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Deinstitutionalisation and transformation of social services – approach of the regions and the Ministry of Labour and Social Affairs, as reflected in strategy documents

Survey Report 2023

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Deinstitutionalisation and transformation of social services – approach of the regions and the Ministry of Labour and Social Affairs, as reflected in strategy documents

A survey conducted by the Public Defender of Rights in 2023

The survey has been carried out within the project “Reinforcing the activities of the Public Defender of Rights in the protection of human rights (with the aim of establishing a National Human Rights Institution in the Czech Republic)”, No. LPPDP3-001. This project is financed from the EEA and Norway Grants 2014–2021 and the State budget of the Czech Republic.

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The Defender's Mission

Since 2001, the Defender has been defending individuals against unlawful or otherwise incorrect procedure of administrative authorities and other institutions, as well as against their inactivity. The Defender may peruse administrative and court files, request explanations from the authorities and carry out unannounced inquiries on site. If the Defender finds errors in the activities of an authority and fails to achieve a remedy, the Defender may inform the superior authority or the public.

Since 2006, the Defender has acted in the capacity of the national preventive mechanism pursuant to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Defender systematically visits facilities where persons are restricted in their freedom, either ex officio or as a result of dependence on the care provided. The purpose of the visits is to strengthen protection against ill-treatment. The Defender generalises his or her findings and recommendations in summary reports on visits and formulates standards of treatment on their basis. Recommendations of the Defender concerning improvement of the conditions ascertained and elimination of ill-treatment, if applicable, are directed both to the facilities themselves and their operators as well as to central governmental authorities.

In 2009, the Defender assumed the role of the national equality body. The Defender thus contributes to the enforcement of the right to equal treatment of all persons regardless of their race or ethnicity, nationality, sex/gender, sexual orientation, age, disability, religion, belief or worldview. For that purpose, the Defender provides assistance to victims of discrimination, carries out surveys, publishes reports and issues recommendations with respect to matters of discrimination, and ensures exchange of the available information with the relevant European bodies.

Since 2011, the Defender has also been monitoring the detention of foreign nationals and the performance of administrative expulsion.

In January 2018, the Defender became a monitoring body for the implementation of rights recognised in the Convention on the Rights of Persons with Disabilities, also helping European Union citizens who live and work in the Czech Republic. The Defender provides them with information on their rights and helps them in cases of suspected discrimination on grounds of their citizenship.

The special powers of the Defender include the right to file a petition with the Constitutional Court, seeking the annulment of a secondary legal regulation; the right to become an enjoined party in Constitutional Court proceedings on the annulment of a law or its part; the right to lodge an administrative action to protect a general interest or to file an application to initiate disciplinary proceedings with the president or vice-president of a court. The Defender may also recommend that a relevant public authority issue, amend or cancel a legal or internal regulation. The Defender advises the Government to amend laws.

The Defender is independent and impartial, and accountable for the performance of his or her office to the Chamber of Deputies, which elected him or her as the Defender. The Defender has one elected deputy, who can be authorised to assume some of the Defender's competences. The Defender regularly informs the public of his or her findings through the media, web, social networks, professional workshops, roundtables and conferences. The most important findings and recommendations are summarised in the Annual Report on the Activities of the Public Defender of Rights, submitted to the Chamber of Deputies.

Important terminology explained

The survey report employs a number of concepts the scope of which must be perceived through the prism of their respective meanings and origins. The report draws on the terminology used by the Ministry of Labour and Social Affairs in the Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation,[1] as well as the terminology used by the UN Convention on the Rights of Persons with Disabilities[2] and the UN Committee on the Rights of Persons with Disabilities.

The Convention lays down the right of people with disabilities to a life in a community and to full inclusion and integration in the community. People with disabilities should have the freedom to choose where and with whom they live without being forced to live **in a particular environment**. The Convention primarily uses the term **"institution"** in this context, describing in particular the way in which the social service is provided. A large capacity, i.e. a large number of people served simultaneously at a given place, is not the only element defining an institution. According to the Convention, services with a small number of clients are also considered institutions if they provide their services in an institutional manner (e.g. with a paternalistic approach to the client, segregation or isolation of clients, etc.). The term "institution" is used predominantly in the first, theoretical part of the report, e.g. when outlining the right to an independent way of life and inclusion in the community under the Convention[3].

The Czech laws do not currently include a definition of the terms "institution" or "community-based social service". We have therefore used the **definitions from the Criteria** in our survey. Although these could well be **updated and refined in our opinion, we consider them the most appropriate of those currently available**. They follow the principles of the Convention, and there is a certain degree of general agreement on them. The Ministry requires compliance with the Criteria for the Transformation of Social Services, especially when dealing with projects financed from European funds.[4]

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[1] Ministry of Labour and Social Affairs. Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation. Online, 2022. Available [in Czech] at: https://www.mpsv.cz/documents/20142/1060378/Krit%C3%A9ria+transformace+a+DI. pdf/f9b9cf13-724c-8b35-7f03-7870a2e68b91 [retrieved on 14 January 2024].

[2] UN Convention on the Rights of Persons with Disabilities – promulgated under No. 10/2010 Coll. of International Treaties

[3] Article 19 of the Convention on the Rights of Persons with Disabilities.

[4] For example, within the IROP and OPE+ programmes.

The Criteria use the term **"residential social service of an institutional nature"** and define it on the basis of the way the service is provided, its overall capacity and the size of the households. Defining institutional and community social services only through "soft criteria" (i.e. especially the way the service is provided) would necessarily entail a fundamental difficulty in verifying whether a particular social service fulfils these criteria. Such verification is difficult, if not impossible, given the current setup of the social service system and the scope of data collection. In principle, the actual fulfilment of the "soft criteria" can be verified only on site, using an appropriate method. The definition in the Criteria therefore combines suitably the principles enshrined in the Convention with measurable conditions, which allow us to analyse the strategic deinstitutionalisation documents prepared by the Ministry and the regions.

The individual terms are listed according to topic, rather than alphabetically.

Institution[5] – an environment or facility that does not allow people with disabilities to live independently and be included in the community. It deprives them of their independence and the possibility to make personal choices and imposes a certain way of life on them.[6] There are certain defining elements of an institution, such as:

- obligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from;
- isolation and segregation from independent life within the community;
- lack of control over day-to-day decisions; lack of choice over whom to live with;
- rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority;
- a paternalistic approach in service provision.[7]
- Other defining elements of an institution include supervision of living arrangements and usually also a disproportion in the number of persons with disabilities living in the same environment.

Deinstitutionalisation plans[8] – strategies and action plans required by the Convention to replace institutions (institutional settings) with services that promote independent living and accessible mainstream (public) services. It is through these plans that the State fulfils its immediately applicable obligation to take (immediately or within a reasonably short period of time) deliberate, concrete, targeted steps using all appropriate means[9] in order to achieve the progressive realisation of economic, social and cultural rights under Article 19 (b) and (c) of the Convention. The creation of specific action plans to promote independent living and community inclusion, the development and provision of support and other services are essential elements of Article 19.[10] The deinstitutionalisation plans should meet certain requirements, including the following:[11]

- They reflect the fact that the systematic realisation of the right to independent living, and in particular deinstitutionalisation in all its forms, requires structural changes and a coordinated approach at national government level and among other institutions.[12]

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[5] Source of definition: UN Committee on the Rights of Persons with Disabilities. General comment no. 5 (2017) on living independently and being included in the community, Online. New York: United Nations, 27 October 2017 [retrieved on 14 January 2024]. CRPD/C/GC/5. Available at: www.ohchr.org. Czech version available at: www.ochrance.cz.

[6] According to the UN Committee on the Rights of Persons with Disabilities, institutional settings may offer persons with disabilities a certain degree of choice and control; however, these choices are limited to specific areas of life and do not change the segregating character of institutions.

[7] A social service with a small number of clients can still exhibit these elements characteristic of an institution.

[8] Source of definition: UN Committee on the Rights of Persons with Disabilities. General comment no. 5 (2017) on living independently and being included in the community. Online. 27 October 2017 [retrieved on 14 January 2024]. CRPD/C/GC/5. Available at: www.ohchr.org. Czech version available at: www.ochrance.cz.

[9] Article 4 (2) of the Convention and paragraphs 39 and 41 of the General Comment.

[10] Cf. General Comment, paragraph 38 (c) and (e).

[11] Cf. General Comment, paragraphs 39, 41, 42, 57-59, 70.

[12] Cf. General Comment, paragraphs 41 and 58, and the Deinstitutionalisation Guidelines, paragraph 67.

- The aim is to close institutions, prevent institutionalisation and develop support[13] and other services (including housing) to enable people with disabilities to live independent lives and be included in the community.[14] The States do not have any margin of appreciation in **whether** to replace institutions, but they can consider **what** programmatic steps they will prepare to replace the institutional settings.[15]
- They are based on a clearly stated declaration of what is to be achieved through the deinstitutionalization process.[16]
- They use the maximum resources to achieve the goals. They clearly define the human, technical and financial resources needed and available.
- They are devised in consultation with people with disabilities and organisations advocating their interests.[17]
- They contain clear deadlines and timelines.
- They contain benchmarks enabling evaluation.

Residential social service of an institutional nature (also institutional service or institution)[18] – an institution providing clients with continuous care associated with housing, meals and other services replacing the mainstream way of life.

- In the context of social services, the term refers to residential social services where people are isolated from the wider community, forced to cohabitate and exposed to the negative effects of institutionalisation. These negative effects include living in buildings specifically designated "for the disabled", isolation of people based on a common feature (type of disability, e.g. intellectual disability), suppression of their individuality, compliance with the facility's regime, clear hierarchical distinction between the clients and the staff.
- The principle of institutional care is that an individual accommodates to the institution's system, instead of the institution accommodating to the individual. The Czech equivalent ("ústav") is a historical term with pejorative connotations.
- Other defining elements are: obligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from; isolation and segregation from independent life within the community; lack of control over day-to-day decisions; lack of choice over whom to live with; rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority; a paternalistic approach in service provision; supervision of living arrangements and usually also a disproportion in the number of persons with disabilities living in the same environment. **While an institution is not defined by its size, the processes of isolation and institutionalisation that do define institutions tend to be more pronounced in larger residential services.**
- In terms of cumulative fulfilment of the criteria below, we define an institution as a **residential social service provided to 19 or more clients at one site, or smaller facilities with shared premises not divided into individual households for 6 clients or fewer clients.**

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[13] In accordance with the General Comment (especially paragraph 60), support services must be available (locally and temporally), accessible, affordable, acceptable (of sufficient quality) and adaptable (individualised according to the needs of the given person).

[14] Cf. General Comment, paragraphs 41, 42, 58 to 60, and Deinstitutionalisation Guidelines, paragraph 67.

[15] Cf. General Comment, paragraph 42.

[16] Deinstitutionalisation Guidelines, paragraph 68.

[17] Cf. Article 4 (3) of the Convention, General Comment, paragraphs 42 and 70, and Deinstitutionalisation Guidelines, paragraphs 34 and 67 in fine.

[18] Source of definition: Ministry of Labour and Social Affairs. Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation. Online, 2022. Available at: www.mpsv.cz [retrieved on 14 January 2024].

Community-based social service (or community service)[19] – a social service aimed at resolving an individual's unfavourable social situation in their natural environment. The service may be provided in an ambulatory, outreach and residential form; in any case, it is situated within the municipality at sites with similar locations to other facilities serving the same purpose rather than being concentrated with other services of the same nature at a single site. In the case of ambulatory and residential services, the maximum number of clients per facility is capped. A community-based social service does not exclude individuals from the community either in terms of the location where it is provided or by the way it is realised. It supports individuals in using the local mainstream resources and supports them in employing all their abilities and developing them further, and in establishing and maintaining usual social relationships and roles.

- Capacity of residential services – individual households with 1 or 2 clients, group households with 3 to 6 clients, sheltered housing with up to 4 clients. The cap is set at no more than 12 clients living in a single-family or residential building if they require a low or medium level of support (adults), or 18 clients if they require a high level of support.
- Capacity of ambulatory services – ambulatory services and day programs are used by a maximum of 32 clients in one facility at any one time. Ideally 5, but no more than 10 clients will attend one programme in one room at the same time.

Deinstitutionalisation[20] – a process in which institutional care for people with disabilities is transformed into community care. The aim is to improve the lives of people with disabilities and enable them to live a normal life comparable to that of their peers. Deinstitutionalisation involves controlled closure of institutions and development of community social services. The resulting structure and operation of social services will pivot first and foremost around the needs of the clients and their social inclusion, without exposing them to institutionalisation.

Transformation[21] – a set of processes to change the management, funding, education, location and form of service delivery so that care is provided in an individual's natural environment, and to reduce institutional capacity.

Humanisation – a term previously used[22] to describe the first stage of transformation of large-scale institutions. It consisted in investments in modification of the environment and care. Self-evidently, humanisation aimed to make the conditions in the institution more humane, more bearable for life. The primary purpose of humanisation was not to eliminate the institutional elements of the service, and we therefore do not consider it sufficient in terms of fulfilling the goals of deinstitutionalisation. Investments in humanisation are de facto investments in institutions, which the Convention prohibits.

Medium-term plan for the development of social services – a strategy document prepared by a municipality or region and approved always for a period of 3 years, outlining the underlying data and analyses and summarising their results, providing a description of the method of preparing the plan, including the details regarding the involvement of the municipalities, providers and recipients of social services, and a description and analysis of the resources available and the needs of the persons for whom the social services are intended, including an economic evaluation, the strategy for the provision and development of social services, including a description of the future desired state and the measures through

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[19] Source of definition: Ministry of Labour and Social Affairs. Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation. Online, 2022. Available at: www.mpsv.cz [retrieved on 14 January 2024].

[20] Source of definition: Ministry of Labour and Social Affairs. Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation. Online, 2022. Available at: www.mpsv.cz [retrieved on 14 January 2024].

[21] Source of definition: Ministry of Labour and Social Affairs. Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation. Online, 2022. Available at: www.mpsv.cz [retrieved on 14 January 2024].

[22] Cf. MoLSA: Recommended Procedure No. 4/2009 - Criteria for Transformation, Humanisation and Deinstitutionalisation of Selected Social Care Services, page 3: "Humanisation is a process that leads to transformation of the care system and environment to fulfil the rights and needs of its users. Deinstitutionalisation is one of the components of humanisation. The concept of humanisation – investment in modifying the former large-scale facilities – is used in the context of improving the conditions in the existing facilities." Available at: www.mpsv.cz. Cf. MoLSA: Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation (2016), page 3: "Humanisation of social services – improvement of the conditions for the provision of residential social services aiming to better the care provided by a social service and the respective environment. The aim of humanisation is to gradually ensure that care is provided in the natural environment. Humanisation is the first stage of transformation." Available [in Czech] at: www.trass.cz.

which this state should be achieved, the obligations of the entities involved, the procedure for monitoring and evaluating the plan's implementation, including the way to make changes to the provision of social services, and the way to establish a network of social services on the territory of the given region.[23] The Social Services Act requires regions to prepare their medium-term plans; municipalities may prepare it at their discretion.[24]

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[23] Pursuant to Section 3 (h) of Act No. 108/2006 Coll., on Social Services.

[24] Cf. Sections 94 (d) and 95 (d) of the Social Services Act.

List of abbreviations

CMH – centre for mental health

HPD – home for people with disabilities

SRH – special-regime home

SH – sheltered housing

IROP – integrated regional operational programme, which provides subsidies to improve the quality of life in the regions

RISSS – the Regional Information System for Social Services is a tool for addressing social issues on the level of regions, municipalities, founders and providers of social services

Criteria – Criteria for Community-based Social Services and Criteria for Transformation and Deinstitutionalisation

MoLSA – Ministry of Labour and Social Affairs

National Action Plan – National Action Plan for Mental Health

National Strategy – National Strategy for the Development of Social Services

General Comment – UN Committee General comment No. 5 on living independently and being included in the community[25]

OPE – Operational Programme Employment is an instrument for drawing financial resources from the European Social Fund

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[25] UN Committee on the Rights of Persons with Disabilities. Guidelines on deinstitutionalization, including in emergencies. Online, 2022. CRPD/C/5. Available at: www.ohchr.org. Czech translation is available at: www.ochrance.cz.

Deinstitutionalisation Guidelines – Guidelines on deinstitutionalization, including in emergencies[26] adopted by the UN Committee in 2022

SIL – support for independent living

Regional action plan – a regional action plan is a national intervention instrument designed exclusively to address the territorial dimension of EU funds for selected topics

Medium-term plan – medium-term plan for the development of social services

UN Committee – UN Committee on the Rights of Persons with Disabilities

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[26] UN Committee on the Rights of Persons with Disabilities. General comment no. 5 (2017) on living independently and being included in the community Online, 2017. CRPD/C/GC/5. Available at: documents.un.org. Czech version available at: www.ochrance.cz.

Foreword

Since 2009, the Czech Republic has been a State party to the Convention on the Rights of Persons with Disabilities, laying down the obligation to realise the right of people with disabilities to live independently and to be included fully in the community.[27] This is inextricably linked with the obligation to implement deinstitutionalisation.

The Convention defines deinstitutionalisation as the transition from segregation and isolation of people with disabilities to individualised support that enables them to live independently as they choose and to be fully and effectively included in the community. Deinstitutionalisation involves a number of processes and structural reforms, including the transformation of social services and closure of institutions.

The transformation of social services is a legal, political and social matter. It is an urgent issue that is often overlooked by those in charge. Generous, and indeed sincere promises have been made in this area, only to be repeatedly broken. But what one must bear in mind above anything else is that we are dealing with the fates of tens of thousands of people with disabilities who currently live in various institutions deprived of the freedom to which they are entitled. We are also dealing with the fates of countless carers who strain their physical and mental health to care every day for their children and later adult offspring with disabilities who would often have no choice but to live in an institution without this support.

In the Czech Republic, too, coordinated care for people with disabilities used to take place predominantly in large-scale facilities for tens or hundreds of people, in former castles, monasteries or villas, often in remote areas – on the figurative as well as literal fringes of society. Life in such institutions would inherently involve a regime universally applicable to all, defined by the rules and needs of the institution.[28] Unfortunately, such facilities still exist to this day. Other people were dependent on the care of their parents or relatives throughout their lives, with no other support services available to them. Family care was the only alternative to living in an institution, leading to further isolation and dependence on caregivers.

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[27] Article 19 of the Convention.

[28] The historical development of Czech institutional care can be illustrated by the story of Mr Jarda, who has spent the last decades in one of Czechia’s large-scale institutions. He has seen the institution’s transformation from the point where care was provided by nuns to the present day and described his experiences for the podcast “Who even cares?”. Author: Brit Jensen. The podcast is part of the research project Life Stories for Human Rights implemented at the Faculty of Humanities, Charles University. Available [in Czech] at https://ceskepodcasty.cz/epizoda/328245 [retrieved on 15 January 2024].

The Defender has been pointing out the unacceptability of the institutional settings since as early as 2006.[29] Since 2018, it has been an integral part of my role as the monitoring body for the implementation of the Convention to follow the changes to the system of care and support for people with disabilities over time. My office issued a recommendation to the Ministry of Labour and Social Affairs “to support the transformation and deinstitutionalisation of residential social services” and “to actively instigate the founders and providers of residential social services to transform and deinstitutionalise” already in the 2020 report on the systematic visits to homes for people with disabilities[30]. The reports on systematic visits conducted after 2020 bring forward recurring findings about the existence of institutions, institutional elements in transformed facilities and the lack of transformation plans.[31]

Experts in the field agree that the process of deinstitutionalisation has not been successfully completed in the Czech Republic. For example, according to the 2021 report on the situation in residential services for people with intellectual disabilities entitled “To live like the others do”[32], 15,000 people with intellectual disabilities live in residential social services, two thirds of them in unsuitable conditions.

I therefore decided to conduct a survey on how the Czech Republic approaches its obligation to deinstitutionalise and how it involves people with disabilities in the process. My goal is to map out the current stage of deinstitutionalisation in the Czech Republic and the ways in which the Ministry of Labour and Social Affairs and the regional governments are approaching the matter. In particular, I focus on the existing barriers to deinstitutionalisation. By way of conclusion, recommendations are formulated for the Ministry and the regional governments based on the results of my survey.

The basic obligation of a State party under the Convention is to have concrete and high-quality deinstitutionalisation plans that will lead as quickly as possible to the full realisation of the right of people with disabilities to independent living in the community, with the maximum resources used to this end. The survey therefore focuses primarily on deinstitutionalisation plans at the national and regional levels and on their quality, considered through the prism of the Convention.

The primary topic is the deinstitutionalisation of homes for people with disabilities and special-regime homes founded by the Ministry of Labour and Social Affairs and the regions[33] offering services to “people with intellectual disabilities” or “people with chronic mental illnesses” aged 18 to 64.[34] This target group has been chosen because we assume that most people who could potentially live independently in the community currently reside precisely in institutional homes for people with disabilities and special-regime homes intended for this target group.[35]

The survey employs two research methods. The first was a content analysis of the strategy documents of the regions and the MoLSA aimed at establishing the level of their commitment to deinstitutionalisation. The

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[29] The Defender visited five social care institutions for people with physical disabilities. In particular, he criticised the fact that the facilities still resembled hospitals, the clients lacked privacy, there were shortages of staff, which meant the clients had to follow regime measures. For more details, see the Summary Report on the Defender’s activities in 2006, pages 91 et seq. Available [in English] at: www.ochrance.cz.

[30] Summary Report on Systematic Visits to Homes for Persons with Disabilities, 22 October 2019, Case No. 11/2017/NZ, eso.ochrance.cz.

[31] Cf. e.g. the report on a visit to a facility of 9 November 2022, Case No. 40/2022/NZ, eso.ochrance.cz or the report on a visit to a facility of 14 December 2022, Case No. 30/2022/NZ, eso.ochrance.cz.

[32] Společnost pro podporu lidí s mentálním postižením v ČR, z. s. (Society for the Support of People with Intellectual Disabilities in the Czech Republic), Jednota pro deinstitucionalizaci – JDI, z. s. (Deinstitutionalisation Union), Žít jako ostatní. Zpráva o stavu pobytových služeb pro lidi s mentálním postižením v roce 2021. (To live like the others do. Report on the situation in residential services for people with intellectual disabilities in 2021.) Online, 2021. Available [in Czech] at: www.spmpcr.cz/.

[33] According to the Defender’s report entitled The Lives of Clients in Homes for Persons with Disabilities (Case No. 6/2019/OZP/MR), 71% of homes for persons with disabilities are founded by the regions.

[34] The characteristics of the facilities – their target group and age category – were selected using the application for browsing and searching in the public register of social service providers available at: https://www.mpsv.cz/web/cz/registr-poskytovatelu-sluzeb [retrieved on 7 April 2022].

[35] Společnost pro podporu lidí s mentálním postižením v ČR, z. s. (Society for the Support of People with Intellectual Disabilities in the Czech Republic), Jednota pro deinstitucionalizaci – JDI, z. s. (Deinstitutionalisation Union), Žít jako ostatní. Zpráva o stavu pobytových služeb pro lidi s mentálním postižením v roce 2021. (To live like the others do. Report on the situation in residential services for people with intellectual disabilities in 2021.) Online, 2021, page 8. Available [in Czech] at: www.spmpcr.cz [retrieved on 10 September 2023].

second research method consisted in a thematic analysis of semi-structured interviews with representatives of the regions and the MoLSA as the main agents of deinstitutionalisation and also the founders of homes for people with disabilities and special-regime homes. The aim of the thematic analysis was to better understand the obstacles and dilemmas arising in the context of deinstitutionalisation and social services development planning.

We cannot overlook the fact that many a success has been achieved in the field of deinstitutionalisation in the Czech Republic over the past 30 years. I appreciate the work of all those who have contributed to the cause so far. I also express my gratitude to those who work in social services, because it is only thanks to them and their activities that people with disabilities can receive respectful, high-quality care and support.

Regardless of the progress made so far, the unfinished deinstitutionalisation still prevents people with disabilities in the Czech Republic from living truly independent lives and being fully included in the community. I believe that the findings following from this survey could provide a new impulse for a systematic removal of all obstacles to deinstitutionalisation. It is my hope that this report will inspire a renewal of efforts to make fundamental changes, not only at the system level, but also in how we think about deinstitutionalisation. We must not forget that the primary purpose of the process is to realise the rights of people with disabilities, who are an integral part of our society. Their experience, suggestions and recommendations should be seen as crucial signpost on our way to deinstitutionalisation.

JUDr. Vít Alexander Schorm
Deputy Public Defender of Rights

Summary

The Czech Republic must constantly bear in mind its obligation to deinstitutionalise following from the Convention.[36] It must consider this commitment when planning the development of social services and allocating the necessary funds. It must not cease in its efforts to remove any obstacles preventing the deinstitutionalisation efforts. The Czech Republic must use as many resources as possible to create a system that enables people with disabilities to live independent lives and be fully included in the community. The essential tools for achieving this goal include high-quality deinstitutionalisation plans that effectively involve people with disabilities and their representative organisations at all stages.

1. Content analysis of strategy documents

The Czech Republic's national and regional deinstitutionalisation plans fail to meet the requirements under the Convention on the Rights of Persons with Disabilities. Neither the Ministry of Labour and Social Affairs (MoLSA) nor the regions provide a clear statement in their strategy documents as to their deinstitutionalisation goals. They also have inconsistent understandings and definitions of the basic concepts associated with deinstitutionalisation. The MoLSA and the regions also do not sufficiently and effectively involve people with disabilities or their representative organisations in the planning for deinstitutionalisation.

1. Deinstitutionalisation should result in the development of community-based social services, among other goals. Neither the National Strategy for the Development of Social Services (National Strategy) nor the regional medium-term plans for the development of social services (medium-term plans) contain a **definition of the term "community-based services".** In fact, it is included in the medium-term plan for the development of social services of only one region (i.e. 7% of all regions). If the individual actors (except one) fail to define what community-based services are, the expectations regarding deinstitutionalisation are likewise unclear.

2. **The medium-term plans fail to (sufficiently) define the terms "deinstitutionalisation" and "transformation".** In more than half of the plans (57%), the term "deinstitutionalisation" was present but not accompanied by a specific definition. The same proportion of regional plans (57%) used the term "transformation" without any explanation. Only the National Strategy and one regional plan included a definition of "deinstitutionalisation" consistent with the Criteria. A definition of "transformation" conforming with the Criteria was used in the National Strategy and two of the regional plans. The lack of consensus on the meaning of "deinstitutionalisation" and the processes related to it hinders the possibility of achieving deinstitutionalisation, to which the Czech Republic has committed.

3. **The strategy documents (whether the National Strategy or the medium-term plans) fail to define the term "humanisation".** This may cause a situation where the regions and the MoLSA confuse humanisation with transformation and continue investing in institutional services.

4. Most strategy documents **lack proposals for measures to prevent new services from adopting some institutional elements**. More than four fifths of the medium-term plans (86%) contain no measures to prevent the adoption of institutional elements. Even the National Strategy does not include such measures. We thus face a risk of creating facilities that resemble community facilities in terms of their material and technical equipment, but in which services are provided in an institutional form and in contradiction to the deinstitutionalisation goals.

5. The strategy documents **do not focus sufficiently on reducing the capacity of institutional services and the closure of institutions**. Only four medium-term plans (29%) contain measures to close institutional services. Mere two regions (14%) mention reducing the capacity of institutional services to meet the levels characteristic of community-based services.[37] The National Strategy contains sub-objectives that should lead to a complete closure of institutional services as well as to reduction of their capacity. However, it is not clear whether the reduction in capacity will make the services equivalent to community-based ones.

6. **The medium-term plans set out vague sub-objectives**, which decreases the likelihood of their achievement. Almost three quarters of the regions (71%) did not indicate in the sub-objectives defined in their medium-term plans the entity responsible for achieving the objectives. More than half of the plans (57%) failed to set deadlines for meeting the objectives, and six of the 14 regions (43%) failed to set in their medium-term plans criteria by which they could determine whether the objective has been met.

7. Beyond the medium-term plans, three regions issued **specific strategy documents** focusing exclusively on deinstitutionalisation. These documents **can serve as examples of good regional practice in the approach to deinstitutionalisation** because:
    a. They were adopted for an average of eight years, which allows for strategic planning for deinstitutionalisation and transformation over a longer period than is the case with the medium-term plans. Longer validity also helps to keep deinstitutionalisation and transformation a priority regardless of the changing distribution of political power.
    b. They contained definitions of community-based services (in two out of the four documents).
    c. They contained deinstitutionalisation visions and goals (development of community services, care in the natural environment, social inclusion, reduction of capacities of institutional services and abolition of institutions, focus on the needs of clients and prevention of institutionalisation).
    d. Most were reducing the capacity of institutional services down to the level characteristic of community-based services (which the medium-term plans failed to do).

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[36] Article 19 of the Convention.

[37] Community-based services as defined in the Criteria. For more details, see chapter Important terminology explained.

2. Thematic analysis of interviews with representatives of the regions and the MoLSA

The stage and pace of transformation of social services vary from region to region. The factual involvement of people with disabilities in strategic planning for deinstitutionalisation is very low and not deliberate. Neither the MoLSA nor the regions have established mechanisms to facilitate and improve direct involvement of people with disabilities. The realisation of the commitment to deinstitutionalisation is hindered by a number of procedural and systemic obstacles. Successful deinstitutionalisation requires cooperation among the central ministries and among the MoLSA and the regions. The MoLSA has the greatest power in deinstitutionalisation matters and therefore bears most responsibility for the outcome.

1. **The stage of transformation of social services varies from one region to another.** In the past 15 years, all regions have (at least partially) transformed their homes for persons with disabilities. Five regions reported that they had transformed their special-regime homes. No region has transformed all its homes for people with disabilities and special-regime homes. **None of the five social service facilities directly founded by the MoLSA has undergone transformation, despite being large-scale services of an institutional nature.**

2. Ten regions are planning to transform their homes for people with disabilities, and three of these regions are also planning to transform their special-regime homes. The regions are also focusing on the development of community-based residential services (sheltered housing, special-regime homes and homes for people with disabilities) and on the development of ambulatory and outreach services. The MoLSA has not provided any information on its specific plans for the transformation of its social services.

3. **The level of involvement of people with disabilities in the preparation of plans is very low**. Almost half of the regions and the MoLSA reported that people with disabilities were not directly involved in the planning for the development of social services. The most common way of involvement is membership of regional working groups. Several regions anticipate that people with disabilities will be actively involved in the public comment procedure regarding the plans. However, **most of the regions have failed to ensure that the social service development plans are prepared in conditions that allow for the process to be accessible and adapted to the needs of people with disabilities and enable their effective participation**.

4. Representatives of the regions most frequently mentioned the following procedural **barriers to deinstitutionalisation** (in descending order of frequency):

    a. **public prejudices and fears** about social service clients (especially those with intellectual disabilities or mental illnesses);

    b. **the attitudes of the management and staff** of social service facilities that are to undergo transformation;

    c. **the unavailability of housing** and suitable properties, including land;

    d. **lack of qualified staff** (identified as the most important barrier by the MoLSA);

    e. **attitudes of guardians and caregivers**;

    f. lack of availability and adaptability of services providing care in the natural environments.

5. The obstacles mentioned by the regions stem from the **setup of the social services system**. The most frequently mentioned obstacle is the set-up of the system of financing the operation and development of social services. The regions as well as the MoLSA see a barrier in the fact that **the amounts of funding** available for these purposes **are uncertain** and **the funding for the services comes from multiple sources, usually on a year-by-year basis**. Other obstacles to deinstitutionalisation stem from the **strict and constantly changing rules governing the implementation of** service transformation **projects**. The regions and the MoLSA consider it problematic that there is no **binding definition of "community-based services".**

6. The activities of the MoLSA as the central authority for social services and the body responsible for the implementation of the Convention are essential for successful deinstitutionalisation.[38] **However, the regional representatives consider the MoLSA's activities insufficient.** They believe the MoLSA hinders deinstitutionalisation by **failing to commit unequivocally to** deinstitutionalisation, **providing insufficient conceptual guidance** and procedural coordination (e.g. defective methodological guidance, absence of a long-term vision at the national level, insufficient support extended to the regions, low level of coordination between the individual stakeholders, etc.).

7. Another necessary condition for successful deinstitutionalisation is the **cooperation of all actors**, which **is currently insufficient** according to the regions and the MoLSA. They see an obstacle to deinstitutionalisation in the lack of cooperation at the central level, i.e. among the Ministry of Labour and Social Affairs, the Ministry of Health and the Ministry of Finance. Another obstacle is the problematic cooperation in the implementation of deinstitutionalisation among the MoLSA and the regions.

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[38] The MoLSA is the body responsible for the implementation of the Convention on the basis of Government Resolution No. 284 of 19 March 2007. The MoLSA also acts as a focal point under Article 33 (1) of the Convention. According to the recommendations of the UN High Commissioner for Human Rights, the primary role of the focal point is to promote awareness of the rights of people with disabilities under the Convention, participate in the development of the action plan for the implementation of the Convention and monitor and report on the implementation of the Convention within the focal point's functional area.

Legislation

1. Right to living independently and being included in the community

The Czech Republic ratified the UN Convention on the Rights of Persons with Disabilities in 2009. This step made the Convention legally binding on the Czech Republic. The Czech Republic must therefore take all measures to ensure that the rights of people with disabilities are actually realised within its jurisdiction.

This applies also to the right to an independent way of life, which is provided for in Article 19 of the Convention.[39] The right has a direct link to other rights whose fulfilment comes hand in hand with an independent life in the community. Article 19 of the Convention is therefore considered to be one of the most important in the Convention and a stepping stone for the Convention's full implementation.[40]

We interpret the right to an independent life[41] primarily as the right of people with disabilities **to make choices regarding their lives**, particularly about how, where and with whom they live. It is not only a matter of where they wish to live, but also how they wish to spend their days and how they wish to live their lives, whether they wish to live alone, with a partner or with other flatmates, in the city or in the countryside. Making choices about one's life also means being able to change one's decisions in the course of one's life according to one's current circumstances and life priorities. People with disabilities have an equal right to an independent lifestyle. Their right can only be realised if they have a choice[42] and if there are multiple options from which to choose. It is not enough if the only option is care or support provided by the family.[43] It is also not acceptable for a person with a disability to have to choose a particular place to live, such as an institution. The right to make choices about one's life is also linked to the prohibition of depriving people of liberty solely on the grounds of their disability.[44]

The right to independent living also includes the right to **freely choose a support service that should be tailored to the relevant person's needs, of sufficient quality and also locally, temporally and financially accessible**. This can be realised through a variety of services provided at home or elsewhere. Individual support services must be based on the needs and wishes of the individual concerned and their design should prevent isolation and segregation – i.e. separation and exclusion from the community. The services should support individuals in living independent lives in both the private (e.g. support for family life) and the public sphere (e.g. support for civic and political life or employment).[45]

The right to independent living also entails the right of a person with a disability to be included in mainstream society, to be part of the community. This implies **living a full social life** and having **access to all services offered to the public** (e.g. housing, transportation, shopping, education, employment, culture, sports and other leisure activities, but also the Internet and social media, etc.). These services are to be:

- available (locally, temporally, financially);
- universally accessible (physically, through the relevant information);
- acceptable (from the perspective of the culture and traditions of the person to whom they are provided, also taking into account their age and gender);
- adaptable (high quality and individualisation).[46]

OBLIGATIONS OF THE STATE

The rights of persons with disabilities under Article 19 are mirrored in the **obligations on the part of the State parties, which have undertaken to ensure and promote the full realisation of all human rights** and fundamental freedoms guaranteed by the Convention.[47] Each of the States has the obligation to respect, protect and fulfil the right to an independent way of life in the community under Article 19.

The **obligation to respect the right to an independent way of life** means that **the State must not place people in institutions either at a systemic or an individual** level. It must respect their choice of where, how and with whom they wish to live. At the systemic level, this obligation means creating conditions that do not force people with disabilities to live in a particular environment. The State must not adopt and implement policies and strategies that allow the institutionalisation of people with disabilities. It must abandon such policies and strategies, and if it does not have such instruments, it must refrain from creating them. At the level of individual people with disabilities, the State must ensure that these individuals are not involuntarily institutionalised. It must create conditions (for example, the availability of individual support services) to ensure that people with disabilities have an actual right to choose where and how they live. The State also has a duty to remove barriers (such as legislation or policies) that prevent people with disabilities from accessing support services and facilities and mainstream services.

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

a) persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

b) persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

c) community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs."

[40] General Comment, paragraph 6.

[41] The content of the right to living independently and being included in the community and the related obligations of the Czech Republic are interpreted in line with the General Comment and the Deinstitutionalisation Guidelines.

[42] The **right to make choices** is inextricably linked to Article 12 of the Convention (Equality before the law), which states that people with disabilities should have full legal capacity on an equal basis with others. Only then can they fully exercise their right to choose where, how and with whom they wish to live. For more details, see the General Comment, paragraph 80.

[43] Cf. e.g. General Comment, paragraphs 25, 26, 38(c) in fine.

[44] Cf. Article 14 of the Convention.

[45] Cf. e.g. the General Comment, paragraphs 29 et seq.

[46] Cf. e.g. the General Comment, paragraph 32.

[47] Article 4 of the Convention.

The State also has a **duty to protect** people with disabilities from third parties (family members, service providers, landlords, etc.) interfering with their right to live independently in the community. For example, the State has a duty to verify whether service providers are providing high-quality support and to protect people with disabilities from isolation in their families or institutions.[48] It should also protect people with disabilities against discrimination in access to services, including housing.

Finally, the **obligation of the State to realise the** right to independent living in the community implies the obligation to adopt and implement various measures, including legislative ones, to this end and to remove obstacles that prevent people with disabilities from exercising the right. The State has an obligation to deinstitutionalise, i.e. to transform services for all people with disabilities so that these are provided in a way that enables independent living in the community. This is matched by the obligation to ensure accessible, individualised services of the necessary quality within the community.

The **time scales within which the State has to make steps towards fulfilling** (and accomplish the fulfilment of) **its obligations** follow from the nature of the individual rights, as implied by international human rights law. Article 19 contains **civil rights**, such as the right to decide freely where and with whom one will live. Such rights are absolute and subject to immediate application.[49]

However, it also entails **economic, social and cultural rights**, such as the right to access to individualised support services or the right to accessibility and availability of mainstream (public) services to people with disabilities. These rights are subject to progressive application. They need not be applied immediately to the full extent envisaged by the Convention as the ideal state of affairs. The realisation of these rights and the corresponding obligations depends on further factors, such as the economic situation.[50] **The States must aim for the progressive realisation of these rights and use the maximum of their resources to do so.[51]** The State should not lower the standard of realisation of these rights already achieved (prohibition of retrogression) unless there are substantial reasons to do so and the State provides a thorough justification.

However, the State must take certain steps with regard to these rights immediately; in particular, it must prepare and adopt specific strategies and plans and earmark the resources required.[52] Although **the rights under Article 19 (b) and (c) of the Convention are realised progressively, they entail an immediate obligation for the State to have deinstitutionalisation plans.[53]** The UN Committee noted that this obligation must be fulfilled to a high standard of quality and as soon as possible, as the lack of strategies and plans to support deinstitutionalisation and continued investment in institutions constitute barriers to the implementation of Article 19.[54]

In summary, in order for every person with a disability to be able to realise their right to live independently and be included in mainstream society, the **Czech Republic must meet its duty and guarantee the right of people with disabilities to live outside institutions**.[55] This obligation applies regardless of the nature and severity of the individual's disability. It is therefore contrary to Article 19 for the State to argue that some individuals should live in institutions since it is too difficult or expensive to provide the necessary support for them to live in the natural environment.[56]

The Convention obliges the Czech Republic to take effective measures to ensure that people with disabilities live outside institutions. The aim of these measures should be to transition from institutional social services to services enabling independent living in the community.

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[48] General Comment, paragraph 52.

[49] General Comment, paragraph 39.

[50] General Comment, paragraph 7.

[51] Article 4 (2) of the Convention.

[52] General Comment, paragraph 39.

[53] The term "deinstitutionalisation plans" is explained and the corresponding definition is provided in chapter Important terminology explained.

[54] General Comment, paragraph 15 (e).

[55] For more details on the definition of term "institution", see chapter Important terminology explained.

