National Deinstitutionalisation Strategy of the Republic of Macedonia for 2018–2027 'Timjanik' & Action plan

The Republic of Macedonia
Ministry of Labour and Social Policy

English translation of the National Deinstitutionalisation Strategy of the Republic of Macedonia for 2018-2027 'Timjanik', as adopted by the Government

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CONTENTS

PREFACE

The National Deinstitutionalisation Strategy of the Republic of Macedonia 2018–2020 'Timjanik' and its Action Plan were developed with financial and technical support of the European Union through a participatory and consultation process that was implemented by means of a large number of meetings, discussions, debates and conferences. These events were organised at different stages of the Strategy development – from analysis of the current situation identification of the challenges and priorities to formulation of the final text.

Extensive support and contribution was provided by many activists and disabled persons, experts, practitioners and academics, public and political figures, and all those who are interested in development of human resources and deinstitutionalisation policy in the Republic of Macedonia.

Day-to-day management of the Strategy development was implemented by four Working Groups established by the Ministry of Labour and Social Policy, guided and supported by two experts acting within the EU Technical Assistance project implemented by *Agriconsulting Europe S.A*. (Belgium) - AESA.

This first draft of the Strategy was produced in January 2018 presented to the key stakeholders including national authorities, residential institutions, social service providers, development partners, experts and other players in the field of education. Based on their recommendations and comments, the initial draft version of the Strategy was reviewed, and a further improved version was presented for public debate in May – June 2018.

As part of the public debate, discussions were held at the Commission on Labour and Social Policy at the Parliament of the Republic of Macedonia, the Faculty of Philosophy in Skopje and the municipalities of Kavadarci, Strumica and Bitola. All interested citizens had an opportunity to send written comments electronically.

The final version of the National Deinstitutionalisation Strategy of the Republic of Macedonia 2018-2027 reflects comments and recommendations received during the public debate. This participatory approach shall become one of the most important guarantees for the successful implementation of the Strategy.

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This Strategy bears the name 'Timjanik' in the honour of the citizens of the Village of Timjanik, in the Municipality of Negotino, who supported the establishment of a small group home for children with intellectual disability in their community during the finalisation of the document (Summer 2018). Contrary to the initial reluctance, the citizens of Timjanik accepted and welcomed their new neighbours, becoming a role model of a community offering inclusion and equal opportunities for all.

LIST OF ACRONYMS

Banja Bansko	Rehabilitation Institution Banja Bansko
GoRM	Government of the Republic of Macedonia
CSO	Civil society organisation
Demir Kapija	Special Institution Demir Kapija
HISC	Home for Infants and Small Children (Bitola)
EU	European Union
CRC	UN Convention on the Rights of the Child
CRPD	UN Convention on the Rights of Persons with Disabilities
MoH	Ministry of Health
MoES	Ministry of Education and Science
MoLSP	Ministry of Labour and Social Policy
Topaansko Pole	Rehabilitation Institution for Children and Youth Topaansko Pole
11 Oktomvri	Children's Home for Children without Parents and Parental Care '11 October'
25 Maj	Public Institution for Fostering Children with Social Problems and Disrupted Behaviour '25 May'

1 INTRODUCTION

1. The National Deinstitutionalisation Strategy of the Republic of Macedonia for 2018–2027 'Timjanik', presents the vision, the objectives and strategic approach of the Government as well as actions to be advanced in the implementation of the transition from institutional care towards a system of social care in the family and community supported by social services.

1.1 BACKGROUND

2. The period of implementation of the National Strategy on Deinstitutionalisation 2008–2018 is at the very end. This National Deinstitutionalisation Strategy 2018–2027 'Timjanik' takes into account of this past strategy, but it extends the focus and offers a comprehensive overview of the social service sector in the current context. It identifies the present challenges and includes an Action Plan with a logical sequencing of actions. The past strategy paved the way for new developments and has achieved a certain number of favourable results both in terms of resettlement of residents from residential institutions into the community as well as in terms of establishing new services. It has also had a role in guiding some reforms of the legal framework and social service system. However, the National Deinstitutionalisation Strategy 2008–2018 did not attain all the goals set and, after an initial impetus, the activities have subsided over the last years. In addition to the comprehensive analysis of the present situation, this new National Deinstitutionalisation Strategy 2018–2027 is also based on a thorough evaluation of the results achieved in the implementation of the previous strategy.

1.2 METHODOLOGY

3. This Strategy is owned by the Government of the Republic of Macedonia (GoRM), and the development and consultation was led by the Ministry of Labour and Social Policy (MoLSP). The consultation process has involved all relevant line Ministries and agencies: MoLSP and their affiliated structures, social and educational institutions, residential institutions, social service providers, civil society organisations (CSO) and the donor and development partners. They have all contributed with information, ideas, comment and inputs which have shaped this document.

4. Work on the comprehensive Situation Analysis and Assessment/Evaluation Report of Implementation of the National Strategy on Deinstitutionalisation 2008–2018[1] was conducted from April to November 2017. This study, along with the *Common European Guidelines on the Transition from Institutional to Community-based Care*[21] of the European Union (EU), provides the base of this strategy, and both documents contain relevant detailed data and information.

5. Identification of the challenges, priorities and measures was done by:

   a. Assessing needs of the vulnerable groups exposed to the risk of institutionalisation, assessing the situation in the residential institutions and of the process of resettlement from them, assessment of relevant policies and services in the community and by assessing the contextual implications for the deinstitutionalisation.
   b. Review of relevant national and international documents, research on the relevant issues, compiling and analysing the existing data and the information that was accumulated by field visits, interviews, organised and spontaneous discussions as well as practical training activities and a student camp[3] in the Special Institute of Demir Kapija.
   c. Applying an active approach, advocacy and dialogue with all the parties involved thus enabling a transparent process and extensive involvement of stakeholders including residential institutions and their residents, CSOs, community services, services users and their relatives, development partners and other actors.

