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On the concept of the deinstitutionalisation of care and the measures taken. Possibilities and limits

Abstract

The article is a voice in the debate regarding the effect of deinstitutionalisation on of the lives of dependent people who require care: children without parental care (foster children and those deprived of their parents' care), people with disabilities and people experiencing mental health crises, and the elderly needing long-term care. The article is both illustrative and review-based. It uses historical knowledge and the results of comparative studies, as well as the knowledge of the practice of the functioning of care institutions for many categories of dependence not only in Poland but also in other countries of Central and Eastern Europe. It draws attention to the limitations of the deinstitutionalisation process and the necessary preparation of local authorities and local communities to create conditions for taking dependent people from large institutions of collective living to smaller ones, open to the support of local social communities. It draws attention to the fact that deinstitutionalisation policy is in fact a long-term process of re-institutionalisation, which may be socially beneficial under defined conditions, but requires investment

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outlays for transformations, renovations and, to some extent, for new investment of social infrastructure.

Keywords: foster care, people with disabilities, people in mental health crisis, older people, deinstitutionalisation

Introduction

The postulate for deinstitutionalising the lives of people with various limitations to living independently who are necessarily placed in institutions for collective housing and care has now become not only a demand for equality from progressive circles but also the direction of concrete action by public authorities.

In the European Union, the move towards deinstitutionalisation is supported in the social policies of the member states by soft regulation tools and Structural Funds measures. This has made the problem of people living in institutions a particularly topical issue for social policy, but also a cause for concern with a certain one-sidedness in posing the problems of dependency/self-sufficiency in people's lives and advocating for appropriate forms of living and care. This is contained in the belief that any institutional form is somehow inferior to any non-institutionalised, family and quasi-family care.

Addressing the topic of deinstitutionalisation, the article considers how to explain this direction in social policy in three contexts: (1) the historical development of institutional care for people unable to live independently, (2) well-established concepts (theories) about the functioning of non-family living and care institutions for dependent people, and (3) the practice of solutions regulating the institutional care system today. Awareness of these contexts makes it possible to assess the possibilities for change and the so-called causal power of the measures taken in the directionally postulated goals.

The article has an illustrative character. It draws on historical knowledge and the results of comparative research, as well as knowledge of the practice of care institutions for many categories of dependency not only in Poland but also in other Central and Eastern European countries[2].

Addressing deinstitutionalisation in a broader context here is a warning against a one-sided approach to the extremely complex problems of spending one's life in institutions. This complexity is due to many different kinds of dependency in human life, on the one hand, and the different qualities of living and caring institutions shaped at

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[2] The author's involvement in the practical activities of institutions for the assistance of orphans, the disabled and the elderly was of an organisational and advisory nature. On this occasion, qualitative research was usually carried out, allowing the theoretical and political theses, often ideologically embedded, to be confronted with the varied realities of the existence of dependent people, their caregivers and the authorities organising care and responsible for its quality. Recently (2022), the author has participated in consulting and carrying out research work focused on the development of social services and supporting independence as part of the project entitled *Development and pilot implementation of mechanisms and plans for deinstitutionalisation of social services* carried out at the Institute of Labour and Social Studies (IPiSS) as a project partner, under the supervision of Agnieszka Sowa-Kofta.

different stages of economic and social development in various countries on the other. Therefore, any direction, whether towards institutionalisation or deinstitutionalisation, proposed in social policy towards dependent people requires extremely careful implementation.

Institutional care in this case is understood to be that which:

- is provided in stationary (usually large) facilities, isolated from the community;
- operates within general rules and regulations, backed by standard rules of professional conduct, e.g. medical, pedagogical or even psychological, with limited opportunities to take into account residents' individual abilities, needs and preferences;
- takes control and responsibility for residents' lives, depriving them of many social skills and, at the same time, the ability to be independent in assessing life situations, planning actions, and being consistent in their implementation.

From institutionalisation to deinstitutionalisation

The basic living context in human life is the family. Traditionally it was a large family, comprising at least three generations, with numerous relatives and affinities, as well as the immediate local community. Changes in how people lived, most strongly linked to industrialisation and urbanisation, caused people to migrate *en masse*. They abandoned their traditional places of residence and moved to cities near and far, including those overseas. Broken ties were not reconstructed in the new destinations. Urban families increasingly ran two-generation households. The phenomenon of abandoning or giving away children who could not be "fed" was not a rare occurrence.

In the 19th century, in many European countries, the responsibility for abandoned and surrendered children, as well as for the disabled, the elderly and the poor became the subject of government regulation and actions by local authorities. Collective homes (congregate settings) were set up for them.

In the UK, with a long tradition of laws for the poor, so-called workhouses were created for abandoned, surrendered and orphaned children. In these, younger children were offered elementary school education, while the older ones had to work (Chance, 2018).

As the role of the state in family matters increased, an additional reason for institutional care also emerged – the removal of children as a result of oppressive or what was deemed to be immoral parenting by their parents. Children were also taken away from adolescent and single mothers. Public authorities were supported as well as guided by religious organisations (often convents) and private philanthropic activities.

Collective homes were also places for people with disabilities, chronic illnesses, mental disorders and the elderly. They were most often supervised by medical bodies and called hospitals or sanatoriums, e.g., for people with tuberculosis.

The buildings in which various groups of dependents lived were usually large and surrounded by outbuildings and crops. Generally, they were situated outside the urban built-up area, one could say, in rural areas. The organisation of life there was unified and the conditions were austere, although hygienic. Contact between the residents and the outside world was limited and controlled.

For many decades of the 20th century, collective homes for dependent people were assessed rather positively, more on the basis of intentions than on the real conditions and consequences of living in institutionalised forms. Children's homes (and so-called hospitals) in the Soviet Union received particularly good marks. Anton Makarenko's book known as a pedagogical poem[3] shaped the image of a positive hero coming from an orphanage, which in the collectively organised life of communist society was neither a pedagogical nor a social problem.