[56] The United Nations Committee on the Rights of Persons with Disabilities made this clear in its Deinstitutionalisation Guidelines: "Institutionalization contradicts the right of persons with disabilities to live independently and be included in the community." [paragraph 7];"**States parties should abolish all forms of institutionalization, end new placements in institutions and refrain from investing in institutions.** Institutionalization must never be considered a form of protection of persons with disabilities, or a 'choice'."[paragraph 8]"There is no justification to perpetuate institutionalization. States parties should not use lack of support and services in the community, poverty or stigmas to justify the ongoing maintenance of institutions, or delays to their closure." [paragraph 9].

This commitment also includes the obligation **not to build new institutions**. Similarly, **existing institutions should not be renovated**, except for the most urgent interventions to protect the clients' safety. Institutions must not be expanded and new clients must not be accepted to replace those who have left.

A **specific national deinstitutionalisation plan** should **be drawn up** with a clearly defined objective to complete the process, a clear timetable, identification of the parties responsible for achieving the objective and a quantification of the total cost. The next logical step is to **implement** this plan and **regularly evaluate its performance, including collecting data** on the number of social services transformed and the number of people with disabilities leaving the facilities.

The following chapters of this report discuss the stage to which the Czech Republic has managed to fulfil the obligation to have a deinstitutionalisation plan.

2. Participation of people with disabilities in deinstitutionalisation plans and monitoring as a requirement under the Convention

The principle of effective involvement of people with disabilities in all decisions that affect and influence them permeates the entire Convention.[57] People with disabilities and their representative organisations were involved in the drafting of the Convention itself and in the development of the Deinstitutionalisation Guidelines. All of this mirrors the slogan "Nothing about us without us", which is historically linked to the global movement to achieve full inclusion and equal opportunities for people with disabilities.

The Convention obliges the Czech Republic to consult and actively involve people with disabilities (including children with disabilities), through their representative organisations, in the drafting of legislation and policies to implement the Convention, as well as in decision-making on other issues concerning them.[58] People with disabilities and their representative organisations should also be actively involved in monitoring the Convention's implementation.[59]

In working with organisations representing people with disabilities, the State should give priority to those that meet the features described by the UN Committee in General comment No. 7 on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention.[60]

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[57] Cf. For example, the Preamble to the Convention in paragraphs (m) and (n), which read: "(m) Recognizing the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty, (n) Recognizing the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices".

[58] Article 4 (3) of the Convention.

[59] Article 33 (2) and (3) of the Convention. Section 21c of the Public Defender of Rights Act entrusts the Defender with tasks related to the monitoring of the rights of persons with disabilities within the meaning of Article 33 (2) of the Convention and the Defender has therefore established the Advisory Body for the Protection of the Rights of Persons with Disabilities to be involved in the monitoring.

[60] Paragraph 11 of General comment no. 7; UN Committee on Persons with Disabilities: General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention. Available online at: www.ochrance.cz/.

According to the Committee, the characteristics of an organisation representing people with disabilities include the following: "Organizations of persons with disabilities should be rooted, committed to and fully respect the principles and rights recognized in the Convention. They can only be those that are led, directed and governed by persons with disabilities. A clear majority of their membership should be recruited among persons with disabilities themselves. (...)Organizations of persons with disabilities have certain characteristic aspects, including the fact that: (a) They are established predominantly with the aim of collectively acting, expressing, promoting, pursuing and/or defending the rights of persons with disabilities and should be generally recognized as such; (b) They employ, are represented by, entrust or specifically nominate/appoint persons with disabilities themselves; (c) They are not affiliated, in the majority of cases, to any political party and are independent from public authorities and any other non-governmental organizations of which they might be part/members of; (d)They may represent one or more constituencies based on actual or perceived impairment or can be open to membership of all persons with disabilities; (e) They represent groups of persons with disabilities reflecting the diversity of their backgrounds (in terms of, for example, sex, gender, race, age, or migrant or refugee status). They can include constituencies based on transversal identities (for example, children, women or indigenous people with disabilities) and comprise members with various impairments; (f)They can be local, national, regional or international in scope; (g)They can operate as individual organizations, coalitions or cross-disability or umbrella organizations of persons with disabilities, seeking to provide a collaborative and coordinated voice for persons with disabilities in their interactions with, among others, public authorities, international organizations and private entities."

Deinstitutionalisation is one of the "other issues" that directly concern people with disabilities.[61] The State is therefore **obliged to consult people with disabilities** (organisations advocating their rights) **when adopting laws, strategies and policies and other decisions concerning deinstitutionalisation.** It should work closely with the representative organisations **at the local, regional as well as national** level.

The involvement of people with disabilities should be meaningful, not symbolic or formal. Effective participation must be based on respect and deference, and the State must attach due weight to the information gathered in this process. The process should lead to full and effective inclusion of people with all types of disabilities in the community. This is their civil and political right, which the State is obliged to realise immediately. For participation to be effective, the relevant people must be contacted systematically, rather than just randomly, in a meaningful and timely manner.[62] The State must create and promote inclusive mechanisms and platforms enabling full and effective participation of people with various disabilities in public and political life.

Meaningful participation depends on access to information. The information needed must be provided in a variety of formats and communication methods, including, for example, sign language and machine-readable or easy-to-read documents.

It is therefore essential that, in the course of fulfilling its commitment to deinstitutionalisation, the Czech Republic should **directly involve people with disabilities**, through their representative organisations at local, regional and national level. This applies not only to the development of the deinstitutionalisation plan mentioned in the previous chapter, but also the actual transformation process. People with disabilities should also be involved in the follow-up monitoring of the Convention's implementation.

3. Right to provision of social services in the least restrictive environment

The Czech Republic's commitment to guaranteeing people with disabilities the right to living independently and being included in the community was reflected in the 2011 amendment to the Social Services Act.[63] The amended law newly enshrines the **right of people with disabilities to be provided with social services in the least restrictive environment possible**.[64] In the explanatory memorandum, the legislator commented on this change stating that the newly defined right fully corresponds to the obligations arising from Article 19 of the Convention. The State's obligations include, among others, the obligation to ensure that people with disabilities can live outside institutions. In this context, the right to the provision of social services in the least restrictive environment possible must therefore be interpreted in accordance with the Convention **as the right to live outside institutions**.

The Constitutional Court likewise commented on the right of people with disabilities to be provided with social services in the least restrictive environment possible in a ruling issued in 2018.[65] The Court argued that in an ideal situation where this right is fully realised, a variety of social services of different kinds and natures should be available to people with disabilities. Each person would then be able to use the services most suited to their particular needs, and most help and support would be therefore provided with the **minimum level of restrictions possible**.

According to the Constitutional Court, this is an **ideal situation** which the public authorities are not obliged to implement immediately, but which they **must work towards gradually**. The public authorities should therefore **take reasonable steps**, within their means and discretion, to gradually ensure the availability of a wide range of the least restrictive social services. The public authorities in this case are the regional governments, which are obliged to ensure adequate social services in their respective territories. The regional governments must ensure that people in unfavourable social situations have access to the necessary social services within the region.[66] The regional governments are therefore not obliged to immediately provide social services to individuals with a disability in the least restrictive environment, i.e. outside of institutions. **However, they must take appropriate steps to gradually provide these services, especially through the transformation of institutional social services and the development of community-based services in their respective territories. According to the UN Committee, these steps must be as sizeable as possible in the light of available resources.[67]**

Specifically, the regions should have regional deinstitutionalisation plans with a clearly defined objective to complete the process, a clear timetable, identification of the parties responsible for achieving the objective, clear rules for the involvement of people with disabilities and a quantification of the total cost. The regions are also responsible for regularly evaluating the regional plans' performance, including collecting data on the number of social services transformed and the number of people with disabilities leaving these facilities.

4. Role of the Ministry of Labour and Social Affairs

As explained above, by ratifying the Convention, the Czech Republic has committed to safeguarding the right of people with disabilities to live outside institutions. As the entities responsible for the provision of social services on their territories, regional governments are also obliged to take steps to realise the right of people with disabilities to live outside institutions, or the right to the provision of social services in the least restrictive environment possible. The State and the regions must therefore strive to successfully complete the process of transforming all social services of an institutional nature.

The MoLSA is responsible for the implementation of the **Convention[68]** and its role is to translate the ideal state envisaged by the Convention into practice (which involves ensuring the maximum amount of resources, including funding). It is therefore directly responsible for the implementation of Article 19 of the Convention and for completion of the transformation in the Czech Republic. As the authority responsible for **the area of social services**, it can use a number of conceptual and strategic tools to unify and accelerate the transformation while also setting clear implementation conditions. For example, the MoLSA prepares the national strategy for the development of social services and provides methodological support in connection with the provision of social services.

The MoLSA's role is also important because it **provides the regions with** special-purpose **subsidies** from the State budget to finance current expenditures related to the provision of the basic types and forms of social services.[69] Providers of services of a national or supra-regional nature may receive subsidies directly from the Ministry.[70] The Ministry therefore also holds **a crucial position in deciding** on the flow of funds in social services, or rather the **flow of funds in favour of transformation**.

The MoLSA is also able to influence the **use of EU funding from the Structural Funds,[71]** and most recently also through the **National Recovery Plan.[72]** The MoLSA can exercise its influence over the use of these funds for deinstitutionalisation and transformation of social services, for example, when formulating the

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[61] Ibid., paragraph 20.

[62] Ibid., paragraph 22.

[63] The Social Services Act was amended by Act No. 366/2011 Coll.

[64] Section 38 of the Social Services Act reads: "Social care services help individuals to attain physical and mental self-reliance with the aim to support their living in their natural social environment and to enable them to engage as much as possible in the regular life of society and, in cases where this is impossible due to their condition, to provide them with a dignified environment and treatment. Everyone has the right to receive social services in the least restrictive environment possible."

[65] Constitutional Court ruling of 23 January 2018, Case No. I. ÚS 2637/17, available [in Czech] at nalus.usoud.cz.

[66] Section 95 of the Social Services Act.

[67] General Comment, paragraph 41.

[68] On the basis of Government Resolution No. 284 of 19 March 2007.

[69] Section 101a (1) of the Social Services Act.

[70] Section 104 (2) and (3) of the Social Services Act.

[71] In the 2021–2027 programming period, the topics of deinstitutionalisation and transformation are covered by the **Operational Programme Employment+ and the Integrated Regional Operational Programme**. As to investment calls that focus on the construction or renovation of social services facilities, the MoLSA generally uses the **Criteria** to determine the conditions for the ultimately supported facilities.

[72] Support for the deinstitutionalisation and transformation of social services is included in component 3.3 of the National Recovery Plan, where, for example, the development of social service facilities that respect the right to independent living enshrined in the Convention is supported under Investment 3. The MoLSA is the owner of this component, i.e. it is responsible for setting the conditions in calls to grant support to specific projects. It is worth noting that the **relevant calls under the National Recovery Plan do not set the conditions based on the Criteria, but rather a specially designed material and technical standard.** Unlike the Criteria, the standard allows for the construction of facilities with a capacity of 25 or even up to 70 people for certain types of services and for certain target groups.

conditions for applicants for project support when announcing calls for proposals from individual operational programmes or when implementing its own projects to support the transformation of social services.[73] The European Union as a whole ratified the Convention in 2011 and it therefore has the same obligations and commitments regarding the right to independent living and community inclusion as the Czech Republic. There clearly has been an effort to apply the principles of the Convention more consistently in the drawing of the structural funds in the 2021–2027 programming period.[74] This is EU's response to criticism that it is financially supporting investments in the construction or renovation of institutions, which is contrary to the Convention. The goal not to invest in institutions is difficult to attain and it has only been achieved to a limited extent.[75]

The key responsibility for the successful transformation in the Czech Republic lies with the Ministry of Labour and Social Affairs, which has the conceptual, strategic and financial instruments to achieve the goal. The Ministry should make even greater effort to transform all its institutional social services, reflecting the urgency of the matter.

5. Deinstitutionalisation plans in the Czech Republic and the stage of their implementation

In the first chapters, we concluded that the Convention obliges the State to **develop a specific national deinstitutionalisation plan** with a clearly defined objective to complete the process, a set timetable, identification of responsible parties and allocation of maximum resources to gradually realise the right of people with disabilities to independent living in the community. Although the State may implement this right progressively, it is obliged to create the deinstitutionalisation plan immediately. Since a significant part of the powers related to social services is delegated to the regional governments, the regions are also **obliged to have their deinstitutionalisation plans**. People with disabilities and their representative organisations must be involved in the development and monitoring of the plans, and the State must create suitable conditions for their full and effective participation.

Our survey focused on analysing these plans. The MoLSA submitted for analysis the **National Strategy for the Development of Social Services** for 2016–2025 (National Strategy), which set as its first strategic goal "To ensure the transition from the institutional model of care to the support of people in their natural environments".[76] The National Strategy foresees the publication of an **action plan for the transition from institutional care to support in the natural environment**. The State only worked towards fulfilling this obligation until 2018. Reaching a consensus on the content of the next "deinstitutionalisation action plan", as this document is often referred to in professional debate, was accompanied by considerable difficulties. The Deinstitutionalisation Action Plan for 2023–2025[77] was only finally approved by the Government in October 2023. Given the date of its adoption, we did not analyse the Action Plan.

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[73] In the past, the MoLSA used systemic projects financed from the European funds to support transformation and deinstitutionalisation. Currently, the MoLSA has returned to this practice after a certain hiatus and started to implement a new project to support deinstitutionalisation in the Czech Republic on 1 January 2023.

[74] This goal is supported by the Regulation on the common provisions on certain EU funds (Regulation (EU) 2021/1060 of the European Parliament and of the Council of 24 June 2021 laying down common provisions on the European Regional Development Fund, the European Social Fund Plus, the Cohesion Fund, the Just Transition Fund and the European Maritime, Fisheries and Aquaculture Fund and financial rules for those and for the Asylum, Migration and Integration Fund, the Internal Security Fund and the Instrument for Financial Support for Border Management and Visa Policy; available at: eur-lex.europa.eu). It stresses that States should respect the Convention when implementing the Funds, including the principle of involving people with disabilities as partners in each programme and the emphasis on accessibility. The Regulation also sets out horizontal and thematic baseline conditions for each Fund, which are reflected in the specific operational programmes. (In this respect, cf. Annex III to the Regulation in fine and Annex IV to Conditions 4.4 and 4.6).

[75] For more information, see, for example, the report of the Fundamental Rights Agency, which is part of the European framework for monitoring the implementation of the Convention. Available at: fra.europa.eu.

[76] Cf. National Strategy, pages 56 et seq.

[77] MoLSA: Action Plan for the Transition of Social Services to Community-Based Care, for Greater Individualisation of Care, and for Supporting the Deinstitutionalisation of Social Services in the Czech Republic in 2023–2025; online. Available at: www.mpsv.cz.

However, goals aiming at deinstitutionalisation can also be found in the **National Plan on Promoting Equal Opportunities for Persons with Disabilities** for 2021–2025.[78] Like the National Strategy, the National Plan includes a mechanism for periodic evaluation.[79]

In this survey, we also asked the regional governments to send us their plans for transformation and deinstitutionalisation. All the regions referred to their **medium-term plans for the development of social services**, some of them also sent **other strategy documents,** a part of which were devoted directly to the transformation of social services. It is debatable whether the issue of transformation is sufficiently addressed in the regional medium-term development plans for social services. These plans only cover a limited period of time and it is unlikely that they could address the transformation comprehensively. This issue is discussed in more detail in the content analysis and its summary.

Neither the national nor the regional strategy documents on deinstitutionalisation provide any answers regarding the current stage of deinstitutionalisation in the Czech Republic. The Czech Republic began supporting the transformation of social services even before ratifying the Convention. In 2007, the Government approved the Policy on Supporting the Transformation of Residential Social Services into Other Types of Social Services Provided in the User's Natural Community and Supporting the User's Social Inclusion into Society. Even before this date, efforts were underway to change the institutional setup of care and run pilot projects to transform individual facilities. The policy was gradually followed up by other strategy documents and projects prepared by the MoLSA to further support some individual actors and facilities in the process of transition.

It is essential to stress that **much good has been achieved in the Czech Republic in terms of deinstitutionalisation**, both in closing or reducing the capacity of institutions and in the development, availability and quality of individualised support enabling people with disabilities to live as they choose and be included in the community. However, the process is far from complete, as the UN Committee pointed out in its concluding observations provided to the Czech Republic after the submission of the initial report on the implementation of the Convention.[80] Moreover, as already mentioned in the introduction, the pace of deinstitutionalisation is stagnating in the Czech Republic.

It is very difficult to describe comprehensively the stage of deinstitutionalisation based on the data collected by the State[81]. We have attempted in this report to **illustrate the stagnation of the deinstitutionalisation process** using data available from the 2007, 2015 and 2022 Labour and Social Statistical Yearbooks. Given the focus of our survey, we concentrated on social services used by people with intellectual disabilities and mental illnesses, of both residential nature (sheltered housing, homes for people with disabilities) and outreach nature (support for independent living and personal assistance).

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[78] Government Committee for Persons with Disabilities (Government Committee): National Plan on Promoting Equal Opportunities for Persons with Disabilities 2021–2025. Available online [in Czech] at: vlada.gov.cz. Goals aiming at the realisation of the right to an independent way of life can be found on pages 45 et seq.

[79] The most recent **report on the implementation of the National Plan on Promoting Equal Opportunities for Persons with Disabilities**, issued by the Government Committee and acknowledged by the Government in its resolution, is available here. The report shows, for example, that work aiming at implementing the measures titled "Continue deinstitutionalisation of residential facilities for persons with disabilities, including facilities where deinstitutionalisation has not yet begun" (measure 5.3.1) and "Implement deinstitutionalisation as a gradual transition from large psychiatric hospitals to community-based care, including the development of acute care capacity in psychiatric and pediatric wards of general hospitals" (measure 9.3.4) was underway as of the end of 2022 according to the Government Committee.

The latest report on the implementation of the National Strategy as of the date of the survey report dates from 2021 and the next one is to be submitted by the MoLSA to the Government by 31 March 2024. Performance reports, including the 2021 report, indicate that the State has been "only partially able" (quotation from the report) **to fulfil the National Strategy measure titled "Implement the individual steps to fulfil the plan for transitioning from institutional care to support in natural environments"** . This is due to long-standing difficulties in approving the deinstitutionalisation action plans and the amendment of the Social Services Act. For example, the MoLSA has long not been able to prepare and enforce a comprehensive amendment to the Social Services Act that would define the concept of community services or establish the preference for community-based services.

[80] UN Committee: Concluding observations on the initial report of the Czech Republic (2015) CRPD/C/CZE/CO/1; available [in Czech] at: www.mpsv.cz. The Committee criticised the Czech Republic for its high investment in institutions and shortcomings in the deinstitutionalisation plans. The Committee further recommended that the deinstitutionalisation process be boosted and that the maximum amount of resources be used to this end (cf. the report cited above, paragraphs 38 et seq.). The UN Committee focused on deinstitutionalisation also in the questions posed to the Czech Republic for the combined second and third periodic reports. Unfortunately, the Committee's observations on the combined second and third reports are not yet available, as the Czech Republic did not submit the combined reports for the second and third monitoring periods until 2024.

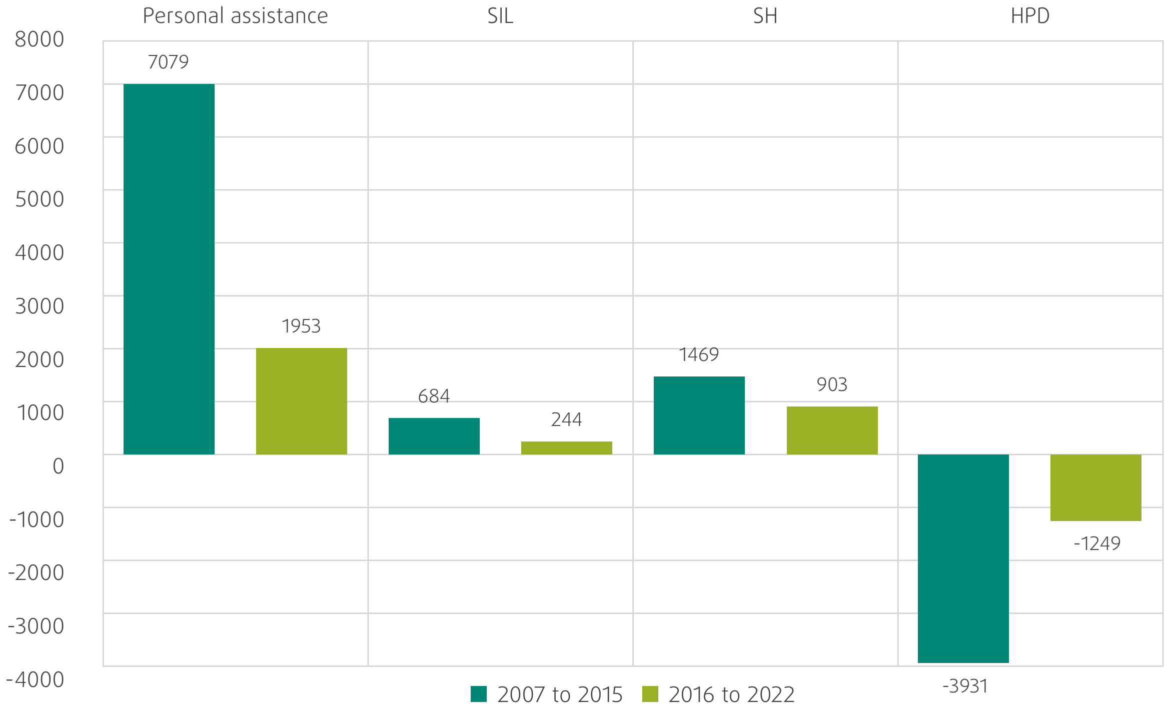
[81] E.g. the Labour and Social Statistical Yearbooks available online [in Czech] at: www.mpsv.cz.

We have not included the special-regime home services in this section. There was a significant increase in the numbers of these facilities between 2007 and 2015 and 2022. The substantial increase in the number of special-regime home clients (by more than 21,000) is most likely the result of demographic developments[82] (ageing of population) and the associated increase in neurodegenerative diseases such as Alzheimer's dementia associated with a high level of need for continuous support. However, the available data does not allow to identify special-regime home facilities for people with mental illnesses aged 18–64, and we have therefore opted not to include these in the following comparison.

Chart 1 shows that the number of clients using outreach services increased significantly between 2007 and 2015. This is a positive trend from the viewpoint of deinstitutionalisation. However, the growth slowed down after 2016. The number of new clients joining the supported independent living service was about one third of the previous increase (i.e. there was a decrease of 64%). In the case of personal assistance, the number of new clients increased by only about a quarter of the increase in the previous period (a drop by 72%).

A similar trend can be observed in the use of sheltered housing. The increase in the number of clients of this service was 39% lower between 2016 and 2022 than in the previous period between 2007 and 2015. The rate of utilisation of the capacities of sheltered housing, an environment less restrictive than homes for people with disabilities and special-regime homes, has slowed. Sheltered housing facilities usually have lower capacities than homes for people with disabilities. Although the Convention does not consider capacity, i.e. the number of people living in a facility, an element defining an institution, a lower number of clients in a facility means a lower, or even zero, likelihood that the service will be provided in an institutional manner.

Chart 1 – Increase/decrease in the number of clients using selected services, as compared in the periods between 2007 and 2015 and 2016 and 2022



Note: Negative numbers in the chart indicate a decline in clients of the service over the given period (0 to -4,000). Positive numbers indicate new clients incoming into the service (0 to 8,000).

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[82] According to the Czech Statistical Office, the share of people over 65 years of age rose from 14.6% in 2007 to 20.4% in 2022. The age index, which measures the ratio of the population aged 65 and over to the population aged 0–14, increased from 102.4 in 2007 to 126.1 in 2022. Quoted from data published by the Czech Statistical Office, available at: www.czso.cz/ [retrieved on 19 March 2024]. The Czech Alzheimer's Society's 2016 Dementia Status Report notes that "While one in 866 people under the age of 65 suffers from dementia, the share for people over 65 is one in 13. In the highest age categories over 80 years of age, one in five suffers from dementia, and the same is true in almost one in two people in the category over 90 years of age."
Available [in Czech] at: www.alzheimer.cz [retrieved on 19 March 2024].

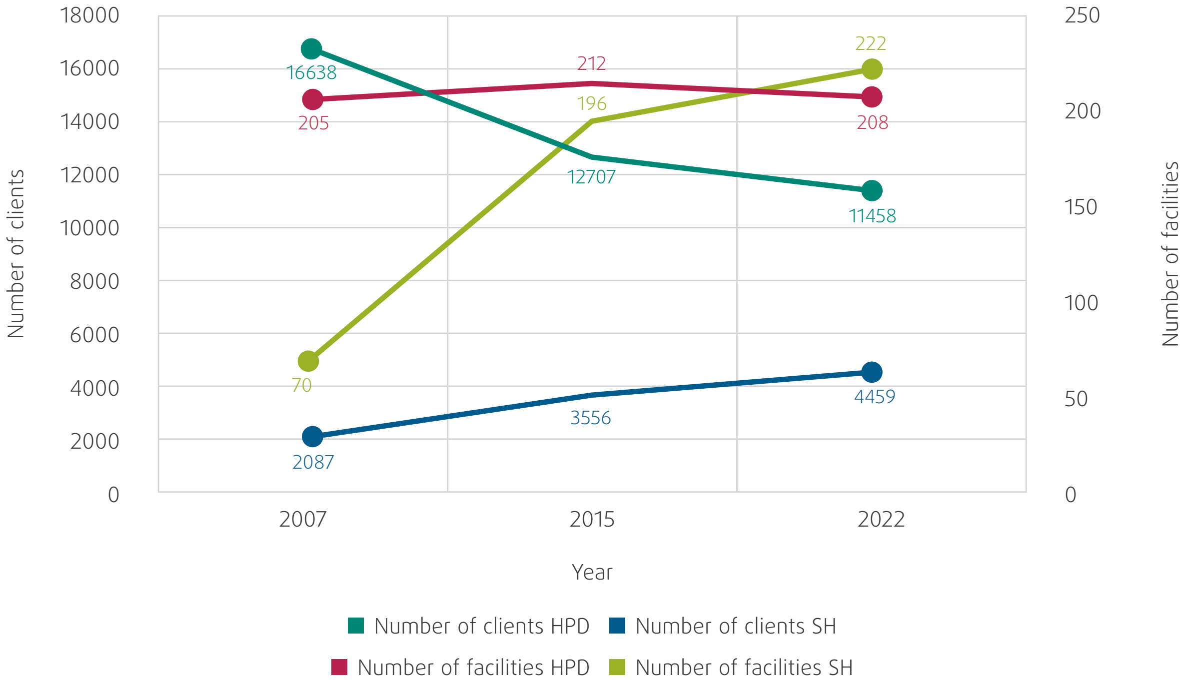
Chart 2 shows the developments in the number of clients and the number of homes for people with disabilities and sheltered housing facilities between 2007 and 2015 and 2022. The fact that the number of clients of homes for people with disabilities decreased by almost 4,000 people between 2007 and 2015 could be considered positive from the perspective of achieving the deinstitutionalisation goals. Unfortunately, the rate at which the numbers of clients of homes for people with disabilities are decreasing has slowed since 2016, with the numbers of clients decreasing by less than 1 300 by 2022. The data available also does not show whether the clients have moved from homes for people with disabilities to facilities where the service is provided in a non-institutional way (which is not necessarily the case even in sheltered housing facilities).

There has been a **slight increase in the number of homes for people with disabilities** between 2007 and 2022. In 2007, there were 205 homes for people with disabilities in the Czech Republic. By 2015, seven more such facilities were established. Several of the facilities were closed in the following period and **there were 208 homes for people with disabilities as of 2022**, i.e. three more than in 2007.

While 126 sheltered housing facilities were built between 2007 and 2015, the construction process slowed by almost four fifths between 2016 and 2022. Only 26 new sheltered housing facilities were built during that period. In 2022, there were 222 sheltered housing facilities.

The trends that we consider positive from the perspective of deinstitutionalisation (i.e. increasing number of clients using outreach services and sheltered housing, decreasing number of clients in homes for people with disabilities) were more pronounced between 2007 and 2015 than between 2016 and 2022.

Chart 2 – Developments in the total number of selected residential services and the number of clients using them between 2007 and 2015 and 2022

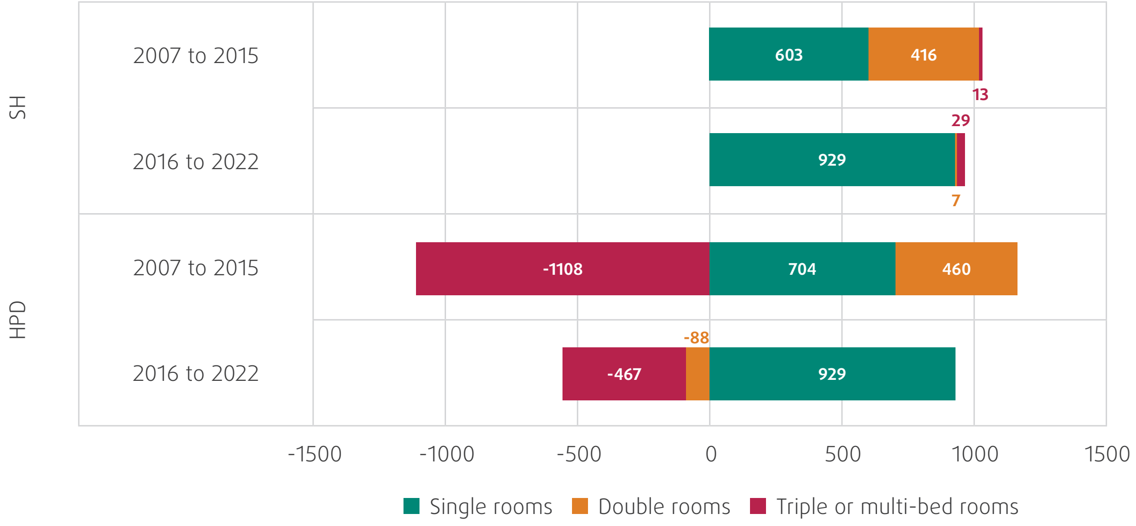


The last chart, which is intended to clarify the deinstitutionalisation trends in the Czech Republic, focuses on the number of newly created or closed single and multi-bed rooms between 2007 and 2015 and 2016 and 2022 for selected types of residential services (Chart 3).

The number of single and double rooms in sheltered housing services increased between 2007 and 2015, while single rooms clearly prevailed after 2016. **Single rooms are more likely to be in line with the right to choose with whom one wishes to live.** Worryingly, the number of triple and multi-bed rooms in sheltered housing has increased by almost thirty since 2016.

There has been a pronounced decrease in the number of triple and multi-bed rooms in homes for people with disabilities. The decrease was likewise faster between 2007 and 2015 than in the following period to 2022. The emphasis on building single rooms can be considered a positive trend that was strongly manifested in the period 2016 to 2022. We must add, however, that the Convention prohibits any investment in institutions. The data available does not show whether the homes for people with disabilities with more single rooms are still institutional in their nature,[83] but we can venture an educated guess that a significant proportion of them are. There is no evidence that the extensive investment made in the transformation has contributed significantly to the realisation of the right to independent living and community inclusion.

Chart 3 – Comparison of the number of new/closed single/multi-bed rooms between 2007 and 2015 and between 2016 and 2022 for selected types of residential services



Note: Negative numbers in the chart indicate the number of rooms closed (0 to -2,000). Positive numbers indicate the number of new rooms created (0 to 7,000).

We can try to estimate what the deinstitutionalisation trend will be in the coming years based on the data provided by the MoLSA during our survey. This data shows that the MoLSA expects to implement 74 projects for the transformation of social services worth CZK 3.8–4.5 billion in the new programming period. The data also shows that the numbers of clients in homes for people with disabilities are expected to drop further (Table 1). The current capacity is 214 homes for people with disabilities with a total of 11,647 beds (as of May 2023) and the MoLSA expects the total capacity to decrease to 9,318 beds, i.e. by almost one fifth, by 2030.

At the time of the data submission, the MoLSA expected that 80% of the planned capacity of homes for people with disabilities would be provided in community-based homes by 2030. However, this expectation no longer holds at the time of writing this report, as the approved Action Plan does not aim for 80% of the capacity to be provided in community-based homes for people with disabilities, but only for the approval of steps that will lead to this goal.[84]

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[83] For more on this concept, see chapter Important terminology explained.

[84] The condition that 80% of the capacity should be provided in community-based homes for people with disabilities in 2030 was derived from the Deinstitutionalisation Action Plan for 2023–2025, in the version as of the time of the data submission (May 2023). This objective has been changed in the approved version of the Deinstitutionalisation Action Plan, which reads (cf. page 15 of the quoted document): "**The aim of the Action Plan (...) is to prepare the process [of deinstitutionalisation] so that in the following period the Government can approve steps to reach the goal of having 80% of the entire capacity of homes for people with disabilities provided in community-based homes by 2030 and so that these steps can be approved on the basis of comprehensive and relevant documents.** The Plan also aims to ensure that the conditions for supporting the creation of community-based services is anchored in legislation by 2025." We feel that this objective is much less ambitious than the original one.

Table 1 – Expected developments in the capacity of homes for people with disabilities (maximum numbers of clients) according to the data of the Ministry of Labour and Social Affairs

Region	Number of homes for people with disabilities	Current residential capacity (May 2023)	Expected residential capacity in 2030
Capital City of Prague	11	479	383
South Bohemian Region	7	562	450
South Moravian Region	24	1 161	929
Karlovy Vary Region	8	399	319
Hradec Králové Region	11	626	501
Liberec Region	10	345	276
Moravian-Silesian Region	25	1 253	1 002
Olomouc Region	10	962	770
Pardubice Region	9	619	495
Plzeň Region	12	1 058	846
Central Bohemian Region	28	1 560	1 248
Ústí nad Labem Region	32	1 445	1 156
Vysočina Region	9	502	402
Zlín Region	18	676	541
TOTAL	**214**	**11 647**	**9 318**

All the above information shows that the **Czech Republic's primary issue is the lack of quality data that would allow monitoring of the progress of deinstitutionalisation**. The data available also does not show how much of the investment intended to transform the relevant services has been spent on an actual conversion to community-based services and in how many cases the investment resulted in another service of an institutional nature. The indicators selected lead us to the conclusion that the rate of deinstitutionalisation is stagnating for the selected types of services.

The approach of the regions and the Ministry of Labour and Social Affairs to deinstitutionalisation

We focused on mapping the approach of the regions/the Capital City of Prague (to which we jointly refer as "regions" throughout the survey) and the MoLSA to deinstitutionalisation. For this purpose, we conducted a content analysis of the regions' strategy documents valid as of April 2022 and the National Strategy for the Development of Social Services of the Ministry of Labour and Social Affairs for 2016–2025 (the "National Strategy"). The results of this analysis are presented in Chapter 1.

The second research method aimed to gain a deeper understanding of the obstacles and dilemmas encountered by the regions and the MoLSA in relation to deinstitutionalisation and social services development planning and consisted in a thematic analysis of 15 interviews with representatives of the regions and the MoLSA. The results of this analysis are presented in Chapter 2.

1. Results of content analysis of strategy documents

This chapter presents the content analysis results focused on the strategy documents of the regions and the MoLSA concerning deinstitutionalisation. We collected the strategy documents in April 2022 and classified them according to a coding key of our design between October 2022 and April 2023. We divided the documents into three categories:

- Medium-term plans for the development of social services (valid as of April 2022) were analysed for all regions (14 medium-term plans).
- We analysed specific strategy documents on deinstitutionalisation only for those regions that had any. These were four documents sent to us by three regions: South Moravian Region, Hradec Králové Region and Pardubice Region It should be noted that the validity of these documents significantly exceeded the period addressed by the medium-term plans – their average validity was eight years.
- National Strategy for the Social Services Development for 2016–2025 of the Ministry of Labour and Social Affairs, valid from 21 March 2016.[85]

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[85] The National Strategy was approved by Government Resolution No. 245 of 21 March 2016.

The content analysis focused on several areas:

- The first area examines whether and how social service providers define key concepts in their strategy documents(Chapter 1.1).
- The second area explores methods of involving people with disabilities in the preparation of the documents (Chapter 1.2).
- The third area assesses whether or not deinstitutionalisation appears among the strategic objectives of the documents analysed (Chapter 1.3).
- The fourth area monitors the sub-objectives of the strategy documents and whether they reflect the processes related to the transformation of institutional facilities (Chapter 1.4).
- The fifth area looks at the sub-objectives of the strategy documents and whether they reflect the processes related to the development of community-based services (Chapter 1.5).
- Another area examines the quality of the feasibility indicators of the strategy documents (Chapter 1.6).
- The last area of the content analysis presents a summary of the main findings with a legal commentary (Chapter 1.7).

First, we describe each area and explain why we have decided to investigate it. Then we present the results of the analysis of the medium-term plans for the development of social services, illustrated graphically in a chart. Finally, we summarise the results of the analysis of the National Strategy for the Development of Social Services and the specific strategy documents.

1.1 DEFINITIONS OF KEY TERMS

The first area we examined was how the regions and the MoLSA understand key terms such as "community service", "deinstitutionalisation" and "transformation". We were interested in how these terms are included and defined in the strategy documents, as a lack of their uniform interpretation can have a significant impact on the objectives and strategies of deinstitutionalisation of social services. Inconsistent definitions of these underlying terms can result in inconsistent ideas on what precisely deinstitutionalisation involves and what steps can be taken to achieve it.

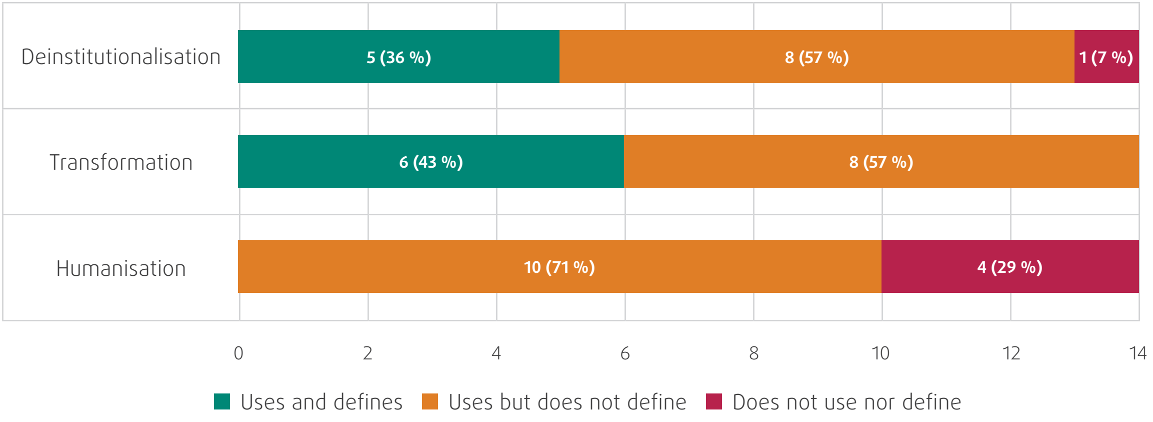
We investigated how often the three key terms "deinstitutionalisation", "transformation" and "humanisation" appear in the strategy documents and whether and how they are defined (Chapter 1.1.1). The next chapter examines alignment of the definitions with the Criteria (Chapter 1.1.2). This is followed by a chapter which focuses on the use of the terms designating community-based services (Chapter 1.1.3). We also inquired whether the documents included definitions of the term "community-based service" (Chapter 1.1.4), and then we assessed the definitions (Chapter 1.1.5).

1.1.1 FREQUENCY AND DEFINITIONS OF THE TERMS "DEINSTITUTIONALISATION", "TRANSFORMATION" AND "HUMANISATION"

First, we examined the way in which the three specific terms – "deinstitutionalisation", "transformation" and "humanisation" – are included and defined in the documents analysed.

Chart 4 shows that only about a third of the **medium-term plans for the development of social services** mention and define the term "deinstitutionalisation" (36%). In more than half of the plans, the term appears without any specific definition (57%). One region does not use or define the term (7%). The term "transformation" appears in all medium-term plans for the development of social services. More than half of the medium-term plans mention the term without further explanation (57%). In the remaining cases, the term is also accompanied by an explanation (43%). The term "humanisation" is not used as often by the regions as the previous two terms. In four medium-term plans, i.e. in less than a third, the term "humanisation" is neither used nor defined (29%). The remaining plans mention the term but lack a more detailed explanation (71%).