1.3 STRUCTURE

6. The document covers two diverse but complimentary aspects of deinstitutionalisation as a policy:

   1) The strategic pillars – goals of the very process of deinstitutionalisation which are:
      a. transformation and closure of the institutions,
      b. resettlement or residents into community,
      c. development of the community services,
      d. prevention of institutionalisation;

   2) Strategic tools – policies and measures to support this process: coordinated and complementary public policies, social inclusion and capacity strengthening.

   The structuring is done in a way that provides a review of the situation and past achievements, identified challenges, priorities and objectives. The priorities and objectives were then used as grounds to formulate the action plan, presented as an annex to this document.

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1 Flaker, V., Krstovski, V. (2017) Situation Analysis and Assessment/ Evaluation Report of Implementation of National Strategy on Deinstitutionalisation 2008–2018. Technical assistance support for the deinstitutionalisation process in social sector (EuropeAid/132633/C/SER/MULTI) European Union project; Skopje: A.E.S.A. Consortium & Alternative Consulting

2 European Expert Group on the Transition from Institutional to Community–based Care (2012) Common European Guidelines on the Transition from Institutional to Community-based Care (Guidance on implementing and supporting a sustained transition from institutional care to family-based and community-based alternatives for children, persons with disabilities, persons with mental health problems and older persons in Europe), Brussels. [On line] Available at: deinstitutionalisationguide.eu/wp-content/uploads/2012/12/2012-12-07-Guidelines-11-123-2012-FINAL-WEB-VERSION.pdf

3 The student camp provided opportunities for the Professors and students from the University of Ss. Cyril and Methodius together with the University of Ljubljana to work with the Director and staff of the Special Institute of Demir Kapija in assessment of residents' needs and assessment of the state of play in Municipalities to provide support to community based housing and community based services.

1.4 TERMINOLOGY

7. In this document, the term *social protection* is used to signify the greater and wider system of social welfare and protection and *social care* refers to the system that is intended for direct care and support of the users of the system. The term *persons with disabilities* is used in wider meaning including also people with long-term mental health difficulties, and people of old age who depend on the substantial support of others. Such usage is in line with a wider interpretation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD)[4], and also in Common European Guidelines. In addition, the target group is sometimes, for the reasons of differentiation and when appropriate, referred to as 'people in need' or 'service users'. The term *group homes* is used as the most appropriate and least misleading term instead of some others that are commonly used. Instead of 'case management', which is most familiar term but outdated, the terms 'coordinated care' and 'personal planning' are used in this Strategy.

1.5 DEFINITIONS

8. Deinstitutionalisation is recognised at international and EU level as the best way to support children and adults with social care and assistance needs. The principle and practice of deinstitutionalisation is contained in a number of international binding agreements such as the CRPD. Deinstitutionalisation is a public good and provides a common benefit as it delivers better care and support for those in need while enhancing users' rights and also contributing to a better quality of life for the whole community and to a better society as a whole.

9. Deinstitutionalisation is defined as *closure of institutions* and *simultaneous development of community social services*. It is an integrated planning process of transforming institutions, reducing their capacity and/or their elimination, with the simultaneous establishment of services in the community, based on human rights standards of performance.

10. The process of deinstitutionalisation also includes:

    – a *change of relations* between professionals and users,
    – acquiring *new social roles* and involvement of users and their active engagement in decisions about their own care and support matching their needs,
    – a *shift of power* from the experts, the professionals and the institutions to the users, and
    – as a *change of understanding (epistemology)* of long-term care.

11. *Institutions* are defined by 'The Common European Guidelines on the Transition from Institutional to Community-based Care' in terms of and in the context of *human rights* and the *dignity of users*, their *quality of life* and *health*, *independence* and *social inclusion*. They are characterised by:

    – the isolation of residents,
    – collective arrangement of the residence
    – the resident's lack of influence over their own life, and the
    – predominance of the interests of the organisation over individual needs of residents.

[4] *United Nations Convention on the Rights of Persons with Disabilities* (2007) [On line] Available at: http://www.un.org/disabilities/convention/conventionfull.shtml

Institutions are characterised by a high number of residents in large buildings, but even more so by the institutional culture. Even if the structure is small, it can bear the characteristics of an institution or a user's experience of an institutional life.

12. Deinstitutionalisation is based on the realisation that institutional care is *harmful*, *ineffective*, an *unethical* solution which *violates human rights*.

13. *Trans-institutionalisation* occurs when residents from one institution are transferred to another institution usually due to the inability of the community services to meet their needs. *Re-institutionalisation* is a process that can be detected at the personal, organisational or system level. At the personal level it is when a former resident of an institution returns to an institution after a time in the community. At the level of an organisation, it not only refers re-admission and increase of number of residents in an institution, but it also involves a reversal to a rigid and closed system. Also, re-institutionalisation at organisational level occurs when group homes, day centres and even the individualised care provision arrangements acquire more and more institutional features. At the system level, re-institutionalisation means that, after a period of diminishing capacities, there is an increase in the number of places available in a state run institution.

14. A basic dimensions of deinstitutionalisation is the transition from institutional to *community (based) care*. Community care is not just a change of location, it is also a profound change of the way services are provided. It implies a communal process, the participation of diverse providers, the assertion of human dignity, user empowerment to assume various roles and to lead an ordinary life. It means the right of a user to *be included in the community*, as emphasised in UNCRPD, article 3:

    "relates to the principle of full and effective inclusion and participation in society ... living a full social life and having access to all services offered to the public and to support services offered to persons with disabilities to enable them be fully included and participate in all spheres of social life. These services, among others, can relate to housing, transport, shopping, education, employment, recreational activities and all other facilities and services offered to the public, including social media. The right also includes, having access to all measures and events of political and cultural life in the community, among others public meetings, sports events, cultural and religious festivals and any other activity in which the person with disability wishes to participate."