In the socialist countries that operated under the political and institutional system of the communist regime after the Second World War, care for dependents developed mainly in state care institutions, generally closed and remote from the family and local community. Only in the countryside did family care take place to a greater extent, especially in Poland in peasant families, which – as private (unsocialised) entities – were deprived of social security for several decades. Institutional care was frequently better than family care, especially with regard to dependent elderly persons, who were considered a significant burden on the peasant farm's production potential.

Over time, the negative and even drastic consequences of living in institutions began to be revealed. On the one hand, difficult living conditions were evidenced, especially in poorer countries, and on the other, the negative psychological consequences of the lack of family ties and affection, isolation and dependency were pointed out. The American sociologist, Erving Goffman formulated the concept of **the total institution**, (which is a generalisation of the specific characteristics of a collective, closed institution, with standardised rules of behaviour and a uniform rhythm of daily life, as well as compulsions enforced by the staff (Goffmann, 2011). This concept, which is a generalised experience of how psychiatric institutions functioned, has been transferred to other closed institutions for the care of dependents, sometimes disavowing them altogether. While this has met with justified criticism (Posłuszny, 2017), it has sparked a move towards opening closed institutions, including psychiatric hospitals.

In the 1980s, some countries started to move dependents from various closed facilities into the community, supported caregivers financially and then decommissioned the old facilities (in part or in whole). After more than half a century, neither the sentiment nor programmatic deinstitutionalisation efforts, despite difficulties, have been weakened.

At the turn of the century (the late 20th and the early 21st century), social movements for the right to self-determination developed; encompassing all people with limitations and fewer opportunities for self-determination; including children, people with disabilities and the elderly. They influenced the emergence of international regulations (primarily UN conventions) and began the slow process of implementing the provisions contained in these regulations signed onto by numerous countries.

The problem of empowerment, seeking to reduce people's dependence on institutional structures, entered the agenda of social strategies against poverty and social

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[3] The first edition of Makarenko's book, *Poemat pedagogiczny*, in Polish was published in 1949.

exclusion of the European Union in the second decade of the 21st century[4]. At the same time, the European Commission has identified implementation tools targeting four main groups at risk of spending their lives in institutions: children deprived of parental care, people with disabilities, people with mental illness and elderly people unable to live independently[5].

Children deprived of parental care

Among the many articles of the UN Convention on the Rights of the Child adopted by the General Assembly in 1989, the right of the child to live in a family is enshrined. Yet almost 10 million children in the world do not have the opportunity to be brought up in a family environment. Typical reasons for the lack of family care are orphaning as a result of warfare and accidents, abandonment (surrender) of the child due to poverty and social immaturity (e.g., teenage mothers), as well as inability to provide care due to parents' health and behavioural limitations (mental, addictions to psychoactive substances) and children's developmental and health problems – disabilities and limitations in intellectual development. Judicial termination of parental authority due to abuse in families of origin, such as violence and other types of child abuse, is also of growing importance.

In Poland, against the background of the varied causes of the phenomenon of abandoned children, there is a heated debate in society concerning the practice of family courts limiting parental authority due to multifaceted justifications (Kolankiewicz, 2022). When court decisions are predominantly justified by the use of violence and other forms of child abuse, these decisions are sometimes said to be excessive. The culture of "smack and belt" in disciplining children is still present[6].

Research on developmental deficits, conducted on a larger scale in the second half of the 20th century, showed that the lack of proper individual care in the earliest stages of development has a serious impact on the psychosomatic development of children. This was highlighted by the results of studies (using new medical technologies that enable brain research) collected and cited by UNICEF (2009). Specific deficits including physical development (growth), cognitive function, neurodevelopment and socio-psychological health were documented. In 2015, an article was published in a reputable

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[4] Relevant EU structural funds have been identified for the adaptation of the deinstitutionalisation concept (European Expert Group, 2014)

[5] Some deinstitutionalisation strategies include also people experiencing the crisis of homelessness, for whom collective shelters are created in situations where living "in the street" is hampered by bad weather or tighter controls on public places. In this case, the aim is more to support such people in acquiring decent and affordable housing of their own, rather than deinstitutionalisation in the sense of leaving a large total institution for other unspecified specific solutions.

[6] The phenomenon of children being beaten at home has only recently received attention and action, which includes the creation of what is called "Blue Card". How insufficient this is, is evidenced by reports from doctors and journalists depicting the most drastic incidents, see: Hołub, 2021.

medical journal – the Lancet – presenting the results of a contemporary study (Berens & Nelson, 2015) on the damage done to children's psychosomatic development by placing them in large institutions in their earliest years of life (up to two-three years of age).

Avoiding developmental deficits among young children without parental care is ensured by early interventions in the form of early adoption, placement in properly prepared foster families or quasi-familial care. These are the three classic forms of parental care substitution. They constitute an important element of social policy towards children in every country and are included in Polish regulations. The measures taken are similar in general terms, but public policy preferences for a particular form may differ.

Development of the adoption system

The adoption system is "as old as the world", although it was only in the 20th century that it became subject to strict legislation (O'Halloran, 2009). It has been described from a few perspectives: those of adopted children, their adoptive parents and those working in adoption agencies.

Adoption has its successes and failures, but it is an obvious solution. There are differences in the practice of adopting children regarding the eligibility for adoption and the procedures used. In many countries, the adoption process takes too long, which is disadvantageous to the formation of bonds between children and parents. The psychological theory of attachment emphasises the importance of being together as early as possible (Bowlby, 2007).