Chart 4 – Number of medium-term plans that use and define the terms "transformation", "deinstitutionalisation" and "humanisation" (N=14)



The **National Strategy for the Development of Social Services** uses and defines the terms "deinstitutionalisation" and "transformation". The document also includes the term "humanisation", albeit without a definition.

The terms "deinstitutionalisation" and "transformation" **appear in all four specific strategy documents.** Two of them, however, lack a definition of the terms.

1.1.2 QUALITATIVE EVALUATION OF THE DEFINITIONS OF THE TERMS "DEINSTITUTIONALISATION", "TRANSFORMATION" AND "HUMANISATION"

We also focused specifically on the definitions of the terms in the strategy documents. The definitions used in the Criteria served as the basis for the comparison (except for the comparison of the definition of deinstitutionalisation in the medium-term plans and the specific documents); for more details on the reasons for using the Criteria as a basis, see chapter Important terminology explained.

We selected the key elements of the definition of **deinstitutionalisation** in the Criteria and checked whether these elements were included in the definitions in the strategy documents. The key elements are:

- transformation of institutional care into community-based care;
- the goal is to improve the quality of life of social services clients;
- the goal is to enable normal life comparable to the life of one's peers;
- controlled closing of institutions (i.e. reducing institutional capacity so that the result is not an institutional service, the ideal outcome being a complete closure of the institution);
- development of community social services;
- the resulting structure and operation of the service is oriented towards the users' needs;
- the resulting structure and operation of services is oriented towards the users' social inclusion;
- non-exposure to institutionalisation (i.e. prevention of institutionalisation).

The underlying national document, the National Strategy, contains a definition of "deinstitutionalisation" consistent with the Criteria,[86] with one exception: The National Strategy emphasises that community-based services can be provided in all forms, including residential services. We therefore use the National Strategy's understanding of the term "deinstitutionalisation" for comparison with the definitions in the medium-term plans.

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[86] For more details, see chapter Important terminology explained.

Three regions define "deinstitutionalisation" similarly as the National Strategy. One region's definition included all the above elements except prevention of institutionalisation. The definitions of two regions were identical to the definition in the National Strategy, and only omitted the mention of disability. The definitions of "deinstitutionalisation" of two other regions are only partially consistent with the National Strategy's definition. One region has created its own definition and one other emphasises services provided according to the needs of the individual, social inclusion and living in the natural environment outside an institution.

The term "deinstitutionalisation" is also defined in two specific strategy documents. The definition partially aligns with the National Strategy. Both documents lacked the element of controlled closure of institutions, one of them also lacked the element of transformation of institutional care and the other did not include the element targeting the quality of life.

We compared the definition of "**transformation**" with the definition set out in the Criteria.[87]

In contrast to the definition outlined in the Criteria, "transformation" as defined in the National Strategy does include as a clear objective and outcome ensuring care in an individual's natural environment and reducing institutional capacity. This is not a fundamental difference as transformation refers to the process of deinstitutionalisation, the definition of which includes the element of reducing institutional capacity and one of its objectives is "to enable normal life comparable to that of one's peers".

Regarding the definition of "transformation" in medium-term plans, two regions used a definition consistent in terms of its contents with the definition set out in the Criteria. In the case of two other regions, we observed only partial alignment because at least one of the elements included in the Criteria's definition of transformation was missing. One region defined "transformation" differently than the Criteria in that it included the goal of enabling the return of clients living outside the region's territory. This is based on a local specificity and historical circumstances of building social services facilities and we do not consider this a deviation from the definition outlined in the Criteria. We found the last region's **definition problematic** because it emphasised the individual needs of the clients in the context of "humanising" the facilities and reducing their maximum capacity.[88] We have evaluated this definition as deviating from the meaning of "deinstitutionalisation" and "transformation" envisaged by the Criteria.

All three specific strategy documents defined the term "transformation" in a way that only partially aligned with the Criteria's definition.

It should be added that two specific strategy documents also contained the term "humanisation". According to both definitions, "humanisation" leads to creation of institutional facilities and is thus not considered a sufficient measure in the process of deinstitutionalisation. In this sense, the definition of "humanisation" is a good practice that can prevent the creation and preservation of institutional care facilities.

1.1.3 TERMS DESIGNATING COMMUNITY-BASED SERVICES

The aim of deinstitutionalisation of social services is to move from the institutional care model to the community model. For this reason, we focused on definitions that describe community-based services. The definition of community-based services is crucial to the planning and provision of these services.

Chart 5 provides an overview of the terms used in the **medium-term plans for the development of social services** to describe community-based services. The most commonly used term is "community service", which appears in twelve documents (86%). Nine documents use the terms "community-based service" and "community care", representing more than three quarters of the plans examined (79%). Less than two thirds of the medium-term plans contain the term "community-based social services" (64%). One plan mentions the term "care services in natural environment" which was categorised as "Other" (7%).

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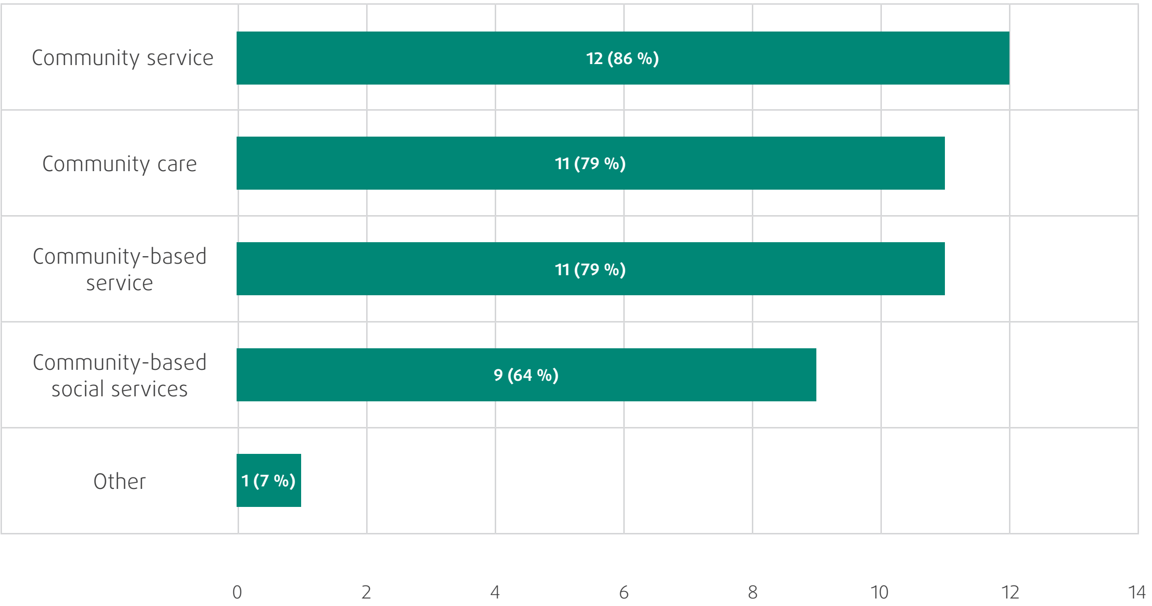
[87] Criteria, page 5: "Transformation – a set of processes to change the management, funding, education, location and form of service delivery so that care is provided in an individual's natural environment, and to reduce institutional capacity."

[88] "An important goal of the transformation is to provide social services in accordance with the individual needs of the service users through subsidy programmes aimed at supporting the creation of merely residential facilities with humanising elements, i.e. facilities with a capacity of 50 or less users located in a natural community and respecting the clients' privacy and interests."

Chart 5 – Terms used in medium-term plans to describe community-based services (N=14)



Note: The above shares do not add up to 100%, as one document could be classified in several categories.

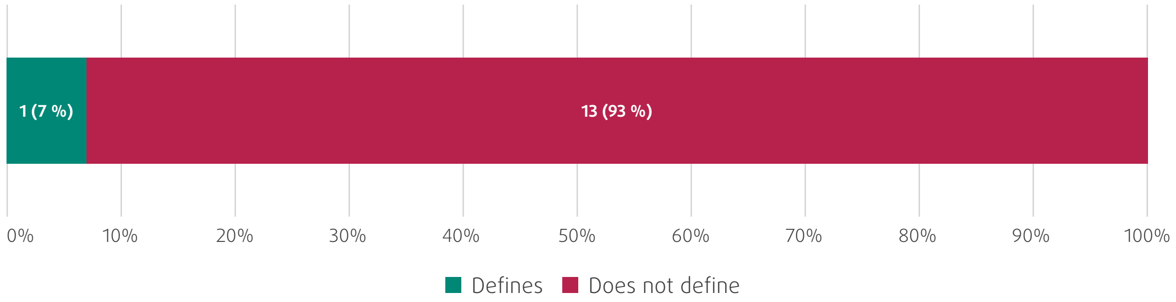
The **National Strategy for the Development of Social Services** includes all four terms. It should, however, be noted that the term "community care" is not used synonymously with other terms referring to community-based services. Community care refers to only one form of community-based services, specifically care provided in a community (see Chapter 1.1.5 Qualitative assessment of the definitions of terms denoting community-based services).

As regards the **specific strategy documents**, one uses the terms "community social services", "community service" and "community-based service". The remaining three specific documents use only two terms: "community service" and "community-based service".

1.1.4 DEFINITIONS OF TERMS DESIGNATING COMMUNITY-BASED SERVICES

We were also interested in whether the **medium-term plans** included a definition of community-based services (Chart 6). Only one plan contained this definition (7%). This means that in the majority of documents, namely in 13, the definition is not provided (93%).

Chart 6 – Number of medium-term plans that include a definition of the term "community-based services" (N=14)



The **National Strategy for the Development of Social Services** does not contain definitions of community-based services.

Although none of the regions define the term "community-based services" in their medium-term plans, the term's explanation can be found in two specific strategy documents.

1.1.5 QUALITATIVE ASSESSMENT OF THE DEFINITIONS OF TERMS DENOTING COMMUNITY-BASED SERVICES

We also looked at the actual definition of community-based services. Similar to the terms "deinstitutionalisation", "transformation" and "humanisation", the definition of "community-based services" from the Criteria serves as a basis for comparison.[89]

The National Strategy does not include a definition of the term referring to "community-based services". The only similar definition included in this document is the definition of "community care" as "assistance and support provided to people with disabilities in a community using community-based social services, publicly available services and informal support".[90] The National Strategy distinguishes "community care" from the term "community-based social service". The National Strategy thus understands "community-based social services" as one of the forms of community care, together with the publicly available services and informal support.

Only one of all the regions included in its medium-term plan a definition of this service that matched exactly the definition from the Criteria. One other region defined community care in its medium-term plan – but not literally according to the National Strategy, so it is not a definition of a "community-based service".

Two specific strategy documents provided their own definitions. Although these did not correspond literally to the Criteria,[91] they were aimed at fulfilling the right to live an independent way of life, which is essential.

1.2 PARTICIPATION OF PEOPLE WITH DISABILITIES IN THE PREPARATION OF THE DOCUMENT

Under the Convention, States have an obligation to involve people with disabilities in the planning of all policies that affect them. The recognition of the right of people with disabilities to full and effective participation in political, economic, social and cultural life should be reflected in the process of planning the social services development, and it is important to take into account their needs, experience and perspectives. The Czech Republic has committed to ensuring that people with disabilities have the opportunity to actively contribute to the design and implementation of social service development strategies tailored to their needs.

For a successful preparation of the plan, the active involvement of people with disabilities as well as the related disability organisations is crucial. For the purposes of the survey, disability organisations mean organisations representing the interests of people with disabilities, formal[92] and informal caregivers, municipalities, service providers, founders and other organisations that address the rights and needs of people with disabilities.

We therefore looked for information in the strategy plans on which disability organisations were involved in the preparation of the document by the regions/MoLSA (Chapter 1.2.1). We also wanted to find out whether these organisations also focused on the group of people with disabilities targeted in our survey, i.e. people with chronic mental illnesses and people with intellectual disabilities (Chapter 1.2.2).

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[89] For more details on the Criteria, see chapter Important terminology explained.

[90] For more details, see p. 112 of the National Strategy.

[91] "Community Services: Social services provided in the natural environment, where service users use public services, participate in social life, work if they can and are natural members of the community. These services are provided at the home of the person with disabilities, help them in all areas where they are unable to provide for themselves without assistance, reflecting their individuality; care and assistance is provided without the need to relocate to a highly specialised institutional facility."

"Community Service: A service provided in the natural environment where users can naturally interact with mainstream civil society. The aim of deinstitutionalisation is to provide social services in a community-based manner, in a location of the user's choice and the scope according to the user's individual needs. The criteria for community services (see the Manual for Transformation of Institutions) set a maximum of 4 clients per household as the threshold capacity for non-institutional residential community social service. No more than 12 clients may live in one house or housing unit with no more than 4 households associated with the provision of social services.

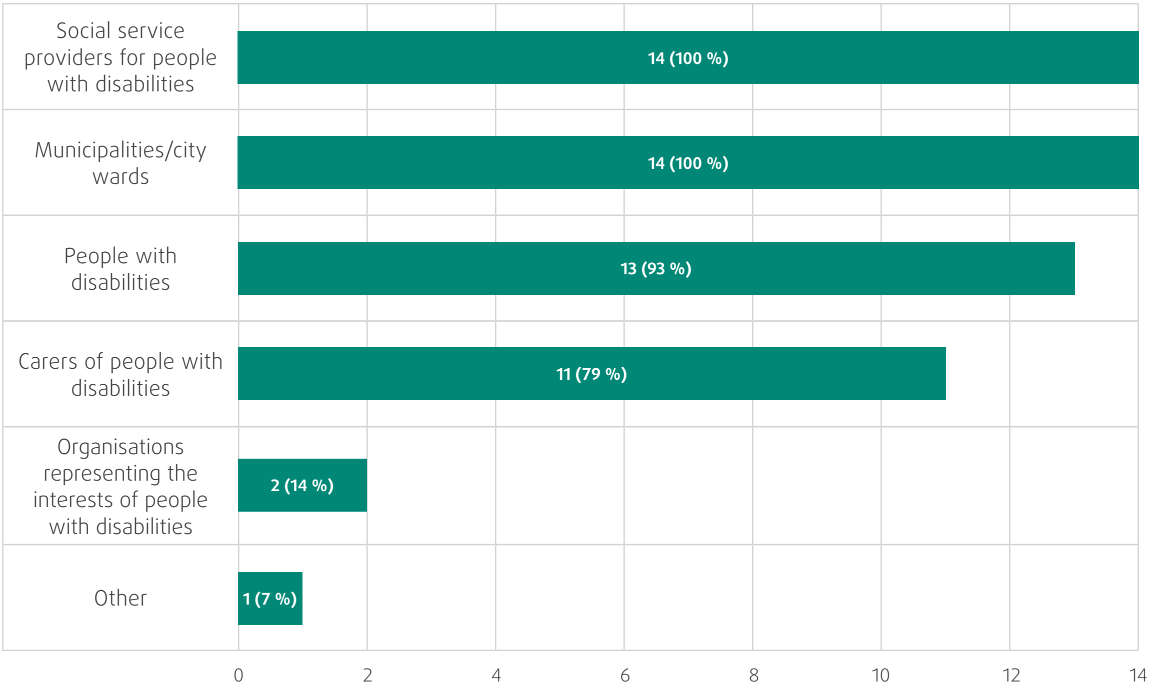
These households can be group households, i.e. 3 or more persons living in one household or unit, or individual households for 1–2 users. The rooms can accommodate a maximum of 2 people (persons who prefer cohabitation or partners)."

[92] Formal caregivers mean social care assistants pursuant to Section 83 of the Social Services Act.

1.2.1 INFORMATION ON ORGANISATIONS PARTICIPATING IN THE PREPARATION OF THE PLAN

As shown in Chart 7, the **medium-term plans for the development of social services** indicate that several groups of entities were involved in their preparation. All plans reported the involvement of municipalities/city wards and social service providers (100%). The medium-term plans also reported a high degree of involvement of people with disabilities, specifically 13 of the 14 regional plans (93%). Four fifths of the regional plans included information that persons caring for people with disabilities were also involved in their preparation (79%). Organisations representing the interests of people with disabilities were significantly less involved in the planning process, with only two regions (14%) mentioning their participation. One medium-term plan mentioned the involvement of other government organisations such as the Institute for Social Work and the Agency for Social Inclusion (7%).

Chart 7 – Types of disability organisations who participated and are mentioned in the medium-term plans (N=14)



Note: The above shares do not add up to 100%, as one document could be classified in several categories.

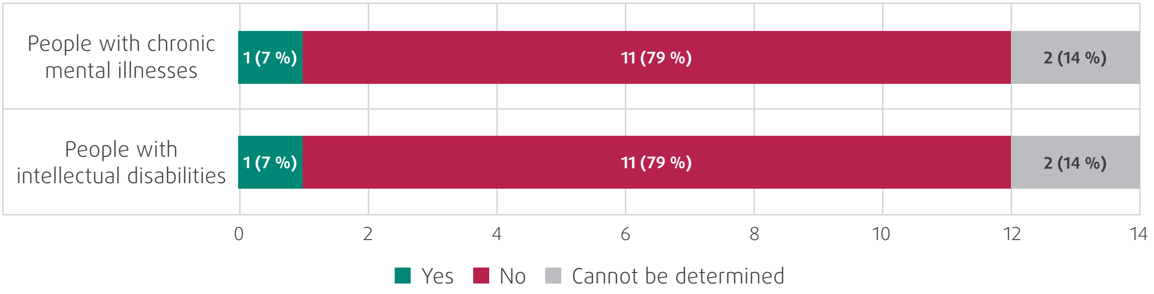
The **National Strategy for the Development of Social Services** states that the Ministry involved organisations representing the interests of people with disabilities and social service providers in the preparation of the National Strategy.

Information on the involvement of the disability organisations was reported in only one **specific strategy document** where persons caring for people with disabilities and social service providers were actively involved in the preparation.

1.2.2 PARTICIPATION OF ORGANISATIONS WORKING WITH PEOPLE WITH CHRONIC MENTAL ILLNESSES AND PEOPLE WITH INTELLECTUAL DISABILITIES IN THE PREPARATION OF THE PLAN

We were also interested in the involvement of organisations for people with specific types of disability in the process of preparing the document (Chart 8). We focused on two groups of people with disabilities – people with chronic mental illnesses and people with intellectual disabilities. Only one region (7%) provided information in its **medium-term plan for the development of social services** on the involvement of these entities. About four fifths of the regions did not list any organisations for a specific type of disability (79%) and for two regions we were unable to identify whether such organisations were involved (14%).

Chart 8 – Disability organisations involved in the preparation of the medium-term plan by type of disability (N=14)



The **National Strategy for the Development of Social Services** does not indicate that any organisations for people with intellectual disabilities or people with chronic mental illnesses were involved in the development of the strategy.

Information on the involvement of organisations appeared in only one **specific strategy document**. None of the organisations focus explicitly on people with intellectual disabilities or people with chronic mental illnesses.

1.3 STRATEGIC OBJECTIVES AIMING AT DEINSTITUTIONALISATION

The following chapter focuses on the analysis of the strategic objectives contained in the medium-term plans for the development of social services and documents related to deinstitutionalisation. In this context, strategic objectives meant **general objectives and visions that determine the direction of the social services development in the region and are further specified and supplemented with sub-objectives**. The intention behind this analysis is to assess the extent to which the regions have committed in their strategic objectives to the vision and objectives of deinstitutionalisation.[93]

Chart 9 shows that regions emphasised some elements of the definition of deinstitutionalisation more than others in their goals. All of the **medium-term plans** examined have strategic objectives aimed at developing community-based services (100%). The majority of regions include care in the natural environment in their medium-term plans (93%); only one plan omits this topic (7%). Social inclusion is a strategic objective in more than three quarters of the plans (86%) and less than three quarters of the plans also include reducing the capacity of institutional services (71%). This topic is not present in plans of four regions (29%). Half of the regional plans aim at closing the institutional services and focusing on the needs of users (50%). Prevention of institutionalisation was included in the objectives of three medium-term plans (21%), while the remaining four fifths of the plans do not include this element (79%).

It is important to note that strategic objectives related to the closing of institutional services and reduction of the capacity did not appear at all in the plans of four regions (29%). Three regions have only committed to reducing capacity (21%), while seven others plan to both close and reduce the capacity of institutional services (50%).

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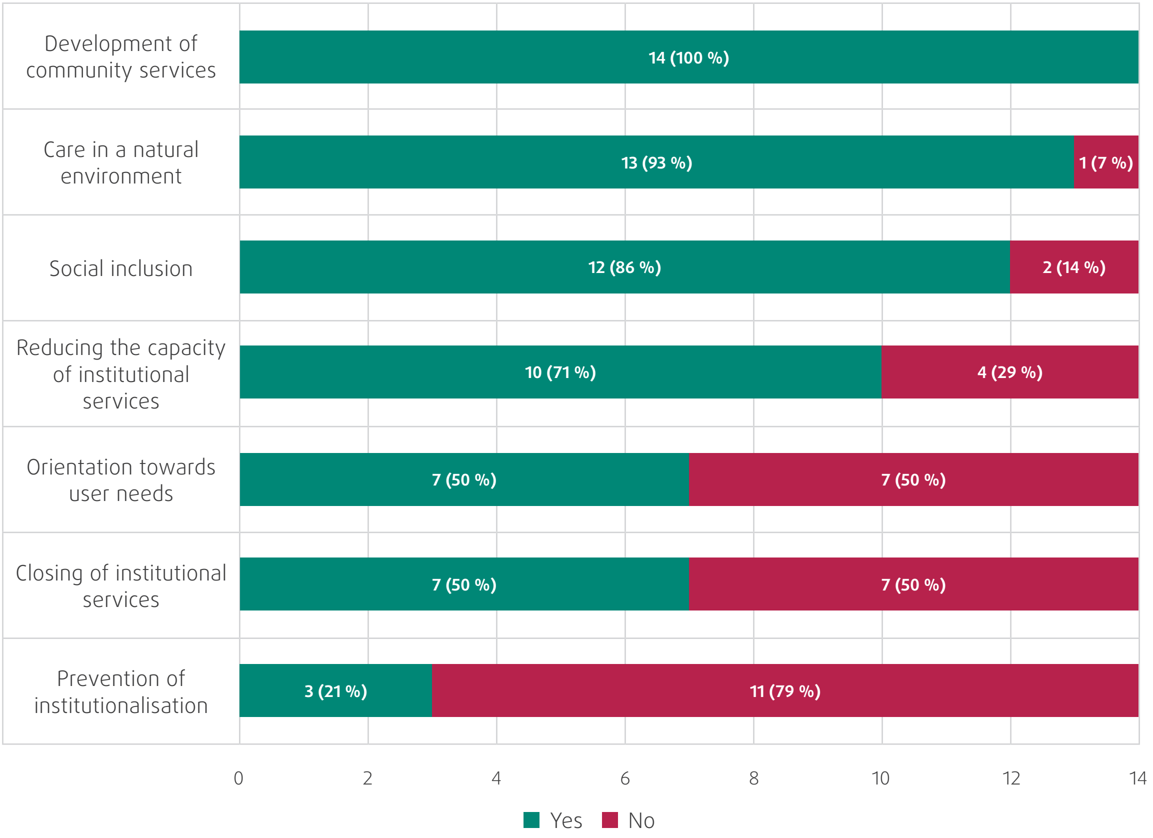
[93] The vision of deinstitutionalisation defined in the Criteria served as a basis for the analysis (p. 7): "Deinstitutionalisation of social services means a gradual and long-term process of change/transformation of institutional care into community care. This change aims to ensure that social service users can live as they choose in their own homes, similar to the majority society.

To achieve the vision of deinstitutionalisation, three basic objectives must be realised (Criteria, p. 8): 1. Prevent institutionalisation of more people; 2. transform institutional social care; 3. ensure availability of support in the community.

Chart 9 – Types of strategic objectives committing to the elements of deinstitutionalisation included in the medium-term plans (N=14)



The strategic objectives of the **National Strategy for the Development of Social Services** include all elements related to the commitment to fulfil the vision of deinstitutionalisation and its goals.

All of the **specific strategy documents** contained all of the elements examined. In some cases, they thus complemented the elements missing in the given region's medium-term plan. For example, one region's medium-term plan lacked a focus on the users' needs and the prevention of institutionalisation. Both of these elements were part of the objectives set out in the region's specific strategy document. Similarly, another region's medium-term plan lacked the prevention of institutionalisation, which this region targets in its specific strategy document.

1.4 TRANSFORMATION OF SOCIAL SERVICES IN SUB-OBJECTIVES

In the following chapter, we focus on how the transformation of social services is integrated into the sub-objectives of the strategy documents. While the previous chapter described how the documents work with the vision and strategic objective of deinstitutionalisation, this chapter focuses on sub-objectives. Sub-objectives refer to the most specific objectives. Their analysis will give us an insight into how measures and steps towards transformation of social services are planned.

We divided the sub-objectives into two groups. The first group concerns the reduction of capacity of institutional services (Chapter 1.4.1). The second group aims at the closure of institutional services and prevention of transmission of institutional elements in services that have undergone transformation (Chapter 1.4.2). We also wanted to find out whether the regions are planning a transformation of homes for people with disabilities and special-regime homes and whether the services provided in these facilities are intended for the target group, i.e. persons with intellectual disabilities or chronic mental illnesses (Chapter 1.4.3).

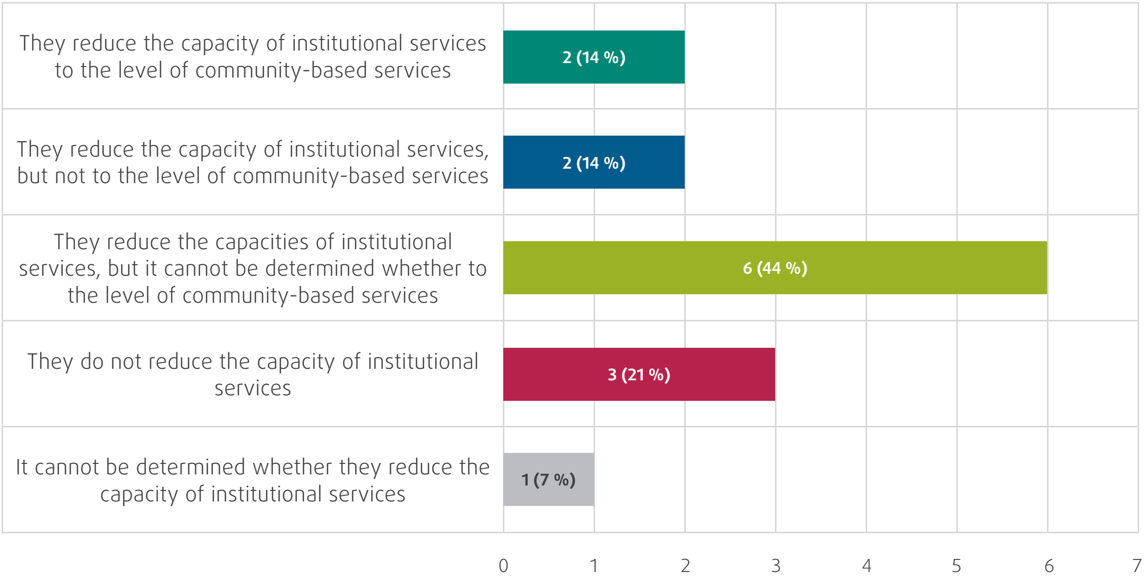
1.4.1 SUB-OBJECTIVES LEADING TO A REDUCTION IN THE CAPACITIES OF INSTITUTIONAL SERVICES

The analysis focuses on specific objectives that lead to a reduction in the capacities of institutional services to the level of community-based services (Chart 10). The Criteria served as a basis for the assessment of the capacities; a facility was considered a community-based service if it met the following conditions:[94]

1. Residential services in individual households can accommodate one or two clients; group services can have three to six clients, and sheltered housing can accommodate a maximum of four clients.
2. There is a maximum of 12 clients with low/medium level of support and 18 clients with high level of support per facility.
3. For ambulatory services, a maximum of 32 clients can use one facility at the same time, and up to 10 clients are allowed in one program.

In nearly half of the **medium-term plans** (44%), it is impossible to clearly determine whether they include reducing the capacity of institutional services to the level of community-based services. More than one fifth of the plans do not mention any reduction in the capacity of institutional services (21%). Two documents state that the capacity of institutional services is being reduced but not to the level of community-based services (14%). Two regional plans contain objectives aimed at reducing the capacity of institutional services to the level of community-based services (14%).

Chart 10 – Types of objectives specified in the medium-term plans aimed at reducing the capacity of institutional services to the level of community-based services for people with intellectual disabilities and people with chronic mental illnesses (N=14)



The sub-objectives set out in the **National Strategy for the Development of Social Services** are aimed at the reduction in the capacity of institutional services. However, it cannot be unambiguously determined whether these objectives lead to achieving the level of capacity of community-based services.

Three **specific strategy documents** define the objective of reducing the capacity of institutional services to the level of community-based services. One specific document mentions a partial reduction in the capacity of institutional services, but it is not clear whether or not the aim is to reach the level of community-based services.

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[94] We were unable to ascertain from the strategy documents whether other criteria for community-based services, such as the location of the service and the manner of its delivery, were met. We therefore only considered the capacity criterion.

1.4.2 SUB-OBJECTIVES AIMED AT THE CLOSURE OF INSTITUTIONAL SERVICES AND PREVENTING THE TRANSMISSION OF INSTITUTIONAL ELEMENTS

We also examined whether the sub-objectives include measures aimed at the complete closure of institutional services in favour of community-based services (including a moratorium).

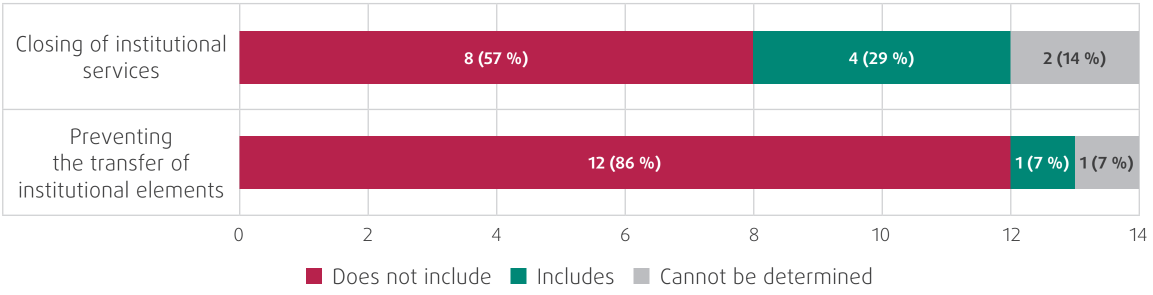
We were also interested in whether the sub-objectives aim to minimise the transformed facility's adoption of elements characteristic for institutional services. We inspected the plans for the following measures:

- regular audit of institutional elements;
- training of staff (in transformed facilities) on preventing the transmission of institutional elements;
- mechanism for quality control of services with emphasis on detection and elimination of institutional elements;
- fulfilment of material and technical requirements to prevent the transmission of institutional elements into transformed facilities;
- fulfilment of personnel standards to prevent the transmission of institutional elements into transformed facilities;
- external environment standards (i.e. compliance with the criteria for a community-based service in terms of the location of the facility within the municipality or a specific site).

It is clear from the analysis results (Chart 11) that more than half of the **medium-term plans** examined do not include closure of institutional services (57%). In less than a third of the documents, this aspiration is explicitly reflected in sub-objectives aiming to terminate institutional services altogether (29%). In two documents, it was not possible to determine whether or not they contained this element (14%).

It follows from the medium-term plans examined that more than four fifths of them contain no measures to prevent the transmission of institutional elements (86%). Only one plan includes this element (7%), and there is one plan where we were unable to clearly identify whether or not the element is present (7%).

Chart 11 – Types of objectives in the medium-term plans aimed at preventing the transmission of institutional elements and closing of institutional services for people with intellectual disabilities and people with chronic mental illnesses (N=14)



The **National Strategy for the Development of Social Services** contains sub-objectives aimed at complete closure of institutional services for people with intellectual disabilities and people with chronic mental illnesses. Moreover, the National Strategy does not set any sub-objectives aimed at preventing the transmission of institutional elements into the transformed facilities.

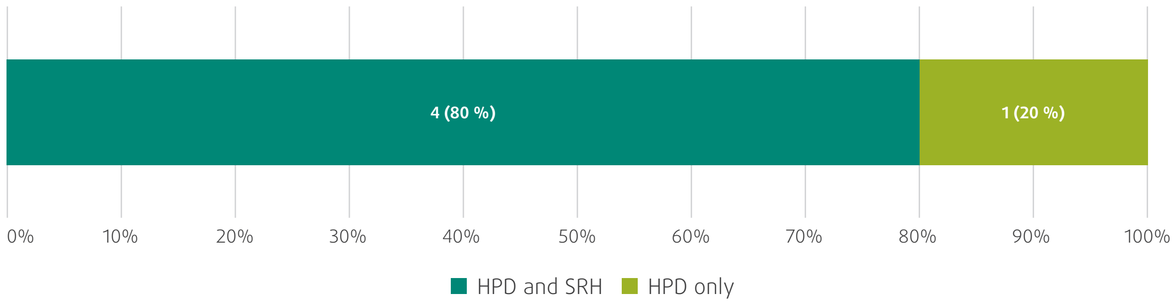
All four **specific strategy documents** contain objectives aimed at the closure of institutional services for people with intellectual disabilities and people with chronic mental illnesses. Preventing the transformed facilities from adopting institutional elements was mentioned only by one specific document.

1.4.3 TARGET GROUPS AND TYPES OF TRANSFORMED SERVICES

For strategy documents that focus on the transformation of social services and include the closing of institutional services, preventing the transmission of institutional elements or reducing the capacity, we examined whether the services provided in these facilities are intended for the target group, i.e. people with intellectual disabilities and people with chronic mental illnesses. The results show that in all five **medium-term plans** referencing some form of transformation of social services, these services are intended for the target groups mentioned (100%). This finding is consistent not only with the **National Strategy for the Development of Social Services**, but also with all four **specific strategy documents** (100%). The regions are planning to transform services for both monitored groups.

Furthermore, we were interested in whether the homes for people with disabilities and special-regime homes were undergoing transformation. We found that four out of five **medium-term plans** report that the transformation includes both of the above services (80%). Only one regional plan mentions transformation only with respect to homes for people with disabilities (20%).

Chart 12 – Selected types of services intended for transformation under the medium-term plans for the development of social services (N=5)



The **National Strategy for the Development of Social Services** did not specify any particular type of service in its sub-objectives. Moreover, all four **specific strategy documents** anticipate transformation of homes for people with disabilities as well as special-regime homes.

1.5 DEVELOPMENT OF COMMUNITY-BASED SOCIAL SERVICES IN SUB-OBJECTIVES

As regards sub-objectives, we looked not just at the efforts to transform the services, but also the regions' plans to ensure the development of community-based social services. Our analysis focused primarily on services for people with intellectual disabilities and chronic mental illnesses.

In the first part, we examine the sub-objectives that aim at the development of community services as defined in the individual strategy documents (Chapter 1.5.1). We then assess whether these objectives meet the criteria set for community-based services (Chapter 1.5.2). The following section discusses the client groups for which the newly developed community services are intended (Chapter 1.5.3). We also focus on the specific services that each region plans to develop, we assess their community character (Chapter 1.5.4) and characterise the types of these services (Chapter 1.5.5).

1.5.1 SUB-OBJECTIVES AIMED AT THE DEVELOPMENT OF COMMUNITY-BASED SERVICES

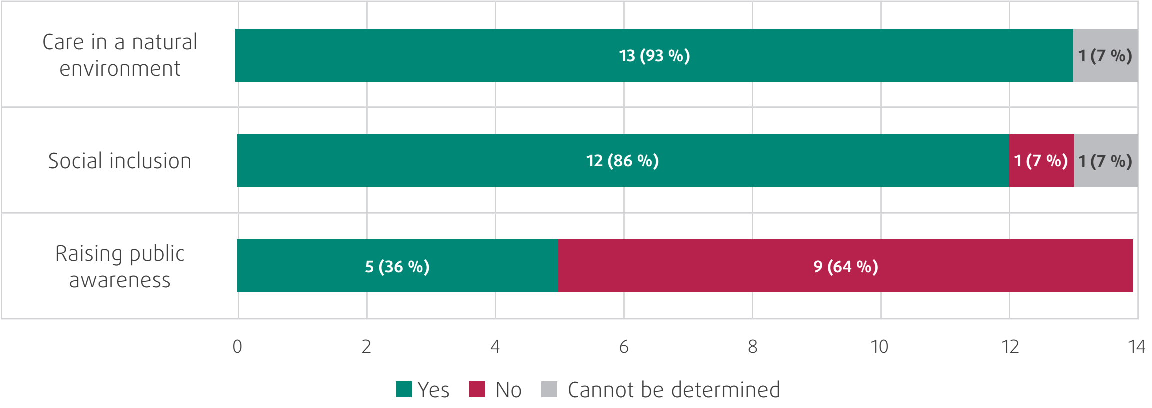
We examined whether the sub-objectives included areas crucial for the development and strengthening of community-based services for people with disabilities and their inclusion in the community. In the sub-objectives defined in the individual documents, we looked at three key aspects:

- Raising public awareness: This aspect includes objectives that focus on communicating with the public to avoid concerns about building new facilities for community-based services. This also concerns raising awareness on the topic of disability, including the rights and needs of people with disabilities and rebutting myths and prejudices. Another component of this area is sharing good practice in the provision of community-based services and informing about the negative consequences of institutionalisation and the benefits of deinstitutionalisation.

- Social inclusion of people with disabilities: This aspect is related to activities aimed at increasing the social inclusion of people with disabilities, i.e. setting social inclusion goals, developing various services that support contact with the community, including employment, education, housing, etc.
- Providing care in the natural environment: This aspect focuses on whether the sub-objectives lead to the development and promotion of care for people with disabilities in their natural environment. This includes establishing or increasing the capacity of services that support care in the home environment, improving the accessibility of these services or supporting informal care, such as support for carers.

The sub-objectives of almost all **medium-term plans** are aimed at promoting and developing care in the natural environment (93%), as shown in Chart 13. In one document, we were unable to determine whether its sub-objectives included this aspect (7%). Almost four fifths of the regional plans include objectives aimed at social inclusion of people with disabilities (86%). One document does not include this aspect (7%), and we were unable to identify this in one plan (7%). Furthermore, we found that about one third of the medium-term plans include objectives aimed at raising public awareness (36%), while about two thirds of the documents lack measures that would address this aspect (64%).

Chart 13 – Types of objectives specified in the medium-term plans aimed at the development of community-based services for people with intellectual disabilities and/or people with chronic mental illnesses (N=14)



The **National Strategy for the Development of Social Services** covers all three aspects: raising public awareness, social inclusion and care in the natural environment.

All **specific strategy documents** include measures to support care for people with disabilities in the home environment and objectives aimed at social inclusion. Raising public awareness of disability-related issues is included in three of the four documents.

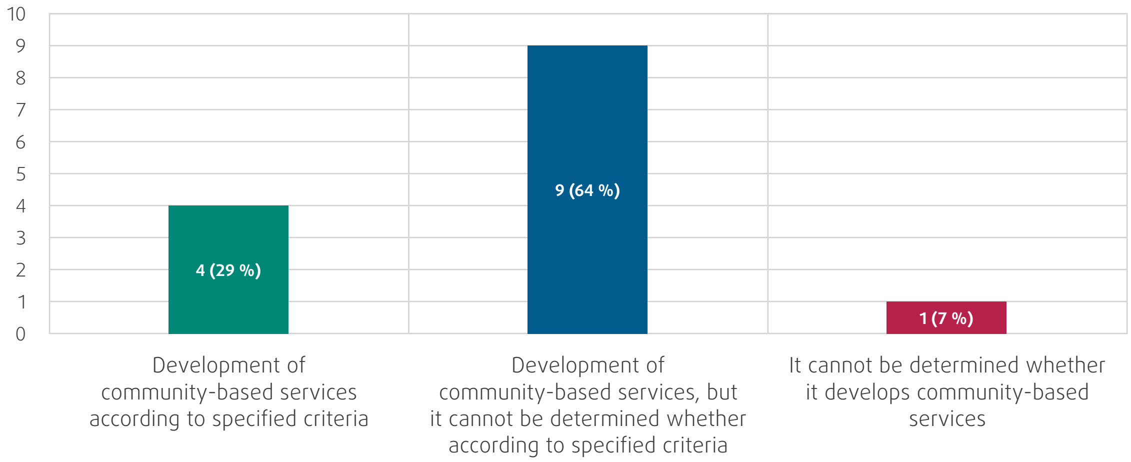
1.5.2 SUB-OBJECTIVES AIMED AT THE DEVELOPMENT OF COMMUNITY-BASED SERVICES ACCORDING TO THE CRITERIA

We investigated whether at least one of the sub-objectives focused on developing a community-based social service for people with intellectual disabilities or people with chronic mental illnesses. In accordance with the Criteria, we considered a service to be community-based if it met the criterion of suitable location within a municipality and the criterion of small capacity:

- Suitable location within a municipality: The community-based service is located within the municipality in the same way as other premises that serve the same purpose but is not concentrated with other services of the same nature in one place.
- Small capacity – see Chapter 1.4.1.