    Hence, from the rights perspective, community care means not only provision and access to services in the community, but above all a full social life, access to all society's amenities and support to participate in personally meaningful activities.

15. *Independent living* is the key concept and the major goal of deinstitutionalisation.

    "Independent living or living independently means that individuals with disabilities are provided with all necessary means enabling them to exercise choice and control over their lives and make all decisions concerning their lives. Personal autonomy and self-determination is fundamental to independent living, including access to transport, information, communication and personal assistance, place of residence, daily routine, habits, decent employment, personal relationships, clothing, nutrition, hygiene and health care, religious, cultural and sexual and reproductive rights. These activities are linked to the development of a person's identity and personality: where we live, with whom, what we eat, whether we like to sleep in or go to bed late at night, be inside or outdoors, have a tablecloth and candles on the table, have pets or listen to music. Such actions and decisions constitute who we are.

    Independent living is an essential part of the individual's autonomy and freedom, and does not necessarily mean living alone. It should also not be interpreted solely as the ability of carrying out daily activities

by oneself. Rather, it should be regarded as the freedom to choice and control, in line with the respect for inherent dignity and individual autonomy, as enshrined in article 3 (a) of the Convention. Independence as a form of personal autonomy means that the person with disability is not deprived of the opportunity of choice and control regarding personal lifestyle and daily activities.[5]

16. Independent living is not to be misunderstood for absence of dependence on support of another; it means quite the opposite – the need of support to live independently and to have control over the needed support. It is 'independent living with support' and refers also to *independent community living*.

17. *Person centred care* is the main avenue of achieving independent living. One of the main objectives of deinstitutionalisation is to organise and establish services that are tailored to the needs of each person and to replace the total and standardised response of institutions.

    "Traditionally, support has been provided in a service-centred way; that is, trying to fit the person into existing service options. Instead, the needs and preferences of the person and the child should be at the centre and the support should be tailored to their individual situation and should offer personal choices. This means that users and families should also be actively involved in the design and the evaluation of services."[6]

18. Deinstitutionalisation and development of community services require new ways of planning, organising and funding services for the person - user, in order to provide the required support in their ordinary environment. New methods of planning and providing care are based on the tradition of classical 'casework', by diverting resources previously held by institutional care system to community services and individual users, providing support workers, stronger organisational framework and a comprehensive approach. 'Case management', 'care management', 'independent brokerage', 'personalised care packages' and others are types of care provision developed to personalise care support. They take in consideration the individual human needs, ambitions and wishes, tailor the care to each individual and increase the choice, control and power of users themselves.

19. The main tool of personalisation or person centred care is *personal planning* (to be distinguished from 'individual planning'). It is a proactive, empowering method, based on person's goals, accepting the user's perspective, and seeing the user from the *strengths perspective*, as competent and able and an approach which supports and is enabling him or her to achieve a desired quality of life.

20. *Group homes* are a necessary part of deinstitutionalisation. They should, however, not be seen as "the default solution that presumes to embody the principles of the right to live in the community"[7]. More efforts should be invested in removing barriers in the environment, providing accessible housing, and developing supported living arrangements, as well as alternative family-based care options for children.

21. *Day-care centres* for adults and older people provide advice, support, meals and some aspects of personal care, as well as social and cultural activities. For older and especially frail people, they may be of considerable advantage as they can be effective in combating loneliness and isolation.

22. *Long-term care* is a relatively new outlook on organising and funding services to people who need continuous, comprehensive, organised and coordinated care. It emphasises the right to live in the community, promotes the independent living approach and secures the dignity of people in long-term need of support and assistance. Long-term care posits the personal priorities in the foreground of users and is grounds for integrated, continuous and coordinated provision of social, health and education services.

5 Cf.: Common European Guidelines
6 Cf.: Common European Guidelines
7 Cf.: Common European Guidelines

1.6 LEGAL BASIS FOR DEINSTITUTIONALISATION

23. Deinstitutionalisation is an aim and objective laid out in international and European Conventions, Treaties and documentation. CRPD provides the right of persons with disabilities to independent living and inclusion in the community including equal access to community services and facilities (Article 19). The UN Convention on the Rights of the Child (CRC) states that: '*State Parties shall take all appropriate measures that the child is protected against all forms of discrimination or punishment…*'(Article 2); '*in all actions concerning children... the best interest of the child shall be the primary consideration*' (Article 3); Article 19 refers to appropriate social programmes, and Article 23 refers to the rights of children with disabilities including the right to '*recreational opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development*'. The EU Charter of Fundamental Rights, part of the EU Treaties, sets out the right of persons with disabilities and older persons to live independently (Articles 26 and 25 respectively) and the need to act in the best interest of the child in all actions (Article 25). The European Convention on Human Rights provides that non-one shall be subject to inhuman or degrading treatment or punishment (Article 3) and reaffirms the right for respect private and family life and home (Article 8). The European Disability Strategy 2010–2020 presents the EU commitment to promoting the transition from institutional to community-based care offering EU funds to support the development of community based services.

24. Macedonia is bound and committed to realise deinstitutionalisation as it has signed and ratified the above stated UN Conventions and the European Convention on Human Rights. Macedonia is committed to the process of EU accession and thereby is taking active measures to accord with EU principle and practice.

25. In addition to this National Strategy on Deinstitutionalisation 2018–2027, Macedonia has a number of other strategies of relevance and in support of the deinstitutionalisation including – the *National Strategy for Equalisation of the Rights of Persons with Disabilities (Revised) 2010–2018, National Strategy on Equality and Non-discrimination 2016–2020, Strategy for Demographic Policies 2015–2024, National Employment Strategy 2016–2020, National Strategy for Old People 2010–2020, National Strategy for Reduction of Poverty and Social Exclusion in the Republic of Macedonia (revised 2010–2020),* and the *Employment and Social Reform Programme 2020.*

26. The national legislative provisions that provide a legal basis for the deinstitutionalisation are presented in Section 7 of this Strategy.