In Poland, there is a two- or four-year wait for a child. The reasons are not only of legal and administrative nature. It is also because there is an increasing number of applicants trying to adopt a child, due to the growing infertility problem (Jasieńska et al., 2022). At the same time, the population of abandoned children lacks the characteristics most desired by their potential parents, who want healthy children, as young as possible, while, in fact, most of the abandoned children are faced with health problems and developmental limitations.

A significant problem of the adoption system is the insufficient preparation of parents and the limitations of adoption centres. Potential parents do not know what health and behavioural problems an abandoned child may be faced with. Furthermore, they are not aware their own capabilities and skills. Accepting another child as their own and providing the resources they need may be more difficult than expected and they may identify their own limitations, discovering that they are not sufficiently prepared to overcome these problems. This is why they sometimes give up and terminate the adoption contract[7].

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[7] Cases of adoption abandonment – dramatic for children and parents – are collected and described in Marta Wroniszewska's book *Tu jest teraz twój dom* (2021).

Development of family foster care

Most abandoned children have no chance of being adopted, especially when they are "older" and have developmental deficits, siblings, and the biological parents do not want to give up their rights despite abandoning the child (or having had the child taken away). Thus, they end up in institutions, mainly in what is referred to as orphanages, which have generally had a bad reputation in general. A new form of foster care has emerged on the spectrum of possibilities: adoption or children's homes. The concept of family foster care is based on the theory of inclusive care, which centres on a relationship between children and carers that allows children to participate in decisions and family activities. Developed in the 1980s, it found recognition through research, particularly in Canada (Steinhauer, 1984).

In Poland, as a result of a 2004 Act and its amendments in 2011[8], there are three main types of foster families: (1) kinship, when persons from a large family (grandparents, siblings) take over the care of a child whose parents whose parental rights have been terminated by a court decision, (2) professional foster families (which also include small family children's homes), and (3) other, namely, non-professional foster families. Foster parents are paid as caring for children is their professional job.

Foster families, which is a relatively new solution, is developing gradually and with an unexpected turn towards dysfunctional forms, which is not prevented (but is rather enabled) by regulations. Various disadvantages of foster care are recognised but they are not clear-cut when the point of view of the respective sides is taken into account. Reports indicate the existence of the following critical problems:

- The decision to hand over a child to a foster family (at first to take them away from their biological parents) takes a long time and must be considered by several institutions (family courts, social assistance, family support centres, police). Meanwhile, the younger the child, the greater the chance of overcoming destructive developmental tendencies and of forming an attachment to carers (Bowlby, 2007).
- Biological parents, if their parental rights have not been judicially terminated, can remain in contact with the child and support the caregivers (Racław-Markowska, 2017). In practice, the influence of the biological parents is sometimes incompatible with the parenting line of the caregivers, who complain that contact with the biological parents disrupts their pedagogical work and destabilises the children emotionally (Wroniszewska, 2021). There is also no system in place to formulate the requirements and controls for effective rehabilitation and treatment towards biological parents, granting them the right to have contact with their children.
- Checking the competences and providing adequate training for foster parent candidates is insufficient. It sometimes happens that family foster homes become a "business" for carers, with housework being done by the children and caregivers oriented mainly towards income generation.
- Foster carers do not have full information about the child's health, and when problems arise, they are very often unable to cope with them (see: Wroniszewska, 2021). Meanwhile, children ending up in foster care generally have multiple health

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[8] Act of 9 June 2011 on family support and foster care system (see: Ustawa…, 2011).

problems. A serious issue is FAS (Fetal Alcohol Syndrome), i.e., an irreversible brain damage as a result of alcohol consumption by pregnant women, which is destructive for the child's neurodevelopment and behaviour (Banach & Matejek, 2016, Pawłowska-Jaroń, 2015)[9].

- The transfer of children does not always consider the obvious constraints on foster care due to the excessive number of children entrusted and the lack of support persons. Difficulties also arise when the age of the children is too varied as small children as well as teenagers are entrusted to a single family. Older children in a large foster family do not always follow the rules and discipline of living in a larger group and change carers ("transfer children", "children on the move"), seeking placements with limited control, which generally is not beneficial for them.

All in all, the process of transferring children to foster families in Poland is full of systemic imperfections, administrative limitations, and human helplessness. There are certainly many good practices of foster family care, despite imperfect regulations and difficult local conditions. This, however, is not enough to treat this solution as a model and to give it sole preference in family policy. Family foster care may be a good direction towards deinstitutionalisation, although good results in improving the lives of abandoned children are indeed conditioned by the complex interaction of several factors: the intentions of carers, their competencies (both formal and awareness of responsibility and relevant character traits, such as empathy, emotional intelligence, resourcefulness, thrift), their living facilities, as well as effective and efficient support (and control) institutions.

Children's homes

There will always be some scale of abandoned children reliant on institutional care throughout their lives, regardless of the drive in family policy to place children deprived of parental authority with other families instead of putting them in foster care. A form of institutional care for children deprived of parental authority is the so-called children's home, commonly a permanent part of the foster care system. They have undergone numerous changes over many decades and continue to do so. They also vary: by the age of the children, by the ideological system of the organisation running them (e.g. homes run by religious organisations), by their location within the structure of public responsibility (education, health, social welfare) and the responsibility of the territorial authority (central, regional or local).

UNICEF (2017) estimates that 2.7 million children worldwide live in orphanages. This scale does not move down. In post-communist countries, a strong increase in the number of children in institutions took place at the turn of the decade. The collapse

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[9] FAS is a relatively common phenomenon in many countries around the world, where alcohol consumption is high (many times more common than the developmental limitations caused by Down syndrome) but the epidemiological recognition of the problem is not yet sufficient. Scientific data have emerged relatively late (Popova et al., 2017), resulting in a paucity of preventive measures for pregnant women; both in healthcare and in social work. Also in the process of treating health disorders among children, the diagnosis of FAS is insufficient.

of the communist system entailed changes in social relations and the functioning of communities. There was also an increase in the number of abandoned children due to poverty and the emigration of their parents. They ended up in orphanages even though more than 90% had at least one biological parent (Carter, 2005). Institutions of collective living for children and young people were still needed, while public resources for their functioning were very limited.