Chart 14 shows that almost two thirds of the **medium-term plans** aim to develop services presented as community-based, but it is not possible to determine from the formulation of the sub-objective whether they meet the criteria for a community-based service (64%). Four medium-term plans develop services that meet the criteria for a community-based service (29%). For one plan, we were unable to assess whether or not the services to be developed are community-based services (7%).

Chart 14 – Types of objectives specified in the medium-term plans aimed at the development of community-based services meeting the identified criteria (N=14)

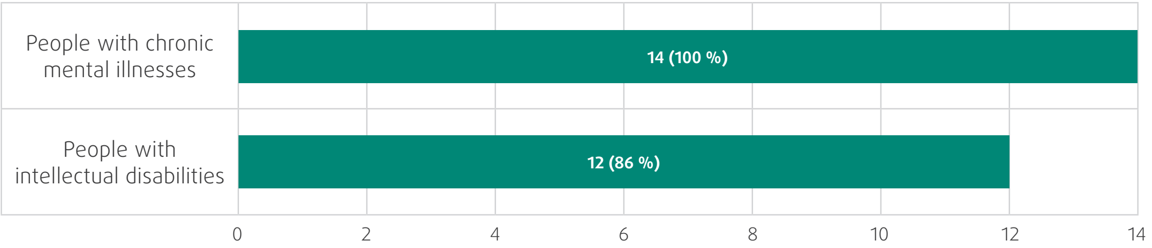


The **National Strategy for the Development of Social Services** contains objectives to develop services presented as community-based, but we have not been able to assess whether the services meet the specified criteria. The same is true for one **specific strategy document.** The remaining three specific strategy documents contain objectives that are clearly aimed at the development of community-based services.

1.5.3 TARGET GROUPS OF THE COMMUNITY-BASED SERVICES TO BE DEVELOPED

In the case of strategy documents that focus on the development of community-based social services, we examined whether these services are intended for the target groups, i.e. people with intellectual disabilities and people with chronic mental illnesses (Chart 15). The development of community-based services outlined in all **medium-term plans** is targeted at people with chronic mental illnesses (100%) and, in more than four fifths of plans, also at people with intellectual disabilities (86%).

Chart 15 – Selected types of target groups (people with intellectual disabilities and people with chronic mental illnesses) for whom the community-based services projected in the regions' medium-term plans are intended (N=14)



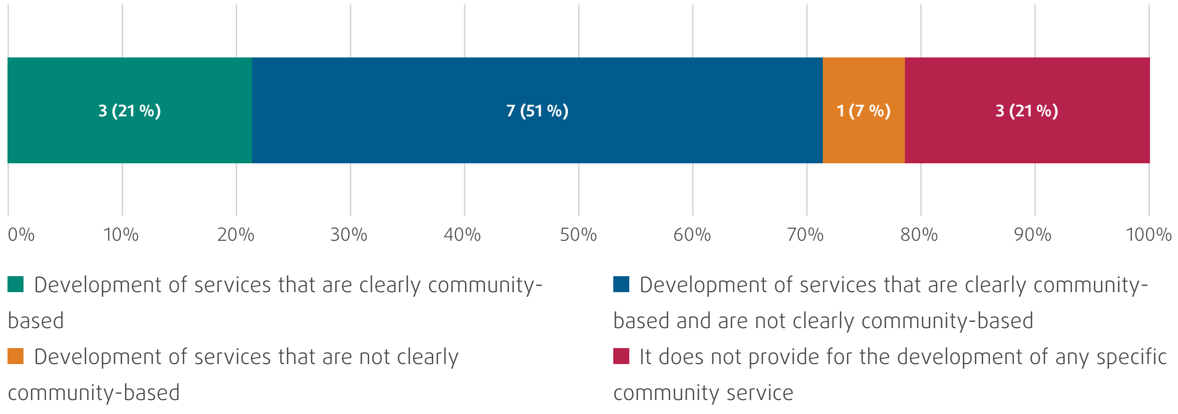
The sub-objectives of the **National Strategy for the Development of Social Services** aimed at the development of community-based services are designed for people with intellectual disabilities and people with chronic mental illnesses. The sub-objectives of the four **specific strategy documents** have the same function.

1.5.4 COMMUNITY CHARACTER OF THE SPECIFIC TYPES OF SERVICES TO BE DEVELOPED

We researched which community-based services are to be developed under one of the document's sub-objectives. We have divided these services into two categories according to whether or not they can be clearly and definitely considered as community-based.

Chart 16 shows that three **medium-term plans** focus exclusively on the development of services that are clearly community-based (21%). More than half of the plans address the development of both services that we believe are community-based and services for which we are unable to determine the community character (51%). One region is planning to develop services for which we could not clearly identify whether they are community-based (7%). Three plans did not specify in their sub-objectives any specific types of community-based services they planned to develop (21%). The sub-objectives in these documents mostly described the development of services in general, without specifying their type.

Chart 16 – Number of the medium-term plans that target the development of specific community-based services (N=14)



The sub-objectives of the **National Strategy for the Development of Social Services** did not specify the development of any particular type of community-based service. At the same time, all the **specific strategy documents** include plans to develop services that we have identified as clearly community-based.

1.5.5 TYPES OF COMMUNITY-BASED SERVICES TO BE DEVELOPED

We have focused on the specific types of community-based services that are to be developed according to the strategy documents. Chart 17 shows that almost three quarters of the medium-term plans contained sub-objectives aimed at developing personal assistance (71%), a service that is community-based by its nature.

We give particular attention to services that are often transformed into community-based services. These include **sheltered housing**, **special-regime homes** and **homes for people with disabilities**. First, the development of clearly community-based sheltered housing is projected in over half of the plans (57%). Three plans aim at the development of sheltered housing, but we were unable to determine whether this will be a community-based service (21%). Second, only one plan (7%) mentions the development of explicitly community-based special-regime homes. In less than half of all plans (43%), we were unable to determine whether these would be community-based services. Third, only less than a third of the plans envisage the development of explicitly community-based homes for people with disabilities (29%); in less than half of the plans, it was not possible to determine whether they were aimed at developing community-based homes for people with disabilities (43%).

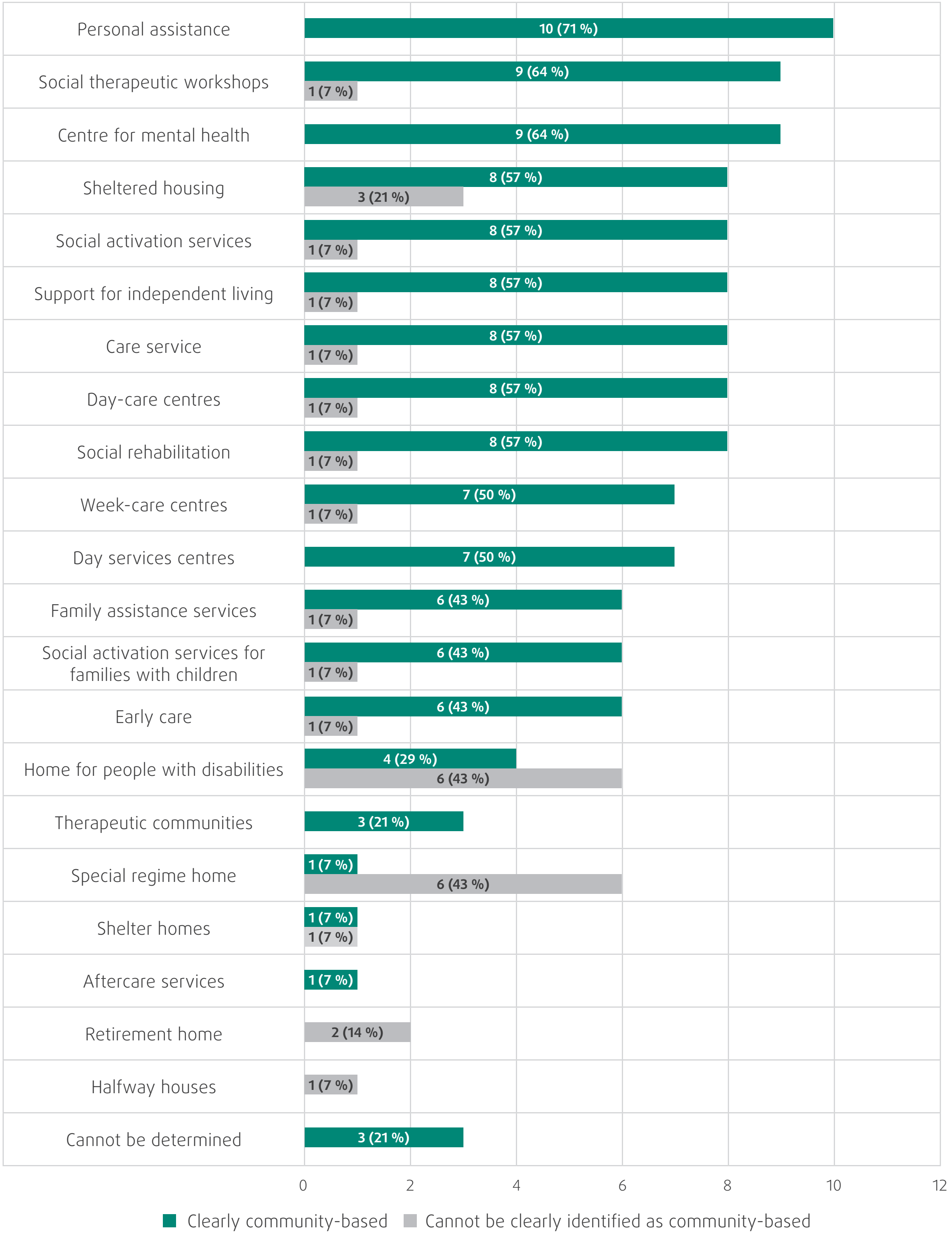
Approximately two thirds of the medium-term plans contained sub-objectives aimed at developing community **mental health centres** and **social therapy workshops** (64%). One other plan targets the development of these workshops, but it is not clear whether they will be community-based (7%).

More than half of the medium-term plans envisage the development of services that we consider to be community-based (57%). These include **social rehabilitation**, **day-care centres**, **care service**, **support for independent living** and **social activation services** for the elderly and people with disabilities. All these services also appear in the objectives of one other plan, but it was not clear from the description whether these are community-based services (7%).

Half of the medium-term plans focused on the development of **day service centres and week-care centres** that are clearly community-based (50%). One plan also mentions the development of week-care centres (7%), but the formulation of the sub-objective does not make it clear whether this is a community-based service.

Interestingly, one fifth of the regions mention the development of community-based services in their documents (21%). However, the type of these services was not clear from their description, so we categorised these plans under "Cannot be determined."

Chart 17 – Types of community-based services intended for development under the regional medium-term plans (N=14)

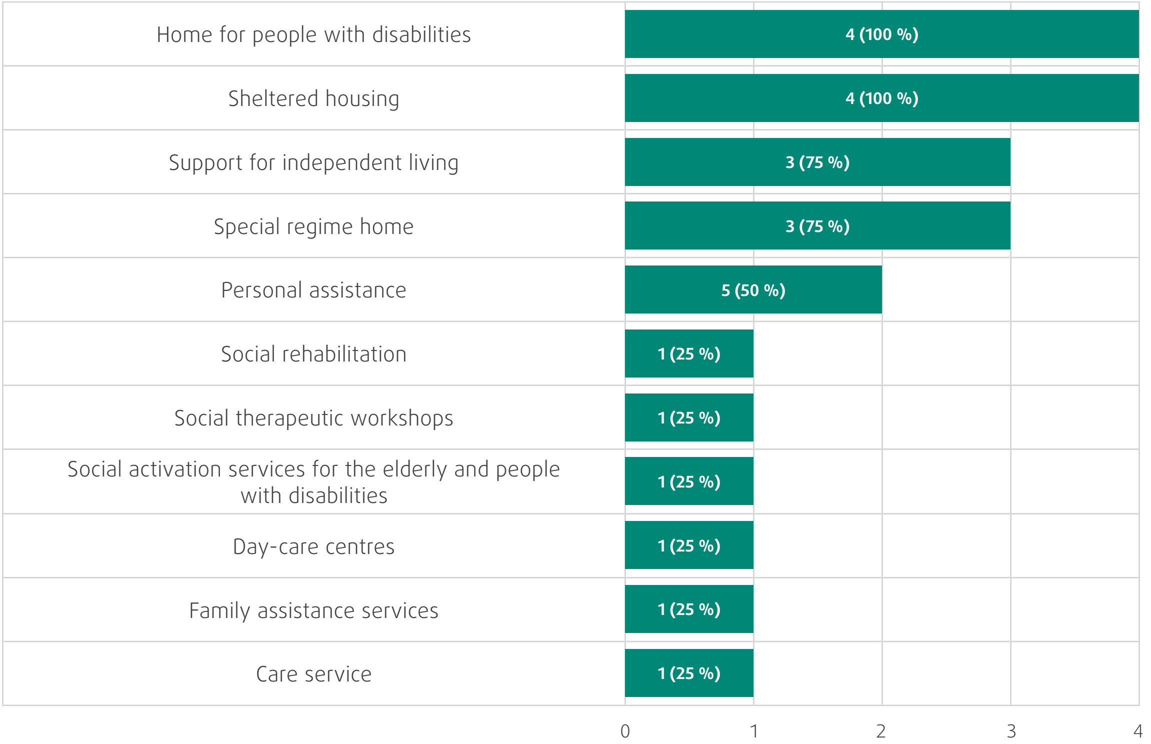


Note: The above shares do not add up to 100%, as one document could be classified in several categories.

The sub-objectives of the **National Strategy for the Development of Social Services** did not specify the development of any particular type of community-based service.

The analysis of **specific strategy documents** revealed an interesting insight regarding the priorities assigned to the development of the individual types of community-based social services (Chart 18). Most documents target the development of sheltered housing and homes for people with disabilities. All the specific documents on social services development include these services in their objectives (100%). Three documents (75%) included services such as a special-regime home and support for independent living. Two documents envisaged the development of personal assistance (50%). Other services (i.e. care services, family assistance services, day-care centres, social activation services for the elderly and people with disabilities, social therapy workshops and social rehabilitation) were included in the objectives of one document (25%).

Chart 18 – Types of community-based services targeted by the specific regional strategy documents (N=14)



Note: The above shares do not add up to 100%, as one document could be classified in several categories.

1.6 RELEVANCE OF THE OBJECTIVES OF THE STRATEGY DOCUMENT

To ascertain whether we are on course to attain or have already attained the objectives, it is imperative that the objectives are well-formulated. We selected a number indicators from the methodology of the Ministry of Regional Development[95] to assess the quality and feasibility of specific sub-objectives. These include:

- Measurability: The purpose of this indicator was to determine whether the sub-objectives include defined measurable outputs, against which their attainment can be evaluated.
- Designated activities: This indicator monitors whether the strategy document defines activities leading to the achievement of the sub-objective.

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[95] MINISTRY FOR REGIONAL DEVELOPMENT. Methodology of Public Strategy Development. Online, 2012. Available [in Czech] at: www.mmr.cz.[retrieved on 19 March 2021].

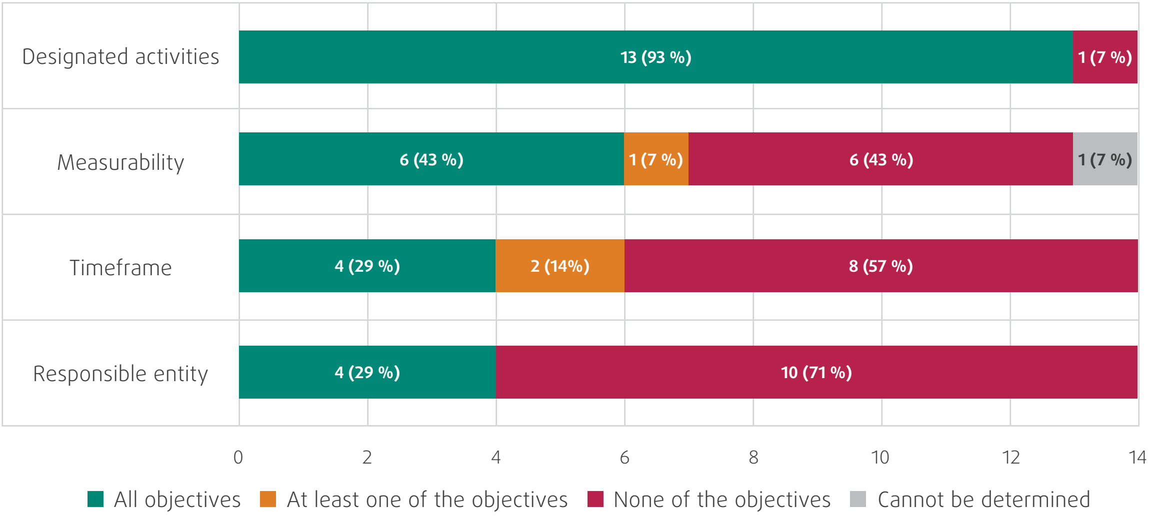
- Responsible entity: This indicator determines whether the sub-objective identifies a person (or group of persons) responsible for its achievement.
- Timeframe: The purpose of this indicator is to determine whether there is a clearly defined timeframe for the attainment of the sub-objective. We examined whether there was a defined date of commencement of the activities leading to the objective and a deadline for achieving the objective. We also looked at whether the document contained at least one of these dates.
- Funding: This indicator monitors whether the strategy document has identified the financial costs and resources that will be used to finance the activities aimed at achieving the sub-objective. We explored whether the medium-term plans for the development of social services included a completed cost plan table as required by law.

The following chapters provide an assessment of how the objectives contained in the strategy documents meet these indicators.

1.6.1 WHICH INDICATORS ARE INCLUDED IN THE PLANS AND HOW FREQUENTLY

Chart 19 shows that 13 of the 14 medium-term plans contain activities aimed at attaining the objectives (93%). One plan does not include specific measures for any of the objectives (7%). Less than half of the medium-term plans have clearly defined measurability for all sub-objectives (43%). Conversely, the same proportion of plans do not include any indicator to determine whether the given objective has been attained (43%). Only one medium-term plan includes a measurability indicator for at least one of the sub-objectives (7%). For one other plan, we cannot clearly determine whether any form of measurability is established or not (7%). More than half of the plans do not have a specific timeframe for any of the sub-objectives (57%), and less than a third of the plans have one common timeframe for all objectives (29%). Two plans indicate a deadline for at least one sub-objective (14%). The entity responsible for meeting the objectives is identified for all objectives in about a third of the documents (29%). The remaining plans have no designated responsible entity (71%).

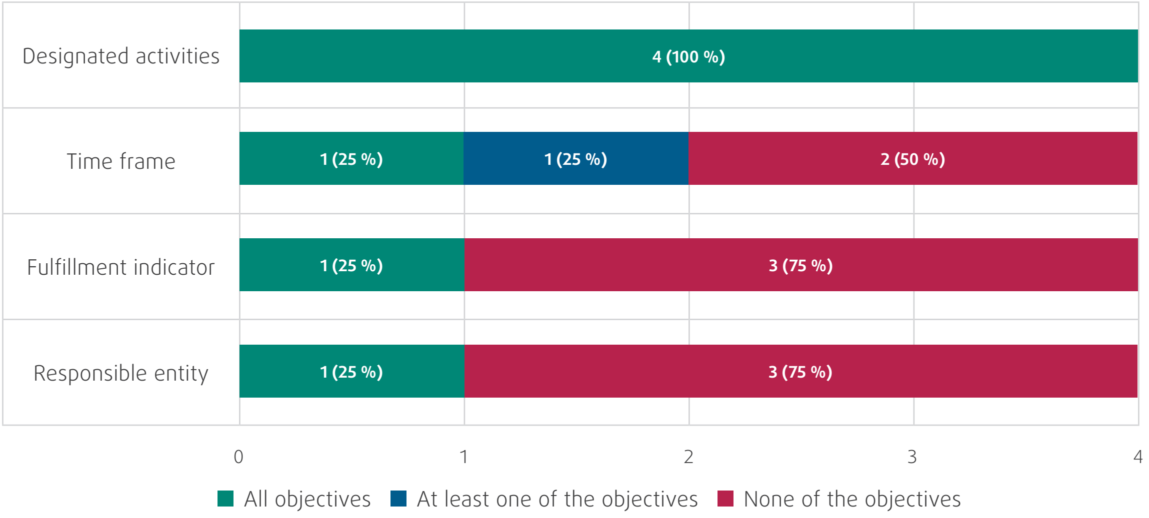
Chart 19 – Selected indicators included in the sub-objectives of the medium-term plans (N=14)



All the objectives of the **National Strategy** have a specified timeframe, an entity responsible for achieving the objectives and activities that will lead to their attainment. At least one objective of the National Strategy does not include a measurability indicator.

The same elements were observed in the **specific strategy documents** (Chart 20). All the strategies analysed specify in the sub-objectives the activities aimed at achieving the sub-objectives (100%). Only one document (25%) clearly sets out a timeframe for achieving all the objectives, and half of the documents analysed do not include any such timeframe (50%). Only one document outlines objectives that are all measurable (25%). Only one strategy has a clearly defined responsible entity for all its objectives (25%).

Chart 20 – Selected indicators included in the sub-objectives of specific strategy documents (N=4)

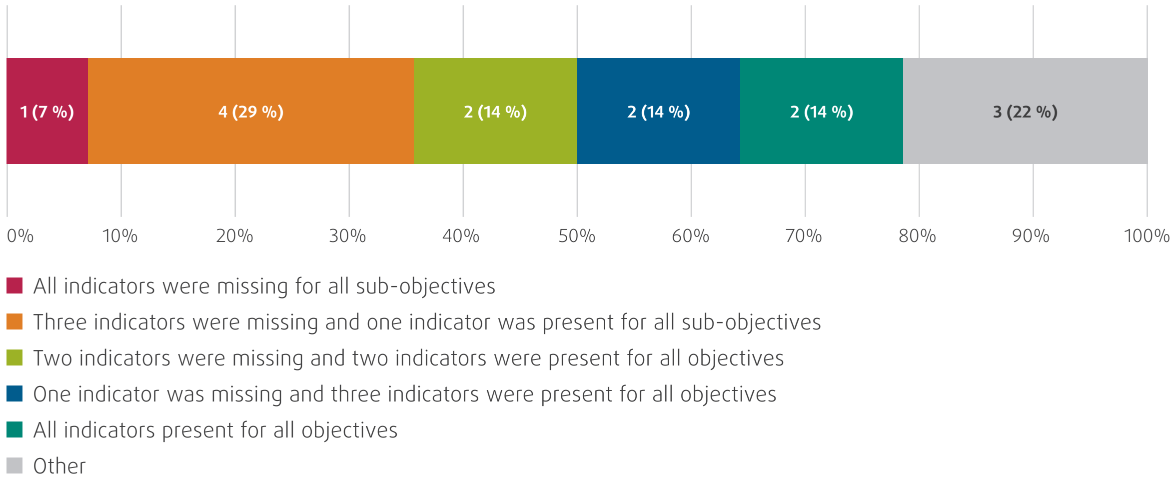


1.6.2 INDICATORS INCLUDED IN THE INDIVIDUAL PLANS

We also examined whether the medium-term plans included the indicators monitored above (Figure 21). We found that one medium-term plan did not include any indicator (7%). Just under a third of the medium-term plans (29%) lacked three of the four indicators monitored. These plans described only the activities aimed at meeting the sub-objective.

The sub-objectives in two of the medium-term plans specified two indicators (14%). Both these plans included measures to achieve the sub-objectives; one of them also included a measurability indicator and the other specified the responsible entity. Two medium-term plans envisaged monitoring three of the four indicators for all their sub-objectives (14%). The only one missing was the responsible entity. Another two medium-term plans included all the indicators monitored for all the sub-objectives (14%). We categorised three other plans under “Other” as there was a different combination of indicators present and missing (22%).

Chart 21 – Number of the medium-term plans that include the selected indicators (N=14)



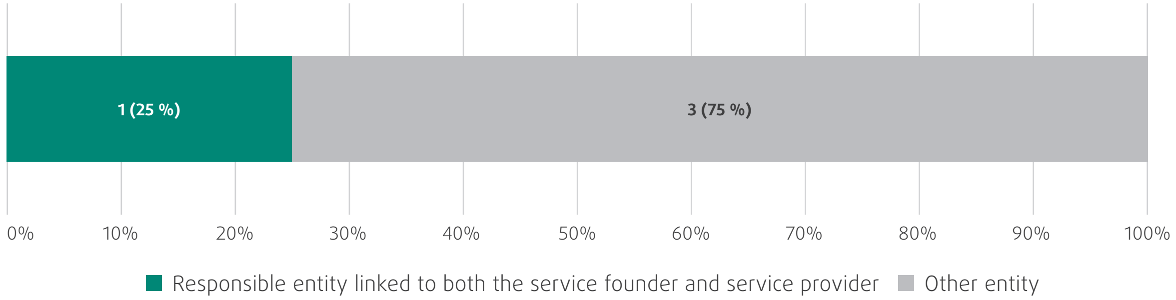
All the objectives of the **National Strategy** have a specified time frame, an entity responsible for achieving the objectives and activities that will lead to their attainment. At least one objective of the National Strategy does not include a measurability indicator.

None of the **specific strategy documents** included all the indicators for all their sub-objectives. Two strategies specified only the activities aimed at achieving each of their sub-objectives. One document only lacked a designated responsible entity. One other strategy had activities and a responsible entity listed for all objectives, and some of its objectives also included a time frame. On the other hand, the measurability indicator was missing altogether.

1.6.3 ENTITIES RESPONSIBLE FOR ATTAINING THE SUB-OBJECTIVES

For strategy documents that identify a responsible entity for at least one objective, we also explored who this entity was. Chart 22 shows that in a quarter of the **medium-term plans**, this entity is the founder or the provider with authority over the operation and financing of social services (25%). In other cases, the responsible entities were mainly the municipalities, the MoLSA, government authorities or NGOs.

Chart 22 – Types of entities responsible for achieving the sub-objectives in the medium-term plans (N=4)

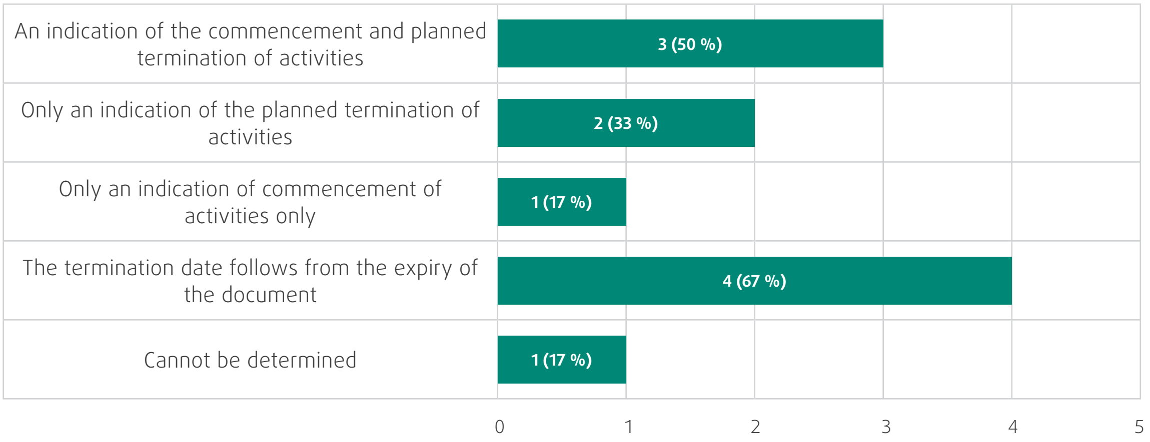


The **National Strategy for the Development of Social Services** lists multiple responsible entities. These are mainly the MoLSA, expert groups, regions, municipalities and NGOs. In one **specific strategy document**, the responsible entity was linked to both the service founder and the service provider. Another responsible entity for this region were the municipalities.

1.6.4 TIME FRAME

Chart 23 shows that more than two thirds of the medium-term plans implicate that activities should be completed by the expiry of the document (67%). Half of the medium-term plans provide the date of both commencement and termination of the activities (50%). Two medium-term plans only include an indication of the planned completion of the activities (33%), while the sub-objectives of one medium-term plan only specify the date of planned commencement of the activities (17%). One plan described the performance as progressive, which we categorised under “Cannot be determined” (17%).

Chart 23 – Nature of the time specification for medium-term plans whose sub-objectives have a specified time frame (N=6)



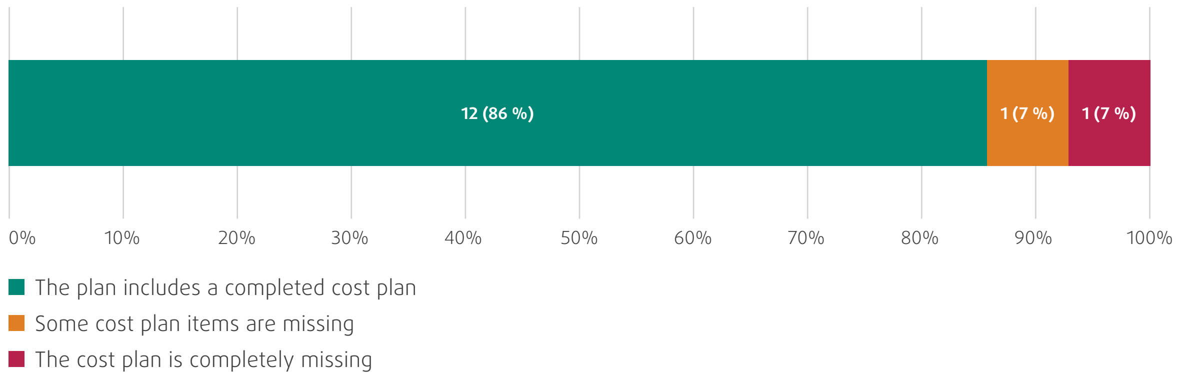
Note: The above shares do not add up to 100%, as one document could be classified in several categories.

The sub-objectives under the **National Strategy for the Development of Social Services** either provided an indication of the planned termination of activities, or the termination date was implicitly set at the end of the strategy period. Both of the **specific strategy documents** that include a time frame for their sub-objectives define the period of performance for the planned activities with both commencement and termination dates. Moreover, one of these documents identifies the achievement of some objectives as progressive.

1.6.5 FUNDING

We were interested in the financial aspect of the medium-term planning (Chart 24). Pursuant to Annex 3 to Decree No. 505/2006 Coll., the regions are obliged to include a cost plan in their medium-term plans.[96] The analysis results show that more than four fifths of the **medium-term plans** include a completed cost plan table (86%). Some of the items of the cost plan were missing in one plan (7%). None of the medium-term plans that include a cost plan provide a link between the cost plan and the implementation of individual sub-objectives. One regional plan did not include a cost plan (7%) and listed the sources of funding for each activity in the strategic sections of individual sub-objectives.

Chart 24 – Manners of incorporating the cost plan table in the medium-term plans (N=14)



The **National Strategy for the Development of Social Services** does not include a cost plan. Unlike the medium-term plans, neither the Social Services Act nor the implementing decree sets out the mandatory elements of a national strategy. The National Strategy was developed in accordance with the Methodology for the Preparation of Public Strategies of 2012, issued under the guidance of the Ministry of Finance.[97] The structure and form of the material should be in line with this methodology.[98] The costs are listed under the individual sub-objectives. Moreover, the National Strategy does not identify any sources from which the costs associated with the objectives should be covered.

We also carried out an analysis of the **specific strategy documents** to see whether they include information on the funding of the individual sub-objectives. One strategy referred to an annex which was supposed to list the costs of the activities identified, but the annex was not attached to the document. We thus could not determine whether the strategy included a cost plan or some other specification of resources and costs.

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[96] Pursuant to Section 39a (3) of Decree No. 505/2006 Coll., the analytical part of the medium-term plans must also contain an economic analysis, including an analysis of possible sources for securing the identified needs; the economic analysis includes:

1) a summary of the financial impact analysis results of the proposed objectives and measures at least for the duration of the medium-term plan;
2) the actual cost of each type of social service, including an indication of the usual costs;
3) an analysis of the funding sources structure for social services, including the outlook for the period of the medium-term plan;
4) an estimated total cost of each type of social service; the **cost plan for social services** shall be drawn up in accordance with Annex 3 to the Decree.

[97] Ministry of Finance (2012), Methodology of Preparation of Public Strategies. MoF. Prague; available [in Czech] at: mmr.gov.cz.

[98] "In the context of the Methodology for the Preparation of Public Strategies, the term public strategy means a document prepared by a public administration body as a comprehensive set of measures aimed at achieving objectives in a defined area. In this sense, a strategy contains a definition of the problem along with a summary of the underlying analyses and data, defines a vision (i.e. the future desired state of affairs) and sets out objectives to be achieved. Furthermore, the strategy includes measures through which the individual objectives will be attained. The strategy also defines the implementation framework (including the definition of the actors involved in the strategy implementation, the time and financial framework for implementation, etc.)." p. 6 of the Methodology.

One strategy document did not include a cost plan, and its finance section provided only a vague description of the funding resources. This document lacks quantification of the costs and the sources from which the activities will be financed. The other documents did not include a cost plan, and a quantification of the costs or funding sources for the individual sub-objectives were also missing.

1.7 CONTENT ANALYSIS – SUMMARY OF FINDINGS

This chapter compares the results of our analysis of the strategy documents' contents with the requirements of the Convention for deinstitutionalisation plans. Focus is placed mainly on whether the requirements of the Convention are met by the National Strategy for the Development of Social Services, as the underlying document on deinstitutionalisation at the national level. We also look at whether specific regional strategies set an example of good practice contributing to deinstitutionalisation.

1.7.1 FRAGMENTATION OF DEFINITIONS AND ITS IMPACT ON THE QUALITY OF THE STRATEGY COMMITMENTS TO DEINSTITUTIONALISATION

For the commitment of deinstitutionalisation to be realised, the strategy documents must establish clear steps that will help fulfil the mission. The plans must be based on a precise definition of the objectives and a consensus on the meaning of the concepts related to the system transformation and structural reform. This is all the more true in the case of the Czech social services system, where a substantial part of responsibility has been transferred from the national level (MoLSA) to the regions. **Only a harmonised use and understanding of the key concepts can ensure a clearly defined objective (consistent across all regions).**

The definitions provided in the strategy plans can be viewed from two perspectives: whether the plans actually include the definitions, and whether these definitions align with those outlined in the Criteria.

The content analysis of the strategy documents clearly showed that the key actors **do not define the concepts related to deinstitutionalisation in a uniform manner.**[99] The National Strategy, as a fundamental document, defines "deinstitutionalisation" and "transformation" but does not comment on the meaning of terms "community-based social service" and "humanisation". The absence of these definitions entails the risks described below.

The definition of "community-based service" is missing in the National Strategy and 13 of the 14 medium-term plans (with another two regions providing the definition outside their medium-term plans in specific strategy documents).[100] Nevertheless, the definition of "deinstitutionalisation" provided by the National Strategy refers directly to the development of community-based services.[101] Deinstitutionalisation cannot be implemented without the development of community-based social services.

The lack of consensus on the characteristics of a community-based social service impedes deinstitutionalisation in at least three aspects.

First, the **absence of a definition may lead to an ambiguity in the objectives of deinstitutionalisation**. Community-based services are being developed in the course of deinstitutionalisation. If we do not clearly define the features and characteristics of community-based services, the objectives of deinstitutionalisation may be vitiated by inconsistencies due to the inconsistent understanding of the term used to describe these services. In fact, one of the requirements for deinstitutionalisation plans is a clear formulation of exact goals the deinstitutionalisation is supposed to achieve.[102] The National Strategy for the Development of Social Services as well as most regional strategy plans fail to meet this requirement.

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[99] See Chart 4 in Chapter 1.1.1 for more details**.**

[100] See Chart 6 in Chapter 1.1.4 for more details.

[101] Pursuant to the National Strategy, deinstitutionalisation is a process in which institutional care for people with disabilities is transformed into community care. The aim is to improve the lives of people with disabilities and enable them to live a normal life comparable to that of their peers. Deinstitutionalisation involves controlled closure of institutions and development of community social services (ambulatory, outreach and residential forms). The resulting structure and operation of social services will pivot first and foremost around the needs of the users and their social inclusion, without exposing them to institutionalisation.

[102] For more information, see chapter Important terminology explained.

Second, the **absence of a definition of "community-based social services" makes it fundamentally more difficult to assess the progress of deinstitutionalisation**. If we lack a clear definition of community-based services, being one of the basic criteria of deinstitutionalisation, we cannot evaluate the progress and monitor the implementation of individual steps. The vision of developing community-based social services currently encompasses the support for a wide range of facilities and services, many of which meet the characteristics of institutional services.

This relates to the third undesirable consequence of a missing definition of "community-based services". If we do not agree on the contents of the term "community-based service", **there is a risk that we will de facto support the establishment and maintenance of institutions and still consider the process as "transformation"**. The failure to define the notion of "humanisation" is similarly problematic, as it allows, among other things, to brand "humanisation" as "transformation." In this respect, we consider it good practice for specific regional strategy documents to include the definition and emphasise that humanisation of social service facilities alone is not sufficient to achieve the objectives of deinstitutionalisation.

The fragmentation and inconsistency of terminology in the strategy documents reduce the quality of deinstitutionalisation objectives set by the individual strategy plans. The content analysis revealed that some regions align their goals with the Criteria by adhering to the definitions of the key terms, while other regions adopt a more flexible approach to the terminology. The goal and desired outcome of deinstitutionalisation according to a specific strategy plan cannot be clear unless there is a general consensus on the basic concepts. Inconsistent interpretation of the terms "transformation", "humanisation" and "community-based service" can thus lead to differences in the deinstitutionalisation process and its results in individual regions.

1.7.2 LACK OF PARTICIPATION OF PEOPLE WITH DISABILITIES IN THE DEVELOPMENT OF PLANS

The Convention requires the States to consistently involve people with disabilities through organisations advocating their rights in the creation of all laws and policies that affect them, including strategy plans for the development of social services and deinstitutionalisation.[103] In the Deinstitutionalisation Guidelines, the UN Committee requires that States should involve people with disabilities and their representative organisations in all stages of deinstitutionalisation process, and also give priority to the views of persons leaving institutions and survivors of institutionalisation.[104]

The strategy documents do formally satisfy the requirement for involving people with disabilities (more on this below) but they fail to indicate the respective ways and methods. **The strategies indicate no clear and systematic ways and procedures for involving people with disabilities.**

The content analysis revealed that the MoLSA **had not directly involved people with disabilities in the creation of the National Strategy, although the National Strategy mentions the involvement of organisations advocating their rights.[105]** On closer inspection beyond the analysis presented[106], we find that these organisations had no representation in the group overseeing the creation of the National Strategy; they only had four representatives among the forty-eight participants in the working groups. A lower representation in relation to other participants does not necessarily mean that the principle of participation has not been respected. However, the National Strategy fails to specify the ways in which the views of organisations advocating the rights of people with disabilities were taken into account, or the extent to which their input played a fundamental or decisive role in the adoption of the National Strategy. **It thus cannot be confirmed that the principle of participation was at least formally met in the creation of the National Strategy**.