1.7 INTERNATIONAL EXPERIENCE IN THE FIELD OF DEINSTITUTIONALISATION

27. The process of deinstitutionalisation began after the World War 2. After successful implementation of deinstitutionalisation in some countries across Europe and internationally, it has increasingly become an accepted global policy and is recognised as the best means to assure service user needs and rights: deinstitutionalisation has brought a greater quality of life of users, a greater level of services, improved user well-being and encouraged user involvement in the communities, which on the other hand became more lively, inclusive communities – at virtually the same costs.

28. Experiences in countries where deinstitutionalisation has been implemented show that it takes time to transform all institutions, but it also has shown that the process needs to be implemented swiftly and decisively. The setting up community services alone is not enough, this must be accompanied by an active and efficient transformation and closure of institutions. For prompt, effective and successful deinstitutionalisation, a solid political will over the short, medium and long-term periods is needed as well as an active, inclusive and

democratic leadership of institutions. Also required are: quality (re)training of staff and service providers, new methods and organisational structures, the participation of civil society, a strong coalition in favour of deinstitutionalisation from all stakeholders; involvement of users, a commitment to users' rights and service user empowerment, and a coordination of activities, good monitoring and routing processes based on evaluations and research.

2

VISION, GOALS AND OBJECTIVES OF DEINSTITUTIONALISATION

2.1 VISION OF A NEW SYSTEM OF CARE AND SERVICE SUPPORT

29. The Vision of this Strategy is a *system of social service delivery based on a human rights approach that promotes the rights, inclusion and dignity of users*. Starting point will be recognition of the *individual users' needs*, life priorities and desires, and the overarching principle will be to *empower* and support the users to *exercise their will* and to have *control over their life* including the *services* they receive. Personalisation, social inclusion, support for an independent life, enabling service users to live an ordinary life shared with other people will be the criteria of effectiveness and success.

30. Practically in the future system there will be no more residential care institutions – they will undergo a transformation process and will have a new role in the social protection system, while residential care will be supplanted by community support services and community based living services. There will be some small residential facilities (it is recommended not more than six residents living in a housing unit) for short, medium and long periods of accommodation. The preferred solution will be that people with support needs will live in *their own homes;* or accommodated into new homes, i.e. community based accommodation with support (for residents resettling from institutions, people moving on from their parents etc.).

31. People in need (ex-residents, service users and others) will be fully integrated and included in productive, cultural, social and leisure activities. They will be supported and enabled to take care of everyday activities such as housework, personal care, errands, transport, communication and others. They will be part of various social networks of kinship, neighbourhood, peer groups, interest and support groups etc.

32. The community support will be made possible by: a) direct personal support, b) organising settings that will enable inclusion and engagement and c) through indirect interventions thereby either strengthening solidarity in communities and the position of service users in them or by statutory measures providing the means needed for improved quality of life of users.

33. The backbone of a new system will be *personalised care and support* services well integrated at all levels, flexible and able to adapt to change and new needs, well-managed and transparent as well as cost-efficient. *Personalised care and support services* such as:

- *coordinated care* and *personal packages* for users with intense and complex needs to be delivered by different carers;
- *personal assistants* and *family assistants* for children and adults with disabilities and for users with intense and relatively complex needs;
- *home care and home help* for users with relatively simple needs or response;
- simpler and less intensive support services (accompanying or light personal assistance support, counselling, casework, outreach, mobile services, social catering and others), as a part of more complex services or distinct single services.

34. *Residential services* such as accommodation in small group homes will be available when desired or needed by users or in the case emergency or urgent need (e.g. in cases of „insupportable" home conditions – experience of violence, poverty). Such provision would be for short and temporary residence or, in case of prolonged accommodation needs, with the personalisation of a new environment to the maximum extent. Sheltered or supported housing and accommodation should be preferred solutions.[8] In some cases possibilities for domestic, regular life with others (such as living with another family, foster care (children), cohabitation) will be used.

35. Access to work opportunities and creative leisure activities will be provided in two ways: through individual involvement, with the support of personal assistants, in activities of employment organisations, associations and spaces for social activities and social life; or by providing opportunities for group and community socialisation and community based actions (day centres, social clubs, workshops; social enterprises and cooperatives, training programmes , users' associations and cultural and sports groups, etc.). Such activities have to be created with the prevailing influence of users and the engagement of the general public and the community.

36. The Community itself should also become a care provider based on the needs of its community members and by employing micro-projects of services and activities that would serve the whole community and for the common good. In this way the community will develop better understanding about social inclusion and the value of persons from vulnerable groups as equal members of the community.

2.1.1 BASIC FEATURES OF THE PROCESS

37. The Government led process should be implemented with dedication. It will require dialogue with and of all involved stakeholders, but placing the user at forefront. The process is to take into account the realities on the ground to be based on empirical data and local experience.

38. The starting point is identification of the needs and available resources, and work on simultaneously transforming and closing down of residential institutions and establishing of new services in the community. The necessary management, legal and material basis for implementation of deinstitutionalisation must be established. The creation of mechanisms for monitoring, and systematic, periodic audits in order to allow flexibility and corrections of the activities or ways to achieve the main goals.

[8] The expressions 'sheltered', 'protected' housing or 'housing with organised support' should retain its standard linguistic meaning and be reserved for personalised solutions that enable community based independent living and not as a euphemism for group homes or any other collectively organised residential facilities as it is now currently understood. Otherwise we can extend the meaning to the extreme and rename the existing institutions, since they also provide 'organised accommodation with support'.

