Act on Family Support and the System of Foster Care”, approved by the Polish Parliament in June 2011, introduces deinstitutionalisation (DI) reforms by preventing children’s separation from their families and increasing day care services. The law also forbids institutionalisation of children under 10. However, due to the lack of foster families, infants under three years are still placed in institutions. Larger institutions have been given a seven-year transitory period.

Despite positive developments, the Polish Government still has no clear national strategy for DI. The old system of big institutions for 30 to 70 children still prevails. Moreover, the system is fragmented with 460 different counties responsible for institutional care and no effective monitoring procedure.

**Persons with mental health problems**

The Mental Health Act was approved in 1994. Until 1994, there was no definitive legal protection for the rights of people with mental health disorders. The National Programme of Mental Health Protection was prepared by the Institute of Psychiatry and Neurology and was approved by the Polish Psychiatric Society and the Ministry of Health in 2006. Ideas included in the National Programme of Mental Health Protection give hope to many participants of the mental health system for transformation towards community-based mental health care. A significant reduction of psychiatric hospital beds is planned and consequently daily care units should be created. Daily care is seen as a better way to increase the availability and access to mental health services. According to expert opinions the resources are allocated improperly. In some places, the availability of mental health services is very high while in other areas the access is almost blocked. Great expectations are tied with the idea of the so-called local mental health centres, which are planned to cover a population of 200 000. (27)

Protection Programme was implemented between 2011 and 2015. It provided further support for transformation towards community-based mental health care. Specific objectives of the Programme included the following regarding provision of comprehensive and easily accessible health care and other forms of assistance to people with mental disorders, necessary to live in the family and community.

**Homelessness**

Initial measures were taken in 2012 to improve the shelter system, and this has developed extensively as reported in 2013 through action taken to design a system of social services to support transitions out of homelessness (more below under improvement of service provision). Although Poland does not yet have a homelessness strategy, it seems to have laid the foundations for a strategy with clear standards for the functioning of local services aimed at homeless people.

**Elderly**

In the framework of the Operational Programme Knowledge, Education and Development, (OP KED), a number of projects will be implemented in the area of support for the deinstitutionalization of care for dependent persons, including the elderly, through the development of alternative forms of care for dependent persons.

**Inclusive education**

The Act on the Education System provides that any child may attend any type of school and parents have the right to decide which type of school is most appropriate.
In practice, however, in spite of the fact that the mainstream school has a legal responsibility to educate the child, parents of children with intellectual disabilities wishing to enrol their child in a mainstream school are often under pressure from the school to place the child in a special school.

EU Structural Funds

Progress toward DI

As of 2014 there were altogether 86,119 persons living in public 24-hour nursing houses. Each year around 11,000 persons are sent to nursing houses, with the number of persons waiting around 8000. The average number of persons living in a nursing house, as per 2014, is 106.

The number of full-time nursing homes is still growing (from 801 in 2012 to 812 in 2014), as is the number of residents (85,007 in 2012 to 86,119 in 2014). As stated in the Human Rights Defender report, “the Ministry of Labour and Social Policy plans to further increase the number of places in nursing homes.

Outpatient psychiatric facilities including community care

As of 2014 there were 8514 persons living in commercial nursing institutions, 2709 living in sheltered houses (of which some hundred are persons with disabilities) and 175 in family nursing homes. The average number of persons (as of 2014) living in a commercial institution was 24, in a sheltered house - 4, in a family nursing home.

The number of day care centres is slightly decreasing (230 centres with 19,596 places in 2012 and 226 centres with 19,278 places in 2013), whereas the “number of support centres is slightly increasing compared with previous years” (as of 2012: 1,702 centres and 122,569 users; 2013: 1,760 centres and 126,892 users, without distinguishing persons with disabilities). Also the public nursing and specialist care services at the place of residence were experiencing a 2% rise between 2012 and 2013 (with 102,770 persons using this form of aid in 2013).