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[103] Cf. General Comment, paragraph 70: "Consultations with and the active involvement of persons with disabilities, through their representative organizations (art. 4 (3)), is critical for the adoption of all plans and strategies as well as for follow-up and monitoring when implementing the right to independent living in the community. **Decision makers at all levels must actively involve and consult the full range of persons with disabilities** including organizations of women with disabilities, older persons with disabilities, children with disabilities, persons with psychosocial disabilities and persons with intellectual disabilities."

[104] Cf. Deinstitutionalisation Guidelines, paragraph 34.

[105] Chapter 1.2.1.

[106] Cf. National Strategy, pages 107 et seq.

The regions are obliged to prepare their medium-term plans in cooperation with the municipalities in their respective territories, representatives of the social service providers and representatives of persons receiving the social services.[107] It should be noted that the State has transferred some of its crucial deinstitutionalisation responsibilities to the regions. The regions are thus responsible for shaping the network of services and their availability in their respective territories. They also prepare the medium-term plans, which significantly influence the deinstitutionalisation process within their jurisdictions. In this **sense, it is necessary to insist on applying the principle of participation also in the adoption of the medium-term plans**.[108]

According to the content analysis, all regions cooperate with the municipalities and social service providers in the development of their medium-term plans.[109] The involvement of people with disabilities in the medium-term plans for the development of social services is usually described in sections on the process of developing the plans. Almost all regions state that they engage **people with disabilities** but fail to specify the type of disability.[110] Only one region explicitly mentioned the involvement of people with intellectual disabilities and mental illnesses.[111]

The **involvement of organisations representing the interests of people with disabilities is very low**, with only two regions mentioning them.[112] In contrast, eleven regions declare the involvement of caregivers. Clearly, the involvement of people with disabilities takes place mostly **indirectly**, through entities that also promote their own particular interests. Municipalities, service providers and even caregivers may prioritise aspects of social service development in the creation of the plans that are not necessarily the most relevant to people with disabilities.[113] The consequence of an overall higher representation of municipalities, service providers or caregivers may lead to further weakening of the voice of people with disabilities. **Therefore, the principle of participation is not fully met in the case of medium-term plans either.**

1.7.3 RISK OF SUPPORTING THE ESTABLISHMENT AND PRESERVATION OF INSTITUTIONS

Under the Convention, the Czech Republic is obliged to ensure the closure of institutions, reduction of the capacity of institutional social services and the transition of clients to community services as part of the transformation. This commitment also includes the obligation **not to build new institutions**. Similarly, **existing institutions should not be renovated**, except for the most urgent interventions to ensure the clients' safety. Institutions must not be expanded and new clients must not be accepted to replace those who have left.

The risk of supporting institutions is also heightened by other issues, apart from the above-mentioned fragmentation of terminology.[114]

With the **exception of a single medium-term plan, the strategy plans do not focus on preventing the transfer of institutional elements into services undergoing transformation**. This objective is not explicitly included in the National Strategy for the Development of Social Services either.[115] In practice, giving up on this important goal may lead to allocation of resources to construction of facilities with a reduced capacity and a better material and technical standard, which are however still institutional in their nature, as the transformation fails to eliminate the institutional elements in the delivery of the service or prevent their transmission.

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[107] Pursuant to Section 95 (d) of the Social Services Act.

[108] For more details, see footnote 105 above.

[109] See Chart 7 in Chapter 1.2.1 for more details.

[110] See Chart 7 in Chapter 1.2.1 for more details.

[111] See Chart 8 in Chapter 1.2.2 for more details.

[112] See Chart 7 in Chapter 1.2.1 for more details.

[113] This is especially true for deinstitutionalisation – cf. Deinstitutionalisation Guidelines, paragraph 34 in fine: "Service providers, charities, professional and religious groups, trade unions and those with financial or other interests in keeping institutions open should be prevented from influencing decision-making processes related to deinstitutionalization."

[114] Chapter 1.7.1

[115] See Chart 11 in Chapter 1.4.2 for more details.

The risk of de facto supporting the establishment and preservation of institutions is further compounded by the **lack of emphasis on closing institutions and reducing the capacity of institutional services to the levels of community services**.[116] The National Strategy aims at shutting down institutions and reducing institutional capacity. However, it does not specify whether the capacity should be reduced to match that of community services. Four medium-term plans foresee the closure of institutions, and only two plans project reducing the capacity of institutional services to the levels of community services. Along with the above-mentioned fragmentation of terminology, the inevitable conclusion is that **the strategy plans at both national and regional level fail to define clearly and unambiguously the objective of deinstitutionalisation**.

1.7.4 FULFILLING THE OBLIGATION TO ADOPT HIGH-QUALITY DEINSTITUTIONALISATION PLANS

There are several requirements that must be included in high-quality deinstitutionalisation plans:

- they must specify the activities aimed at meeting the objectives;
- they should define the human, technical and financial resources needed and available;
- they must include deadlines and a time frame of their completion;
- they must allow for assessment of whether the objective has been met (measurability).

The National Strategy **largely aligns with the above indicators.**[117]

This, however, is not the case for medium-term plans. Only two medium-term plans included all the essential quality indicators for all their objectives.[118]

Strategy documents (whether national or regional) laying down objectives that do not fulfil the above indicators cannot be considered adequate deinstitutionalisation plans under the Convention.

1.7.5 SPECIFIC STRATEGY DOCUMENTS AS GOOD PRACTICE

Only three regions submitted specific strategy documents related to deinstitutionalisation. All these documents were adopted for periods exceeding the period of the medium-term plans, specifically eight years on average. We consider this long-term nature favourable, as deinstitutionalisation and transformation are processes requiring time and strategic planning over a long period of time. Adopting a specific deinstitutionalisation and transformation strategy can serve as an additional guarantee that the regions will unambiguously aim at deinstitutionalisation in the long term, and that the process and its pace will not be influenced by the fluctuating distribution of political power.

2. Thematic analysis – interviews with representatives of the regions and the MoLSA

We also wanted to find out what obstacles and dilemmas arise for the regions and the MoLSA in the context of deinstitutionalisation and social services development planning. To this end, we conducted 14 interviews with representatives of the regions, as founders of homes for people with disabilities and special-regime homes ensuring the development and availability of social services in their respective territories. Another interview was conducted with representatives of the MoLSA, which is also the founder of five homes for people with disabilities with nationwide competence.[119] The interviews were conducted with employees of the regions and the MoLSA working at various positions and levels of management of social services development, including the development of strategy and deinstitutionalisation plans. The interviews took place in person or in an online form between June and August 2023.

In order to obtain the most accurate information, we have guaranteed complete anonymity for the participants. We only made two exemptions from this principle:

First, we did not anonymise the responses of the MoLSA representatives. The MoLSA is responsible for the provision of social services in the Czech Republic and, compared to the regions, it has specific duties, competencies and responsibilities as the central authority of State administration in the field of social care, care for citizens in need of special assistance and other social policy issues[120].

Second, we asked the representatives of regions in our interviews about the types of services that had undergone the process of deinstitutionalisation and what services they planned to transform in the future. The respondents' identities are not concealed for these answers as the aim of our research was also to map the level of deinstitutionalisation in the Czech Republic in a comparison between the individual regions.

We informed the subjects about the exemptions before commencing the interviews. The interview transcripts were subjected to thematic analysis between October and December 2023.

Thematic analysis is a qualitative method that aims to identify topics in data,[121] in this case semi-structured interviews with open-ended questions. The form of open-ended questions allowed us to find out how respondents interpreted the problem at hand. Thematic analysis organises, systematises and describes the meanings that emerged from the responses. The aim of the qualitative design of our research is therefore to obtain a detailed and comprehensive picture of the dilemmas related to the planning of social services development and deinstitutionalisation, as interpreted by individual regions and the MoLSA. In other words, the aim is not to identify the exact number of regions that interpret the problem similarly or that face the same obstacles. The aim is to present a comprehensive range of topics, interpretations and issues that the regions associate with the topics raised in our questions.

Hence, not all regions necessarily have to identify with the topics and meanings presented in the individual chapters of this report. As a general rule, we included any topic that appeared in the responses of at least two regions (with the exception of situations when we explicitly note that the topic was raised by "one region" in the responses). In view of the limitations of qualitative research, we decided to include the relative frequency with which the topics recurred in the responses of the regions in this report in two ways:

- in the introduction of each topic, we indicate the relative frequency with words such as "all", "most" (more than half), "some" or "a few" (less than half), "two" and "one". These expressions serve to indicate whether the topic resonated more (all, most) or less (some, etc.) strongly among the respondents;
- we arranged the sections introducing the individual topics according to the relative frequency of the given topic. Hence, topics appearing in paragraphs at the beginning of each chapter were mentioned more frequently (by more regions) than topics appearing at the end of the same chapter. An exception was only made in the case of the MoLSA, which is included in chapters devoted to topics on which it commented in its responses. The same logic of ordering the sections according to the relative strength of the associated meaning applies to the way the subsections are ordered in Chapters 2.7 to 2.9. These Chapters focus on obstacles to planning the development of social services and deinstitutionalisation and ways in which they can be overcome. We have therefore also ordered the subchapters according to relative frequency, each of them focusing on one identified barrier or solution.

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[116] See Chart 10 in Chapter 1.4.1 and Chapter 11 in Chapter 1.4.2 for more details.

[117] Chapter 1.6.1.

[118] See Chart 11 in Chapter 1.4.2 for more details.

[119] An overview of contributory organisations established by the MoLSA is available [in Czech] at: https://www.mpsv.cz/seznam-organizaci-mpsv.

[120] Section 9 of Act No. 2/1969 Coll., on the establishment of ministries and other central authorities of State administration of the Czech Republic.

[121] Hendl, J. (2016) Kvalitativní výzkum: základní teorie, metody a aplikace (Qualitative research: basic theory, methods and applications) / Jan Hendl. 2023. ISBN 9788026219682.

We structured the thematic analysis as follows:

- Chapter One presents the visions of the regions and the MoLSA regarding the development of social services (Chapter 2.1);
- Chapter Two focuses on the methodological background of planning the development of social services (Chapter 2.2);
- Chapter Three presents the ways in which the regions and the MoLSA collect information on the services need for the purpose of planning the development of services (Chapter 2.3);
- Chapter Four deals with the involvement of people with disabilities in the process of planning the development of social services at the regional and ministerial level (Chapter 2.4);
- Chapter Five explains how representatives of the regions and the MoLSA understand the key terms related to deinstitutionalisation (Chapter 2.5);
- Chapter Six maps the level of deinstitutionalisation in the Czech Republic and presents the types of services that the regions and the MoLSA have transformed in the past or are planning to transform and the types of community-based services they are planning to develop (Chapter 2.6);
- Chapter Seven summarises the barriers to deinstitutionalisation that the regions and the MoLSA described to us (Chapter 2.7);
- Chapter Eight presents solutions to remove these barriers as proposed by the regions and the MoLSA (Chapter 2.8);
- Chapter Nine supplements the previous findings with the barriers and solutions that the regions and the MoLSA have identified in the system of planning the development of social services (Chapter 2.9);
- Chapter Ten gives a summary of the most important findings (Chapter 2.10).

2.1 VISIONS REGARDING THE FORM AND DEVELOPMENT OF SOCIAL SERVICES

The key element in any strategy for the development of social services is a clear vision regarding the direction of future development. Bearing this principle in mind, we asked the individual regions about their long-term objectives and visions for the development of social services and the transformation of the care provided. Three main priorities emerged in the regional representatives' answers: development of community-based services, improvement of the quality of services and deinstitutionalisation.

Most regions identified the **development of community-based services** as a key priority in their visions. They emphasised increasing the availability of these services with regard to the individual needs of the clients, with the aim to provide clients with the care and support they need while giving the caregivers more flexibility and improving their work-life balance.

> "We have a vision that the basic building block of the network should be outreach and ambulatory services. We have set requirements for these services, we want the caregivers to have the right to some kind of private and working life (...) these services must (...) declare when they become part of the network, for example, that their ambulatory service is opened until five p.m., so that the caregivers can work their regular jobs and there is no exclusion of working people, because a day-care centre opened until two o'clock is of no use. We have care services there available until the evening hours, including weekends."

The development of community-based services also means a focus on the development of home care. The regions aim to keep clients in their home environments as long as possible to prevent their placement in residential care.

> "The vision is in the medium-term plan. We still stand behind it and it focuses on supporting community-based services, keeping clients in their homes."

The second important vision of some regions was to **improve the overall quality of social services provided**. These regions focused on defining quality parameters, setting standards, and evaluating quality as a means to improve care. These parameters should then serve as a basis for the regions to decide whether to include (or exclude) certain services in the network. The definition of quality parameters served as a precursor for the creation of service evaluation systems:

> "We want to achieve that [the service network] offers high-quality services. So now we need to define the quality criteria. (...) we have identified some nine criteria. (...) We have a definition of quality, we have developed a quality reporting system so that the quality really is high."

For the regions, improving quality means in particular:

- efforts to provide more flexible services to respond to the current needs;
- higher availability of services;
- higher efficiency; and
- focus on the client's individual needs and development.

The third type of vision concerns **deinstitutionalisation**. Several regions have presented their visions by explaining their objectives related to deinstitutionalisation, specifically the development of small-scale facilities and reduction of the capacity of institutional services. However, these regions also stressed that achieving these objectives was a difficult process.

> "We would like to see all facilities slowly becoming community-based, but it is not possible everywhere. (...) For example, there was a need (...) to create a residential service for children with intellectual disabilities, but also for children with behavioural disorders. So we did not approach any third-party provider in the region, but we approached our contributory organisations whose focus was the closest to this target group. And we now have (...) The capacity in one facility was 10 and in the other it was 12 just for children with intellectual disabilities and behavioural disorders. This is because the operation of the service is very (...) financially demanding. And the subsidy we receive from the ministry does not cover the operation of the services."

We also asked the **MoLSA** about its vision for the development of social services. The Ministry stated that it had two visions for the development at the national level. The first is the development of social services that are available financially, locally, regionally and temporally. The second vision is sufficient staffing of social services in the Czech Republic. In order to realise these visions, it is necessary to ensure a transparent and comprehensible system of social services and stable financing, according to the MoLSA:

> "A part of the vision reaches as far as 2050, but the standard outlook reaches to 2030 and this is more or less in line with the vision of the European Care Strategy. The vision has two prongs in that it actually envisages social services that are affordable financially, locally, regionally, and temporally. That is the basis. The second prong concerns ensuring sufficient staffing. This relates to the availability, ensuring financial stability and certainty for the providers and comprehensibility and transparency for the public, because the system is terribly complex and (...) creating a sufficiently effective system in the context of State budgets."

The MoLSA told us that it was reflecting its intentions in the legislative steps under consideration. The current legislative initiatives mentioned by the MoLSA in this respect include two amendments to the Social Services Act. The first amendment was scheduled to come into effect on 1 January 2024 and was supposed to introduce a complaint mechanism and a new administrative offence punishing conduct that does not qualify as a criminal offence and had not been previously punishable. In addition, it was to expand some specific services. However, this amendment has not been adopted at the time of publication of this survey.

The second amendment, scheduled to take effect on 1 January 2025, addresses new financing of social services and a new planning system. The MoLSA intends to introduce a new system of planning of social services at the regional level, using a participatory model and certain elements inspired by the health sector.[122]

2.1.1 CONNECTION TO THE MENTAL HEALTH CARE REFORM

The mental health care reform, implemented in the Czech Republic on the basis of the Psychiatric Care Reform Strategy[123] from 2013, aims to improve the interconnectedness of health, social and other related services provided to people with mental illnesses, among other goals. The State support for this reform has been gradually declining since 2022.[124] In view of this development, we have decided to take a closer look at how the individual regions were reacting to this change. We identified two key themes in the regions' responses:

- the manner in which the regions integrate the mental health care reform into their long-term planning of social services (Chapter 2.1.1.1); and
- specific activities based on the ongoing mental health care reform in the territories of the individual regions (Chapter 2.1.1.2).

We were also interested in the MoLSA's opinion of the current status of the mental health care reform (Chapter 2.1.1.3).

2.1.1.1 Regional perspectives on further mental health care reform

Several regions have expressed disillusionment with the withdrawal of the central support for the reform. However, some regions continue to pursue the reform on the basis of their own priorities and defined needs. Some of them stressed that the reform was still ongoing, as can be seen from the following quote:

> "The reform is underway in our region, it was already underway before this medium-term plan, it was one of the priorities (...), and it continues regardless of the Ministry's position."

However, in view of the mental health care reform, the regions often emphasise the difficulties associated with the cooperation among the healthcare authorities and the authorities responsible for social services. This problem is perceived especially on the legislative and ministerial (departmental) levels, which creates challenges with regard to the support for the development of social services. Some regions are trying to take a proactive approach to addressing this problem, as is illustrated by the following quote:

> "We certainly see some kind of coordination with the health care system, where it is not legally or legislatively anchored; there is some kind of coordinated system of crisis care, whether for adults or children, in cooperation with university hospitals and the emergency medical services."

The coordination between healthcare facilities, especially psychiatric hospitals and social services, is the key topic for several regions. Some regions mention problematic communication and emphasise the need for a coordinator who could effectively manage such cooperation. They are also directing their efforts towards finding funding for this key position. The importance of this role is underlined by the following quote:

> "We would imagine this to be more flexible in the field, however from 1 August, a new inter-disciplinary coordinator will be available; this is a new position where we have a worker who has years of experience in providing services for people with mental illnesses, so we believe that thanks to this position someone will finally be able to fully focus on this area and we'll be able to achieve some progress."

2.1.1.2 Regional activities in the framework of the mental health reform

Most regions reported that they operated centres for mental health and intended to continue to support and develop them. Some regions were planning to establish additional centres for mental health.

Moreover, several regions are actively maintaining and developing a crisis care system in their territories, putting an emphasis on a multidisciplinary approach. One region commented on the topic as follows:

> "We have a European project that we have started to implement. It concerns extending the collaboration with multidisciplinary teams, we have (...) two such teams."

Several regions have transformed or are planning to transform their residential services for people with chronic mental illnesses. Some regions have published their own strategy documents that set the framework for their future activities connected to the mental health care reform. Two regions highlighted their activities focusing on destigmatisation and normalisation of the topic of mental illnesses in the public space.

> "(...) we now have a project and now we have PR consultants, we have self-help group leaders, public talks are being prepared to get the possibility of help out there, because even mental illnesses, like anorexia or self-harm, are an important topic and we need to talk about them."

2.1.1.3 MoLSA's commentary on the mental health care reform

In response to questions about the mental health care reform, the MoLSA told us that the National Action Plan for Mental Health, which was approved in January 2020, refers to the National Strategy. Although it does not explicitly include mental health care, the document declares cooperation with the Ministry of Health on the continuation of the mental health care reform (especially on the development of centres for mental health). The MoLSA noted that the National Strategy is based on a broader vision that is tied to the mental health care reform, and it envisages the coordination of social and healthcare services and their mutual links. The MoLSA has stated that its long-term vision is to develop integrated social and health care. This care would not only target clients with mental illnesses, but a wide range of clients using services at the intersection of healthcare and social services.

> "There is [in the National Action Plan] a direct reference to the National Strategy for the Development of Social Services. (...) the vision is to develop integrated social and health care. An integrated social and healthcare service."

2.2 METHODOLOGICAL BACKGROUND OF PLANNING THE DEVELOPMENT OF SOCIAL SERVICES

The development of social services is a demanding and complex process that requires effective management. When looking into this issue, we decided to find out what the methodological background is for each region. We were interested in how the regions plan and manage their steps in the area of social services development. The first part of the analysis focused on finding out which methodological materials the regions rely on when planning and implementing their social services strategies (Chapter 2.2.1). The second part assessed the perception of the MoLSA's methodological guidance by the regions (Chapter 2.2.2).

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[122] We interviewed the MoLSA in June 2023. Since then, the planned actions of the MoLSA have changed. In February 2024, three partial amendments to the Social Services Act were pending in the legislative process, one of which related to the intersection of social care and health care.

[123] Ministry of Health: Psychiatric Care Reform Strategy. Online, 2013. Available [in Czech] at: https://www.reformapsychiatrie.cz/ [retrieved on 28 February 2024].

[124] Cf. e.g. here: https://www.irozhlas.cz/ [retrieved on 28 February 2024].

2.2.1 METHODOLOGICAL MATERIALS

In order to better understand the methods and strategies used by the regions in this area, we examined the methodologies they follow when developing their social services. We found that the regions do not rely on uniform methodological documents. Their answers indicate that there is no generally accepted methodological framework or document that would serve as a basis for planning the social services development. The only supporting document referred to by most regions is the Decree.[125]

> "We follow the structure that is given by the law and the Decree, and we do not have [any other methodological materials]. In this area, we would appreciate more methodological support (...)."

Several respondents mentioned the use of the planning methodology published by the Ministry of Labour and Social Affairs[126] or the Ministry for Regional Development as a guide for developing strategies and plans for the social services development. A representative of one of the regions said:

> "We have, of course, we follow the planning methodology of the [Ministry of Labour and Social Affairs], which we use in the basic parameters."

Several regions identified other sources of methodological support. Some regions revealed that they have their own documents and procedures to organise the process of developing the medium-term plan.

2.2.2 MOLSA

We also focused on the methodological support provided by the MoLSA to the regions in social services planning and development. The answers we received from the regions show that they **lack active and regular methodological support from the MoLSA**.

Most regions clearly declared that they did not receive any type of support from the central authority with regard to the social services development. This is evidenced by the following quote:

> "Well, we don't have any methodological support from the Ministry in terms of networking and planning, that's a fact, the Ministry does not convene any working meetings or meetings with the regional authorities focusing on planning and networking. If anything, there is a meeting of the department heads, where, of course, as you know, the discussions don't deal with the particulars or go into any greater depth and so, as representatives of the regions, we feel that it is missing in a way (...)"

Several regional representatives added that the MoLSA organises occasional meetings or training sessions focusing on specific topics related to the social services development. As an example, one of the regional representatives said:

> "The Ministry of Labour is going to organise training for us now or will be organising workshops focusing on the calls, various calls, for example training about grant calls organised from their side, so that we know what calls are being planned (...) we also have meetings of methodologists and registration authorities with the Ministry of Labour and Social Affairs and often one of the topics focuses on information, where there is still room for some questions and additional matters that we may need to sort out with the Ministry, so there is some space for that too. But it takes place only sporadically, but the meeting is always focused on these topics as well."

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[125] Decree No. 505/2006 Coll., implementing certain provisions of the Social Services Act. It regulates the development of the medium-term plans in Part Seven, Sections 39a to 39c.

[126] There are three different methodologies applied in the regional medium-term plans for the social services development. However, not all regions apply at least one of these methodologies and, on the other hand, some regions do not use several of these methodologies at once. These methodologies are laid down the following methodological documents: 1. MoLSA: Updated methodological recommendations for social service planning, 2020 available [in Czech] at: https://www.mpsv.cz 2. MoLSA; Minimum Quality Criteria for Social Service Development Planning at the Regional Level, 2015 available [in Czech] at: https://www.mpsv.cz/ 3. MoLSA: Methodologies for social services planning available [in Czech] at: www.mpsv.cz.

We also asked representatives of the **MoLSA** about the cooperation between the regional and central levels in the area of methodological guidance. The Ministry staff informed us of two processes that shape this cooperation. However, we have identified some discrepancies in their responses regarding the areas in which the MoLSA claims it provides methodological guidance.

The Ministry informed us that regular meetings with the representatives of the regions are being held (with certain exceptions) every three months to facilitate the cooperation with the regions focusing on the preparation for planning the development of social services. These meetings are held at various levels with the participation of the department heads and section directors. The MoLSA states that these meetings provide a platform for discussion and resolution of methodological issues related to social service planning, social work and financing. The second form of cooperation is the possibility of individual consultations between the regions and the MoLSA, which focus on various technical issues and take place in situations where the regions need to discuss specific topics related to the social services development plan.

During our interview with several representatives of the MoLSA, we identified several contradictions in their statements. Firstly, there were contradictions with regard to the specification of the areas where the Ministry provides methodological guidance. Secondly, we have found certain discrepancies in the role of financial inspection in the provision of funds for the administration and development of social services in the process of methodological guidance.

With regard to social services planning, one representative of the MoLSA first told us that planning the development of social services is an independent competence of the individual regions and the Ministry's role in this respect is weaker than in the case of methodological guidance in areas with delegated competence:

> "Where the regions are acting within the framework of delegated competence, the role of the Ministry of Labour and Social Affairs is of course stronger (...) If we stay for a moment with the planning of social services as such, it is currently an activity that is carried out at the level of the regions as part of their independent competence. (...) And that is, as far as planning is concerned, the area of inclusion of individual social service providers into the regional networks."

Following this communication, another representative of the MoLSA told us that their obligations include administration of the planning of social services:

> "The point is that we are in charge of the administration of the medium-term plans, it is not that they are fully in the competence of the self-governing authorities. Because we oversee legislative activities."

Hence, the MoLSA drew a line between the responsibility for methodological guidance in the area of the planning of social services development on the one hand and the administrative management of social work and its financing on the other:

> "We manage methodological guidance with regard to the planning of social services, and social services methodology in general. That's one administrative area. Then there is the area of social work and the area of financing."

At the same time, it followed from the interview that the MoLSA also believed its role in mandatory planning of the development of social services by the regions was more extensive. First, the Ministry influences the wording of the implementing decrees to lay down the conditions for the preparation of medium-term plans and defines their structure. Second, the medium-term plans are a mandatory part of the applications for subsidies for the financing of social services, which the regions submit each year to the MoLSA. Third, the MoLSA also influences the medium-term planning through establishing a control system to check that the funds from these subsidies are used to implement the medium-term plans.

In the interview, the MoLSA used the term "control" in two different senses, firstly to refer to the control of the medium-term plan submitted with the application for a subsidy for the financing of social services, and secondly with regard to the control of how the funds from this subsidy were used. During the interview, the differences between the financial control of the use of the subsidy[127] and methodological guidance for the planning of social services development in the regions was unclear at times.

> "The point is that we are in charge of the administration of the medium-term plans, it is not that they are fully in the competence of the self-governing authorities. Because we oversee legislative activities." In part seven of the [Implementing Decree No. 505] there is clearly defined, in fact in Sections 39a, 39b, 39c, the definitions are written there, as well as the parts of the medium-term plan for the development of social services and then the actual draft of the medium-term plan and then the action plans, by which the medium-term plans are implemented, and we as providers, we as the MoLSA, not only methodically guide the implementation of what is in the law. We also need to ensure control of the implementation. We comment on them, whether they meet all the requisites. Plus we work with them on this, plus there are methodological meetings with the representatives of the regions where all this is discussed. So this comprises both methodological guidance and a control procedure. If we had sufficient staffing, we should be using them to check that the plan is aligned with the network and to check that the money that we gave to that region goes to cover what they specified in their action plans, the medium-term plans. This is the MoLSA's role."

The problematic relationship between financial control and planning the development of social services was also evident in other parts of the interview with the MoLSA's representatives.

> Representative 1: "Then there's also the control activity, which is not standard methodological guidance, but these controls include some consultation focusing on the specific use of the money."
>
> Representative 2: "But our control is linked to the planning."
>
> Representative 1: "It's not planning, we do financial controls focusing on the use of the funds provided."

2.3 COLLECTING DATA ON THE SERVICES NEEDED FOR THE PURPOSE OF PLANNING THE DEVELOPMENT OF SOCIAL SERVICES

Efficient planning of social services development depends on information on the services need in the territory of individual regions. That is why we contacted the regions and the MoLSA with a view to gaining a deeper understanding of the process of collecting such data. We were interested in the following:

- what resources the regions use to collect information on the services needed in their territory (Chapter 2.3.1);
- whether and how the regions obtain information on people who could potentially use less restrictive residential services, i.e. the group of clients most affected by deinstitutionalisation (Chapter 2.3.2); and
- whether the regions cooperate with each other in collecting this key information (Chapter 2.3.3).

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[127] I.e. a subsidy under Section 101a of the Social Services Act.

2.3.1 SOURCES OF INFORMATION ON THE SOCIAL SERVICES NEEDED

In the process of planning the development of social services, we focused on collecting information about the social services needed through various methods and activities. All regions state that **this information comes primarily from the municipalities,**[128] or municipal districts (in the case of the capital city of Prague). Some regions also draw information on the services needed from municipalities with designated municipal authorities and municipalities with extended competence. Most regions combine several approaches to collecting information, using working groups, participation in community planning, direct negotiations and meetings with other actors in the field of social services (see below), and less frequently questionnaires and other tools. The following region gives an example of an approach that combined multiple tools:

> "We are inviting primarily [municipalities with extended powers], but we now have questionnaires where we invite all municipalities in the entire region to tell us what the needs are in their area; so we are trying to go that way as well, to really reach out to all municipalities. Of course, we primarily work through community planning and gathering information about the needs with the municipalities, and with the municipalities with extended competence. So we have the needs described in the medium-term plan, we have thirteen areas that we are focusing on in the collection of information about the needs (...)"

The second most common source of information is **social service providers**. Several regions emphasised that this information is key for them and they obtain it through working groups, on the initiative of the providers or by approaching the providers directly. One region stated the following:

> "When preparing the medium-term plan, we cooperate with the social service providers, whom we approach. At the same time, we are reaching out to the class 2 and class 3 municipalities, there are regular meetings and we have what we call an advisory group and a design group."

The findings suggest that more than half of the regions supplement the information obtained from the municipalities and providers with other sources. In this regard, the regions informed us that they cooperate with various actors, such as the Czech National Disability Council, hospitals, parent groups, NGOs that bring together people with disabilities and people advocating for their rights, etc. The actors involved and the manner of their involvement vary across the regions.

Working groups where other groups of entities are represented, together with municipalities and providers, constitute a frequently used source of diverse information on the needs. Some regions involve caregivers, representatives of parent organisations, national and regional organisations focusing on people with disabilities and others in these working groups. Two regions informed us that they involve groups linked to the political representation in the preparation of their plans.

> "(...) we have an advisory group and a design group. The design group is formed by the representatives of the social affairs department management, the [municipalities with extended competence] and the VOU, and the advisory group, which was formed later, is composed predominantly of political representatives."

The structure of the working groups varies across the regions and is divided according to various keys. Examples include working groups distinguished by the type of disability, groups broken down by territorial units, by stages in the planning process or groups broken down according to the social services development objectives (deinstitutionalisation, etc.).

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[128] Pursuant to Section 94 of the Social Services Act, the municipality, in its independent competence, identifies the needs for the provision of social services to persons or groups of persons in its territory; it cooperates with the region in the preparation and implementation of the medium-term plan for the development of social services of the region; to this effect, it communicates to the region information on the needs for the provision of social services to persons or groups of persons in the municipality's territory, on the possibilities of meeting these needs through social services and on the resources available; it cooperates with the region in determining the network of social services in the territory of the region; to this end, it communicates to the region information on the capacity of social services that are needed to meet the needs of persons in the territory of the municipality and co-creates the conditions for meeting the needs of these persons.

In addition to the working groups, some regions are taking a more innovative approach to collecting information. Several regions are carrying out or planning specific projects to collect statistical data that could serve as a basis for planning the development of social services.

Some regions are also developing questionnaires targeting specific groups. These regions consider questionnaires to be an effective tool for obtaining direct feedback from the clients of social services, caregivers and other stakeholders. One region stated:

> "And this is sent to those individual respondents, whether they are municipalities, services, or everyone who is involved in that mapping. And there is the demand for each need, there is also a description of what the need actually means, because it is quite a big shift in thinking (...) it offers a range of options for how each need can be addressed, from simple advice, counselling, to providing a certain service."

The **MoLSA** primarily uses working groups to collect information on the services needed at the national level for the purposes of developing the National Strategy. Various actors from different areas are represented in these working groups, including representatives of the clients (client and patient organisations), social service providers, professional organisations and trade unions, etc. The process of information collection at the level of the MoLSA is illustrated by the following quote:

> "It is more or less the case that at these platforms, both at meetings with the regions and at meetings with other [stakeholders], there is usually a working group where suggestions are gathered on what should be addressed in the national strategy. After two or three meetings where these suggestions are discussed, a structure is created which is then subject to further discussions."

2.3.2 COLLECTING INFORMATION ABOUT PEOPLE WITH THE POTENTIAL TO USE LESS RESTRICTIVE RESIDENTIAL SERVICES

We were also interested in whether the regions are collecting information about clients who could potentially use less restrictive residential services. Most of the regions do not systematically collect this information. Some regions emphasised that they anticipate obtaining information about these clients directly from the service providers or through the traditional process of collecting information on the services needed.

Some regions believe that the service providers themselves are responsible for collecting this specific kind of information, which should then be translated in the regional plans. This position was highlighted by one region in the following way:

> "This is largely a matter of the providers working with those people in general as part of their target group (...) So it's always up to the provider to comply with those existing principles that have been established and that we've been trying to achieve for a number of years and guide the providers to achieve them as well."

One of the initiatives in this area highlighted by one region was the performance of methodological visits. This region encourages service providers to only accept people who need a high level of support and cannot stay at home or use less restrictive services. You can read the full statement below:

> "We put a lot of emphasis on this, we carry out methodological visits in our contributory organisations. And we really have set up a system in our organisations that they should accept a target group of people who really cannot be at home, who are truly very dependent on the support, and we also guide social workers to re-evaluate the needs of people on an ongoing basis. To accept people who are really highly dependent on the care."

2.3.3 INTERREGIONAL COOPERATION

We also asked whether the regions cooperate with each other or with the MoLSA in collecting information. The regions stated that they **do not receive any information on the services needed from the MoLSA**.

The majority of regions stated that they do not systematically cooperate with other regions. If there is any cooperation between the regions, it is usually a cooperation between neighbouring regions. However, this is usually not a matter of cooperation focused on network planning, but rather cooperation aimed at resolving the situation of a specific client or lack of capacity for specific groups of clients. One region stated the following:

> "We cooperate when we deal with adverse social situations and specific clients, we certainly do so in such cases. But you are probably more interested in cooperation on a different level than this. As far as the development of the [medium-term plans] is concerned, of course we do not cooperate."

Several regions reported that they had developed services specifically focusing on small groups of clients or groups of clients with special needs. These regions then offer the capacity of these specific services to other regions as well. The services include services for people with Huntington's disease or people with autism spectrum disorders and challenging behaviour.

2.4 INVOLVING PEOPLE WITH DISABILITIES IN THE PROCESS OF PLANNING THE DEVELOPMENT OF SOCIAL SERVICES

As we have repeatedly emphasised, the participation of people with disabilities and organisations advocating for their rights in planning the design and development of social services is a key element of the obligation under the Convention on the Rights of Persons with Disabilities. In order to better understand the ways in which the regions and the MoLSA involve this important group in the planning process, we focused on three key aspects. The first is the way in which people with disabilities are involved in planning the development of social services (Chapter 2.4.1). We also examined whether the regions actively modified and adapted the conditions under which the plans are prepared in order to minimise any obstacles to participation for this group of people (Chapter 2.4.2). Furthermore, we were interested in whether people with disabilities who are not directly clients of social service providers are involved in the process of preparing the plans (Chapter 2.4.3).

2.4.1 METHODS OF PARTICIPATION OF PEOPLE WITH DISABILITIES

The regions do not have a system in place to ensure the participation of people with disabilities in planning the development of social services.

Almost half of the regions informed us that people with disabilities are not involved in the planning. A quotation of one region can serve as an example:

> "The principle of participation is probably not fully realised in our region. Of course, I think we formally meet this condition at the very beginning by putting a notice on the official board that the preparation of the medium-term plan is starting, and that everybody can get involved, but in practice this doesn't really work."

The **MoLSA** has made similar comments and it does not directly involve persons with disabilities in the planning processes either. Participation within working groups takes place mainly through client and patient organisations. Although individuals with disabilities are represented in these groups, their participation through these organisations may not meet the requirement of participation as stated by the MoLSA itself:

> "If individual people with disabilities are involved in this: yes, they are involved but probably insufficiently or through patient and client organisations. We have enough of those. But the question remains the same."

Several regions reported that people with disabilities are or have been members of their working groups. Moreover, one region also engages people with disabilities in another regional administrative body:

> "We involved people with mental illnesses or with first-hand experience involved in our Regional Council committee, and we even prepared a policy for the development of services for people with mental illnesses, so we have those people involved there. We also have them in our working groups."

Several regions informed us that people with disabilities can get involved by responding to public calls for participation in the plan development or through other mechanisms, which assume that the citizens will actively seek out ways to participate. Two regions also report working with the regional office of the Czech National Disability Council in developing the plan. One of them summarises it as follows:

> "We have very good cooperation with the regional office of the Czech National Disability Council, the region chairman (...) has been in the office for about ten, maybe even twelve, thirteen years now and it's great because he (...) he knows the issues he's very reasonable, rational, great to work with, so a lot of input comes through him and I regularly attend the Council's committee meetings (...)"

Only a few regions conducted a questionnaire survey where they directly addressed people with disabilities. One of the regional representatives commented on this as follows:

> "As part of the new medium-term plan, we actually carried out a relatively large questionnaire survey of this kind, and we also addressed the social services to give their clients and family members or caregivers the opportunity to comment on the development of the medium-term plan and to give us some feedback on what is the most important for them, what needs to be improved, supported, and how they perceive the current policy of the region in general. We received 200 replies from the clients and caregivers within the survey."

2.4.2 MODIFICATION OF CONDITIONS FOR THE PLAN DEVELOPMENT

Another key question was whether the regions are in any way modifying the conditions for the preparation of the plan for the social services development in order to reduce obstacles and adapt the whole process to the needs of people with disabilities**. Most of the regions told us that they do not use this option**. One region commented:

> "I'm not sure. I don't think that we [modify the conditions in the development of plans] (...) you've listed exactly the things that would have to be done in order for them to be able to [participate in the planning process], that it would have to be the simplified form. I don't know if it's realistic to do all this."

Similarly, the **MoLSA** stated that it does not create conditions for direct involvement of people with disabilities, as is evident from the comment below:

> "There is a lack of the ideal (...) material and technical facilities for [people with disabilities] (...) to participate. Of course, there's work to be done in this regard. (...) It is true that we primarily work with representatives of those client and patient organisations (...) We are not going any deeper at the moment and we are certainly not making it in the easy-to-read format or any other form that would be more comprehensible."

The most specific form of support was presented to us by two regions that have established partnerships with non-profit organizations to promote the participation of people with hearing impairments. However, as the following quote suggests, this support has not yet been fully used:

> "We have started a partnership for people with hearing impairments, we have reserved laptops here for transcription, we have trained people, but I'll say that we do not use it, there is no demand for it."

2.4.3 INVOLVEMENT OF PEOPLE WITH DISABILITIES WHO ARE NOT CLIENTS OF SOCIAL SERVICES

Another aspect of our analysis was examining the possibilities of involving a specific target group – people with disabilities who are not clients of social services. In this area, it has become apparent that the regions lacked a way to efficiently involve these people in planning the development of social services.

In most cases, the regions rely on information gathered through the collection of information about the services needed or responses to public calls. As one region commented on the topic:

> "However, the law lays down that it must be available to the public for commentary procedure and we do not communicate directly with these people, but through their [client and parent] associations (...)"

2.5 TERMINOLOGY RELATED TO DEINSTITUTIONALISATION

Successful deinstitutionalisation presupposes an unambiguous understanding of what this process involves, what aspects it includes and what is its ultimate objective. If the key terms are not clearly defined, there may be a lack of consensus on their meaning, which complicates the achievement of the deinstitutionalisation objectives. This Chapter therefore focuses on how each region understands the key terms associated with deinstitutionalisation. The first part (Chapter 2.5.1) explores the terms "deinstitutionalisation", "transformation" and "humanisation", while the second part (Chapter 2.5.2) describes how the regions interpret the term "community-based social service" or "community services".

2.5.1 "DEINSTITUTIONALISATION", "TRANSFORMATION" AND "HUMANISATION"

We asked respondents from the regions and the MoLSA how they understood the terms "deinstitutionalisation", "transformation" and "humanisation". The answers show that **there is a considerable variability in the meanings that the regional representatives assign to these terms.**

The lack of consistency in the definition of these terms across the regions is also clear from the fact that several respondents answered the question according to their own understanding of the terms, not as their region defined them in the medium-term plans.