The process of deinstitutionalising children deprived of parental care in the Central and Eastern European region began only in the early 21st century, which was strongly affected by economic factors.

In Poland, the process of reforming institutional foster care for children abandoned and deprived of parental care, which can be qualified as a type of deinstitutionalisation (Kolankiewicz, 2022), has been ongoing since 2000. Regulatory preference is given to small children's homes, open to local community participation, providing closer relationships with carers and selected social circles. Modern, child-friendly pedagogical principles are formulated for them. The empowerment of children as they grow up in institutions is promoted, e.g. assistance in obtaining housing, preparation for entry into the labour market, integration into community life.

However, the real process of change in children's homes looks different from the plans and regulations. Existing children's homes are far from the desired model. The management of children's homes described by authors involved in the management of the institutions (see: Andrzejewski, 2007), point not so much to the poverty of the institutions, despite calling them "poorhouses" or "foundling homes" (colloquial Pol. *bidul*), as to systemic dysfunctions. Caregivers have an essential role to play as foster parents. Therefore, their training, recruitment, remuneration and promotion path require consistent and sustainable solutions. They are, however, not provided and, consequently, we are faced with a shortage of carers willing to do the job in children's homes.

The initiated deinstitutionalisation of children's homes in Poland, consisting in their "extinction" and the application of forms of family foster care on a larger scale instead, has not contributed to a radical improvement in the fate of children deprived of parental care. It has rather created new needs and problems that are increasingly difficult to manage (Kolankiewicz, 2022). It is, therefore, reasonable to believe that orphanages should retain a place in the structure of care solutions for abandoned children and children deprived of parental authority, but they should be modern homes, with a changed emphasis on pedagogical action, facilitating 'children's access to culture, sport, learning about and respecting nature, caring for animals or other support activities. Rather, the idea of reforming existing 'children's homes based on a model of competent and friendly care and servant management open to cooperation in the local environment is to be considered. This would require a multidisciplinary and coordinated action; both at the conception and implementation stages, respecting established principles.

People with disabilities

The efforts for the self-determination of people with disabilities have a long and specific history. In agrarian times, people with disabilities lived next to their families, and when they were rejected, then if they were not cared for by a religious organisation, they lived on their own in some public place – next to churches and/or train stations, where they could, by evoking pity, receive a handout.

In the era of industrialisation, which was accompanied by increased work accidents leading to permanent disability, insurance against work incapacity due to occupational accidents was established. Pensioners were more able to live with their families, who were more willing to take care of them when they could pay for their maintenance.

One of the greatest achievements at the turn of the 21st century was the drafting and agreement on the content of the UN Convention on the Rights of Persons with Disabilities (hereinafter referred to as Convention), which was adopted on December 13, 2006, in New York[10]. According to the UN Convention, persons with disabilities are defined as those with long-term physical, mental, intellectual or sensory impairments which, in interaction with various external barriers, may hinder their full and effective participation in society on an equal basis with others (Article 1 of the Convention). Under the Convention, disability is no longer a ground for exclusion from society. On the contrary, a right to participate has been established; a right that must be universally recognised and respected, with the conditions for its realisation ensured.

Children with disabilities from birth

Disability can occur at any stage of life. In earlier life phases it can be the result of genetic defects, or damage to organs or disrupted mechanisms during foetal or infant life, or the result of accidents or injuries. Although statistically it most often appears later in life due to the onset of pathologies of the body (wear and tear of some of its organs) and the incidence of chronic diseases, the biggest problem from the point of view of the organisation of care in the event of disability concerns children who are born with severe developmental limitations. These children spend their lives primarily in various institutions. In the scheme below, the main groups of factors influencing their institutionalisation are given.

Reports and guidelines from international organisations such as UNCRC, UNCRPD, and UNICEF (Jones, 2019) and European Union resolutions (European Commission, 2010, 2013, 2014) for many years have proclaimed that the ideal place for any child to live, even more so for those with disabilities, is in a family that provides a caring atmosphere, or if necessary, community-based care adapted to the individual needs of children and the development and promotion of their abilities. However, such a family does not always exist, or is not able or willing to care for a child with disabilities and raise her or him. In such cases, the child lives in institutions with numerous constraints and, at the same time, the facilities for such children vary greatly in terms of quality and capacity to meet their care, health, rehabilitation and educational needs.

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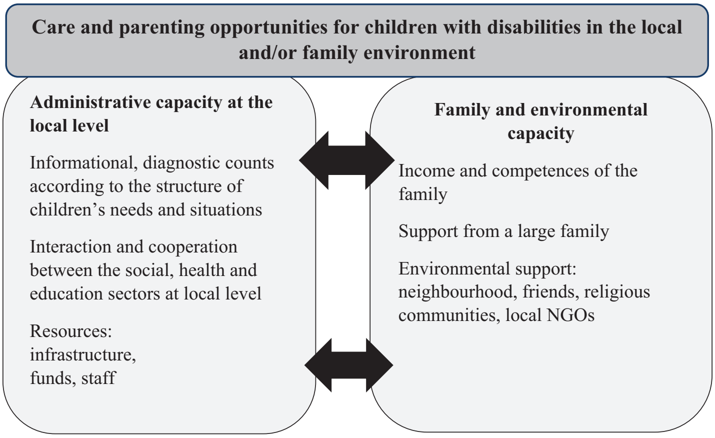
[10] The UN Convention on Rights of Persons with Disabilities (CPRD) 2006. Recognising the momentousness of this document, Poland, along with other 81 UN member countries, signed the Convention on March 30, 2007. Its ratification did not take place until September 6, 2012; https://bit.ly/UNCRPD-Status.