Support in the community

Access to all these community-based services (ex. care services and specialised care services provided at a place of residence, support centres, in particular social self-help houses, 24-hour residence rooms in social self-help houses for temporary stay, sheltered housing, family nursing houses) is very limited. The support for the persons with little self-reliance who need intensive and specialised support is particularly inaccessible. Specialised care services – as a form of individual support at home and in the local community – are in practice hard to reach, especially for adults. “The residents of small towns or villages are in a particularly difficult situation. The support on offer is the poorest, or is even completely unavailable. This ends up with the persons in need of support in their independent life being left without such support, or being moved to a distant institution”. (28)

Involvement of users

Important facts

DI is explicitly mentioned in the Partnership Agreements (PAs) and the Operational Programmes (OPs)

The ex-ante conditionality not entirely respected

DI is not mentioned in the National Reform Programmes (NRP) and National Social Reports (NSR),

No additional info regarding DI in the Country Specific Recommendations (CSRs) for each country
Serbia

Legal & Policy Context

DI has been one of the stated objectives of the Serbian social welfare policy since 2002. While some progress has been made in relation to children (not so much in relation to children with disabilities), adults with disabilities still have very few options other than institutional care.

Relevant policies/legislation include:
- Strategy for the Development of Social Protection (2005): realisation of a network of community services planned as one of the goals; Strategy for Improving the Position of Persons with Disabilities (2007) – DI is not included in the general goals, but mentioned under specific objectives;
- Strategy and Action Plan for Mental Health Protection Development (2007) – sets out to establish community-based services (CBS) for people with mental health problems, as well as to decrease the number of beds in big psychiatric hospitals;
- Law on the Social Protection (2011) – most detailed account of the future DI plans; states that the current network of institutions should be questioned together with the services and quality of current institutional placement;
- Law on the Protection of Persons with Mental Disabilities (May 2013) – criticised by users and their representative organisations, who have been left out of the drafting process. (Source: Roadmap on DI)

One key issue is the financing of services in the community, which are the responsibility of the local self-governments (unless the municipality is underdeveloped). However, this decentralisation of responsibility has not been followed by decentralisation of the budget. This means that local self-governments have no incentive to bring those currently in institutions back to the community, where they would be financially responsible for them. Rather, it is easier for local self-governments to send people with more complex needs to the state funded institutions (often far away from where they come from). A separate issue is the lack of understanding at the local (and national) level how community-based services should be developed. (29)

According to the MoLEVSA, the most available services in the community are the home help for older people and day care centres. Families of children with disabilities complain about the lack of early intervention services, fragmentation of family-support and a tendency for social care services to replace education for children with disabilities.

The MoLEVSA has recently formed a Working group for the transformation of social care institutions into a community services (DI WG). The WG’s task is to monitor and support DI piloting and to develop a National DI Strategy. At the same time, the MoH have established a National Expert Committee for Mental Health with a mandate to evaluate the possibility and draft recommendations concerning the transformation (deinstitutionalisation) of psychiatric hospitals. Coordination between the two Ministries has been missing. Therefore, the MoH and the MoLEVSA have set up a joint working group, in order to find solutions in the fields where cross-sectoral cooperation is needed. NGOs advocating for deinstitutionalisation have complained about being excluded or not informed about the above mentioned working group(s).

Budget allocation

All the social care institutions have a common founder - the Ministry of Labour, Employment, Veteran and Social Affairs (MoLEVSA) - except for those located in the Provincial Region of Vojvodina. They are financed from the state budget and a part of expenses (health staff) are covered from the National Health Fund (NHF). In addition to the running costs, institutions also receive on an irregular basis investment budgets. Psychiatric hospitals are established by the Ministry of Health (MoH) and financed from the NHF. Part of the expenses linked to the running long term care (more social than health beds) is covered from state social care budget.

EU Structural Funds

Serbia is a candidate country and does not have access to SF, but it receives other types of EU funding (such as IPA). Sustainability of EU funding, with many CBS discontinuing after the end of funding, has been raised as a problem.
Progress toward DI

Data

There are about 5,500 places in 17 social care institutions, which accommodate mainly adults with mental health problems and intellectual disabilities. Four of these are specialised for people with mental health problems, some are exclusively for people with intellectual disabilities and some are mixed. In addition, there are 5 special psychiatric hospitals with a total capacity of about 3,000 beds (about half of which are long-term beds). There are about 7,500 beds in social care institutions for older people. The number of beds in social care institutions has been the same for a long time. One psychiatric hospital has reduced the number of beds by 1/3, but the residents were just moved to other institutions. (30)

According to UNICEF’s TransMonEE database, there are a total of 3,100 children in residential care (public and private); 1,485 children with disabilities in public residential care; 1,566 children without parental care in public residential care; and 3,404 children without parental care in family-based care. (Source: TransMonEE; last available data for 2011, accessed in December 2014). The number of children in institutions has been reduced in recent years, but the number of children out of family care is still growing.