The answers of several respondents show that they did not make significant distinction between "deinstitutionalisation", "transformation" and "humanisation". They understand all three terms to be linked to a similar objective, specifically a focus on the individual needs of the client. This is evidenced by the following quote:

> "(...) whatever other term it may be, I think it's what we watch, what the outcome is and what we want to achieve. (...) to live in one's own way (...) Rather than to have one's life completely determined by others, eat at a given time; because everybody else is eating, so I have to eat too, and things like that. That is, to some extent, more freedom."

The answers of several regional representatives indicate that they do not distinguish between the meanings of the terms "deinstitutionalisation" and "transformation". This is evidenced by the following quote:

> "For my part, I admit that I have never fully understood the difference between transformation and deinstitutionalisation. Even though I tried. I have always seen it as some kind of transition process from institutional services, which are clearly defined in my opinion."

Furthermore, some of the answers tend to combine the meanings of "deinstitutionalisation" and "humanisation". These respondents emphasised the improvement of the existing environment, renovations, and creation of smaller community-based services in their description of both these terms.

> "When we improve the existing environment, we feel that deinstitutionalisation does not necessarily mean that we have to leave the facility, but various reconstructions are ongoing so that it meets the characteristics of a smaller community-based service. So that we can make individual households there and so on (...) The notions are interlinked, in my view. Humanisation and deinstitutionalisation."

It is important to note that the **MoLSA** has made it clear that its understanding of "deinstitutionalisation" and "transformation" is based on the Criteria. At the same time, the Ministry stressed that "humanisation" as it understands it is not the process of deinstitutionalisation. For the MoLSA, "humanisation" includes aspects such as reducing capacity or setting up community care elements in large-scale social care facilities.

> "We understand the term in the sense of the approved Criteria for the transformation of social services, where the definitions are (...) But the definition is quite clear, that's what we

> are working with. We as the MoLSA (...) reject humanisation (...). It means only making things a little more humane."

The issues stemming from different interpretations of these terms were also confirmed in an interview with the **MoLSA**. The Ministry stated that the definition set out in the Criteria is not universally accepted by all the actors:

> "The fact that the definition (...) is not currently agreed on throughout the Czech Republic is another problem. It is not even a compromise. Some regions refuse it (...)"

The analysis of the meanings of the terms revealed interesting nuances in their perception. The following section provides details of the understanding of each notion as presented by the individual respondents.

First, most often the representatives of the regions understand **"deinstitutionalisation"** as a move away from institutional care, as their gradual abolition. This is evidenced by the following statement:

> "I understand deinstitutionalisation in the sense of, say, breaking down a large-scale social facility into a number of smaller facilities. And it doesn't really matter whether they are flats, houses or anything else."

When asked about "deinstitutionalisation", several other respondents emphasised a shift in thinking and an effort to prevent the transfer of institutional elements to the new forms of social services. One of them summed it up as follows:

> "(...) deinstitutionalisation is a higher level of transformation where the institutional elements are abolished. Just because there has been a transformation, it does not mean that the institutional elements have been abolished."

Second, the term "transformation" has been interpreted by the regional representatives in various ways. Some saw "transformation" as a change in the type of service. In those cases, "transformation" was understood as the change of (institutional) services into another form of support, as illustrated by the following quote:

> "Transformation for us is that we actually change it into a different form of support. Whether it's sheltered housing, moving some people completely into their own housing with outreach support."

In this regard, some respondents understood "transformation" as the change of institutional services into community-based services, as can be seen from the quote below:

> "We see transformation more in the narrower sense of replacing the capacity of institutional services with community-based services."

On the other hand, some regional representatives understood "transformation" as a process of material and technical changes in the manner of providing the services, as follows from this quote:

> "(...) transformation is really some kind of a material and technical change, or that's how I see it, into the services being provided in smaller buildings, better integrated into the area (...)"

The respondents also emphasised that the "transformation" of services leads to the creation of support that is as close to the natural environment as possible and prioritises the clients' needs. In this respect, one respondent mentioned that "transformation" includes a shift in the mindset of social service workers, which is necessary to avoid the transfer of institutional elements to the transformed facilities:

> "Deinstitutionalisation means stepping out of those institutional forms and I see it as the same or similar concept, where transformation is a change of the mindset for me and that's probably the most important thing because you don't just move out of an institution, you have to change the services, you have to change the people who are providing the services and so on."

Third, the meaning of "**humanisation**" shows a strong consensus among the respondents, especially in the effort to improve the environment of institutional services towards dignity and respect for the clients' rights. This concept was aptly characterised by the one respondent as follows:

> "I think everybody understands humanisation, it's some kind of improvement of the environment in those existing services towards making them dignified, to meet some kind of standard requirements for how a person lives. So that, as my colleague mentioned, there are no pass-through multi-bed rooms, so that the rights of those people are respected and so on."

Nevertheless, several representatives of the regions expressed a different view of "humanisation". For them, "humanisation" is not only about adjusting the environment, but also about supporting clients towards maximum independence and achieving a mainstream life within their abilities. Another aspect of "humanisation" was perceived by one respondent as a humane approach, as the following quote illustrates:

> "Humanisation, humane approach, humanity, empathy."

2.5.2 CHARACTERISTICS OF COMMUNITY-BASED SERVICES

We also focused on the interpretation of the term "community-based services". Representatives of the regions differed in the features they considered important for defining this type of service: one of the most frequently mentioned features was capacity, which was also brought up by the **MoLSA** in its response. Many respondents stressed that these are **small-scale facilities with a set number of clients for different levels of dependency or types of service**. This is evidenced by the following quote:

> "Community-based services (...) they are services that are closer to everyday life. Like I said, it's a smaller household with a small number of clients. As we said, we stick to the transformation criteria, so mostly twelve, not more than eighteen, with an increased level of support (...)"

The second frequently mentioned characteristic **was the connection of the community-based service to everyday life in the local community**. The clients have the opportunity to use the mainstream services available in the area and are in active contact with their surroundings, as is illustrated by the following quote:

> "So we understand it, of course, as a low-capacity social service that is really somewhere in the community, connected to the life of the community, preferably, of course, in a larger city, so that there is a possibility of using mainstream services (...)"

Less than half of the respondents stressed that a **"community-based service" should resemble "mainstream" life**. The same number of regional representatives mentioned that a characteristic of the "community-based service" is its **placement in the community**. One regional representative put it this way:

> "It's about the locality, that it's not some institution tucked away on the edge of town, it's in the centre of things. That client is involved in that city, the city itself is involved, more of those services are working together."

One other less frequently mentioned characteristic was that the **service should be oriented towards the clients' individual needs**. This aspect was also mentioned by the **MoLSA** representatives, who told us the following:

> "(...) but for me, the community-based service, that's where the client should always come first and that's also included in our transformation plans, there's that monitoring of the client file where the facilities that get involved in the process would fill out the client's status before the process starts, then after the process ends and then two years later to monitor the entire process, what happened to that client."

Several regions also stressed the importance of the division into individual households, which creates an environment similar to natural domestic life:

> "We have [divided it into] these households (…) It is also a problem to find, for example, separate housing units within residential buildings, so buying a villa and creating separate households in the villa, where more clients live, there are two households, for example, everyone has their own space, their own room (…) ordinary life. They have everything there, it's their little home."

Two regional representatives also stressed that a characteristic feature of "community-based services" is that the **various social services are not concentrated in one place**.

2.6 TYPES OF TRANSFORMED SERVICES

The aim of our research was to evaluate the course of the transformation in the Czech Republic and to map the level of deinstitutionalisation in the Czech Republic in comparison between the individual regions. For this reason, we asked about the types of transformed services specifically and the answers are not anonymised. Our first interest was to find out what specific types of services the regions had transformed in the last 15 years (Chapter 2.6.1). We were also interested in the planned transformations and the goals set by the regions for the future (Chapter 2.6.2). Finally, we focused on the planned development of community-based services, where we again anonymise the responses of the regional representatives (Chapter 2.6.3).

2.6.1 TYPES OF SERVICES TRANSFORMED BY 2023

We found that a certain level transformation of homes for persons with disabilities has taken place in all regions. Five regions reported that they had transformed their special-regime homes in the given period. However, it should be noted that some regions included partial transformation in this category. The regions confirmed that transformation of the services provided in homes for persons with disabilities is underway or has taken place in their territory, with the level of transformation varying significantly between regions. Most regions have initiated the transformation of large facilities in the past and this transformation is currently ongoing. This usually concerns a gradual reduction in the number of beds. The South Moravian Region can serve as an example:

> "(…) in the period from 2014 to 2020, when the first strategy was created, we moved 185 people out of the large-scale homes for people with disabilities into either sheltered housing or small-scale homes for people with disabilities. Under the new 2021–2027 strategy, our facilities continue in their gradual transformation, where we plan to further reduce the capacity of the large-scale facilities and, in 2027 we should completely close the Habrovanský zámek and Emin zámek facilities and the people should transfer to other forms of support, either lower, if this is a viable option for them, or to sheltered housing or small-scale facilities."

Several regions reported that the transformation of some facilities in their area has been completed, but **no region stated that all of its facilities had been transformed**. The stage of transformation varies across the Czech Republic: several regions have transformed some of their facilities and are now transforming other services. Some regions have just begun transforming their first facilities. Others have carried out the transformation only partially and are still awaiting the launch of other projects, which indicates that these regions have not yet launched any full transformation project.

Another topic we identified concerned the partial transformation of the services provided by homes for people with disabilities, which is underway or has taken place in some regions. The partial transformation involves reducing the capacity of the facility and moving only some of the clients of the institutional services to sheltered housing or other community-based services. The following quote shows how a partial transformation was conceived by the Central Bohemian Region:

> "One facility underwent a complete transformation, where it was finished in 2014 and actually the whole facility is dissolved in the community (…) From what I know (…) looking at some information from the past, six facilities underwent some kind of partial [transformation] (…) Partial meaning the fact that part of the capacity was moved somewhere in the community, to a sheltered housing service or to a community-based home for people with disabilities. Alternatively, some of these providers do not have sheltered housing, but they have a home for people with disabilities and then an outreach service, independent living support. So most of those providers have some sort of community-based service or service that is actually provided in the field."

The second type of services undergoing transformation were special-regime homes. Five regions – the Zlín Region, the Moravian-Silesian Region, the Pardubice Region, the Olomouc Region and the Capital City of Prague – informed us that transformation of their special-regime homes has been completed or is ongoing. The Olomouc Region has informed us that the transformation of one of the homes for people with disabilities also includes a transformation of a special-regime home. The Zlín Region has started the transformation of one special-regime home, which has been partially completed, and plans to continue this process. The Capital City of Prague has three large-scale special-regime homes, one of which has already been fully transformed and the transformation of the others is planned. The Moravian-Silesian and Pardubice Regions have transformed at least one special-regime home, according to their statements. For example, the Moravian-Silesian Region told us:

> "The services of the home for people with disabilities have been transformed and I think some of the special-regime homes as well."

2.6.2 TYPES OF SERVICES TO BE TRANSFORMED AFTER 2023

We also asked what types of services the regions planned to transform in the future. Ten regions informed us that they intend to transform the homes for people with disabilities, and three of them – the South Moravian Region, the Zlín Region and the Ústí Region – have included the transformation of their special-regime homes in the plans. However, it is important to note that some of these transformations are only partial. Two regions, namely the South Bohemian Region and the Pilsen Region, stated that they currently have no plans to transform new facilities. The Pilsen Region told us directly:

> "We don't have a plan for any transformation in the social services yet."

For two regions, the Vysočina Region and the Karlovy Vary Region, it was not possible to unambiguously determine from the answers which specific types of institutional services they plan to transform. However, their answers showed a commitment to transformation, as evidenced, for example, by the statement of the Vysočina Region:

> "(…) in the near future, we would like to transform the last two facilities for people with intellectual and combined disabilities, because these are the ones left and we don't really want institutional services for this target group (…)"

2.6.3 PLANNED DEVELOPMENT OF COMMUNITY-BASED SERVICES

We also asked what community-based services the regions planned to develop in the future. The regional representatives' responses will be anonymised again. **The regions most often focus on the development of community-based sheltered housing**, as we have been told by nine regions. One region specifically stated:

> "We are also building sheltered housing (…) for people with mental illnesses. Further sheltered housing (…) should be provided for people with physical, intellectual, that is, combined disabilities, not involving a mental disorder."

Fewer regions are planning to develop community-based special-regime homes, which are intended primarily for people with autism spectrum disorder, chronic mental illness, special needs, and clients with challenging behaviour.

> "(…) we call it a community-based special-regime home. But its structure corresponds to that of sheltered housing. This means that the clients have more freedom, they have a completely different set-up. The people working there will totally accept this, they will provide the service as they should."

Several regions are now focusing their efforts on developing outreach and ambulatory services. The aim of the development of these services is to create a supportive network of social services that will enable for the people to receive care in their home environment for as long as possible. The regions see this approach as a **prevention to the placement of clients in residential services**. One region stated the following:

> "That's why I also say that we will have to focus more on strengthening our outreach and ambulatory services that allow people to not have to move anywhere, to stay in their flats with their parents moving out, for example (...) so that we don't have to move those people anywhere, when we often don't even have anywhere to move them at the given time (...) or we have to deliver that service to that person in their home."

Another important aspect of the planned development is the **strengthening of services to support independent living**. Support for independent living is considered by several regions to be a key element in the transition of clients out of the residential services system. The priority of this service was highlighted by one region as follows:

> "(...) we have high priority, medium priority and low priority services. In addition to traditional ambulatory and outreach services, high priority is also given to supporting independent living."

Several regions are planning to develop community-based homes for people with disabilities. One region specifically states:

> "We are also designing homes for people with disabilities(...) 2, 3 houses, 12 clients in total, again for people with mental illness, they should be opened in, er, the second half of 2025 or first half of 2026. So the region (...) plans to develop services supporting sheltered housing and homes for people with disabilities."

Furthermore, only one region stated that they did not know whether their contributory organisations planned to further develop community-based social services. This region has also indicated that it planned to develop homes for people with disabilities that do not meet the criteria for community-based services.

2.7 OBSTACLES TO SUCCESSFUL DEINSTITUTIONALISATION

We aimed to identify the key obstacles that hinder or slow down the deinstitutionalisation process. We identified two main types of barriers. First, procedural obstacles faced by regions when implementing the deinstitutionalisation plan (Chapter 2.7.1).

Second, obstacles arising out of the institutional framework (Chapter 2.7.2). These obstacles are associated with legislation, division of competences, system of social services funding and other aspects.

In order to gain a more comprehensive and detailed insight into the issue of deinstitutionalisation, we inquired into whether the obstacles identified differ for the individual client groups (Chapter 2.7.3).

2.7.1 PROCEDURAL BARRIERS TO DEINSTITUTIONALISATION

We focused on identifying recurrent obstacles in the process of deinstitutionalisation in each region. We present the barriers in a descending order from the most frequently mentioned ones to those mentioned only by a few regions:

- insufficient information about the lives of people with disabilities and prejudices of the public against these people (Chapter 2.7.1.1);
- approach of service providers and staff to the topic of deinstitutionalisation (Chapter 2.7.1.2);
- lack of suitable land for the establishment of community-based services (Chapter 2.7.1.3);
- lack of staff (Chapter 2.7.1.4);
- attitude of guardians and families of people with disabilities towards community-based services (Chapter 2.7.1.5); and
- availability and flexibility of social services provided in the region (Chapter 2.7.1.6).

2.7.1.1 Public opinion as an obstacle to deinstitutionalisation

It follows from the interviews that the most frequent obstacle to deinstitutionalisation is the negative attitude of the public towards issues related to people with disabilities. **Regions often mentioned public concern and its opposition towards social services and their clients.** The respondents stated that the public was prejudiced against the clients, especially those with intellectual disabilities or mental illnesses, as illustrated by the following quote:

> "And what's more, there were and still are huge barriers in that the general public is afraid of clients who are different (...)[People] with mental illnesses face the greatest [barrier]. Even though their neighbour might have a mental illness too, they just don't know it and don't take medication (...) People don't like to see people with intellectual disabilities. (...) Simply, the society is willing to donate money, but not to have these people around."

According to the regions, the public may be poorly informed about what the transformation of social services entails, how the new services may affect the community, and who the clients of these services are. They believe that the public attitude is based on stereotypes about people with different types of disabilities. Thus, safety concerns arise in the communities out of ignorance and fear of the unknown and hinder deinstitutionalisation:

> "When we establish a new facility, we tend to say that what is holding it back was maybe the 'healthy population's' fear and lack of knowledge. They believe that the facility will be full of dangerous people, that they won't be able to let their kids go out alone out of fear that the people in the facility are going to kill them or something. It's simply the lack of awareness in the society regarding the types of diagnoses or who these people are. In the eyes of the public, they are all the same."

The regions stressed the need to raise awareness and communicate with the public and municipalities. The majority of the public's fear of clients is based on the lack of knowledge concerning the clients' needs and way of life, as well as a lack of understanding of how community-based social services work. Providing information, proactive communication and debunking myths can help remove these concerns.

> "It may be caused by the fact that the [awareness-related] activities are usually aimed at service workers. I think the awareness among them is much higher than among general population. When I start explaining what transformation means, I often hear: 'But they can't live on their own, or they can't use a certain service...' They do not even know what 'sheltered housing' means. We have to explain that it does not mean that we move in a bunch of people and leave them there, the workers move in with them and assist them."

The regions stated that it was necessary to debunk myths and prejudices and, at the same time, explain to the public what the transformation of social services involves and what its real impact is. A possible solution is raising public awareness, which includes deepening understanding of different types of disabilities and the clients' needs. According to several regions, awareness-raising activities include communication with local communities and municipalities undergoing changes in the provision of services for people with disabilities:

> "As we have said, municipalities are often against establishing a community-based social service, so [it would help] to have some kind of awareness-raising campaign. To let the public know that just because someone has an autism spectrum disorder, it does not mean that they are a murderer."

It is important to emphasise that regions that have gained experience in integrating people with disabilities into the community observe a gradual elimination of the prejudices. Gaining positive experience and developing good practice to which one can refer are key factors in overcoming concerns and distrust of the public towards social services. This is illustrated by the following quote:

> "(...) when they are concerned, we can show them how it works. We already have examples of good practice, they can visit the mayors and the municipalities, look at the house and see (...) what the care looks like, that it's a regular household and that the neighbours have nothing to worry about."

The experience of the regions has also been confirmed by the **MoLSA**, which told us that the deinstitutionalisation plan can raise opposition by the citizens, petition initiatives, etc. According to the MoLSA, it gradually became clear that the State had failed to effectively explain the effects of deinstitutionalisation to its citizens:

> "(...) there was a wave of indignation from the citizens in places where sheltered housing was to be established, and both the regions and the political representatives of that region or city lost their footing. They faced constant criticism by the citizens who petitioned to the municipal assembly and so on. This certainly ended more than ten transformations in different facilities (...)"

The MoLSA also stated that the negative attitude towards deinstitutionalisation was also manifested on the political level:

> "(...) this also closely relates (...) to political views, because not only in the past, but also in the present (...) it is becoming a political issue, and certain political groups perceive the topic of deinstitutionalisation negatively."

Several representatives of the regions also pointed out that public attitudes are reflected in the attitudes of the regional political representation. Representatives of the regions and regional assembly influence the way new services are accepted in the communities. At the same time, these actors may be just as uninformed about the clients' way of live and the functioning of social services and have the same prejudices as some parts of the public. In the words of one of the regions:

> "However, the approval processes [to implement deinstitutionalisation] are being approved by elected representatives, where we often encounter certain barriers, a lack of understanding that a person with a disability has the same right to live in a less restrictive environment as any other person."

The reason why the political representation may have reservations about deinstitutionalisation is the financial demands and long horizons required to complete the process. At the same time, political support is crucial for deinstitutionalisation**.** As illustrated by a quote from one respondent:

> "(...) that some kind of deinstitutionalisation was planned and then a new political representation was elected and put an end to it. (...) Of course, it is always difficult to find a rational balance between what is economically sustainable and what is humane. Suddenly, the economic discourse took over, which then hindered further steps towards transformation."

2.7.1.2 Provider's and staff's opinion as an obstacle to deinstitutionalisation

Another barrier is the attitude of social service workers in residential institutions that are to undergo transformation and their willingness to adapt to new procedures and working methods. In this context, the regions stated that the attitude of the management of the given institution towards transformation also plays an important role.

Some workers may be sceptical about deinstitutionalisation or fear the impact on their jobs. The regions explained that **changing the mindset of the employees has a key influence on the transformation process**. Many employees are used to the current manner of service provision and may be concerned about new working methods and environment. Some even oppose these changes. In order for the transformation to be successful, it is essential to motivate the staff and gain its support. In this respect, one survey participant stated:

> "But (...) [the approach to deinstitutionalisation] of the employees who reject it and have a different opinion is the worst. It's bad enough that we've just removed one director and the new director of a home near the borders is absolutely unhappy, but she will manage. If only the employees changed their mindset."

In this regard, the approach of the service management plays an important role. Several regions stated that while some directors support the changes, others may be against them. **A positive approach of the management to deinstitutionalisation influences how quickly and successfully the transformation takes place.** As illustrated by the following quote:

> "So (...), as I say, it [the transformation] needs a lot of cooperation from the management. This can work wonders, if the director and the management are enthusiastic about the transformation, it can motivate the people to make incredible changes, even those who are already there."

Several regions also reported that **some employees refused to adapt to the working practices following from the community-based nature of the new services**. The respondents pointed out the need to change the organisational culture in order to support transformation processes.

> "The second setback, which had to be dealt with primarily by the facility itself, was changing the mindset of the staff. That was very important, this was not the region's doing, the home for people with disabilities had its own (...) project for that. Changing the staff's mindset from institutional care to home care was a huge issue they had to address, but they succeeded. Sometimes it brought about employee turnover, change and so on. Some people accepted it and adapted. Some preferred the new state of affairs, some refused it."

The importance of senior employees and management in the process of change is unquestionable. According to two regions, there is a close link between successful transformation and enthusiastic, open and motivated management. Where directors and managers are unwilling to support changes, this may constitute a key barrier. As one respondent sums it up:

> "(...) It always takes us by surprise. There is one facility that we decided to deinstitutionalise. The director there is approximately our age, and he doesn't want to [deinstitutionalise] either (...) That is always surprising, when someone that you would not expect it from simply does not understand. But those are people factors, not systemic ones. If the leader who would advocate the change is not there, then it's us who has to push things forward and it's all the more difficult."

The **MoLSA** also stated that it was aware of the problem of the employees' attitude towards transformation and acknowledged the variety of opinions among the employees. While some are concerned about the new working model, others are looking forward to the changes, considering a greater autonomy a positive factor. The MoLSA has also stated that facilities could now apply for financial support from the OPE+ programme for training and education of employees and clients in relation to the transformations. There are projects for regional coordinators who help facilitate the transformation process and can communicate with the individual facilities.

2.7.1.3 Unavailability of housing and suitable real estate as a barrier to deinstitutionalisation

At the regional level, deinstitutionalisation is also hindered by the unavailability of housing. The regions suggest that this barrier is particularly prominent in some regions, and has three key characteristics:

- limited availability of real estate;
- growing prices of real estate; and
- limited availability of land for the construction of new buildings.

In many regions, there is not enough land and real estate available, making it difficult to find those that could be adapted to provide community-based social services.

> "(...) we are trying to transform as much as possible – we have an investment call, we have funds allocated, and yet we are unable to find land or buildings."

The lack of real estate was also mentioned by the **MoLSA**, which said:

> "Another barrier are the locations – finding construction plots of land is a challenge in itself (...)"

The individual regions discussed this issue in detail in their statements. The lack of available real estate leads to competition between various potential tenants, resulting in growing prices. High prices significantly complicate efforts to obtain suitable housing for social services' clients and increase the overall investment costs. As a result, some regions have problems finding suitable land for the construction of new facilities that they can afford with the allocated funds, as illustrated by the following quote:

> "We're having a hard time finding plots of land, everything is really expensive."

Municipal governments also play a key role in the issue of the lack of suitable real estate and land for the construction of social services facilities. Some regions encounter unwillingness of these governments to cooperate effectively. There are situations where the region expresses interest in certain land or real estate, but the municipal government is reluctant to use it for social services on the grounds that the land is reserved for other, usually more lucrative, purposes. For example, one region describes the situation as follows:

> "(...) and then the Mayor says: '(...) But I can offer you a plot of land over there, at the end of the village by the woods, or some ruined property.' So, unfortunately, this still persists and it has changed only slightly."

One region stated that prejudice against people with disabilities, especially those with mental illnesses or intellectual disabilities, plays an important role in this context. This region is trying to motivate municipalities within its territory and communicate with them in order to overcome these prejudices and make land or property available for community-based residential services. They also added:

> "(...) in relation to housing in regular developed area, the problem is that the regional administration does not really have that much power. It doesn't have its own housing stock, it has no way to influence municipalities, only by positive examples, by communication, and the success is uncertain. (...), in other places, they say: 'We are saving these flats for the elderly, for young families, even for people with intellectual disabilities,' but nobody wants to allow people with mental illnesses to live there. (...) there's that myth again, (...) they'll run around with knives and stuff. We are trying to work with these municipalities, we have a new system of cooperation in place, communication (...)"

2.7.1.4 Lack of staff as an obstacle to deinstitutionalisation

The lack of qualified staff in social services is a serious obstacle to deinstitutionalisation and the development of social services, as several regions told us. One of them pointed out:

> "When a commitment to provide staff for those services is approved, we know that the staff is not available (...) so I think it basically jeopardises the establishment of these services."

The problem of the lack of qualified staff to provide care in the transformed facilities was also mentioned by the **MoLSA**:

> "The third major barrier (...) is the lack of staff (...) Just explaining to the trade unions that we understand that it's easier for the staff to provide care in a multi-storey facility, (...) have their own space, everything etc. than going to three, five facilities every day. So that's (...) a big barrier."

Several regions reported that the demands of work in social services also plays a large role. Finding and maintaining staff is challenging even in cases where the services can offer adequate pay.

> "Just yesterday we had a meeting with our directors; the (new) employees come and after one, sometimes two hours, they realise how demanding the work is, so they quit."

This issue is especially prominent in the case of clients with challenging behaviour who require more staff and specialised care, as another region described:

> "(...) these are clients with challenging behaviour, (...) the family is no longer able to cope, and that's where it gets complicated, that it's really about small-scale services, the shifts are demanding and a lot of staff is required. We would also need to have men among our staff, and we have issues finding new staff members."

According to several regions, high staff turnover also contributes to staff shortages. Employees often leave after a short period of time and seek employment in other sectors, sometimes leaving for more attractive pay. Some respondents pointed out that recruiting staff for direct care is difficult due to high competition from other fields.

> "The turnover of employees between social and healthcare services is high. They are trying to attract each other's employees, poaching and bribing them, offering bonuses. I get it, everybody needs those employees, but it is our big problem."

The low social prestige of working in social services may also contribute to the problem of staff shortages. One region stated that workers sometimes "fear that it's not a prestigious enough job".

Several regions also noted that it was necessary to improve training and support for social services staff, including requalification opportunities. Some respondents stressed the need to strengthen the training of professional staff and improve public involvement in providing the service. This can improve attracting and maintaining staff, as the following quote illustrates:

> "In my opinion, education, especially training of professional staff, also needs to be improved. There is a shortage of staff and we are constantly struggling because of that. I think we need more education opportunities (...)"

Two regions also reported that some services require specific types of workers, which are in short supply. For example, several regions highlighted the shortage of medical staff in social services. One of them summarised the problem as follows:

> "When I have clients that require medical staff, which I don't have at all, and which can be found nowhere in the whole country (...) And I think that's an important discussion, that the barrier there is influenced by the lack of staff all the more."

2.7.1.5 Attitude of guardians and families of people with disabilities as a barrier to deinstitutionalisation

Deinstitutionalisation is also related to the attitude of guardians, both public and private, as well as the families of people with disabilities. Several regions reported that not all guardians were ready to support the transformation. Some of them prefer the existing services of an institutional nature. The regions told us that public guardians may have two reasons for preferring residential institutional services for the individuals under their guardianship. The first reason lies in the idea of certainty, stability and safety when a client is placed in an institutional or more restrictive service, as illustrated by the following quote:

> "(...) for many guardians, the fact that the individual under their guardianship is in a large residential service is a guarantee of some stability and for them, I don't want to say that it's easier, but it's a guarantee they don't want to let go of (...)"

Another reason is that the placement in residential services is less administratively burdensome for public guardians, as stated by the following region:

> "Then it's also the attitude of (often public) guardians who, even though they are guided and motivated to support the person to live the most mainstream way of life possible, still find it easier [to have the individual under their guardianship placed in a residential service]. This is also determined by their work possibilities and their capacity, but again, the residential service is a simpler and safer solution for them, the person is taken care of."

The preference to direct people with disabilities primarily to residential services also resonates with private guardians and families caring for people with disabilities. Some regions reported that family members have more confidence in residential services and are concerned about the future if their children were to receive other types of support. These concerns were linked to a lack of awareness of what services are provided and doubt about inadequate care. As the following region summarises:

> "Well, and then, once we started discussing it with family members, they were afraid we would return the person back to their care. They felt that they [the persons under their care] should preferably be behind bars – have bars in their windows, so that they wouldn't get hurt, but I take it that it was out of concern as they couldn't imagine what the service was like, that they felt that we wouldn't take care of them. So these were probably the fundamental things."

The family's preference of the residential services is also related to the setting of a system of support and payment for services, which motivates the placement of clients in residential services. According to the regions, this problem is related to the low amount of the care allowance and disability pensions. One region noted that especially people with mental illnesses have a low allowance for care and limited ability to work due to their disability, making it difficult for them to live independently or earn a living. At the same time, it is financially demanding for individuals to co-finance field services such as personal assistance or care service. These people's ability to pay for the support they need to live independently is then limited. People with disabilities or their families may thus prefer residential services. The following quote from another region summarises the affordability issue:

> "Another thing I need to mention is that some of the services are 'expensive' for the clients. Even if they have allowance for care, they're not willing to spend it on the service. For example, we are struggling with care services and personal assistance."

A related problem can lie in the discrepancy between the level or amount of allowance for care awarded and the actual cost of the necessary support and care the client needs to pay to secure their basic necessities. One region stated that the amount of the allowance for care may be lower than the costs of covering the actual needs of the individual due to inadequacies in the system of assessing the conditions for the award of allowance for care:

> "Even if the social worker (…), and I think some of them are very good, assess the social situation and the client's degree of self-reliance really well. But less regard is taken to self-care and ability (…). Usually, the physician only considers diagnoses and sometimes it's unbelievable when the person doesn't get any allowance and already needs long-term monitoring and help. So those are also things that don't work in this field."

2.7.1.6 Availability and flexibility of social services as an obstacle to deinstitutionalisation

The regions also see obstacles to deinstitutionalisation in the current conditions for the provision of regional social services. Here, we identify two main topics:

- the lack of availability of services providing care in an individual's natural environment; and
- the manner of provision of social services, which insufficiently responds to the clients' needs.

First, the regions highlighted the need to develop community services and provide support in an individual's natural environment. Respondents emphasised the need for the establishment of modern and flexible services that would enable the clients to remain at home while receiving the support they need. An example of such a service is the idea of creating "night-time" care centres that would allow carers to rest at night. The risk of complete exhaustion of carers would thus decrease, which could prevent them from placing the individuals under their care in residential services.

Second, the outdated nature of the existing social services system raises concerns in several regions. The system was established in 2007 and is perceived by some regions as insufficient and inflexible in 2023. Thus, the regions emphasised the need to provide different types of services that are able to respond flexibly to the actual needs of clients (for more information, see Chapter 2.7.2.2 on laws and rules related to the transformation and deinstitutionalisation processes). For example, a representative of one region said:

> "The social services system was created in 2007, when it was a huge 'wow', because X years after opening up the borders and adjusting to a completely different system of functioning, we created something new, different kinds of services. However, in 2023, it's no longer sufficient (…) we are advocating twelve kinds of services, simple and efficient services that respond to the people's needs."

Several regions expressed the need to provide social services that are able to respond flexibly to the changing needs of the clients. This includes mapping of the needs and their assessment in terms of time and cost requirements:

> "Mapping of the needs that we will be able to evaluate time- and cost-wise. Currently, we are doing it on our own with a working group we have set up, and we want to map the situation in the course of a year and a half (…) so that it [meeting real needs] (…) is measured in real time and therefore also appropriately remunerated, because when we have a reimbursement decree for care and services. If a person is using prevention services, then after some time, they should have specific individual plans that really (…) address a specific issue and help the person grow. I think that's really holding us back. In general, I think a lot of clients of those services shouldn't be there anymore, the services are not evolving, they're stuck because of the lack of capacity."

2.7.2 BARRIERS AT THE INSTITUTIONAL FRAMEWORK LEVEL

Next, we focused on identifying barriers in the institutional framework that affect deinstitutionalisation. The responses of representatives of the regions helped us identify several key topics:

- sufficient funds and available resources necessary for the successful implementation of deinstitutionalisation (Chapter 2.7.2.1);
- barriers related to the applicable laws and rules related to the processes of transformation and deinstitutionalisation (Chapter 2.7.2.2);
- cooperation among regions and the Ministry of Labour and Social Affairs (Chapter 2.7.2.3);
- and the related need for inter-ministerial cooperation and its quality and effectiveness (Chapter 2.7.2.4).

2.7.2.1 Funding and resources

All regions mentioned issues related to the funding of social services. This concerned, in particular, three aspects:

- financial support for investment costs related to deinstitutionalisation;
- funding the operation of services already transformed; and
- general uncertainty about the funding of social services.

The **first of these aspects** is the financial coverage of the costs related to deinstitutionalisation. The transformation of institutional services involves many financially demanding activities, such as renovation of buildings, investment in equipment and furnishings, etc.

Several regions warned us that the lack of investment funds prevented the implementation of the transformations planned. Many social service transformation projects require more funding than the regions have at their disposal. Some regions thus have to decide whether to limit investments or extend investment plans for several decades ahead.

> "In my opinion, our strategy since the very beginning was to transform what is quite clearly outdated. And for now, let's transform only that, because that's gonna take a while. I don't think that the region can make all those investments. If we were to change everything in the

> course of some ten years, the region would not be able to cover it financially, because it has to make other investments as well."

The investment funds are linked to the sources of funding with which regions can implement their transformation plans. According to the regions' statements, high investment costs and their insufficient coverage lead to the regions drawing support from public budgets and subsidy programmes. Regions and providers thus combine resources from the regional budget, European Structural Funds on the basis of calls under various programmes (especially IROP and regional action programmes), the National Recovery Plan and other sources. The combination of these sources of funding introduces a certain complexity and uncertainty into the transformation process, which one region commented on as follows:

> "(...) there is no legislation on this and it is not clear who will finance it [deinstitutionalisation]. Just seeing how they [the providers] are financed, we're always having meetings and we're always helping providers manage, because they say: 'We have four, five, six sources'. We do everything separately, the funding is inconsistent, non-systemic."

Some regions expressed their concerns about setting up procedures and conditions for drawing subsidies for the transformation of social services. The nature of these issues will be described in more detail in the chapter concerning regulations (Chapter 2.7.2.2). The bottom line is that according to the regions, the current form of multi-source funding may have a negative impact on the progress and implementation of projects. Due to the changing conditions of the individual calls, the regions may face the risk of losing the funds they have already invested in the preparation of subsidy projects. This issue is illustrated by the following quote:

> "(...) in general, the procedure for setting the conditions for drawing subsidies for this [deinstitutionalisation] is highly criticised. Many regions cannot wait for calls, they are preparing transformation plans for the construction of new services. They have projects at the ready. And the changing conditions and requirements for constructions and services complicate their implementation. And then we more or less have projects ready in our archives, which are useless because we don't meet the conditions for the subsidies (...)"

Second, in addition to the costs associated with the transformation of social services itself, the **funding of the operation of the already transformed services** is also problematic.

According to several regions, the operation of smaller and community-oriented services requires increased financial costs. And the (lack of) availability of funding for the future operation of transformed services is an impediment to transformation. As a result of the uncertainty, some organisations may prefer to modify the existing services rather than to fully transform. One region explained this problem as follows:

> "Then, obviously, I am faced with the fact that the establishment of these new transformed facilities is much more expensive, and that's why (...) they don't even do it, they try to improve their existing environments a little bit. They do not undergo a complete transformation, because then they wouldn't have the resources for day-to-day operation afterwards."

One of the largest operational expenses in social services budgets are **staffing costs**. In some cases, there is a lack of qualified staff (see Chapter 2.7.1.4 Lack of staff), which is contrary to the aim of providing high-quality social services. Transformed services are often need more staff than institutional services, which further increases their operational costs. The following statement summarises the whole issue:

> "(...) and then it's the costs of operation. And I mean the situation in social services, which is the same across regions, that means we don't have the staff. (...) if I am to provide a 'high-quality' service, but I do have enough staff, then those people are lacking the most important thing (...)"

According to several regions, the system of social services funding does not reflect the fact that the transformed services are more financially demanding. State funding for these services remains at the same levels as for institutional services, regardless of the fact that the transformation of the institutional model of care into a community-based model is one of the basic pillars of the National Strategy for Social Services Development and regional strategic plans. In other words, a region that fulfils these commitments and transforms the services receives the same amount of money for their provision as it did before the transformation.

> "(...) the barrier, of course, is that the funding of the services depends on subsidies from the State, which are the same no matter if they transform the services or not. The funds received are still the same. It depends on how the region sets it up. We, of course, set it up to take this into account as far as possible. However, we will not (emphasis) receive more from the State. So, there is no support, and naturally the services are afraid they won't be able to make ends meet."

Several of the regions interviewed address this situation by providing additional funding of the social services from their own resources. However, this approach creates disparities across the regions and does not address the systemic problem of insufficient support for the transformed services. This funding affects not only the service providers themselves, but also the regions that are involved in the funding of the transformed social services from their own resources.

> "The problem is the sustainability of remuneration of those workers and also ensuring the flow of the State funds. The region naturally also co-finances these services to the extent of its possibilities, albeit optionally, with some CZK 200 million. Not all regions fund the social services pursuant to Section 105[129] (...)"

The third related problem connecting both the above aspects, i.e. financing of the investments and of the operation of the transformed services, is the **uncertainty regarding social services funding**. This uncertainty concerns not only deinstitutionalisation, but also the overall planning of the development of social services in the individual regions.

According to the respondents, there are two main reasons for the uncertainty. The first factor is the economic situation of the Czech Republic in 2023, in particular, the constraints associated with austerity measures, which create uncertainty about investments in service development, including the transformation process (for more information, see Chapter 2.7.2.4 Inter-ministerial cooperation).

> "(...) we do not know what the Ministry of Finance will do with the money within its austerity packages. If you ask for the opinion of the Ministry of Finance during the voting (...) on the funding of the regional deinstitutionalisation call, you will find that they are not worried about anything. They are able to stop the support immediately. So we cannot venture on the thin ice of, let's say, broader development, because the Ministry of Finance could somehow interfere with the amount of funding for social services and that would be a huge problem."

According to the regions, the second reason for the uncertainty lies in the fact that the system of funding of social services works on a year-by-year basis, which complicates medium-term planning of the service development. This problem affects the whole system of planning the development of social services (see Chapter 2.9.1.2 Non-systemic funding of social services). This leaves very little room to manoeuvre for service development and deinstitutionalisation projects. As one region summed it up:

> "This way, we really do live year-to-year. We never know what allocation we will receive; we can only pray. Sure, the allocation in the State budget increases, but the percentages that go to the regions do not correspond to the reality. We are lacking some 500 million per year and, of course, we first have to pay for the regular operation of services. We pay the people, we cover the operating costs, but there is not much left for development."

The **MoLSA** also considers securing financial resources to be one of the main barriers to deinstitutionalisation. When asked about barriers to deinstitutionalisation, the MoLSA responded clearly:

> "Finance. Securing the necessary funding (...)"

The MoLSA specified that deinstitutionalisation was launched thanks to financial support from the European Union, which not only initiated the process as such, but also inspired a fundamental change in thinking about and approach to the topic. According to its statement, the MoLSA is currently negotiating with the Ministry

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[129] The respondent refers to Section 105 of the Social Services Act: "A municipality or a region may provide a specific subsidy according to a special Act from its budget for the purposes of funding ordinary expenses related to a social services provision, incurred by social services providers entered in the register."

of Finance on the amount of support for the social services development and for increasing the State contribution for community services.