Scheme 1. Factors influencing the institutionalisation of children with disabilities

The postulation of non-institutional solutions for children with disabilities is a common trend. However, a policy of supporting such children in the non-institutional system does not (should not) mean the withdrawal of institutions that would continue to support family or para-family care. Children with disabilities also need services that take into account the process of their biological and social development at successive life stages, hence the necessity of age-appropriate educational services, especially for children with intellectual disabilities (Zakrzewska-Manterys, 2021), and ongoing medical supervision and rehabilitation. This requires the participation of professional staff with medical and pedagogical skills, prepared specially for the type of disability the child has in her or his biological development. Access to services on an individual basis (reaching each child) is often highly limited (staff shortages and relatively high wage costs for service providers). Hence, new solutions in the trend towards deinstitutionalisation include, in fact, other institutional solutions, small local centres, generally day care, with family's or other carers' support.



Scheme 2. Opportunities for disabled children

In arguing for the choice of family and/or community-based care over institutional care, the argument of cost-effectiveness is given in addition to human rights and social justice theses. In reality, the cost of non-institutional care is not lower and the social return is higher. In addition, there may be additional costs in the short term, such as adapting local centres to accommodate wards from large institutions. Such costs, e.g. repairs and modernisation, should be calculated and included in local budgets but do not always occur.

Comparative studies, based on specially collected European data, have supported the conclusion that care in community settings is more effective than care in large closed institutions for people with intellectual disabilities. Small, open institutions were deemed better in terms of the quality of services, and when they gathered more residents, they also gave a positive cost effect (Mansell et al., 2007).

The effective transition of a person in need of care (client) from a large institution to a small centre or a family with more public support for care is only possible under certain conditions, which are sketched out in the scheme below. Taking appropriate action always requires a good recognition of existing family and local possibilities.

Persons with mental disorders

For many years, the classic living arrangement for people with mental disorders was closed psychiatric institutions. Apart from the need for specific medical treatment, significant justifications for isolation included concerns for the safety of the community, especially when the illness was manifested by profound behavioural disorders.

In the mid-20th century, efforts began by medical groups to open psychiatric hospitals and organise care in the community for people in mental crisis (as well as those with serious mental disorders) (Yohanna, 2013).

Three groups of factors triggered the movement to leave psychiatric hospitals into the community. First, there was a growing perception that psychiatric hospitals were inhumane and that behaviour towards patients was cruel (total institutions). Secondly, therapy was changing, and new antipsychotics were emerging, allowing the behaviour of mentally ill people to be controlled. And as usual – measures aimed at saving public expenditure were significant. Psychiatric hospitals are predominantly public institutions everywhere in the world, and the tendency to economise on public expenditure has been prevalent from the 1970s onwards, when there was the first major crisis in the development of the welfare state.

However, opening psychiatric hospitals and organising the treatment process for people with illnesses in community settings has not been universally successful. A review of the opinions of experts (mainly psychiatric practitioners) from 42 countries involved in the deinstitutionalisation process collected by the WHO and the Gulbenkian Global Mental Health Platform (2014) identified several groups of conditions, such as, e.g. suitable locations for open facilities, a welcoming social environment, qualified modern caregivers or additional funding (*sic*!) that are essential for success. These are not being met in a great number of places and countries, including affluent ones, and conducting institutional restructuring without meeting them can create new and difficult problems[11].

For people leaving psychiatric hospitals in some countries, private hospitals, often like luxury hotels, were organised on the one side, and on the other, prison psychiatric hospitals for those with criminal charges. Traditional hospitals continued to dominate the mainstream; usually underfunded and unfriendly. In contrast, the move to supported psychiatric therapy in a decentralised community setting served primarily the middle-class patients, better educated and more affluent people[12], as well as those with new types of mental disorders and new patients (including children and young people).

In Poland, the movement to open psychiatric hospitals started, as Andrzej Cechnicki (2009) writes, from the bottom up. Referring to the work of Antoni Kępiński (famous Polish psychiatrist and philosopher), the Association for the Development of Psychiatry and Community Care was founded in Krakow in 1999. Activists supporting it cooperated with the German Society for Social Psychiatry and the WHO. A long-term programme known as *Schizophrenia – Open the Door* was prepared. This step changed the awareness of psychiatrists and activated the medical community to bring about some change.

In 2010, the National Programme for the Protection of Mental Health (NPOZP, *Narodowy Program Ochrony Zdrowia Psychicznego*), a regulation to provide the legal basis for the postulated change in psychiatric treatment and open care for people with mental illness, was enacted. The evaluation of the implementation of the NPOZP carried out by the Supreme Audit Office (NIK, *Najwyższa Izba Kontroli*) five years after its foundation was devastatingly negative (NIK 2017). This provoked the psychiatric community to prepare a new programme with different action tactics.

For the period from 2017 through 2022, a new programme was enacted, a concept for a territorial network of Mental Health Centres (CZP, *Centra Zdrowia Psychicznego*) was developed and a pilot programme for their establishment was implemented, which is planned to be completed in 2022. The CZP concept takes into account numerous international experiences; uses the existing infrastructural resources of treatment facilities in the country but also assumes the creation of new ones; introduces a new profession of a community assistant and emphasises the need for cooperation with social welfare institutions and local government. In addition, it takes into account the extensive use of new technologies for communication with patients (smartphones and telemedicine). During the implementation period, professional supervision (consultation) by psychiatric and psychological associations is assumed.

