Planning deinstitutionalisation in Slovenia

Assist. Andreja Rafaelič, Ph.D., Assoc. Prof. Mojca Urek, Ph.D.
University of Ljubljana, Faculty of Social Work

Introduction

Based on The Resolution on the National Programme for Social Care 2013-2020, and taking into account *The Common European Guidelines on the Transition from Institutional to Community-based Care*, the Ministry of Labour, Family, Social Affairs and Equal Opportunities commissioned a study for the preparation of deinstitutionalisation in Slovenia.

The purpose of the study is to lay the foundation and frame, and all the necessary elements for a comprehensive approach to the process of deinstitutionalisation. This means:

- to anticipate new residence, care and inclusion,
- integration with the available (or needed) resources in the community,
- including an estimate of the necessary resources,
- the necessary steps and timeline.

In order to achieve this purpose, it was necessary to provide a synthesis of deinstitutionalisation conceptual bases, to provide critical overview of existing and collected data and a projection of the transition from institutional to community care.

The aim is to:

- set up basic parameters of change,
- provide material for an informed discussion in order to construct a national strategy,
- set the main goals and indicators of the process.

General observation were made for all social care institutions in Slovenia, with the analysis and projection being focused on social care homes and training facilities for adults (>65 years).
This poster presentation provides basic ideas and motions extracted from a larger study.

Base of deinstitutionalisation in Slovenia

- Slovenia is bound to deinstitutionalisation by a number of international documents at EU, European Council and the United Nations level. UN Convention on the Rights of Persons with Disabilities requires that States parties shall take all necessary measures to facilitate the exercise of these rights.
- The Slovenian Government is committed to deinstitutionalisation also in the process of the European semester.
- In Slovenia there are no specific legal bases, however, the national programme of social care explicitly demands significant reduction of institutional capacities to 2020 and a very large increase in community provision.

Scale of deinstitutionalisation in Slovenia

The development of community care and efforts for deinstitutionalisation, have due to inconsistency and indecision, and because only the first steps have been made, led to a number of inconsistencies and paradoxes:

1. We have a *long history of deinstitutionalisation*, but still predominantly *institutional care system*.
2. The *rate of the deinstitutionalisation* is significant (more users use community care than institutional care – if we include recipients of allowances and low intensity care), but there is also a *high institutionalisation rate* (the number of resident institutions per capita).
3. The development of a community provision did not reduce the numbers in institutions.
4. The system, thus created is *parallel*, *double-tier*, which *increases costs* and *inhibits* real community alternatives.
5. Spending per user is 4-times greater in the institutions, for comparable (residential) facilities monthly cost is 352.40 € less the community than in an institution.
6. For people who need more care it is, at this price, virtually impossible to provide in the community.
7. In such a system, often ex-residents return to institutions, which in turn means even more intense violations of the right to life in the community, and has the effect of disciplining the users.
8. *Community care services* (personal assistance, coordinated care, residential groups), albeit verified, are not available to all users and act as optional programmes. Those that have the status of publicly available services, however, are unreasonably limited only to a certain groups of users (family assistant) or in a quantity (home care 20 hours).
9. Despite the breakthrough of the social and enabling model of care the old paradigm of correction, medical model and guardian stance of staff persist.
10. Along with the deinstitutionalisation in recent years, also, reinstitutionalisation has been observed – return of the users to the institutions and decrease in spaces in group homes, the strengthening of the closed structures, rendering the old methods of work.

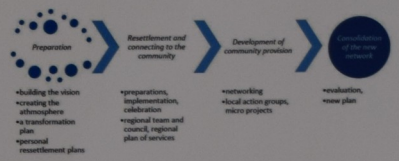
Two models of deinstitutionalisation

here are two possible conceptual models of transition from institutional to community care:

- ***Conversion*** – existing institutions are converted into community services or
- ***Substitution*** – institutions are liquidated and substituted by new services in the community.

Changes need to be initiated by *pilot projects* that will provide experience and a source, an example for the rest of the country. Two such hot spots need to be created — one in the institution, which will be the first to restructure, and another in the geographical area to which the residents of institutions elsewhere in Slovenia will return.

Figure1: The phases of conversion (converson model)



Proposal of a new network of community services

Based on an analysis of existing services and possibility of new, we outline the contours of the new network:

Table 3: Proposal for a new network of community services

Type of care	No. users
Residential	
Permanent residence (4-6 residents)	750
Transitional residence (3 months – 2 years)	750
Short term residence	100
Sheltered housing	750
Care in a host family/ board and lodging	250
Day activities	
Day centres/ clubs	2000
Occupational cooperatives and social enterprises	1000
Personal services	
Personal assistance	2000
Family assistants	1500
Personal care packages and coordinated care	2500
Home care	2500
Tele-care	1000
Supported employment	1000
Low intensity services	
Escort and other support	2500
Counselling and outreach	5000
Advocacy centre	
Micro community projects	300 programmes
Other measures	
Cash allowances	5000 or more
Diminishing of poverty and enabling access to mainstream services	
Centre for community care	
Regional centres or permanent working groups or teams	10
Non-profit housing organisation	1000 or more places

The recommendations for initial steps

1. Process should begin by creating a ***strategy*** of transition from institutional care to community care in a dialogue of all stakeholders; based on additional studies and planning workshops, a detailed *action plan* should be drawn.
2. **A *pilot of transformation of an institution* and *a pilot in planning and creating services*** in one of the *regions* should be drawn.
3. All necessary conditions for provision of ***intensive personal services*** should be provided (amended legal instruments for personal assistance, care coordination, increase the scope of home care and other necessary additional services) and to accelerate the preparation and adoption of the law on long-term care and personal assistance and start with the preparation of other amendments of the legislation.
4. ***Coordinated activity*** of all stakeholders should be ensured (National Council for the deinstitutionalisation, monitoring group, centre for deinstitutionalisation).
5. Intensive *publication* of the relevant material (foreign, local) and preparation of evaluation tools and indicators for monitoring and creation of solid base for training and education.

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Principal researcher: Vito Flaker

Collaborators: Andreja Rafaelič, Sonja Bezjak, Katarina Ficko, Vera Grebenc, Jana Mali, Andreja Ošlaj, Jože Ramovš, Simona Ratajc, Iztok Suhadolnik, Mojca Urek, Nina Žitek

Consultants: Vlado Dimovski, Andrej Kastelic, Jan Pfeiffer

Other contributors: Simona Gerenčer Pegan, group Meduza

Further information
Andreja.Rafaelic@fsd.uni-lj.si
Mojca.Urek@fsd.uni-lj.si