39. The general platform of change applies to institutions and services intended for adults under 65 years of age. In the general, it is applicable to all age groups and users or social service need people may have. For old people a special, in-depth dedicated study and sub-strategy would be needed in order to map out, in more detail, the specific transitional process that would reflect and address specific issues of their life period – namely the fact that the persons are over the age of 65 years.

40. Deinstitutionalisation of old age homes cannot be based chiefly on a process of resettlements; it is necessary to provide tailored and quality community based social services also to old persons In particular it is necessary to create new services that will allow old people to remain at home and live a dignified and socially integrated life (such as via sheltered housing, intensive nursing at home, online and distance care, intergenerational activities, mutual and informal help, community projects, etc.).

41. Residential institutions for children and youth should be replaced by an intense support for family, family-like placements where intensive support will be available. Mechanisms should be established of intensive professional support and assistance for inclusion of children and young persons into them. In particular children should be enabled to live with their peers, attend regular schools and participate in community leisure activities.

2.2 MAJOR GOALS IN THE DEINSTITUTIONALISATION PROCESS

42. The process of deinstitutionalisation consist of basic pillars of transformation of institutions and policy measures required to enable the transformation:

Basic pillars of transformation – main goals	**1) transformation and closure of institutions**	**2) resettlement of residents to community**	**3) provision of community services**	**4) prevention of institutionalisation**
Policy measures accompanying, supporting transformation	**1) coordinated, resolute policies, 2) changes in legislation, 3) change in financing: redirecting funds from institutions to community services; 4) social inclusion and enabling the systems of social care, education and health, 5) provision of social housing, 6) new approaches and methods, 4) new standards of quality, monitoring and development of community services, 8) training and enhancing capacity of the staff , 9) awareness and advocacy, 10) services lead by users; 11) piloting of new initiatives and methodologies**			

43. A reformed legislative framework and system needs to be created, reorganisation facilitated, resources redirected and reallocated. New approaches and methodologies for service provision will be required and additional new services established. The system and the services need to meet the needs and wishes of users and provide appropriate responses to their personal and individual needs and to facilitate and support individual users to achieve their life goals.

44. After accomplishment of the deinstitutionalisation there will be available residential services providing accommodation combined with care and support, day services providing meaningful activities and community participation and personal services providing personalised support as service users would need. The main residential provision will be sheltered housing (with individual tenure) and care in a host family (foster care for children) and to a smaller degree board and lodging with elements of care for adults. A small number of short term residence placements in group homes will be needed for crisis situations, as well as

for transitional residence for resettlements and later for training and rehabilitation, a very small number of places (app. comparable to present number, i.e. 100) in prolonged residence (group homes). For the day activities there will be day centres and clubs providing services to adults and children and there will be work cooperatives and social enterprises enabling users to enter into the work situations. Personal services will be provided in the form of personal assistance, family assistants (supported by professionals), through personal care packages and coordinated care, home care combined with tele-care, supported employment and various services of low intensity (escorting personal assistance and other support). These services will be complemented by counselling, advocacy and outreach centres and by micro community projects and other measures enhancing community solidarity and inclusion.

3

NATIONAL CONTEXT

45. Macedonia is a landlocked country with an estimated population of 2,07[9] million inhabitants and 25.713 km2 surface.

46. Macedonia is heavily urbanised: urban municipalities accommodate more than three quarters of the population. It is estimated that few hundred thousand citizens live in the diaspora.

47. The share of population over 65 years is steadily increasing – from 11,2 % in 2006 to 13,3 % in 2016. The dependency rate is decreasing (from 47 in 2006 to 42 per 100 inhabitants in 2016) while old age dependency ratio has increased in the same period from 14,5 % to 18,7%.

48. The country has achieved relatively stable growth over the last 15 years elevated its status from lower-middle in 2000 to upper-middle income economy. Among 188 countries, Macedonia ranked 82nd in 2016 (stepping back from the 81st kept in 2014 and 2015) and is in the group of the countries with high human development.[10]

49. The poverty indicators showed a slight improvement during the last 5–6 years: the poverty headcount ratio decreased from 26,8 % of population in 2010 to 22,1 % in 2015.[11]

50. In 2016, employment rate of persons between 15 and 64 years of age was 49,1%, which is an increase of 11% compared to 2009. Still, the employment rate for youth (between 15 – 24 years of age) is small and up to 16,2%. [12]

51. The unemployment rate has decreased from 32,3% in 2009 to 23,4% in 2016; it is twice as high for young people (46,4%). The average time of transition from education to work among young people is 6 years (71,6 months).[13]

52. The educational system in Macedonia is well developed, except of the low rate of children included in the nursery or pre-schools. Inclusion of children with disabilities has had some initial results however there are still considerable difficulties to access mainstream education. The new comprehensive Education Strategy 2018–2025includes measures to advance inclusive education.[14]

9 According to the last census from 2001.
10 UNDP, Human Development Report 2015.
11 World Bank, Global Poverty Working Group,
12 State Statistical Office, Labour Force Survey 2016
13 National Employment Stratgy of the Republic of Macedonia 2016-2020.
14 Comprehensive Education Stratgy 2018-2025.

53. Health care is provided by a public network of Health Centres and regional hospitals. Access to primary health facilities is 90,2 %. Health statistical indicators (such as child mortality rates, death due to chronic diseases, life expectancy) are showing an improving trend.

54. The civil sector has been growing in importance and size in the last decades. There are civil organisations which have existed before the change in the system in the 1990s, which tend to have a large representation and membership. More recently established CSOs are generally smaller, but can have a very important in impact in particular in respect of advocacy and public awareness raising.

55. Macedonia is committed to the processes of Euro-Atlantic Integration and the process of accession to the European Union (EU). The country concluded the *Stabilisation and Association Agreement* in 2001 and the candidate status was awarded in December 2005. In June 2018, EU set June 2019 as a date for starting negotiations with Macedonia, provided that key reforms are intensified.