2.7.2.2 Laws, rules

The regulations, rules and laws governing the process form another barrier to deinstitutionalisation. In this area, the regions brought several problems to our attention:

- overly detailed rules and standards that change frequently;
- the absence of a binding definition of community-based services;
- the outdated nature of the Social Services Act; and
- the administrative complexity of the transformation of social services.

1) The first problem lies in the **overly detailed rules and standards** that can cause confusion and difficulties in implementation. The regions mainly mentioned this issue in connection with the material and technical standard and the requirements under some subsidy titles, but it also concerns other requirements on social service facilities (e.g. sanitary or construction regulations). Specifically, there are two aspects:

First, **some standards are too narrow and introduce strict criteria on the basis of which the regions are forced to adjust their services and facilities**. This can increase the transformation costs and make properties inadequate for the needs of ordinary households or community settings. The following statement of one of the regions can serve as an example:

> “(...) a person with a disability cannot live there, because for that, the ceiling would have to be 30 cm higher (...) it’s a bit tied up by some limits, which then prevent even the most simple transformation, where you could find a house in the area where the person or group of people have some ties, and you could just set up the household there very quickly, maybe within a few months, and you wouldn’t have to wait three years for new construction.”

In this regard, it should be noted that one region stated that it resolves both of these issues with material and technical standard by considering it merely as a recommendation and not a binding rule.

In addition, several regions cited as an example of the barrier the requirement of the material and technical standard to maintain a distance of 250 metres between individual social services. Some regions view this measure as problematic in terms of deinstitutionalisation. This requirement was designed with a view to preventing the concentration of social services in one location and thus segregating people with disabilities into a defined area. However, as the regions pointed out, in practice, this can cause complications when new community services are established in areas already covered by other social services. This situation demonstrates that even if a facility reflects the needs of the community, it may not meet this formal criterion. One respondent explained it as follows:

> “In my experience, what we often encounter in practice is that every time we find a suitable property or place, there is always some other social service less than 250 metres away, even though it is completely unrelated to us (...) For example, we have a building in [street name], the city has built a relief service 230 metres behind a railway crossing, and suddenly, an ideal house, a terraced house in a regular street, (...) doesn’t meet the criteria.”

Second, several regions drew attention to the **constant changes in the conditions** for the projects of deinstitutionalisation and transformation of social services, especially regarding:

- changes to the requirements under the subsidy calls; and
- revision of the material and technical standard.

According to the regions, changes in the requirements in between calls are a problem as the regions already have projects prepared on the basis of the previous calls. The regions prepare the design documents in advance to increase their chances of submitting the application on time. As one region reported, the project

preparation process takes almost one year and involves a number of other processes, such as obtaining a planning permit and a construction permit. Sudden changes in the conditions complicate the planning and implementation of the projects. Two regions told us:

> “If you do not start designing in advance, you have no chance of making it in time (...) we start designing, we commission the design for a lot of money and suddenly, when the call is announced, we find out that there are some other requirements, and the project has to be redesigned.”

> “From my observations, it keeps changing – capacity of 20, 25, 75, 6, 12, 18. I know that our colleagues from other regions are going crazy because they constantly have to redraw the design documents and keep investing money. That’s insane.”

The regions also believe that the revision of the material and technical standard leads to a situation where the already-established community-based facilities no longer meet the latest conditions for community services. One region pointed out that a facility built in 2016 for six people as part of a community-based sheltered housing no longer meets the current standard for community services.

2) The second major issue related to regulations and rules is the **lack of a specific definition of community services**. Several regions criticised the vague and variable characteristics of community-based services. According to the regions, the individual actors have different ideas of what the service entails. Thus, several regions voiced the need for a clear and fixed definition of community-based services. One region summed it up as follows:

> “Community service is a problematic issue because the parameters are not anchored anywhere. This means that over the past few years, many community services have been established, but their establishment was ordered by the political representation, which means that they are perhaps even more community-based than they would have to be, regarding the parameters and capacities. This then has an economic as well as operational impact on the provision of that service. We have community services, we support them and we want them, but it would be very helpful if the parameters were clearly anchored somewhere beyond the national and supranational calls for construction and establishment (...).”

The **MoLSA** also mentioned the problem of the ambiguous definition of community services at the level of the institutional framework:

> “(...) community service is currently seen as any service that is not (...) institutionalised or institutional. I say that because there are various definitions of the services– the community planning service, service under the National Recovery Plan, (...) last year the definition was different from what it is this year. (...) There is a lot of room for change and it always depends on how we, as the Czech Republic, are able to communicate it within the public debate and then externally within the European Commission.”

3) The third problem is related to the overall legislative framework for social services in the Czech Republic. The **Social Services Act, which has been in force since 2007, has not been comprehensively revised** and, according to several regions, may no longer adequately reflect the current needs and developments in the field of social services.

> “The Social Services Act dates back to 2006, and as far as I know, it was not fundamentally amended when the services were created. The evolution of the situation and the needs should be addressed. In my opinion, a legislative change in the area of social services is absolutely necessary.”

Several regions stressed the need to create a new system that considers the real need, availability of social services in terms of locality, time and finances, and the nature of the care, including specific interventions (for more on the issue, see Chapter 2.7.1.6 Availability and flexibility of social services). One region gave an example of a situation where organisations deal with too many formalities to the detriment of the care itself:

> “Sometimes, providers care too much about whether they are not overstepping some boundaries instead of providing the service. I understand that they have to comply with the

> registration conditions, that there is a law (…) if I provide an ambulatory counselling service and I have a client who has troubles walking – if I accompany him to the bus stop which is right next to the clinic, am I breaking the law because I am not supposed to work in a field (…) Sometimes, I feel the providers (…) are often too tied up, worried whether they can do something, and then they prefer to register for another kind of service. (…) it seems to me that when compared to other countries, they have more freedom when it comes to the provision of these services, that they don't dwell on every small detail."

4) The fourth problem associated with regulations and standards is the **administrative complexity of the transformation**. The regions told us that they would appreciate simplification of the official procedures and of the processes associated with subsidy applications and service activity reporting, and a greater stability of the service requirements. According to the statement of one of the regions:

> "Unnecessarily complicated administration (…) Maybe not burden the applicants, or the providers, with paperwork and let them work with the people. (…) In this regard, there is too much red tape."

2.7.2.3 Activities of the MoLSA

When analysing the barriers faced by the regions in the process of deinstitutionalisation, we noted in the regions' responses that the MoLSA plays an important role. In response to our question about barriers, one region directly stated that it perceived the MoLSA itself as a "fundamental barrier" to the whole process.

In addition to the lack of methodological guidance mentioned in Chapter 2.2 (Methodological background), several regions see the role of the MoLSA as problematic in other areas as well. **The first problem is the lack of conceptual guidance from the MoLSA.** The respondents complained about the lack of conceptual guidance in the area of deinstitutionalisation and strategic management, which complicates their ability to plan and deinstitutionalise effectively.

The lack of a framework for overall direction affects two areas. First of all, several regions reported that they miss a clear national direction and a long-term strategy from the MoLSA. The regions would welcome the existence of a body or mechanism that would set a clear direction for the future development of social services while emphasising deinstitutionalisation. Such a body could effectively coordinate the different aspects of the process and enable better cooperation between the individual actors. One region said:

> "(…) there always needs to be someone who bangs their fist on the table and says, enough is enough. The opportunities are there, we could have been utilising the funds for over a year now, we could have been preparing for it. And it's still not happening, because we're missing this element. For me, that is a fundamental barrier, the lack of conceptual guidance at the national level."

The missing framework also contributes to the problems in the funding of social services. The regions emphasised that in order to plan better and implement changes in social services, they need a clear national direction and support from the MoLSA. According to several regions, the funding system is currently not linked to the national long-term vision of development of social services. Without this vision and coordination at the national level, it is difficult for the regions to fully deinstitutionalise and effectively utilise the available funds (for more on this issue , see Chapter 2.7.2.1 Funding and resources). One region summed it up as follows:

> "The current system of social services funding is not bad, but of course it is not ideal. And it's certainly not the best it could be, far from it. On the other hand, this imperfect system lacks the basic framework that the MoLSA never provided. The regions have dealt with this in their own ways as unfortunately, they had had no other option."
>
> "(…) anyway, we thought we could proceed in this way [deinstitutionalise] if the Ministry's strategy was long-term. It would not always have to be linked to European projects, if the Ministry itself provided not only investment but also non-investment operating funds to some small households. There are operational subsidies etc., so we think that then it would make sense, but it would also have to be the strategy of the Ministry."

Another major problem that the regions have shared is the **lack of consistency at the central level.** Two regions noted inconsistencies and an insufficient link between the State's declared objectives and the allocated resources. This problem is related to the role of the MoLSA as a body that negotiates policy priorities with various government departments, as described in the chapter on inter-ministerial cooperation (Chapter 2.7.2.4). One respondent commented as follows:

> "The Ministry [of Labour and Social Affairs] is inconsistent in the perception of the whole process, when the conditions change and, from my point of view, the Ministry [of Labour and Social Affairs] is not doing what it should do to lead the other ministries to achieve the transformation (…)"

It should be noted that the regions did not consider the need for a single framework to be a call for greater centralisation. The regions perceived that the responsibilities in the area of social services were transferred to the regions without sufficient support and a clear policy from the MoLSA. However, according to the regions, at present, re-centralisation without sufficient knowledge of the field may lead to non-systemic changes in the provision of social services. Thus, some regions have recently stressed the importance of preserving the local knowledge and experience. The following quote illustrates the issue:

> "If the Ministry of Labour [and Social Affairs] was able to manage this [the provision of social services], that would be a good thing. But I think they have very little insight into the practice, they do not communicate with us enough. As we have discussed, they are not managing it. Over the years, we came to believe that it may be a good thing. That the regions or municipalities know the most about their own situation. That means everything should be probably come from the roots. This is the problem of 'centralisation'."

In this respect, however, two regions mentioned the importance of the MoLSA as a coordinator of the deinstitutionalisation processes. These representatives pointed out the perceived inconsistencies in the understanding and practice regarding deinstitutionalisation and transformation across regions. Some regions would welcome if the MoLSA played the role of a coordinator between the regions, ensuring uniformity and unification of practice in the provision of social services. One region summed it up as follows:

> "They should definitely play the role of a methodological and management body, the regions cannot decide everything independently (…) Some changes may emerge from the bottom, but it will never be systemic, the change will be slow."

Another important area is methodological support (see Chapter 2.2 Methodological background). The respondents emphasised the lack of methodological support from the MoLSA in the area of planning and implementation of deinstitutionalisation projects and the need for faster and more effective communication with the MoLSA. In the area of project planning and implementation, the regions reported that high-quality methodological support would help them better understand the deinstitutionalisation requirements and procedures. According to the regions, the lack of methodological support leads to various problems, ranging from different interpretations of the concepts related to these processes to lack of clarity regarding specific projects. The regions reported that the lack of methodological support is also related to the lack of transformation consultants at the MoLSA. These consultants should be able to provide expert advice and assistance in the preparation of the transformation plans. The respondents consider this lack of professional supervision and consultation a major shortcoming, complicating the preparation and implementation of any changes. One respondent said:

> "(…) moreover, there is no consultant at the Ministry with whom we could consult the drafting of the transformation plans, who would be able to tell us – this is good, this is bad. 'You need to change this or the Ministry won't approve.' This lack of structure in the process prevents us from effectively addressing the issue."

The regions consider the problems in communication with the MoLSA a related issue. They emphasised the delays in receiving feedback and approval of transformation plans by the MoLSA, which further delays the transformation. The following quote illustrates the issue:

> "So we sent [the transformation plans] again, then we waited again and altogether it took about two months to receive feedback. Since last year, we are preparing one plan and I simultaneously work on three others (…)"

2.7.2.4 Inter-ministerial cooperation

Another barrier mentioned by several regions is the lack of cooperation and interconnection among the different ministries and the impact of this lack of a common approach on the processes related to the development of social services, including the deinstitutionalisation process.

The first area discussed by the regions was the perceived lack of coordination among the ministries, specifically between the MoLSA and the Ministry of Education, Youth and Sports, the Ministry of Health and the Ministry of Finance. One region commented on this state of affairs:

> "Barriers, well, I think it all depends on the people (…) we've been to Belgium, Austria, Germany and (…) we've seen how they do it, how the care works, their environment and so on and we've met the clients, it was great. But then we found out that in some matters the [Czech] ministries are terribly old-fashioned. They, the ministries of finance, health, social affairs and also education, they are not willing to cooperate on these things."

The regions acquainted us in more detail with the areas in which the lack of cooperation is manifested. In the area of health care, the regions are primarily faced with issues on the border line between social and healthcare areas, medical interventions in social services, and in the context of mental health care reform. In relation to medical interventions in community-based services, one region pointed out that the medical requirements on a facility may be at variance with the requirements on a community-based facility.

> "(…) currently an amendment to the Healthcare Services Act is being prepared in that social services should have (…) health registration, and that also complicates the functioning of community services. And the question is whether someone will then want to establish a community-based service and what conditions the new community-based service will have to meet. If it also has to comply with the health regulations, then it won't be a community-based service."

Another aspect where the health sector interferes with the operation of social services is the mental health care reform. In this area, the regions noted a lack of inter-ministerial cooperation in further development, especially with respect to the activities performed by medical staff in social services and the emergency care system. One region summed it up as follows:

> "Some kind of link with the health care system, where this is not anchored in the legislation; the system of emergency care is somehow coordinated (…) and the activities of medical staff in social services, and generally a system of emergency assistance, which the health care sector considers as their field (…) that [inter-ministerial] link that we have all been talking about for nearly 20 years and we feel its absence."

The regions also noticed an issue between the MoLSA and the Ministry of Finance, which raises questions about the funding of the operation and development of services in the region (see more in Chapter 2.7.2.1 Funding and resources):

> "I don't know how they distribute the money now. How they create budgets, what are the rules, because the MoLSA certainly has a big amount to distribute, that is clear. But if the ministries cannot agree among themselves, how should we proceed? Those (…) are not set up at all."

The second area related to poor inter-ministerial approach mentioned by two regions is the area of requirements on social service facilities. In this context, the regions perceive a conflict between construction, hygiene and fire safety standards for facilities providing community-based services and the fact that the service provided should resemble a home as much as possible. The requirements that registered services must meet may be contrary to the principle of normality that community-based services are supposed to meet. In this respect, one region said:

> "We are also quite bothered by the hygiene and fire safety decrees, because they require things you do not do in a regular household, you do not have instructions at home how to wash your hands, you do not have a "do not enter" sign on your laundry room door, etc."

2.7.3 DIFFERENCE IN BARRIERS FOR VARIOUS TARGET GROUPS

According to the regions, the barriers to deinstitutionalisation vary between the individual target groups. The most common barrier that affects different target groups differently is the attitude of the public; three main groups can be identified here– the elderly, people with a drug addiction and homeless people, and people with disabilities. Concerns are present in the society particularly regarding people with mental illnesses and intellectual disabilities, resulting partly from a lack of awareness and persistent myths and prejudices (as discussed in Chapter 2.7.1.1 Public attitude). For this reason, local governments may decide not to build facilities providing community-based service on their territories.

The regions stated that not there are differences in political attractivity among the target groups as well. Senior citizens are often at the centre of political attention, while people with disabilities are a politically "unattractive" target group. This inequality in the politicians' interest may affect the allocation of funds to support projects.

> "Municipalities really focus on the target group of senior citizens. When it comes to people with mental illness, there we see greater barriers. Society has yet to learn how to deal with it, it's a social and healthcare issue. It is necessary to work on awareness raising and so on."

This disparity was also highlighted by the **MoLSA**, which told us that senior citizens are the most acceptable group to the public. Paradoxically, however, senior citizens face barriers to deinstitutionalisation, as even the Czech service providers themselves do not perceive senior citizens as a target group for transformation, as can be seen in the following excerpt from an interview with a MoLSA representative:

> "This is such a big systemic barrier, (…) it's the most accessible group in terms of acceptance by the general public, but the professional community completely rejects any transformation of [services for] senior citizens."

2.8 PROPOSALS TO ADDRESS BARRIERS TO DEINSTITUTIONALISATION

In our survey, we did not limit ourselves to identifying obstacles to deinstitutionalisation, but we also mapped possible solutions that the regions would welcome. We focused on two main areas:

- the kind of support from the State that the regions would appreciate in order to reduce barriers to deinstitutionalisation (Chapter 2.8.1);
- the general factors and resources the regions consider necessary for successful deinstitutionalisation Chapter 2.8.2).

This chapter will provide insight into what steps and initiatives could contribute to accelerating the process of transformation and deinstitutionalisation of social services at the regional level.

2.8.1 SUPPORT FROM THE STATE

In the first part, we focused on the support the regions need from the State to reduce the barriers to deinstitutionalisation. The regions most frequently mentioned three key topics:

- the need for clear direction in the social services development (Chapter 2.8.1.1);
- the need to control the quality of social services provided (Chapter 2.8.1.2); and
- development of recommendations and methodology for the deinstitutionalisation process (Chapter 2.8.1.3).

2.8.1.1 Policy framework for the development of social services

Regions clearly expressed the need for a systematic approach to the development of social services that would be stable and predictable (described in more detail in Chapter 2.8.2 Regional recommendations on deinstitutionalisation). This requirement affects several key areas. First, **the regions expressed a desire to honour the commitment to deinstitutionalisation, and not back away from it**, as illustrated by the following quote:

> "(...) on the one hand, they are pursuing a transformation strategy, but on the other hand, they allow, within the framework of the national recovery plan, to simply build mega-capacity facilities again. (...) If they are trying to do something, then everything they do should go in that direction. And not make any decision to the contrary. These obstacles continue to appear."

The **MoLSA** is also aware of the need to address this issue. The Ministry stated that the commitment to deinstitutionalisation needs to be clearly defined at both the strategic and legislative levels, including clear definitions of the individual terms:

> "(...) both strategic and legislative. The commitments need to be clearly defined. In general, we need clear definitions, because if we had them already, then we wouldn't have to argue about whether (...)"

Second, the absence of a clear policy leads to a lack of clear and stable financial conditions. The regions would welcome if the **system of funding of social services was stable, unchanging, predictable and linked to the concept of social services development**. In this context, the regions express the need for a unified policy, stability and planning for the future in the funding of social services, as illustrated by the following quotes:

> "It needs a unified policy that could be set up within a year, but the State would have to take it upon itself to provide the money. And this should be set up with an outlook for some three to five years."

> "In the context of transformation, I have already mentioned it, the conditions should be defined clearly and remain the same. Unless there is a fundamental reason to change them, they should simply remain the same."

The **MoLSA** is aware of the urgency to address both these issues. A key aspect of this barrier is the lack of clearly defined rules for the whole process. This ambiguity is considered a fundamental obstacle, as the lack of a legal framework does not allow for uniform procedures. At the same time, there is a lack of clear and consistent financial support from the State budget. The MoLSA stated that it understands why the regions are cautious: they do not have enough certainty regarding funding from State sources, which limits their active involvement in deinstitutionalisation. According to the MoLSA, the solution to this issue would involve the creation of a clear legislative framework and clear rules for the entire process, along with a transparent setup of financial mechanisms from the State budget. This could create an environment in which regions would be motivated and assured that their efforts in transformation would be adequately rewarded in the form of financial support. A MoLSA representative said in an interview:

> "So if this was resolved, that means if we had a clear legislative setting and clear rules. For example, if I transform, I get a bigger coefficient, a higher subsidy or higher financial support."

Third, the lack of a policy is also reflected in the lack of clear definitions of terms related to deinstitutionalisation and the direction for the development of community-based services and the deinstitutionalisation process. In this context, the regions especially stressed the **need to define a community-based service and to maintain this definition in the future**, including in connection with other regulations and documents such as the material and technical standard. According to several regions, these regulations sometimes contradict the principle that community-based services are provided in an informal environment (see more in Chapter 2.7.2.2 Laws, rules).

Fourth, a unified policy would also include the **unification of practice across regions**, which would lead to greater clarity in the social services system and simpler coordination, for example in the area of collecting information on the need for the services:

> "A unified concept could also lead to greater unification of systems across the regions. A unified concept (...) I imagine that we would at least unify some procedures and reporting at the national level. I know that having a unified system is science fiction, but it would be great. We've stopped collecting data that we're not obliged to collect. To collect information from the territory in a uniform way, for example, data on the services needed, where we all know what we are talking about and are able to evaluate that information."

The **MoLSA** expressed a similar vision, stressing that the next steps in the deinstitutionalisation process are achievable through the implementation of systemic projects. This may, for example, lead to the creation of a unified data base or the introduction of a needs monitoring and evaluation system, providing the region with tools for further development.

However, it should be emphasised that while the regions strive for greater structure and stability, they also oppose greater centralisation:

> "The costs diametrically differ, and if the Ministry [of Labour and Social Affairs] had ambitions to manage the matter centrally, I strongly doubt that it could, because practice shows the exact opposite."

2.8.1.2 Improving the quality of social services

Several regions expressed the need to improve the quality of social services (see Chapter 2.8.2.6 Review of the network and identification of the services needed). In this context, they stressed the importance of support from the MoLSA, especially in providing quality training and methodologies for teams working in social services. The regions also emphasised the need for continuous training of experts who are then able to provide methodological support.

Another quality improvement tool mentioned by the regions is a professional and trained inspection of social services. The regions pointed out that quality control mechanisms for social services should be much more effective and more oriented on the needs of the clients, as illustrated by a representative of one region:

> "The inspection by MoLSA is carried out usually on the basis of complaints. It is not clear whether inspections are also planned, but in any case, they seem to be conducted in places where they are not necessary. That is another aspect that needs to be highlighted. It was ideal when inspections were carried out at the regional level. The inspections were registered, everything was centralised, now it's in the competence of the Ministry."

In relation to quality, one region stressed the need to include municipalities in the social services planning process and advocated for medium-term planning with an emphasis on transparency and municipal control over the services provided. See the full quote below:

> "We need municipalities to be actively involved in the planning of social services, and we need medium-term planning that emphasises transparency and municipal control over the services provided."

2.8.1.3 Methodological support for deinstitutionalisation

Several regions said that they would welcome more methodological support from the MoLSA. One region stated:

> "We follow the structure [medium-term plan] given by law and decree (...). In this area, we would appreciate more methodological support from the Ministry."

The solutions proposed by the regions include appointing methodological consultants at the central level, sharing of best practice and greater inter-regional cooperation:

> "(...) inter-regional cooperation, sharing of best practice, some guidance and maybe awareness raising from the central level."

As a solution to this problem, the **MoLSA** said it was currently implementing a project that provides methodological support to facilities undergoing transformation. This initiative offers the services of three field consultants who can advise facilities in the transition process; see below an excerpt from an interview with a MoLSA representative:

> "We are now implementing the system, a new transformation project. As part of this project, we offer the services of three field consultants in the central team, who will for now provide consultations to the facilities involved in the process (...)"

2.8.2 REGIONAL RECOMMENDATIONS FOR DEINSTITUTIONALISATION

The second key area of our survey was to find out what specific measures could contribute to successful deinstitutionalisation in the individual regions. In the analysis, we identified several key topics:

- clear and fixed rules (Chapter 2.8.2.1);
- a change in the funding system (Chapter 2.8.2.2);
- promoting public awareness on issues related to the lives of people with disabilities and the work of social services (Chapter 2.8.2.3);
- the need for a flexible social services system (Chapter 2.8.2.4);
- the need for training of social services workers and social workers (professional staff) (Chapter 2.8.2.5);
- a network review and needs assessment (Chapter 2.8.2.6).

Some of these topics are closely related to the points made in the chapter on State support (Chapter 2.8.1).

2.8.2.1 Simple and fixed rules

Several regions stressed the need for simple and fixed rules that would make the provision of social services more efficient and reduce the administrative burden. The answers focused on several aspects:

- administrative flexibility;
- speed of the processes; and
- clear funding rules.

First, one of the key points discussed by the regions was the need for **administrative flexibility and reducing the complexity of the processes** related to the provision of social services. The regions stressed the need to establish clear and fixed criteria to reduce the administrative burden:

> "Reduce the red tape that we talked about, the constant reworking of criteria and supplementing the applications, their complexity, reporting and so on."

Second, another aspect was the discussion on the need to reduce administrative complexity, especially in relation to the **speed of calls and preparation of designs**. One region stated that it would welcome the acceleration of calls and simplification of the construction processes in relation to the investment part of providing social services.

Third, the discussion on the rules was not only concerned with the administrative aspect, but also with **funding rules**. The regions expressed the need for clear rules for the use of the funds and emphasised their need to know the conditions under which they can utilise the funds (see Chapter 2.8.2.2 Funding system), as illustrated below:

> "We really need to know the rules. That is, if we choose a certain way, then what services do we have to provide and with what capacities. And the funding then has to be provided of course."

The **MoLSA** is aware of the urgency of this problem, as we have mentioned in the chapter on the policy for the development of social services (Chapter 2.8.1.1). We said that the MoLSA is aware of the necessity to create a clear legislative framework and clear rules for the entire process, along with a transparent mechanism of funding from the State budget.

2.8.2.2 Social services funding system

In our interviews with the regions, we identified several requirements related to the social services funding system:

- change to multiannual funding for social service providers;
- provision of a basic funding framework;
- introduction of a transparent funding system;
- revision of the remuneration system in social services; and
- introduction of mandatory co-financing of social services by municipalities.

First, most of the representatives of the regions emphasised the **need for multiannual funding** of social service providers. The regions talked about the requirement to create a system that would ensure the stability of services and the possibility of their development, with an emphasis on the predictability of funding. For the regions, ensuring long-term financial stability in the form of multiannual funding is a key factor for effective provision of social services. Several regions stated that multiannual funding from the State would enable them to better plan their activities in the area of service development and deinstitutionalisation.

> "First, multiannual funding. And I mean from the State, because the State has the most money. If the funding was provided by the State, the region could follow up on that, because our subsidy programmes are set up on the basis of the [Section] 101 [of the Social Services Act], that's the fundamental barrier. Once I know that even if the funding does not significantly increase, it will not also decrease in the following three years, we can work with that."

Second, another problem is the **absence of a basic funding framework**. The regions stated that they would appreciate the creation of a fixed funding system with transparent rules under the State budget. The proposed framework conditions would allow regions to better take into account the specific needs and quality of services provided. In this regard, one region suggested creating a range of State subsidy per bed (not a fixed amount), where the specific amount allocated would reflect the need for the service and its quality, so that the more care-demanding target groups be also provided for in the funding system. Another region said:

> "To set up a framework, because it is not possible to set a certain amount per bed, it needs to be a range. That means setting up framework conditions for funding for the regions. I will say one more thing. If the region cannot provide adequate funding for a high-quality service for people with combined disabilities, i.e. physical and intellectual disabilities, in its subsidy procedure, I already know from my colleagues that no one wants to provide that service to those target groups, because those services are terribly expensive. (...) So if the rules are not set with the possibility to pay these providers what they need, then that is a really big issue."

Third, the introduction of a transparent funding system included a proposal for the necessary **adjustment of the funding based on indicative numbers**.[130] Some regions mentioned that although they are expanding and improving the quality of the services provided, the allocated funds remain almost unchanged. Thus, State funding does not reflect the fact that some regions are intensively developing more financially demanding community-based services and others are not, which creates an imbalance in the funding. As further specified by the following quote:

> "We are expanding services, but the amount of money we receive is basically the same. They follow some indicative numbers and the State is unable to take into account that some regions are developing those services more (or less) than others, it is reminiscent of the mental health care reform (...), when (...) all regions received money based on the indicative number, it didn't matter that one region had no Mental Health Centre and that we, on the other hand, were building a second one. No one considered that."

The fourth aspect identified concerns the need to **revise the system of remuneration of social services workers**, where several regions drew attention to the existing differences in remuneration received by workers employed in the non-profit sector and those employed in regional contributory organisations.

Fifth, in response to the lack of funding, several regions proposed introducing **mandatory co-financing of social services by municipalities**. This co-financing would be specified by the law and should ensure greater financial involvement of municipalities in the operation of social services. This initiative could help overcome the lack of funding and ensure the sustainability of social services. One of the regions directly proposed a mandatory co-financing of social services by municipalities at a certain percentage of their budget, which would strengthen financial stability:

> "(...) it might be nice, and again we are talking about money, for municipalities to have a statutory duty to co-finance the services. They should dedicate X percent of their budget to social services for their residents. Then, of course, the financial participation of the cities would be greater."

2.8.2.3 Raising awareness

Several regions mentioned that they would welcome a public awareness-raising campaign on the lives of people with disabilities. These respondents stressed that such a campaign should effectively target two key aspects:

- fight prejudice and eliminate fears associated with issues relating to people with disabilities and
- increase awareness of the services provided, especially the work of community-based services.

First, the regions recommended to fight prejudices and to explain to the public who people with disabilities are and to eliminate the fears associated with issues related to these people. They say it is necessary to show the public that such fears are not justified and that people with disabilities can lead full lives in the community. The aim would be to provide a balanced picture, as negative cases are often highly publicised while positive ones remain neglected, as one region told us:

> "(...) this means that you start raising awareness, because all the concerns that people have actually stem from that lack of awareness, which then causes distrust in the target groups (...) You know the usual objection is that they could rape someone etc., which only comes from that ignorance. (...) So, in general, public awareness is important for us now. Managing the prejudices and public awareness."

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[130] The "indicative number" is a percentage share in the total volume of funds allocated in the State budget for the support of social services for a given budget year. According to Section 101a (4) of the Social Services Act, the indicative numbers for the individual regions are specified in the Annex to the same Act. The indicative numbers differ for the individual regions. At the date of this survey report, the percentage ranges from 3.4% to 11.99%.

The second aspect is increasing awareness of the services provided, especially the work of community-based services. The regions reported that they faced a lack of information about the work of social services among ordinary people. The awareness-raising campaign should explain the concepts related to deinstitutionalisation and show how the support of community social services helps people with disabilities lead an integrated and full life. One region stated:

> "(...) to bring into people's awareness (...) when I start explaining what transformation means, I am often faced with: 'But they can't live on their own, or they can't use a certain service...' They do not even know what 'sheltered housing' means. We have to explain that it does not mean that we move in a bunch of people and leave them there, the workers move in with them and assist them."

In some region's experience, sharing positive examples of deinstitutionalisation can effectively fight prejudice and ignorance. The advantage lies in the history and practice of communities, which allows us to present success stories of deinstitutionalisation and to show the sceptics that care outside an institution is not extraordinary and that it is safe. Some regions reported that sharing practical experience, specific examples of successful deinstitutionalisation and descriptions of real situations strengthens awareness of deinstitutionalisation and removes prejudices. The regions have seen a gradual shift in the communities' perception of people with disabilities based on these activities. At the beginning, deinstitutionalisation gave rise to uncertainty, but as time passed, the residents began to perceive it positively.

> "Nowadays, when they are concerned, we can show them how it works. We already have examples of good practice, they can visit the mayors and the municipalities, look at the house and see what the care looks like, that it's a regular household and that the neighbours have nothing to worry about. So that's the advantage, there is already some history, so we can show them that it works."

The **MoLSA** is aware of the problem of awareness raising and is actively preparing measures. A new project is currently being implemented, including the creation of an awareness-raising campaign aimed primarily at the public living in the vicinity of the transformed facilities. Another activity under this project is the organisation of various workshops, educational events, seminars and trainings for professionals in the field of transformation.

2.8.2.4 A flexible service system

In their responses, several regions stressed the need for flexible social services that could respond effectively to the current needs of the people in the region. These regions criticise the rigidity and inflexibility of the current system, which is unable to respond adequately to the evolving needs of the people. Part of the criticism is directed at the outdated nature of the set-up of some social services, which seems to reflect the practice of the previous decades (more in Chapter 2.7.2.2 Laws, rules). Several regions emphasised the need for transformation and flexibility of the social services system to adapt it to the current needs of the clients. Several regions mentioned the need for a legislative amendment in the area of social services that would define social services according to the needs rather than by type. In this way, the social services system could respond to the development and changing composition of clients, as the following quote points out:

> "To have a sustainable network set, but then be flexible. (...) sometimes, it clashes with the legal possibilities (...) if you want to put there [into a residential social service] a disabled or intellectually disabled child and a parent [who also needs support or care from the service] and now it clashes with the fact that the parent is not the target group of that service (...) and they can't live together because it is contrary to (...) They don't want to be separated so we keep them at home and when something happens we have to deal with it ad hoc, for example with an emergency bed (...) to make it [the system of social service provision] more flexible. Because it clashes with the legal standards and the possibilities that are set there."

2.8.2.5 Education

In the area of the training of social services workers and social workers (professional staff), several regions communicated the following proposals and needs:

- insufficient offer of training for professional staff;
- interconnection of the training for professional staff and practice;
- training of judges in relation to decision-making on guardianship.

First, the respondents point out the importance of training for professional staff, stressing that the current offer is not diverse enough and often not affordable for the social services staff. Several regions told us that the current offer of training in this area is limited and does not always correspond to the needs of the workers. An important element is the accreditation of the training by the MoLSA, which can affect the availability of high-quality education. In this regard, one region stated:

> “I also think it would be a very good idea to diversify the offer of training for the employees. In the area of transformation, deinstitutionalisation. (…) It seems to me that the offer of training is not that diverse. And then, when there is some interesting training on offer, we tend to participate only when we have a project to cover the costs, because it’s expensive. And it may not even be accredited. That means that the social service workers cannot afford it. So, for me, training for service workers and in the field of services in general is a very important topic.”

Second, the interconnection between the training and practice is also a key area, particularly in the sense of preparing future professional staff. Two regions proposed changes to the education system as a means of improving professional training and increasing the availability of qualified social service workers. In its response, one region described the German system of interlinking education with practice:

> “We would like to… I don’t know… I’ve seen it in Germany, that a student of social work at a higher vocational school did an internship in a facility for some six months. Maybe not half a year, but definitely for longer than a week, so that they can get a taste of what the work is like, so that they are not surprised later.”

Third, one region also mentioned the training of judges in relation to decision-making on guardianship. This region expressed concern about the excessive use of restrictions of legal capacity and stressed the need for a better understanding of the competencies of clients with disabilities. Judges’ education is seen as a means of ensuring fair decisions that respect the needs and competencies of each client.[131]

In this respect, the **MoLSA** mentioned the preparation of a new law on the professionals in the social services to address the position of social workers as well as, presumably, social service workers. The MoLSA explained that the better-defined position will also include a new concept of education for social services staff, as can be read below:

> “(…) we are also introducing a “law of the professionals” addressing the position of social workers and, presumably, social service workers as well. (…) The position (…) will be better defined, the law will also provide a new system of further education and so on.”

2.8.2.6 Revision of the social services network and identification of the services needed

Several regions expressed support for the revision of the social services network with two goals.

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[131] The issue of support measures is also addressed by the Defender, e.g. in the Support in legal acts leaflet (available at: www.ochrance.cz) or the related episode of the same name of the “Have a cup of coffee with the Ombudsman” podcast (available online at: www.ochrance.cz/).

First, several regions would aim to get an overall view of the network. This survey would serve as a basis for determining the need for social services, as can be seen from the following quote:

> “(…) a quick analysis of the need for residential social services, field social services and, of course, other social services throughout the country. (…) At a certain date, review the network by the individual regions within the country. This should give us an overview of the need for the services for the next three to maybe ten years.”

Second, several regions would revise the network with the aim to guarantee its high quality. Some regions stressed the need for more rigorous quality control of the individual services. One region particularly stressed the need to eliminate dysfunctional or very poor-quality services so as not to jeopardise the functioning of the social services network and the region’s ability to fulfil the social needs within its territory. This should ensure the quality of services and optimise the use of funds, as illustrated in the following quote:

> “To simply exclude those services from the system. To have the courage to exclude the dysfunctional services from the system because now, we can’t exclude anything social because ‘we put something at risk’. We do not, because when something is dysfunctional, it does not contribute anything to the region, it only drains those funds.”

2.9 PLANNING THE DEVELOPMENT OF SOCIAL SERVICES

During the meeting with the respondents, the topic of deinstitutionalisation led to a broader discussion on the planning of development of social services. In this chapter, we focus on issues concerning the barriers and possible solutions in social service planning beyond those that hinder deinstitutionalisation. In the first part (Chapter 2.9.1), we discussed the barriers in this area. We wanted to understand how regions perceive the issues and what they consider to be the main obstacles in the process of planning the development of social services. The second part (Chapter 2.9.2) focuses on possible solutions to the barriers identified. We were interested in ideas and approaches that could help overcome the difficulties associated with social service planning.

2.9.1 BARRIERS IDENTIFIED IN PLANNING THE DEVELOPMENT OF SOCIAL SERVICES

Although the previous section dealt with barriers to deinstitutionalisation, this section focuses on other difficulties associated with planning that go beyond the barriers already mentioned. In the previous chapters, we identified obstacles related to planning, specifically in relation to the institutional framework (Chapter 2.7.2), insufficient methodological support for planning the development of social services (Chapter 2.2) and problematic funding of community-based services (Chapter 2.7.2.1). In this section, we will look at other obstacles:

- collection of data on the services needed (Chapter 2.9.1.1);
- uncertainty regarding funding in the social service planning process (Chapter 2.9.1.2); and
- non-participation of municipalities in the planning of the development of social services (Chapter 2.9.1.3).

2.9.1.1 Collection of data on the services needed

Several regions reported that collecting data on the services needed is one of the key barriers in the process of the planning of social services. The lack of detailed information on the services needed in the regions complicates planning and may result in some potential clients being excluded from the social care system. The challenges associated with collecting data on the services needed reveal gaps in existing reporting mechanisms and the use of available data. More active involvement of actors in the field can contribute to improving the overall social service planning process.

One significant problem is the need for more detailed information on the needs of the citizens in the municipalities. Two regions reported that municipalities do not make sufficient use of the RISSS module, which is used to report on the citizens' needs. Thus, the regions indicated that obtaining information from the municipalities is problematic, as the following quote indicates:

> "However, we do have a module within the RISSS, I am not sure of its name, Need something, something like (...) the municipalities with extended competence are informed that they can write the social situation into the module anonymously and then we try to advise them, address the situation or respond to it in some way. But honestly, they don't use it much."

The second problem mentioned by one region is the inefficient use of data available from the Czech Labour Office. Although the Office has a lot of data on the citizen's situation, the data is not systematically integrated into the social service planning process. There is a lack of tools for systematic assessment of the people's needs, which leads to the identification of problems only in emergency situations and prevent quick response to actual needs in the community.

The **MoLSA** highlighted that there are significant differences among the regions in the collection of data on the services needed. This problem is evident not only in the planning process itself, but also in the decision whether to include specific services and providers in the network. Access to different target groups also varies across regions, which may result in uneven coverage of services for some target groups.

According to the MoLSA, it is necessary to address these variances in the approach to planning and decision-making, not only by creating a uniform data base, but also by unifying the conditions and rules across all regions. The MoLSA highlights the need for central coordination and management:

> "(...) we must use all our strength to set the same rules, the same conditions across all regions. And that is going to require a lot of energy. (...) The point is that we have to unify the rules (...) which is expected of us. We have to maintain a certain quality of our clients' lives (...)"

2.9.1.2 Unsystematic funding of social services

This chapter focuses on issues related to the social services' funding, beyond those described in Chapter 2.7.2.1 Funding and resources. There, we presented the problems related to the financing of investments and operation of social services, as well as the uncertainty regarding the funding of social services.

According to the regions, the unsystematic funding of social services is a serious problem that affects the ability to plan and provide the necessary social services. The regions told us that the framework conditions for funding are not clearly defined, which leads to uncertainty in obtaining funding for the provision of the services. This uncertainty affects effective planning and development of social services, as the following quote shows:

> "Of course, the big problem is the unsystematic funding of the entire segment of social services."

The inconsistency of funding creates a gap between the needs and the funds available. The quote below clearly illustrates the issue:

> "We draft a medium-term plan, which we have done now, the action plan is based on the required capacity and then we write a request for funding to the Ministry. But the funds are distributed on the basis of the indicative numbers. I am not saying that it doesn't matter what we write in the request, but we have to have our needs justified. We would need to develop the network of social services much more, but we don't have the funds to do it."

It can thus be inferred that the inconsistency lies in the lacking links between the allocation of funds and development of services. This barrier prevents effective planning and development of social services. The limited ability to plan with a clear idea about the available funding puts social service providers in a difficult situation, as can be seen from the following quote:

> "(...) there are basically two points missing, which, however, are fundamental to planning – how to determine the services needed and how to distribute the funds. We have to plan without knowing what resources we have available, which I think is a fundamental flaw of any plan, we can agree in the long term that it is very difficult to plan without knowing your budget. It is impossible to plan like that."