Mental health centres are above all a formula for the implementation of a new therapeutic concept in the treatment of mental disorders: open, adapted to existing problems in the specific local environment, flexibly organised (outpatient and inpatient), allowing continuity of therapeutic supervision in the home care system. They are part of the re-institutionalisation rather than deinstitutionalisation stream.

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[11] In the US, people with mental disorders ended up in city streets, along with other homeless people (Rimmerman, 2017).

[12] Research results on this topic were conducted in the USA (Davis et al., 2012).

Dependent people in old age

The loss of independence in old age has increased with the success of lengthening life expectancy, which is not always lived in a healthy state that allows independence and self-reliance. Simultaneous changes in the formation of families (single and small family living), have reduced the possibility of using family resources in caring for the elderly. These resources are being demographically depleted (Kotowska, et al., 2020). The elderly who are not independent and require care are increasingly reliant on institutional solutions.

Care for the needs of people who are ageing gently (are "in good health") and are affluent is not a social problem. They either live independently, using care services at home, or opt for an institutional or quasi-institutional solution to access care and assistance, while allowing for the necessary autonomy and comfort. Comparative data from the OECD databases (2020 and 2021) indicate that in affluent countries, as well as in countries with smaller family demographics and cultures, the supply of "institutional" long-term care places is relatively high. The ratio of long-term care beds (including hospital beds) per 1,000 population aged 65+ is 74% in the Netherlands and around 70% in Belgium and Sweden. In Poland, by contrast, it is only 11.5%. Turkey has a similar ratio of 9.5%.

Over the last decade (2009–2019), the ratio of long-term care and hospital beds per 1,000 people over 65 has changed little (see the graph below). Many countries have seen an increase, e.g. Spain, Germany and Switzerland. The two types of indicators presented as having the highest rates in Poland indicate that access to long-term care for the elderly in Poland is among the lowest among the OECD countries. The differences show that the problems of care for the elderly and dependent persons are quite different in Poland than in the most European countries. It is not the problem of

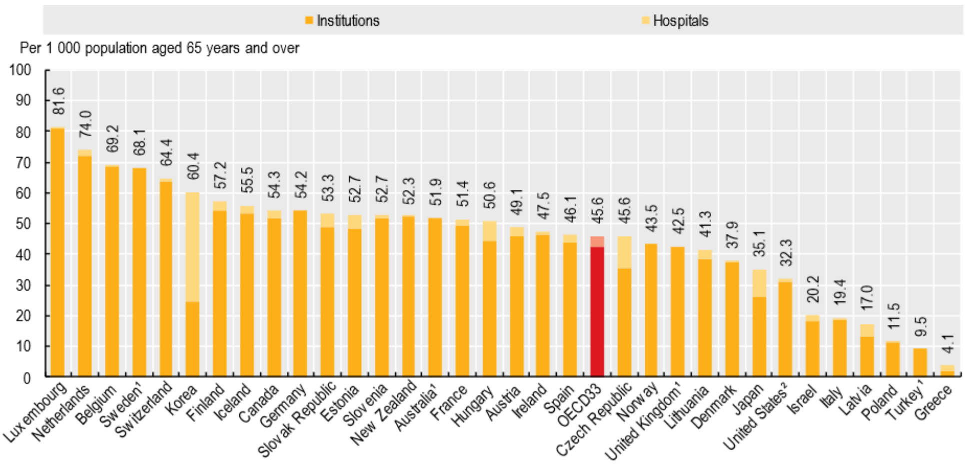

Figure 1. Long-term care beds in institutions and hospitals (2019 or nearest year)

Source: OECD 2021

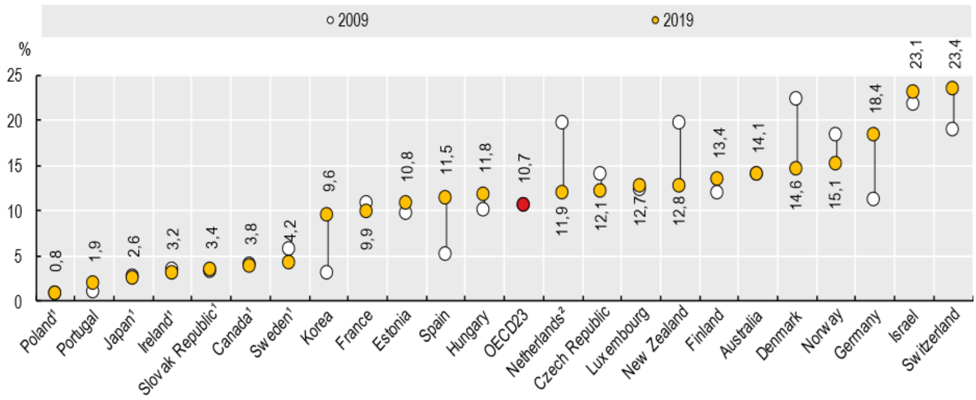

Figure 2. Changes in the ratio of LTC beds for older people per 1,000 population aged 65+ in the decade 2009–2019

Source: OECD 2021

institutionalisation that makes care inadequate. It is the problem of its minimal scale and lack of progress (see: Figure 2) that causes care services to be neglected in Poland. Statistical data indicate a serious shortage, including the needs of those undisputedly requiring residential care

In the face of supply constraints in inpatient care, home care remains an option, where care and nursing needs (as measured by Activities of Daily Living – ADL and instrumental Activities of Daily Living – iADL indices) can be dramatically unmet in many countries. In Poland, these unmet needs affect 70% of older people who are frail, and this percentage is even higher when the range of needs is greater.