4

REVIEW OF THE CURRENT SITUATION REGARDING DEINSTITUTIONALISATION

4.1 NEEDS

56. People's needs are the basis and starting point for deinstitutionalisation and of establishing personalised community based services. The type of needs to be observed in the transition process already are different: housing, work and income, participation in everyday activities (including cultural life, leisure and social activities), social contacts and interaction, emancipation as well as the combatting of social stigma, stress management, etc.

57. The Common EU Guidelines on the Transition from Institutional to Community Based Care refer to three age groups of persons under care of social institutions and users of services: children, adults and the elderly (older than 65 years). There is a differentiation between children with disabilities (physical, sensory and intellectual) and children exposed to social and emotional distress (emotional and personality difficulties, social deprivation, children without parental care, children in conflict with the law). Similarly, the adults can be divided into people with sensory disabilities, physical disabilities or intellectual disabilities and people with mental health difficulties.

58. There is a relatively small but substantial number of residents living in institutions as compared to the total number of social service users. This Strategy also takes into account and consideration the people in need of support and services who are not in contact with social services.

Table 1: Estimate of number of people in need of support and services

Group	Number of residents in institutional care	Number of registered users	Estimate of number of people with difficulties without contact with social services	Estimate of people in need
Children with disabilities	42	7346[15]	700	8000**
Children with social difficulties[16]	200	8176	800	9000**
Children without parental care	146	1034		
Children with social and educational difficulties	54	5132		
Children in conflict with law		2010		
Adults with disabilities (under 65 years)	356 + 122[17]	19.202	6.400-9.600	21.000**
Adults with long-term mental health difficulties or distress	650 beds	2000–3000**	1.000	4000**
Old age	988	11.544	42.600	54.397*
Total	2358	57.202	700	96.397**

59. It could be estimated that the number of children with different needs (disability or social difficulties) who are not in contact with social services is close to 10% of the total number of children users registered in the services.

60. It is estimated that about 6.400 up to 9.600 persons with disability between 18 and 65 years of age are not in contact with the social services (i.e. between 1/3 and 1/2 of the number of registered persons).

61. There are no available statistics regarding *long-term* mental health users. A rough estimate is that there about 3000 people with long-term mental health difficulties who are in touch with social services. At least a quarter more of population with mental health difficulties are not in contact with social services but are in need of help and support other than purely medical treatment.

62. Research shows that on average there is 17 % of people above 65 years old in need of support and services. For the population of 271.986 over 65 years in Macedonia, it can be deduced that the number of the elderly in need of different types of support and services may be up to 54.397.

[15] The stated number is the number of children with disabilities registered as users of social services at the end of 2016; the number of children recipients of special allowance in the same period is 4.587

[16] Including children victims of domestic violence, dysfunctional families, other children with family problems, children at risk, victims of sexual violence, children on street, children drug users, materially deprived families, chronically ill, etc.

[17] 122 persons with disability are under 65 and accommodated in old age homes

4.2 INSTITUTIONAL CARE

63. There are 34 institutions altogether of which 19 are (small) private and 15 public institutions. They accommodate about 2400 long-stay residents, including the institutions for persons with long-term mental health difficulties. Of those there are 1628 residents in social care institutions, most of those are living in old age homes (1146), much fewer (319) in adult institutions and comparably small number of children living in children's institutions (163).

Table 2: Basic data on social institutions in Macedonia

Institution	Type	geographical location	n. residents	n. staff	residents/ staff
adult institutions			319	237	1,35
Demir Kapija	intellectual disabilities	Demir Kapija	221	134	1,73
Banja Bansko	physical disabilities	Strumica	63	40	1,70
Topaansko Pole	intellectual disabilities	Skopje	35[18]	63[19]	0,74[20]
children institutions			163	161	1,01
Bitola	infants without parental care	Bitola	72	59	1,26
11 Oktomvri	children without parental care	Skopje	45	44	1,02
25 Maj	Social difficulties	Skopje	27	28	0,96
Ranka Milanović	CIL	Skopje	19	30	0,63
Old age homes			1146	442	2,54
Majka Tereza Zlokukjani	old age	Skopje, Karpoš	67	14	4,79
dr. Ivan Vlaški	old age	Berovo	15	7	2,14
Kiro Krstevski Platnik	old age	Prilep	112	37	2,67
Zafir Sajto	old age	Kumanovo	149	41	3,39
Sju Rajder	old age	Bitola	201	38	5,15
25 private old age homes	old age	23 in Skopje, Negotino, Radoviš	602	305	1,97

[18] Topaansko Pole institution has 69 users, however some of them are users - day centre visitors; the institution provides care for 35 residents.

[19] Topaansko pole has employees, however 16 of them are employed at the Allowance for Third Person Care Commission. The table presentes number of employees who work on service provision.

[20] The presented ratio was calculated with a correctd value for the staff - 47, 25, taking into account that a quarter of the staff (15,75) works with 34 users-day care visitors.

social care institutions			1628	840	1,94
psychiatric hospitals			**700**[7]	-	-
Bardovci	psychiatric hospital	near Skopje	300	NA	
Demir Hisar	psychiatric hospital	Southern Macedonia	300	NA	
Negorci	psychiatric hospital	South–East	100	NA	
TOTAL institutions			2328		

64. In 2016, the main source of funding was the state budget allocations. In the public homes for old people the MoLSP finances 40 % of the total budget, the other 60 % is paid by the users.

65. According to the annual financial reports, the total expenditure in the twelve public social protection institutions in 2016 was 311.154.996 MKD (5.059.431 €). The average monthly costs per user (total number of users 1065) is 24,347 MKD (396 €) or the average costs per day is 800 MKD (13 €). There are significant differences in the average costs per user depending on the type and the target group of users in the institutions.