Support in the community

Involvement of users
Legal & Policy Context

There was a strong move towards DI last year in 2014. The Government has since changed and the new ruling government does not seem to be motivated for DI promotion, but does not show signs to be strongly against. The Government in general most likely feels they lack professional capacity, which is why they are involving relatively open minded professionals as advisors.

There is a DI Strategy and Action Plan but Institutions for people with mental health problems are not covered by the above mentioned strategies. (31)

A new Act on social services entered into force on January 2014. A number of significant changes have been introduced. The Act now stipulates the maximum capacity for the new residential social service: supported apartment (zariadenie podporovaného bývania). For supported apartments, the threshold is max. 6 persons in one apartment and a maximum of two apartments per building in the case of supported apartment. In addition, the law does not permit any extension of the capacity of social care homes. For example, if a social care home has the capacity for 40 persons – it cannot be increased. New all year residential social care homes (institutions) can’t be registered as a social service since 2014.

Day care centre and social care home, working on a weekly basis cannot provide all year long social service. In addition, they cannot admit children and young people under 18 to be in residential social care homes. Finally, from the finance point of view, for residential institutions (Domov sociálnych služieb) which wishes to enter in the process of transformation, the same level of financing will be maintained and there will be no obligation to meet the criteria in terms of staff while the number of users may decrease.

The Ministry prepared and signed in December 2014 a document entitled ‘National priorities of social services development for 2015 – 2020’, which is the main document for the conception of policy in regions and community plans in municipalities. There are 4 main priorities:

1. Development of community services
2. DI of social services
3. Development of community services in segregated regions for marginalized communities (Roma communities)
4. Development and implementation of social services quality standards at providers level.

Overall, the Strategy is deliberately quite a brief/succinct document. In principle, it is more of a policy statement describing the case for DI, stating the latest EU and international policy developments and Slovakia’s commitments, the current state of affairs in social services and children’s care. It gives examples of good practice, but most of all it focuses on key principles of DI (the substantial part of the paper) and sets out the main implementing measures/documents and time frame for their adoption.

EU Structural Funds

DI is a one of priorities of the MLSAF in the field of children’s care and adults as well. DI is part of OP Human Resources and OP Integrated regional fund (ERDF). There is coordinating working group for DI between these two OPs. From the Ministry of Health there is proposal to include the DI program in mental health care, but details of these plans are not known and are not publicly available for public. Main focus of Ministry of Health in community services area is now at primary care reform, where they want to build Integrated health care centers.

Progress toward DI

From 1990 onward, there were a couple of attempts of transforming social care homes to community based services (Pohorelská Maša, Hodkovce) made by NGOs (for. ex. Social Work Advisory Board, Socia Foundation etc.) but they mostly ended partially done and not part of the social system.

In September 2007, it became apparent that the Regional Operational Program (ROP) proved was oriented on refurbishing of 310 facilities (institutions) and building 30
brand new facilities. About €180 million from the European Regional Development Fund (ERDF) was finally invested into these plans. Investment went mostly to the institutions with a capacity bigger than 50 clients, without any real impact on the quality of life of the clients.

Since March 2013, 7 residential institutions have been included in a pilot national project "Support for the process of deinstitutionalisation and transformation of the social services system" supported by ESF. (32)

**Support in the community**

Social services are provided to 47,400 clients, of which 5103 in a community-based environment.

Slovakia has 320 institutions with a capacity of less than 40 people (6939 clients) and 311 facilities with a capacity of 41 or more (33,919 clients, including elderly people) 12 have a capacity bigger than 200 clients. Altogether, there are 5408 adult clients, mostly persons with intellectual disabilities.

In 2012, there were 14458 children out of family care - 62% of them in foster of professional foster care, 38% (4332) in children's homes. By law, children younger than 3 cannot be placed in any form of institutional care.

**Involvement of users**
SLOVENIA

Legal & Policy Context

In the field of care for the vulnerable target groups in Slovenia, the circumstances differ from those in other parts of Europe. Slovenia is trying to provide for these groups within its capabilities. However, the closure of institutions is not possible yet, due to the absence of community-based services.