The above data clearly indicate that at the current stage of socio-demographic development in Poland, there is a need to increase access to formal care services, both institutional and community-based. Given the low level of development of services in any

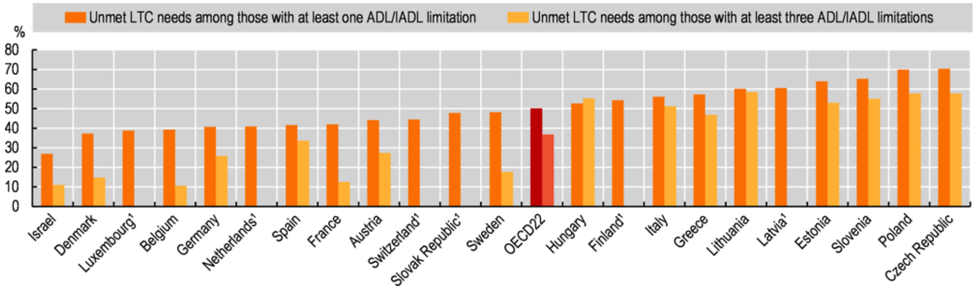

Figure 3. Unmet long-term care needs among people aged 65 and over living at home, 2019–2020

Source: OECD 2021 based on SHARE, wave 8 (2019–2020) formal form, deinstitutionalisation, understood as the replacement of inpatient services by community-based services, in Polish conditions may result in a deterioration of access to any support in caring for dependent older people (Abramowska-Kmon et al., 2022).

Conclusions

Implementing the idea of equal rights for all people, including those unable to live independently, required the initiation of investment in creating appropriate capabilities. This process involved two main routes: on the one hand, the preventive route, and on the other, the emancipatory and supportive route to achieving independence in cases of limitations. The prevention of dependency is not the main topic of consideration in this text. It is a very broad one, both a subject of public health and many other areas of social science. In this paper, we are concerned with mitigating the limitations of dependency that have already arisen and, above all, with creating living conditions that allow dependent people to participate in the life of the community in a good way.

The ideal site to formulate a good life for the well-being of dependent people is, first and foremost, the family and then the community. It is certainly not an institution of collective living. The pursuit of the ideal model is assumed. The family will surround all its members with care and love, including those who have serious deficits in achieving independence. However, the family may be absent or unable to take responsibility for disabled children, the mentally ill or elderly parents in need of care. Furthermore, in view of the socio-demographic changes of the population in Western countries, the modern family can only perform care services for dependents to a limited extent.

When the possibilities for a family-based solution are limited, deinstitutionalisation means *de facto* replacing large and often closed care organisations with smaller ones which are locally rooted and open to local communities, taking advantage of their local potential for social activity. Deinstitutionalisation in this sense means investing in the creation of a network of small facilities, tailored to different types of dependency and to the different life courses of individuals whose needs might not simply occur episodically, but rather demand a lifetime of care.

There are various arguments in favour of creating networks of small, local, and open care institutions. However, these arguments are not always comprehensive, encompassing the various aspects of the problem. Furthermore, even when justified singularly, they are not always sufficiently convincing or documented. We list them in the order they most often appear in reports on deinstitutionalisation.

Firstly, the redevelopment of care institutions is justified by the higher operating costs of large institutions compared to smaller and quasi-family institutions. The economic argument is sometimes decisive in the practice of taking steps towards the reconstruction of care institutions. It is generally accepted that a network of many smaller centres is a cheaper solution than large collective residential (and therapy) homes for dependent people. However, the argument of lower costs is questionable. Yes, a small facility is cheaper than a large one, but a network of small facilities may be more expensive than one collective facility for the same number of people (the phenomenon of lower unit costs according to scale).

In addition, the costs of operating care facilities depend significantly on therapeutic needs, which tend to be higher when dependency is accompanied by health problems requiring medical care and systematic rehabilitation. A review of the comparative literature on the operation of institutions, e.g., for people with intellectual disabilities (see: Mansell et al., 2007, Beadle-Brown & Kozma, 2007) and research in the UK (May et al., 2019) indicates that lower costs are not an obvious argument for moving towards deinstitutionalisation. Undertaking a process of so-called deinstitutionalisation often means, in practice, the need for investment: building a network of small centres in places where no such facilities previously existed. In the past, dependent people were usually placed in large collective facilities away from the urban centre.

A crucial argument for the desirability of undertaking institutional redesign in dependent care **concerns the quality of care**. The advantage of smaller facilities is indisputable as an opportunity for more individualised care, nursing and possible therapy. This does, however, mean that there is a need to prepare a larger pool of service providers with a diverse range of skills: from carrying out supply, cleaning, and supervision work to specialised psycho-educational and medical care. Practice shows that staff shortages are a very serious barrier to the development of small facilities, e.g., for people with mental disorders. While it is always possible to involve volunteers recruited from the local community in care work, this requires the preparation of those willing to provide care (checking capacity and teaching appropriate skills); this is also true when family members are involved. More professionalism is now being demanded of support activities for dependent people because of increasing biological, psychological and pedagogical knowledge, and is also supported by medical research. Voluntary activities can be of great help in providing daily living and organisational services, but they cannot replace the necessary professional services (psychological, pedagogical, health rehabilitation and therapeutic activities), which are provided within the framework of standards and formal regulations.

Another argument raises the local community's responsibility for its societies and its ethical right to benefit from its human resources and social ties. This is linked to the recognition and respect of the **principle of subsidiarity**[13], in which a fundamental role is given to the institution closest to it – the family, and when it does not exist or does not fulfil the care and existence functions for its members – to the people from its immediate surroundings: friends (and relatives), neighbours, local organisations and professional groups or those connected with a common type of social activity. In the era before the development of nation-states, it was natural for caring behaviour to develop in the local community, involving abandoned children, the disabled and the elderly. After two centuries of development in Western societies, traditional local societies are rather disappearing. Their reconstruction requires purposeful action and consistency.