Table 3.Total spending in social protection institutions in 2016

Social care institutions	Total spending	Number of users	Cost per user per month	Cost of services and material %	Labour costs %
adult institutions					
Demir Kapija	70.915.699	227	26.034	39,5	60,5
Banja Bansko	18.578.903	63	24.575	47,2	52,8
Topaansko Pole	32.086.694[8]	68	39.052	43,1	56,9
children institutions					
MIHB Bitola	23.431.112	72	27.119	27,1	72,9
11 Oktomvri	25.392.135	45	47.022	43,7	56,3
25 Maj & Ranka	30.807.032	46	55.810	44,1	55,9
Old age homes					
Berovo	2.932.923	15	16.294	60,2	39,8

[21] For psychiatric hospitals the number of residents is a crude estimate of long-stay patients

[22] For the purpose of this calculation, the total spending of Topaansko pole in 2016 was reduced for 7.000.000 MKD which is the estimated annual cost for the salaries of the employees in the Commission for care and assistance from another person that is operating within the institution (but not included in the 'primary activity')

Zlokukjani	13.015.061	67	16.188	45,6	54,4
Prilep	35.560.000	112	26.458	66,8	33,2
Zafir Kumanovo	28.848.118	149	16.134	61,8	39,2
Bitola	29.587.319	201	12.267	58,2	41,8
All	**311.154.996**	**1065**	**24.347**	**48,8**	**51,2**

All amounts expressed in Macedonian denars (MKD)

66. The institutionalisation rate (number of institution residents per capita) is low, compared to the EU average and, compared to some neighbouring countries, it is extremely low. This low number of people in institutions does not mean that the upcoming deinstitutionalisation process will be easier, but it could be done in a shorter period of time. The second implication of the low institutionalisation rate is that much of the support and assistance currently is undertaken through the informal sector (i.e. family, relatives, the community). The challenge is to find ways to support and improve the support provided in this way thereby preserving the best practice and supplanting the worst with the appropriate community (action) response that will not damage the existing informal support.

67. The State is the dominant provider of institutional care but also of community based services. The initiatives for decentralisation and pluralism in the service provision are still in the initial phases, mostly because of the non-existence of the regulatory mechanisms that could encourage different actors to provide community services, including the possibilities for public financing of the CSOs and private social service providers.

4.3 OVERVIEW OF DEINSTITUTIONALISATION PROCESSES IN MACEDONIA

68. There has been an important experience of deinstitutionalisation over the last twenty years. The results included resettlement of over hundred residents resettled[23] and the creation of a number of new day centres, group homes and of a network of foster carers. Yet the process was of uneven development. The resettlement from the institutions stopped and started a few times and has considerably slowed over the past few years. The goals set ten years ago were not accomplished in terms of numbers of resettled residents, furthermore none of the institutions were transformed completely nor were personalised services or the response by the community adequately developed.

69. It is very important to proceed with determination and expedience in the resettlement and creation of new, culturally adequate services since the need for such support is growing – not only due to an ageing population, but also as a consequence of atomisation or individualisation in society with reduced patterns of traditional family and community level solidarity.

[23] Most frequent were resettlements to group homes which represented more than two thirds (68 %) of all resettlements, while resettlements to foster families represented a little less than one third (28 %). The number of resettlement to original families has been relatively small (4 %).

4.4 COMMUNITY SERVICES: THEIR EFFECTIVENESS AND GAPS

70. Deinstitutionalisation is an explicit dimension of the relevant existing policies (social care, housing, health, education etc.). The existing legal provision allows and provides a legal base for most of the new forms of community based services. The problem is with the mechanisms for the implementation of the policies and legislation. Neither the 'hardware' (i.e. facilities, means) nor the 'software' (i.e. methods, procedures, knowledge and skills) for implementing the transition to the community based services are sufficiently developed.

71. The current funding system for services is based on the financial security of existing service providers. This arrangement does not allow or enable users to be 'purchasers' of the services – by direct public funding or by commissioning services through mechanisms of managed care or any other way that would allow 'the money to follow the service users'. By this virtue the current system is, therefore, fostering a rigid response and curtailing the rights and opportunities of and for users and preventing change and reform of the system.

72. Organisation and management of services (both institutional and community) lacks not so much skill as autonomy of decision-making and creativity and entrepreneurship in innovation – be it for reasons of current custom or administrative and political limitations.

73. There are the basic conceptual knowledge and skills available regarding the deinstitutionalisation. Research in this field has been undertaken. There are gaps in academic education as well as practical training in asserting the users' perspective, empowerment and methods and techniques that would enable personalisation of the service provision (personal care management, independent living, personal assistance, advocacy etc.). Existing support and monitoring is not proactive and propulsive enough. There is monitoring (sometimes in too formal manner) but without much developmental effect.

74. The civil sector has been, in many ways, the carrier and main force of change. Still, CSOs role largely depends on support from international agencies, as well as government decisions. On the other side there is, among the actors and stakeholders, a lot of optimism, enthusiasm and good will to make things happen for deinstitutionalisation.

75. Traditionally there is an evenly spread network of centres for social work[24] across the country, which is a potential and important resource for the community based services. In this aspect, the bureaucratic and guardian orientation of centres for social work should be overcome and the skills inside centres for social work and a mode of working could be developed and modernised in support of creativity, innovation and means to coordinate (manage) and facilitate personalised services in the future.

76. A fair number of new community services (group homes, day centres) were developed and generally they function well. They are unevenly distributed across the country. Some have developed too high a threshold (or demanding entry level requirements i.e. providing only for higher level capacity individuals) and insufficient skills and resources to support people with intense, high level support needs.

77. *Day centres* have played and fulfilled an important role in deinstitutionalisation process up until now and they will be having an important role in the future. In conjunction with foster care and sometimes group homes, they have provided, in many instances, a possibility for resettlement and have been a necessary support for many users that prevented their institutionalisation.