2.9.1.3 Cooperation and financial participation of municipalities

This chapter focuses on the role of municipalities in the planning and funding of social services. The regions mentioned the role of municipalities in relation to three aspects:

- collection of data on the services needed;
- planning at the municipal level; and
- co-financing of social services intended for the citizens of the municipality.

First, municipalities play a key role in the process of collecting information on the need for social services. According to the regions, municipalities have direct contact with citizens and thus obtain valuable data on the needs in the region. This data can serve as a basis for planning and provision of the services. One region suggests that in the current system, obtaining relevant information from municipalities is problematic because an interest in establishing social services may not always be supported by data and a real need for the services, as suggested by the following quote:

> "So we want to start testing with them whether they will really have information that will cover our territory and provide it to us, of course, through the class 3 municipalities [municipalities with extended competence], because we cannot leave them out, but they will provide us with more detailed information about the needs of the people in the municipalities. Because these municipalities are not proving to be very effective in relation to (...) funding, either. When we ask them: 'Tell us if such and such a service is needed,' they write: 'Yeah, we need that,' without anything to back it up with, because they're not funding it, right? And then it happens that the service is not really needed there, but something else might be."

Second, most regions see a problem in the issue of co-financing. The lack of a binding obligation for municipalities to co-finance social services on their territories creates challenges with regard to the amount of funds potentially available. The following quote illustrates this situation:

> "(...) we have a good cooperation with class 3 municipalities[with extended competence], but we need co-financing also from class 2 municipalities, which still works more or less, but for the provision of some services, we also need cooperation from the class 1 municipalities. And currently we have nothing to back that up with. We can appeal to their emotions: 'Look, it's necessary, you want to keep these people at home anyway.' The demographic curve means that we're mostly talking about seniors. But we have nothing to base it on and there's always someone who asks: 'Is there a law that says we have to co-finance it?' Well, there isn't. That would probably make some things a lot easier, but we can do without it, we have to."

Third, the regions stated that variances in the municipalities' planning of the development of social services pose an additional challenge in the social services system. While some municipalities plan intensively, others not as much. Here, the regions mentioned two problems: the municipalities have no obligation to plan, and municipal development plans tend to be set for different time periods than regional plans for the development of social services. Differences between regional and municipal planning can undermine coordination and the effectiveness of planning. The following quote illustrates this situation:

> "Planning is obligatory for the regions, but only voluntary for the municipalities. The Ministry also has an obligation, but I don't really know what is in the Ministry's plans and how it is reflected, for example, in its supra-regional network and so on. But the fact that it does not extend all the way to the level of the municipalities results in the fact that, on the one hand, there are municipalities with a plan, who are dedicated to it and do it intensively, but on the other hand, municipalities that are not as enthusiastic."

The regions mentioned the variances in regional planning periods as a barrier to inter-regional cooperation (different planning periods) and also to cooperation among the regions and the MoLSA, as the following quote shows:

> (...) the problem is also that the time periods of the medium-term plans are not aligned, because it is always for three years, but we are not in sync. The plans are shifted in time, which is also a problem. The plan always has to be prepared for three years, it would be better to say that the plan should be usually prepared for three years and to loosen the deadlines up a little bit. In fact, I think it would probably help us if the region, if the Ministry [of Labour and Social Affairs], in addition to the fundamental structure that is given by the law, defined the priorities that it wants addressed in a given time period. But then the implementation and the manner of planning should be up to the regions in my opinion."

2.9.2 PROPOSED SOLUTIONS

In this chapter, we focus on the proposed solutions and options that could contribute to overcoming the barriers identified in the field of planning the development of social services. One of the key proposals is the aforementioned change to the funding system, which was discussed in Chapter 2.8.2.2. However, the regions are further developing their ideas and coming up with the concept of unified planning (Chapter 2.9.2.1). In the following chapter, we will discuss other proposed solutions presented during the interviews, especially by the MoLSA (Chapter 2.9.2.2).

2.9.2.1 Unification of planning

The development of social services is a key factor for the citizens' quality of life. The regions are interested in unifying several key aspects. This chapter will focus on three main areas of unification of the planning:

- encouraging municipal participation;
- time alignment of regional planning; and
- standardisation of procedures among regions.

First, some regions expressed the belief that **promoting municipal participation in social service planning was crucial to effective and relevant planning**. The regions mentioned many aspects of the involvement, such as the need to involve political representation and financial contribution. Several respondents highlighted the idea that municipalities, especially those with extended competence, should be obliged to plan for and participate in social services. In their opinion, this unification would significantly contribute to the efficiency of the whole system, as the following quote shows:

> "I think it would help us if (...) municipalities with extended competence (...) were obliged to plan. They can plan and some of them do, but if they had the obligation to plan and to participate in the services in the network, (...) In an ideal case, also to participate financially. But their need, their obligation to map the needs and to network would significantly help us with that system."

Second, another important area of unification is the **timing of regional and municipal plans**. The regions emphasised the need to synchronise municipal and regional planning in order to effectively conduct network reviews and work with the established needs. Several regions suggested unifying the procedures at the national level, which would allow for a more efficient timeline and framework of social services' funding. One region stated:

> "That means the Ministry [of Labour and Social Affairs] cannot do this as part of a project, a project is for three years and then the data will be outdated again. That means municipal and regional planning must be synchronised."

Third, several regions emphasised the **need for a single reporting system and standardisation of the procedures at the national level**, particularly in the area of planning and assessment of the services needed. However, it is important to note that the regions consider maintaining their autonomy as crucial, even though they recognise the need for closer links and better inter-regional communication. Representatives of the regions perceive the need for unification and introduction of clear terms and definitions and stress the urgency of improving communication among the regions, especially since the networks and funding are not unified. As one region commented on the topic:

> "(...) I imagine that we would at least unify some procedures and reporting at the national level. I know that having a unified system is science fiction, but it would be great. We've stopped collecting data that we're not obliged to collect. To collect information from the territory in a uniform way, for example, data on the services needed, where all scientists understand the concepts in the same way and are to be able to evaluate the data (...)"

In addition to the central unification topics, the need to extend the planning period was also raised. Several representatives of the regions believe that the three-year planning cycle is too short and should be extended. This would allow for better planning with a long-term outlook and continuity in the development of social services. As one region representative said:

> "It should be emphasised again that the planning period of three years is too short, it should be much longer. When the plan is for three years, it means that once we begin implementing it, we are also already working on a new plan, while the current one has not been evaluated yet (...) Because if we determine some direction within the planning, it is not useful to change that direction every three years anyway. We really need a long-term outlook, which means extending the period that we're planning for."

As already mentioned, the **MoLSA** sees the lack of uniformity in the practice in the individual regions as problematic. As a solution, it proposes to introduce common rules and conditions to be applied by all regions. The aim of such a measure is achieving better coordination of social services at the central level and reducing the differences between regions in the quality and availability of the services. The MoLSA aims to unify the practices of the regions in order to fulfil its vision of providing accessible social services and ensuring financial stability, personnel for the services, transparency and clarity for the public.

The MoLSA is especially interested in unifying the following aspects:

> "(...) the rules are clearly specified, which means a unified form of the transformation plan, unified costs of the operation of social services. Unification of the personnel issues, communication to the public and a useful data base for all these processes. And in general, unification of coordination at the level of each region, of how to lead the transformation in each region, and every city."

2.9.2.2 Others

In the search for new and effective ways to address the problems associated with the development of social services, the MoLSA presented several key aspects that could contribute to creating an environment where social services clients are active and informed participants in the decision-making processes.

The **MoLSA** stresses the need to increase the participation of people with disabilities in the decision-making processes concerning social services. One of the proposed solutions consists in active development of associations focusing on self-advocacy and advocacy techniques. Self-advocacy allows clients to express their needs and preferences. The MoLSA told us:

> "That also includes the development of all those advocacy [techniques] because the employees of those services do not do that. On the contrary, they say: 'You're happy in this facility.' In the case of these processes aimed at increased (...) participation of those clients at the regional level or at a level where conditions are created where I, as a client, can actively express myself, where I do not have to wait for a worker to tell me something like: 'You didn't say anything.'"

In the context of the participation of people with disabilities in the planning the development of social services, the **MoLSA** proposes digitalisation as another important element. This initiative should enable the clients to express their views and increase their involvement in the process of providing social services. The introduction of modern technologies, such as mobile apps and online platforms, can provide clients with the means to express their needs and ideas regarding service quality. At the same time, digitalisation could be a key tool for transparency and interactive communication between the clients and social service providers. As the MoLSA stated:

> "It is the digitalisation of care [in the context of participation of people with disabilities in planning the development of social services] that is perhaps one of the biggest barriers. We have (…) the RISSS. Everybody's doing something with it (…) for the clients and if I had a table or a tablet or anything, they could say: 'I want to express my opinion.' (…) through the app (…) So this is probably what we need (…) to create an interface for communication that reflects both self-advocacy and advocacy, where they can express their opinions. That's probably another possible systemic anchoring."

2.10 THEMATIC ANALYSIS – SUMMARY OF FINDINGS

In the thematic analysis, we analysed the interviews conducted with the representatives of the regions and the MoLSA. We monitored their visions regarding the development of social services and the way they obtain information on the services needed for planning purposes. Similar to the content analysis, we focused on how the regions and the MoLSA understand the concepts related to deinstitutionalisation. Last but not least, we examined what obstacles hinder deinstitutionalisation and how to remove them.

Beyond the overview of the barriers themselves presented in the previous chapters, the analysis revealed several interesting findings. The first is that the regions and the MoLSA understand their commitment to deinstitutionalisation in the context of how we understand the concepts associated with deinstitutionalisation (Chapter 2.10.1). The second finding concerns the key role of the cooperation among the MoLSA and the regions in the implementation of deinstitutionalisation (Chapter 2.10.2). The third finding is the overview of the level of deinstitutionalisation across the regions (Chapter 2.10.3). The last fundamental finding concerns new information on the level of participation of people with disabilities in the preparation of social service development plans (Chapter 2.10.4).

2.10.1 PERCEPTION OF THE COMMITMENT TO DEINSTITUTIONALISATION

The fulfilment of the obligation to have high-quality deinstitutionalisation plans depends directly on the attitudes and approaches of the responsible bodies towards deinstitutionalisation, both at the national and regional levels. The documents submitted by the regions and the MoLSA clearly showed that **planning for deinstitutionalisation is inextricably linked to strategic planning of the social services development**. In this chapter, we will therefore focus on the stakeholders' perception of the commitment to deinstitutionalisation through the prism of the strategic plans.

As concerns the national vision for the social services development, the MoLSA did not mention deinstitutionalisation as such in the interview. According to the interview with the MoLSA, the main visions are the availability of social services and adequate staffing.[132]

According to the regions, the most common regional vision of the social services development is the **development of services within the community.**[133] The regions stressed the need to develop services that enable people to live in their home/natural environment for as long as possible so that they are not forced to use residential social services. They often mentioned efforts to focus on supporting carers. **In principle**, these visions **aim to fulfil two goals of deinstitutionalisation simultaneously**, namely the prevention of institutionalisation and the development of community-based supporting services**. Deinstitutionalisation** itself **was the third most frequently mentioned regional vision for the development of** social services.

Similar to the content analysis, we could see in the interviews that the **respondents were unclear about the desired target state of affairs to be achieved by deinstitutionalisation and the ideas varied between the MoLSA and the regions and even between the individual regions**. The target state largely depends on the perception of the basic concepts and (the lack of) their definition.

It clearly follows from the thematic analysis that the perception of the basic concepts of deinstitutionalisation is not unified across the regions.[134] The MoLSA declared[135] that it stands behind the definitions included in the Criteria. There is no consensus among the individual actors on the adoption of these definitions either.

Some respondents even confused the notions of "humanisation" and "transformation" or "deinstitutionalisation". This may lead to situations where they will consider it sufficient to carry out humanisation of institutions instead of deinstitutionalisation. There is also a lack of consensus on a single, clear and at least relatively fixed definition of "community-based services", which was actually stated by both the regions and the MoLSA as one of the obstacles to successful deinstitutionalisation.

In general, the respondents perceived the need for deinstitutionalisation, but without a clear consensus on what exactly should be the outcome of this process. The MoLSA and the regions also unanimously identified the lack of a clear description of the goal and outcome of deinstitutionalisation as one of the major obstacles to deinstitutionalisation. According to the regions, this obstacle could be eliminated by enshrining the commitment to deinstitutionalisation in legislation and respecting the provisions. Similarly, the MoLSA stated that a **clear definition of the commitment to deinstitutionalisation at the strategic and legislative level**, including clear definitions of the individual terms, **would remove the obstacle mentioned**.[136]

2.10.2 THE ROLE OF THE MOLSA AND THE REGIONS AND THEIR COOPERATION IN DEINSTITUTIONALISATION

The thematic analysis showed that the process of planning the development of social services, and thus deinstitutionalisation, is affected by the current division of roles between the MoLSA and the regions.

The roles of the MoLSA and the regions in the process of planning the development of social services can be briefly summarised as follows. The MoLSA is the responsible authority for the implementation of the Convention in the Czech Republic and also the central State administrative body in the field of social security and social care. It creates the National Strategy, which is the basic strategy document for the development of social services at the national level. It provides the regions with subsidies to finance the social services; within this process, the regions submit their medium-term plans with applications for subsidies. The MoLSA also influences the flow of EU funds for the transformation and development of social services by setting the conditions for the individual calls that determine the requirements binding on the applicants for project funding.[137] The regions adopt their medium-term plans within their independent competence, the MoLSA

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[132] For the sake of completeness, we add that the National Strategy includes a strategic goal of "the transition from the institutional model of care for persons with disabilities to the support of persons in their natural environment" (cf. National Strategy, p. 57), which was not mentioned in the thematic interview.

[133] See Chapter 2.1 for a summary of the regions' visions.

[134] For more details, see Chapter 2.5.

[135] It is necessary to emphasise that this is a **declaration of alignment with the Criteria within the framework of a semi-structured interview**, which is not reflected in the National Strategy as the basic national strategy document for the development of social services. The National Strategy does not include a definition of a community-based service.

At the time of the preparation of the National Strategy (2015–2016), the Criteria did not yet exist in the current wording; therefore, the National Strategy cannot include the Criteria's definition of community-based services, which we have chosen as the reference point for this survey.

The Criteria for Community Social Services and Criteria for Transformation and Deinstitutionalisation were issued by the MoLSA in 2016 and followed up on the Manual for Transformation of Institutions issued by the Ministry of Labour and Social Affairs in 2013 and the Criteria for Transformation, Humanisation and Deinstitutionalisation of Selected Social Care Services from 2011. These "original" Criteria already contained the defining features of community-based services. The "original" 2016 Criteria are available online at: www.trass.cz. Similar to the current Criteria, the original Criteria were never universally binding and they were applied by the MoLSA on an ad hoc basis for the purposes of implementing projects for the construction/reconstruction of social service facilities financed through European funds.

[136] For more information, see Chapter 2.8.1.1.Policy framework for the development of social services.

[137] For example, the binding nature of the Criteria for transformation and deinstitutionalisation projects.

influences the form of the plans and the process of their preparation by setting the rules in laws and secondary regulations. Within their independent competence, the regions have the discretion to decide on the network of social services in their territories and ensure their availability and funding. With a certain degree of simplification, none of them is completely in charge of the process of social services development, and therefore deinstitutionalisation. **Cooperation and agreement among the MoLSA and the regions are therefore essential for successful deinstitutionalisation.**

Neither their relations nor their cooperation in fact smooth. In some respect, we can even speak of distrust or scepticism on the part of the regions; one region even called the MoLSA a fundamental barrier to deinstitutionalisation.[138] The following areas of cooperation with the MoLSA were mentioned by the regions as problematic:

- changing rules for transformation projects;
- lack of consensus on the definition of a community-based service;
- lack of methodological support in the field of development of social services and conceptual guidance in the area of deinstitutionalisation;
- failure to link the system of funding of social services with the long-term vision of their form and the need for greater advocacy for deinstitutionalisation (and allocation of corresponding financial resources) towards other ministries.[139]

In the interviews, the regions also required the MoLSA to provide more high-quality methodological support in the implementation of deinstitutionalisation projects and faster and more effective communication, for example when approving the transformation plans.[140]

The MoLSA, on the other hand, pointed to differences in the approach to determining the network of social services among the individual regions, differences in the identification of needs in the territory and, in general, the need for coordination and communication, i.e. ultimately a certain degree of centralisation, in the area of planning the development of social services.[141]

The relationship between the MoLSA and the regions is also influenced by historical issues. In the interviews, the regions referred[142] to, for example, their experience with the change in the social services funding system that took place in 2015. The regions remember how difficult it was to cope with this change and the further transfer of responsibilities in the field of social services to them, without having sufficient support and a clear policy by the MoLSA during the turbulent period.[143]

The certain degree of disharmony in the cooperation and coordination among the MoLSA and the regions in the field of deinstitutionalisation and development of social services has various causes and was mentioned as one of the obstacles to deinstitutionalisation. However, the thematic analysis also suggests possible proposals for removing this barrier (detailed in Chapter 2.8.1 State support), including:

- the need to be aware of the commitment to deinstitutionalisation and its long-term realisation and enforcement (including a useful definition at the strategic and legislative level);
- reform of the system of funding of social services, so that the system does not work on a year-by-year basis, but is stable, predictable and linked to the policy and vision of social services development;
- a consensus on the definition of a community-based social service.

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[138] For more details, see Chapter 2.7.2.3.

[139] For more information, see Chapter 2.2, Chapter 2.7.2 and Chapter 2.8.1.

[140] For more details, see Chapter 2.8.

[141] For more details, see Chapter 2.9.1.1.

[142] For more details, see Chapter 2.8.2.2.

[143] For more details, see Chapter 2.8.1.

- The thematic analysis showed that both the regions and the MoLSA agree that these issues need to be addressed urgently, which is a basic prerequisite for their successful resolution.

2.10.3 LEVEL OF DEINSTITUTIONALISATION AND ITS FURTHER DEVELOPMENT ON THE BASIS OF THE THEMATIC ANALYSIS

In the interviews, we wanted to obtain more detailed information about the level of deinstitutionalisation in the Czech Republic and the future direction and pace of this process.

Currently, any efforts to monitor deinstitutionalisation are hindered by a lack of relevant data. The information published annually in the Labour and Social Statistical Yearbook can be used only partially and indirectly to track the gradual progress in the field of deinstitutionalisation.[144] The data published by other sources (e.g. the Czech Statistical Office) are not helpful in this respect either. The level of deinstitutionalisation also cannot be reliably evaluated on the basis of the information from the Register of Social Service Providers.[145] There is no information in the register as to whether a certain service is a community-based service (and there cannot be, given the lack of consensus on the definition of the service). The community nature can be inferred from some of the features, e.g. from the form of provision or capacity of the service. However, the register does not record other features needed to distinguish a community-based service, such as the numbers of beds in rooms or the division of the facility into households.

It follows from the interview with the MoLSA that it collects some data on the national transformation beyond the statistical yearbook.[146] However, even this data is very anecdotal – for example, it only concerns homes for people with disabilities and does not monitor the transformation of other types of social services.

The thematic analysis showed that in the past, the regions focused mainly on the transformation of homes for people with disabilities and partly also special-regime homes, a trend that will continue, according to their statements.[147] The regions did not mention in the interviews that they were planning to transform their facilities for the elderly. No region stated that it wanted to completely transform (i.e. abolish) all institutions. If we focus on service development, the regions declare their intention to develop services that are not institutional in their nature. In particular, these include sheltered housing, community-based homes for people with disabilities and field and ambulatory services. We consider the focus on the development of these services to be a good thing, as the development of community-based services is an effective prevention of institutionalisation. This fact was also mentioned by several regions.

The thematic analysis clearly showed that the **level of transformation achieved varies from region to region**. Some regions are just starting out with the transformation, and they see an advantage in the opportunity to learn from the experience of the regions that started the transformation earlier. Other regions began transforming more than 15 years ago. Consequently, some of them are struggling with the fact that the previously transformed facilities no longer correspond to what is currently considered the desirable outcome of transformation. A common opinion shared across the regions is the dissatisfaction with the changing rules concerning the features services should meet after the transformation. The regions also complain about difficulties in finding land for the construction of social services facilities, the length of the construction permit proceedings and the uncertainty of funding of the services' operation. Together, these factors mean that the regions have a very poor experience with investing time, energy and resources in developing service transformation projects, which remain unimplemented. Such experiences may negatively affect the willingness of the regions to further transform.

Both the MoLSA and the regions can primarily influence the transformation of social services facilities operated by the contributory organisations they established. We have described the approach of the regions above. **As regards the MoLSA, at the time of the interview, it did not have a clear plan for the**

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[144] For more details, see the legal section. Labour and Social Statistical Yearbooks for the individual years are available online [in Czech] at: https://www.mpsv.cz.

[145] The Register of Social Service Providers is available [in Czech] at: www.mpsv.cz.

[146] The data of the MoLSA on the deinstitutionalisation of homes for people with disabilities in the Czech Republic can be found in the chapter titled Deinstitutionalisation plans in the Czech Republic and the stage of their realisation.

[147] For more details, see Chapter 2.6.

transformation of “its” social services facilities.[148] All of these facilities are large-capacity residential social services of an institutional nature.

Over the past 15 years, the Czech Republic has made significant progress in transforming institutional services, with the extent of the transformation varying from region to region. However, especially the example of the ministerial social services institutions demonstrates that deinstitutionalisation is not carried out fast and effectively enough in the Czech Republic.

2.10.4 PARTICIPATION OF PEOPLE WITH DISABILITIES

In the interviews with the MoLSA and the regions, we focused on obtaining more detailed information on whether and how they involve people with disabilities in the planning of the development of social services.[149]

Pursuant the Social Services Act, the regions are obliged to prepare the medium-term plans “in cooperation with representatives of the persons to whom social services are provided”.[150] This is one of the three basic groups (contracting entity – service provider – service client), whose cooperation is required by the Social Services Act for drafting of the social service development plans. This group of people should be considered from a broad perspective, also in view of the requirements imposed by the Convention on the participation of people with disabilities. The term “representatives of the persons to whom social services are provided” thus includes not only people who are already clients of social services, but also those who fulfil or are likely to fulfil in the future the conditions for being provided with the relevant social services, but are not yet clients of these services. From the viewpoint of our target groups, this could be, for example, children or (young) adults with intellectual disabilities who are living with the support of carers and are preparing to start their independent lives or who find themselves in a situation where their carers can no longer care for them for whatever reason. This could also include people with mental illnesses whom the mental health care reform has allowed to leave psychiatric hospitals after long-term hospitalisation and reintegrate into the community.

Cooperation with representatives of the people to whom social services are provided means, in a broad sense, not only cooperation with organisations representing people with disabilities and advocating for their rights, but also the possibility of directly involving people with disabilities.

As regards the drafting of the National Strategy, the Social Services Act does not impose on the MoLSA any similar duty to involve people with disabilities, or representatives of social services clients. However, the need to involve people with disabilities can be inferred from the Convention’s requirements for the participation of people with disabilities in the drafting of legislation, strategies and policies that affect them, including deinstitutionalisation plans.

The thematic analysis of the interviews brought different findings than the content analysis, according to which the strategy documents of the MoLSA and the regions showed a high level of involvement of people with disabilities in their drafting.

Almost half of the regions and the MoLSA told us that they did not involve people with disabilities in the planning of the development of social services. Obtaining information from people with disabilities is associated with some difficulties already at the stage of mapping of the needs for the purpose of planning the development of social services. As we elaborate below, the regions and the MoLSA tend to obtain information on the needs of people with disabilities indirectly through various organisations or other mechanisms (e.g. community planning). Neither the regions nor the MoLSA systematically collect information from people living in institutional services or about people who have the potential to use in less restrictive residential services.[151] The mapping of the services needed is not uniform across the regions, and the regions reported a host of approaches and methods. We consider the approaches described by the individual regions, consisting in specific projects for collecting statistical data or questionnaire surveys aimed at obtaining information directly from clients of social services, carers or people with disabilities themselves, to be good practice. Indeed, the regions using these methods described the data collected as unique and useful.

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[148] A list of the contributory organisations founded by the MoLSA that provide social services can be found at: https://www.mpsv.cz.

[149] For more details, see Chapter 2.4.

[150] Cf. Section 95 (d) of the Social Services Act.

[151] Cf. Section 38 of the Social Services Act.

According to the analysis of the interviews with the regional representatives, people with disabilities are involved in the process of drafting of the medium-term plans through community planning at the level of municipalities (or municipalities with extended competence, associations of municipalities or micro-regions). The results are then incorporated into the medium-term plans both in the area of mapping the services needed and in their actual drafting. This survey does not aim to evaluate the level of involvement of people with disabilities in the community planning processes for the development of social services at the sub-regional level; however, the thematic analysis shows that the regions perceive it as one of the ways in which people with disabilities are involved in the drafting of the medium-term plans.

Several regions and the MoLSA mentioned involving people with disabilities in the drafting of plans primarily through “client and patient organisations”, including umbrella organisations advocating for the rights of people with disabilities, or through groups of parents/carers.

The implementation of the principle of participation of people with disabilities in the process of planning of the social services development – and therefore deinstitutionalisation – should be more consistent and of higher quality. Neither the regions nor the MoLSA have a system in place to effectively involve people with disabilities in the process of drafting plans. Some of the respondents even admitted that some ways of involving people with disabilities were merely formal options – for example, the opportunity to engage in the planning process together with the general public.[152] Neither the regions nor the MoLSA regulate the conditions for the preparation of the plans so as to adapt the whole process to the needs of people with disabilities and thus enable their easier participation. **Accessibility of the planning process** of the social services development, including accessibility in the sense of easily comprehensible information, is currently not a priority topic for the MoLSA or the regions.

In terms of participation of people with disabilities in deinstitutionalisation planning through the strategy plans of the MoLSA and the regions, it is significant that **people with an experience of living in an institution are not systematically involved** . The involvement of people with mental illnesses, i.e. “peer consultants”, in the working groups for the drafting of medium-term plans, declared by some regions, can be considered good practice. Neither the MoLSA nor any region stated that they involve people with intellectual disabilities, whose experience with life in institutions or the community would enrich the planning process with unique information.

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[152] Public participation in the drafting of the medium-term plans is regulated by Section 39 of the Implementing Decree. The region is obliged to inform its citizens about the commencement of drafting of the medium-term plan and on the possible ways of participation. The draft medium-term plan is usually discussed publicly with representatives of social service providers, municipalities and persons to whom social services are provided. The public has the opportunity to get acquainted with the draft medium-term plan and send comments to the region within a set deadline, which the region will address in a manner published together with the draft medium-term plan.

Conclusion

In the final chapter, we summarise the findings that followed from the content and thematic analysis with respect to the survey objectives and place them in a broader context. First, we look at the fulfilment of the commitment of the MoLSA and the regions to deinstitutionalisation and their understanding of this process. Next, we will focus on the level of involvement of people with disabilities in the drafting of deinstitutionalisation plans. We will briefly describe the level of deinstitutionalisation in the Czech Republic and the obstacles preventing its successful completion.

1. Deinstitutionalisation plans and development of social services

The basic obligation of the State in fulfilling the right of people with disabilities to live independently and be included in the community is to have high-quality deinstitutionalisation plans at the national and regional levels. This obligation must be fulfilled by the State immediately, regardless of the fact that some obligations under Article 19 of the Convention can be realised progressively. In this survey, we analysed how the Czech Republic fulfils the obligation to have deinstitutionalisation plans.

The content and thematic analysis showed that deinstitutionalisation planning is inextricably linked to the planning of the development of social services. The strategy concerning deinstitutionalisation is primarily laid down in the National Strategy and the individual medium-term plans, according to the MoLSA and the regions. Three regions have also adopted specific strategy documents focused on deinstitutionalisation, which we consider to be good practice. Neither the Social Services Act nor the Implementing Decree explicitly define the obligation of the MoLSA and the regions to take into account the commitment to deinstitutionalisation when planning the development of social services. It is therefore up to the MoLSA and the individual regions how they incorporate it in the planning process.

As we already stated in the legal section of the survey report, the Convention implies that the deinstitutionalisation plans must contain specific steps for the implementation of deinstitutionalisation, a clear statement of what is to be achieved, aiming in particular at the closure of institutions, the prevention of institutionalisation and the development of supporting services (including the availability of housing). The State must use the maximum resources in order to meet these objectives. Deinstitutionalisation plans must be of good quality – they must contain clear objectives, deadlines and time schedule for their implementation, identification of the resources and responsible persons, and criteria for evaluating the completion. People with disabilities and their representative organisations should be involved in all stages of the adoption of deinstitutionalisation plans.

When it comes to a clear statement regarding the objective of deinstitutionalisation, the strategy documents of the regions and the MoLSA have two major shortcomings. First of all, they do not define these objectives at all, or they do so rather vaguely. Only half of the medium-term plans contain strategic objectives aimed at abolishing institutional services (50%) and only about a fifth of them focuses on the prevention of institutionalisation (21%).[153] Neither the National Strategy nor thirteen of the fourteen medium-term plans focus in their sub-objectives on the prevention of the transfer of institutional elements in the transformation of social services, which further weakens the objectives related to the closure of institutions. As the content analysis showed, the reason for the unclear objectives in the deinstitutionalisation plans is mainly the inconsistency in the definition of the basic concepts related to deinstitutionalisation. This is the case e.g. of the unclear objectives focusing on the development of "community-based social services",[154] which are vitiated by a lack of consensus on what characteristics a community-based service should fulfil. In our opinion, another major shortcoming is the fact that the declared deinstitutionalisation objective differs between the MoLSA and the individual regions.

According to the content analysis, the strategy documents of the MoLSA and the regions did not always have well-defined objectives. Complementing the findings by the results of the thematic analysis, we can see that the quality of the deinstitutionalisation objectives and the definition of the required resources is negatively affected by:

- multi-source financing for the development of social services;
- failure to link the system of funding of the social services with their development; and
- unpredictability of the amount of funds that the regions will receive for the development of social services through subsidies from the MoLSA.

It is difficult for the regions to plan and use of the maximum amount of their resources to implement deinstitutionalisation as the system of funding of social services works on a year-by-year basis. Although we consider the specific regional strategy documents aimed at deinstitutionalisation a good practice, the obstacles caused by the system of funding also affect their implementation.

Special attention should also be paid to the fact that the MoLSA itself is the founder of several institutional social service facilities. None of the strategy documents contain objectives that would aim at partial or complete transformation of these facilities. This is problematic from the perspective of fulfilling the obligation under the Convention to have deinstitutionalisation plans, but also from a symbolic perspective where the MoLSA, as the body responsible for compliance with the Convention, should lead by example in fulfilling the commitment to deinstitutionalisation. The State or the MoLSA should set clear steps leading to the transformation of these facilities, including the allocation of sufficient resources.

2. Participation of people with disabilities

A separate requirement for fulfilling the obligation to have quality deinstitutionalisation plans at the national and regional levels is the need to involve people with disabilities and organisations representing them in all stages of drafting strategy documents.

In the summaries of the content and thematic analysis, we described that the **strategy documents of the MoLSA and the regions do not fully reflect the principle of participation as envisaged by the Convention**. The participation of people with disabilities and their representative organisations should not be formal, but rather real and effective. This requires the process of the planning of service development to be accessible

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[153] For more details, see Chart 9 in Chapter 1.3 and Chart 11 in Chapter 1.4.2.

[154] Chart 14 in Chapter 1.5.2 – only 11 medium-term plans focus on the development of community services determined according to specific criteria.

in all respects, including accessibility of information. However, according to the thematic analysis, neither the MoLSA nor the regions systematically focus on making the conditions accessible and reasonably adjusting the information and planning process. Although they believe that especially the involvement of people with disabilities themselves should be encouraged, they do not have the tools and sometimes not even the necessary knowledge to achieve this.

The thematic analysis showed that an effective way of involving these people could consist in community planning as a tool for mapping the needs in the territory of the municipality or micro-region and for developing social services. It is easier to involve people with disabilities at the local level because of the geographic proximity. At the same time, the information obtained from this participation will be specific and will also respond to the current local situation or its specific features compared to other territories. When planning the development of social services, the regions draw information primarily from the municipalities. If people with disabilities are effectively involved in the community planning of municipalities, this information and experience can be transferred through the municipalities to the regions. The regions then must take it into account when drafting their strategic plans. Targeted support of the involvement of people with disabilities themselves in community planning at the sub-regional level can contribute to an overall improvement in the level of participation of people with disabilities in the drafting of strategies.

The shortcomings in the participation of people with disabilities in the drafting of social service development plans are a manifestation of a broader problem – the lack of involvement of people, including those with disabilities, in strategic planning and public decision-making in general. The topic of improving citizen participation in public affairs is addressed in detail, for example, by the Organisation for Economic Cooperation and Development (OECD) in its Public Governance Review of the Czech Republic.[155] In the review, the OECD recommends to the Czech Republic specific steps to improve civic participation. These include, for example:

- » consider adopting a single definition of citizen and stakeholder participation;
- » consider creating a centre of expertise for participation;
- » consider extending the mandate and composition of the existing Council for Non-Governmental Non-Profit Organisations and transform it into the Government Council for Citizen and Stakeholder Participation.[156]

When involving organisations defending the rights of people with disabilities, the MoLSA can draw on the recommendations set out in the Methodology for the Participation of Non-Governmental Non-Profit Organisations in Advisory and Working Bodies and in the Drafting of Public Administration Documents.[157] The methodology pays special attention to the involvement of marginalised and vulnerable groups of citizens, including people with disabilities.

Recommendations to improve the involvement of people, including those with disabilities, in public decision-making can also be applied to the involvement of people with disabilities in the planning of the development of social services. Conversely, any experience that the MoLSA or regions gain in involving people with disabilities in the planning can be used to improve the general participation in public administration.

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[155] In its key findings and recommendations, it states that "islands of good practices in terms of citizen and stakeholder [interested party] participation exist across the whole Czech central administration and at the local level. **Notably, the country has a strong culture of creating advisory and working bodies that include different types of non-public stakeholders. However, existing participatory processes often lack impact and there is currently no overarching vision for citizen and stakeholder [interested party] participation across the public administration.** Moreover, participation is often limited to the 'usual suspects' and guidance, coordination and sharing of good practices needs to be reinforced."

Quotation from OECD: Public Governance Review: Czech Republic Towards a More Modern and Effective Public Administration (2023); available at: www.oecd.org,[retrieved on: 17 January 2024].

[156] Ibid, p. 92 et seq.

[157] Government Council for Non-Governmental Non-Profit Organisations: Methodology for the Participation of Non-Governmental Non-Profit Organisations in Advisory and Working Bodies and in the Drafting of Public Administration Documents (2022); available [in Czech] at: vlada.gov.cz; The Methodology deals with improving the civic participation at the central level. The Methodology does not address participation at the level of local governments, but states that the basic principles and recommendations derived from them are also applicable at this level.

In order to fulfil the obligation for participation of people with disabilities in the drafting of deinstitutionalisation plans, it is essential to **involve people who have experience of living in institutions or transitioning from institutions to the community**. It is the duty of the MoLSA and the regions to look for ways, including innovation or the use of technology, to effectively involve these people in the process of planning of the development of social services and to make the best use of as much as possible of the information, experience and opinions provided by these people in the participation process.

3. Level of deinstitutionalisation and its further development according to the strategy plans of the MoLSA and the regions

Comprehensive mapping of the level of deinstitutionalisation is hindered by the **lack of relevant data**, especially on how many people use community-based services and how many people live in institutional facilities.

The content analysis showed that any mapping of the current situation or forecasting its development is vitiated by a lack of consensus on basic concepts such as "institutional service" / "community-based service", what is "humanisation" and what is full "transformation" of social services. The objectives set out in the strategy plans for the implementation of transformation and deinstitutionalisation may result in a hidden support of institutions – their establishment or maintenance.

The Deinstitutionalisation Action Plan for 2023-2025, which was not analysed in this research, contains measures aimed at creating a system for continuous monitoring and evaluating the deinstitutionalisation process.[158] This initiative is welcome. The content and thematic analysis revealed that the **level of deinstitutionalisation varies substantially from region to region**. The individual regions began transforming their social services at different points in time. **No region has closed or plans to close or fully transform all its institutional services, and none of the facilities founded directly by the MoLSA has undergone transformation.**

4. Removing obstacles to deinstitutionalisation

In the thematic analysis, we focused on the identification of obstacles that prevent faster and more effective deinstitutionalisation in the Czech Republic. We can divide the obstacles into three main areas.

First, **procedural barriers to deinstitutionalisation**: **public prejudices and fears** about social service clients (especially those with intellectual disabilities or mental illnesses); **the attitudes of the management and staff** of social service facilities that are to undergo transformation; **the unavailability of housing** and suitable properties, including land; **lack of qualified staff** (identified as the most important barrier by the MoLSA); **attitudes of guardians and caregivers**; lack of availability and adaptability of services providing care in the natural environment.

Second, we identified systemic obstacles. These include the system of funding of the operation and development of social services, especially the **uncertainty arising from it**. **The strict and ever-changing rules for the implementation of the transformation projects also cause difficulties.** The MoLSA and the regions also perceive a barrier in the lack of a **binding definition of community-based services**.

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[158] Cf. specific objective C3 on page 26 et seq. of the Deinstitutionalisation Action Plan. Under the Action Plan, a single monitoring system should be created by the end of the second quarter of 2024 to monitor and evaluate the deinstitutionalisation process with a clear and understandable description of all the indicators monitored.

Quoted from: MoLSA: Action Plan for the Transition of Social Services to Community-Based Care, for Greater Individualisation of Care, and for Providing Support for the Deinstitutionalisation of Social Services in the Czech Republic for 2023–2025;
available online [in Czech] at: www.mpsv.cz.

The third area is the obstacles resulting from the activities of individual actors and their mutual cooperation. **There is no clear commitment to deinstitutionalisation.** That should be declared, in particular, by the MoLSA as the central authority for the area of social services and the body responsible for the implementation of the Convention. Its role should also consist in **conceptual guidance** and procedural coordination. The thematic analysis revealed deficiencies in all these areas. Deinstitutionalisation is thus hindered especially by insufficient methodological guidance, lack of a national long-term vision and insufficient support for the regions.

In terms of the planned development of social services, the main vision at the national as well as the regional level is to **enable people to live as long as possible in their natural environments**. All strategy documents of the MoLSA and the regions, including specific regional strategy documents, declare sub-objectives aimed at **the development of community-based services for people with intellectual disabilities and mental illnesses.**[159] The content analysis revealed that the National Strategy does not envisage at all the development of services that we identified as clearly community-based and the objective is only defined in three of the medium-term plans. However, all of the specific regional strategy documents aim at developing services that we have identified as community-based.

One of the biggest challenges of the Czech Republic in realising the right to live independently in the community that has been identified in the content and thematic analysis is **finding a consensus on the objective of deinstitutionalisation**. A uniform understanding of the term "community-based services" is crucial. The progressive implementation of the right to live independently and be included in the community inherently places high demands on the State to provide the maximum possible resources and achieve as much progress as possible in the shortest possible time. The transformation of the system from an institutional to a community model entails considerable costs from the public budget. **However, the commitment to deinstitutionalisation arising from the Convention cannot be rejected with a reference to the financial costs involved.**

The content and thematic analysis shows that the **transformation of the facilities for people with mental illnesses and intellectual disabilities faces multiple obstacles**. The public often takes a reserved or even cautious attitude towards people belonging to these target groups. Politicians, whose role is to promote deinstitutionalisation in respect of these target groups at the national and regional level, need to have great political courage and an internal commitment to deinstitutionalisation if they want to support the cause in the long-term. Specific deinstitutionalisation strategy documents with a long-term perspective can promote awareness of the commitment to deinstitutionalisation. A suitable strategic and legislative definition of the commitment to deinstitutionalisation would be of fundamental help.

The public and politicians alike focus primarily on the development of services for the elderly, which is indeed necessary, given the demographic development. The transformation of facilities for people with mental illnesses and intellectual disabilities associated with the development of community-based services may thus sometimes receive less attention. It is primarily the role of the MoLSA, as the body responsible for the implementation of the Convention, to use all possible means, including financial means, to prevent this marginalisation.

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[159] With the exception of two medium-term plans, which declare the intention to develop community-based services for the target group of people with mental illnesses, but not for people with intellectual disabilities.

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