Slovenia does not have a coordinator for deinstitutionalization, although in practice implements a variety of activities, including lifelong learning program which covers all the stakeholders: users, employees and their families.

Different actors (Ministries for Labour, Social Affairs and Equal opportunities, Ministry for Education, Ministry for Health, local authorities…) are responsible. There is no permanent coordination structure.

EU Structural Funds

Progress toward DI

Most progress has been made in the field of mental health (one of the institutions was closed). At the same time, there have been ongoing discussions such as conferences, roundtables, forums and workshops, on how to move towards deinstitutionalization in Slovenia. Numerous undergraduate theses, master's theses and doctoral dissertations have been written on the topic. The result is a fast growth of small residential homes and small group homes, established by both governmental and non-governmental organizations, often at the initiative and with the support of parents. These have not been developed in a systematic way though and parents still prefer to trust the governmental, as opposed to non-governmental organizations. Slovenia is still at the stage of further search for consensus of forms of de-institutionalization, and based on examples of good practice.

In recent years, person centred planning and person centred active support have become more common in service planning. In 2008 Mental Health Act introduced advocates and community coordinators.

But these breakthroughs have not been sufficiently monitored and deinstitutionalisation process has not been implemented comprehensively.

Globally, Slovenia remains an institutionalised country in comparison to others, with approximately 23,000 institutions residents for 2,000,000 people (of which approximately 18,000 persons older than 65 years, 4,000 adults with special needs between 18 and 65 years and 1,000 children and youth with special needs under the age of 18 years) The average ratio of people living in institutions in Slovenia is 11,5/1000 with those above 65 and 2,5/1000 without elderly to be compared with 2/1000 in the EU.

A Resolution on the national social assistance programme 2013-2020 includes specific quantitative objectives for deinstitutionalisation of adults and the development of new initiatives, including resettling 2/3 (2800) of the residents of facilities hosting people with disability and achieve a balance between institutional and home care for older people. The implementation of these objectives is made difficult due to the change of government. It will notably be linked to the reform to Health Care and Long Term Care systems, which is currently blocked.

A legal base for financing Personal Assistance is lacking.

Foster care is the norm for children who can stay within their family. But the situation of children with disability who are often living in institutions as the only option to be able to access education is problematic. (660 children with severe health and special needs live in educational institutions.)

Support in the community

Involvement of users
Collection of country fiches: Analysis of the implementation of deinstitutionalisation
CONCLUSION

This collection of country fiches provides an insight of the state of play of deinstitutionalisation in different European countries. While in general it has been acknowledged that progress is taking place, many people still reside against their will or choice in segregated settings and this needs to be addressed by the European Union and the Member States. Independent living is a right in the United Nations Convention on the Rights of Persons with Disabilities and signing parties are under the obligation to enforce it.

There is a current issue being observed in various European countries: the matter of reinstitutionalisation. There are various reasons for such development to occur. For one, institutions are being closed without having established community based services first. As a result, people in need of support/care have no other solutions than going back to institutions. Another reason, is the lack of information and training. Training the professionals is important. But training the supported person and their families is as important. Someone who has lived their entire life in institutions would not know how to cope with living in the community and how to enjoy this independent life. Therefore, it requires to train both professionals and users and families.

The western believe that institutions provide good care and are good for people is still perpetuating. Good care is not enough, the objective of deinstitutionalisation is to create an inclusive society where no one is sent away in segregated settings based on the reason that better care is only provided there. Quality of life must be the criteria when assessing a service/support.

People with specific needs must be empowered and able to make decisions for themselves. Placing them in institutions inevitably limit their freedom of choice and right to be heard.

Enabling inclusive society and support in the community is not only profitable for the persons in need of support but also for the society as a whole. Everyone will have the opportunity to be an active citizen participating in the community life.

To enforce such changes, it is important to act at all levels and areas concerned such as in schools, in the labour market, in political discussions, in cultural world, in health and social sector, etc. Inclusive society can be reality and requires a shift in policy but also in the mind of all citizens. Persons at risk of institutionalisation and with special needs have great capacities and should be supported in appropriate manner in order to be able to be active citizens and realise their wishes and dreams as all citizens. The use of EU funds should be managed as to encourage investment in people and not in buildings. Convincing everyone that the transition to community based care is the right way is not an easy task and forming alliances such as the EEG is a great way of strengthening our voice.
The members of the Committee are appointed by the Ministry for Labour, Social and Consumer Affairs with due regard to the proposals by ÖAR. They consist of four representatives of disabled peoples’ organisations, one representative of a non-governmental organization working in the field of human rights, one representative of a non-governmental organization working in the field of development cooperation and one representative of academia.