Small locally rooted institutions base their activities on the **social capital of the community**, specifically, the kind of social capital that is both bonding and bridging,

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[13] The principle of subsidiarity distinguishes Western European countries in terms of recognising the significant role of people's immediate communities in relief and care efforts compared to other countries in the world, most notably the United States (Rimmerman, 2017).

a distinction introduced by Robert Putnam (2000). This sounds directionally correct but given the current trend towards individualisation of life and the fact that in countries newer to capitalism social capital is not a common and obvious phenomenon, it cannot, therefore, bring benefits on a mass scale. The presence of social capital can neither be decreed nor programmed. It requires a longer process of coherent interaction between the basic actors of social life: family, school, church, media and public authorities. Individualisation, competition, and a focus on cost-effectiveness, which are needed in the economic sphere, do not work in the care and upbringing of people with developmental deficits and disabilities.

Local government is supported by social activism and **voluntary organisations**. Treating them as partners, not competitors, strengthens local government, but also requires real support for socially useful activists and organisations, not ones that represent influential particular interest groups. Without this, social capital does not develop, and this is essential in building trust and motivating people to be appropriately active in caring for dependent people. Without this, people organise care privately, often informally and with large defects regarding quality. These phenomena have been described not only in Poland, but also in other post-socialist countries (see: Kubalčíková & Havlíková, 2016; Zaviršek, 2017; Kuuse & Toros, 2019).

The effectiveness of care institutions for dependents in small communities relies on **strong local territorial self-government**: capable of decision-making, adequately resourced and supported by national government. Local self-government is not always recognised as a public value by those in power. In countries with young democracies, the autonomy of local territorial structures is sometimes seen as a political threat to the national government's power. In addition, in the presence of sharp political divisions falling at the level of local government, ambiguity and distrust arise. This in turn causes local government to be perceived as an insecure support. Research conducted in Poland by the Batory Foundation (Gendźwiłł & Wiszejko-Wierzbicka, 2022) points to the paradox of declaring strong support for local self-government with the simultaneous conviction that without the intervention of the central authority, the actions of local self-government may be too weak and ineffective. At the same time, some of the central authority's actions or failure to act despite its competence are assessed as a threat to the favourable course of affairs, e.g. regarding the natural environment or education.

Organising care for dependents in the local community requires **adequate resources** and multi-level and multi-sectoral **coordinated work** (at the very least, linking social, health and educational matters), and consequently decisive local government measures, which combine and transcend territorial boundaries and sectoral competences. Waiting for decisions from the central government means a long rule-making process, fraught with battles over priorities along the way, which is not always successful.

Recommendations

The movement towards deinstitutionalisation proposed in social policy for dependent people, meaning *de facto* re-institutionalisation rather than deinstitutionalisation (Grewiński & Lizut, 2022) requires extremely careful implementation. Redevelopment should not be a spontaneous action and should not throw the baby out with the proverbial bathwater.

For this process to advance successfully, it is necessary to have well-developed and socially accepted strategies and a clear legal framework for both national and local action and for each type of dependency, including small children, people with disabilities, the mentally ill and the elderly.

The development of national strategies for the process of re-institutionalisation of care for dependent people should be based on:

- a broad identification of regional and local needs for the support of dependent persons considering a longer-term perspective (forecasts), based on existing and developing databases of demographic and public health statistics as well as specially created collections of information;
- a development of small and open care facilities for all types of dependency, considering living conditions, hygiene and staffing standards;
- developing training for carers of dependent persons at various levels of schooling and adult education: secondary vocational, post-secondary and higher vocational education;
- identifying support for developing networks of facilities and coordinating their operation in various areas (supra-regional and beyond) and in many sectors (educational, social and health);
- identifying sources of funding and payment rules for living and care services for dependent persons;
- preparation of a legal framework of the duties of current and designated carers of dependent persons, as well as assessment of their capabilities, skills and supervision.

The complement to the national strategies and legal framework of the rebuilding process of care institutions for dependent people should be parallel local plans and programmes adopted by the municipal and city councils on medium-term development. Although local development plans are not obligatory in Poland, the need to develop and establish them has gained recognition over time, as was strongly expressed during the Covid-19 pandemic (OECD 2021).

The preparation of parallel local plans requires expertise and information, especially:

- local government offices having appropriate units to diagnose and monitor the demographic and social situation of their inhabitants in terms of their ability to live independently;
- carrying out an analysis of the real estate and infrastructure available for re-institutionalisation programmes, taking into account local spatial plans;
- preparation of investment (and renovation) projects for the development of small care and therapeutic facilities for dependent persons in the given local community, considering the needs and cooperation with municipalities in the neighbourhood;
- preparation of plans for financing the above-mentioned investment projects with applications for funding from relevant national, regional and EU funds – also taking private funds into account;
- preparation of a plan for the employment (with the involvement of the district employment office) of persons able to carry out care and therapeutic work in the facilities to be created;

- preparation of actions to increase the social activity of inhabitants (among other things, as volunteers) who are able to cooperate in care work, inclusion of young people and the promotion and propagation of social and caring attitudes;
- implementation of organisational solutions that enable coordination of care activities, including among educational and health institutions within the created networks and outside the established structures.

To conclude, a general remark. Re-institutionalisation is a process, not a one-off "renovation" or modernisation. Before old homes are demolished, new homes need to be built and the right staff need to be educated and employed so that residents can not only be brought into the home but also provided with the services they need. That is why special attention and care are required to modernise old facilities when a network of new and smaller ones has not yet been established and when the resources needed have not been put in place. In the care of dependants – children, the mentally ill, the disabled and the elderly – waiting for a "better" solution can simply mean failing the current, actual individuals in need.

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