The new law envisages support for inclusion of children with disabilities in mainstream kindergartens and schools to be organized at the level of the kindergartens/schools, including specialize support from psychologists, speech therapists, resource teachers, etc. Special arrangements are also envisaged to ensure early identification of children at risk of developmental difficulties at the entrance of the kindergartens (at 3 years of age) and early intervention.

<table>
<thead>
<tr>
<th></th>
<th>2012/1</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>72</td>
<td>71</td>
<td>68</td>
</tr>
<tr>
<td>Convalescent schools</td>
<td>10</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Schools for mentally retarded</td>
<td>48</td>
<td>47</td>
<td>46</td>
</tr>
<tr>
<td>Schools for hard hearing children, visually handicapped children and speech impaired children</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Number of children with disabilities in kindergartens during the school year 2014/2015: 2789.
Number of children with special educational needs in mainstream schools, school year 2014/2015: 13529.
http://di-dete.bg/
http://unicef.bg/en/article/DEINSTITUTIONALISATION-OF-CHILDREN-IN-BULGARIA-HOW-FAR-AND-WHERETO-
Independent-review-of-progress-and-challenges/786

If, at first, the allowance was supposed to partially decrease after the person earned 641 € per month, according to
the change proposal, the income would begin to decline after the 90-times the daily rate, which in 2016 is 1012.50 €. Thus, in the future, the working ability allowance will also be paid to people earning an average salary. From this amount, the allowance will gradually decline, and it will no longer be paid, if the person's income reaches 1,397.25 €. In case of deficient working ability, the allowance lapses when the person earns 1687.50 € per month. The employer will be compensated for workplace adjustment costs. As a result of the working ability reform, the disabilities do not incur additional costs for the employer any more, and people with disabilities are equal employees. The support provided by the state will create favourable conditions for hiring a disabled person. The Unemployment Insurance Fund will advise employers, provide support in the period of acclimatisation, and help them find solutions to emerging issues.

Map of schools: https://www.hm.ee/en/activities/pre-school-basic-and-secondary-education/special-educational-needs

S-veeb (https://sveeb.sm.ee/index.php?tid=xlZs6i7psUEjYsRjEkhhZhhhhhhhhhhLh0sj7l)
H-veeb (https://hveeb.sm.ee/index.php?tid=sPMJKMCauu7sBoodrrMNpL0l)

(Data from the National Bureau of Statistics). Available online in Romanian: http://www.statistica.md/newsview.php?id=4779&idc=168

HOTĂRÎRE Nr. 523 din 11.07.2011 cu privire la aprobarea Programului de dezvoltare a educaţiei incluzive în Republica


Realisation of the obligations arising from the UN Convention on the Rights of Persons with Disabilities by Poland - Report of the Human Rights Defender for years 2012-2014, p. 46; The Human Rights Defender (in Polish: Rzecznik Praw Obywatelskich; translated also as Ombudsman or Commissioner for Human Rights) is the Polish constitutional authority for legal control and protection in the field of human rights.

Open Arms Project and EEG Seminar Report
Project implementation period 01/2013 – 11/2015 & Budget: 1 000 000,00 EUR. The project aims to initiate and support the process of deinstitutionalisation of social services, as well as prepare and verify a single procedure deinstitutionalisation of social services for people with disabilities and mental health problems.

£45m from NHS England to support transformation of support and services. This includes:

- £30 million to support local areas with transitional costs (with national funding conditional on match-funding from local commissioners).
- £15 million capital funding over 3 years
  ‘Dowries’ for people who have been in units for 5 years or more (CCG/ NHS England money to LA for ‘resettlement’ out of hospital and into a more suitable home).
More information on
www.Deinstitutionalisation.com
www.deinstitutionalisationguide.eu
EUROPEAN EXPERT GROUP ON TRANSITION FROM INSTITUTIONAL TO COMMUNITY-BASED SUPPORT