[24] Centres for social work are the core of the social protection system and have two key roles: provision of social services and administration of the social financial allowances.

78. There are 61 day centre facilities across the country, including social clubs and community mental health centres. More than half of them are intended for children (34); eight are for people of old age and nineteen (19) for adults. In fact, most of the public day centres for children host also adult visitors and can be seen as children and adult day centres. Great majority of day centres hosts people with intellectual disabilities (46), two of those are intended also for people with autism, and there are two, which are meant for this group only. Four community mental health centres are meant for people with long-term mental health distress and eight for old people. One day centre is intended for street children.

79. Most day centres are public (40). The majority of public day centres, those which are intended for children (29) are the responsibility of MoLSP, seven (old age day centres) are responsibility of local authorities, while four community mental health centres are responsibility of Ministry of Health (MoH). The ones under responsibility of MoLSP are usually organisational units of a Centre for Social Work, with few exceptions (a day centre provided by residential institution Topaansko Pole). Two day centres – one for old people and one for children – are joint responsibility of local authority and an CSOs. The rest of the day centres (20), including six social clubs, are run by CSOs. These are mostly for adults and in five cases for children. However, these are for special groups of children (four for autism, one for street children).

80. *Group homes* were established in the process of resettling residents from the institutions. They are used to accommodate ex-residents but also a few people who come to live in them from home instead of being admitted to an institution. The term used for this form in Macedonian legislation is 'service for organised living with support'.

81. Group homes were in the past most effective tool of resettlement. They provide possibility for fast action and are not difficult to organise. In the responsibility and organisation patterns, it is not all that different to institutional care. The provider is, if not the sole, the mainly responsible organisation for the well-being (and safety) of residents and the structure of costs is similar. In a way, they represent a move of the same operation that institution otherwise performs but into the community (into a nicer environment and a more home-like atmosphere with more personalisation and choice). If the management of such facilities is good, the way of working results in empowerment of residents. If resources are sufficient it can be a good solution for *transition* to the community. In Macedonian the group home experience in terms of methods of work and management were, in comparison with similar facilities in other countries, good. However the resources provided to group homes have not been sufficient to resettle people with intensive high level support.

82. There are two major CSO providers of this kind of a service – SOS Children Village for children without parental care and Poraka Negotino for adults with intellectual disability. Centres for social work have established two group homes for children and there are group homes that have been established during the mental health reform process for ex-residents of psychiatric hospitals. The group homes host 105 children and 80 adults (mental health not included).

83. Group homes have on average about three workers working directly with residents The staff resident ratio is on average between 2 and 3 residents per worker. The staff are typically well educated, with some more social workers and a large group of psychologists in SOS staff. The ratio that is much lower than in institutions indicates two issues; firstly, that more independence is promoted, but also that they do not provide care for people with intensive needs or as the organisations usually say that "the users with intensive needs do not fit their programme".

84. *Foster care* has been set as a cornerstone of the 'Macedonian model' of community service provision. However foster care remains concentrated in a limited geographic area, insufficiently supported by outreach and

mobile services and similar, semi-formal kinds of accommodation and support services have not been developed for adults and old people.

85. Foster Care provides accommodation and certain amount of care and support. Providers are individual families, usually supported by centres for social work. Foster families accommodate a total of 214 children, with equal share of children with disabilities and children without disabilities (107). Half of the residents stay in a foster family for more than 5 years, a quarter more than 19 years, foster families provide prolonged, for some permanent stay.

86. Out of necessity, foster care, although it is meant primarily for children, is used also for adults – sometimes because children grow up and stay in the family, sometimes because it seems as an appropriate solution also for adults. Family care, care in another family can be one of the suitable responses also for adults – e.g. – 'care by another family' or just family 'board and lodging'.

87. The *development of personal services* is in initial phase. There are three major types of services of this kind: *mobile* and *outreach* services including variety of *home help and home care*, *personal assistance* and *personal care packages* (including personal planning and care coordination); and many more minor services like delivery of meals, escorting, befriending, attending to personal hygiene etc. Home help has been marginally introduced for the old age users in Macedonia by the CSOs Humanost, Hera and Red Cross, but they need to be further developed. Personal assistance was for the first time introduced in 2018 as a special programme in the Social Protection Legislation, following the implementation of a pilot EU funded project to identify a suitable model and standards for this type of service. Personal care packages are the most complex set of personal services, known as 'case management', 'care management', 'independent service brokerage' or 'coordinated care', but not existing in the country until now.

88. An obvious disadvantage of these personal services is that there are very few of those services in operation in the country at the moment. However, the MOLSP is in process to reform and broadening the system of Social Protection to include a broader range of community and personal services. The moment requires careful planning, a piloting phase (if necessary) and introduction of forms of provision that will be most suitable to the local context.

89. Deinstitutionalisation is an international process that in its basic postulates transcends cultural and contextual differences. However, national context and cultural contingencies have to be taken into account. In Macedonia this is even more important precisely because of a low institutionalisation rate. It will require a smaller effort in the process of resettlement, but a greater degree of well deliberated preservation and activation of informal care and support. The *'Macedonian model'* should involve (on account of the extensive and important role of the informal sector) also community action, community centres, action groups and micro projects that would promote tangible ways of preserving and furthering communal solidarity. Also it should, to this end, exploit more the forms of care and support that lie on the boundary line between formal and informal care (e.g. care families, support of family carers, creation of support circles etc.) which presents another important argument for the development of personalised (thus contextualised) services and ways of individualised and direct funding.

5

STRATEGIC APPROACHES

90. There are two possible conceptual models of transition from institutional to community care – conversion – when existing institutions are converted into community services and substitution – when institutions are closed (liquidated) and substituted by new services by other providers in the community. *In both models institutions are transformed into the community services and institutional spaces are not used for residential care anymore.* In conversion, the *same resources* are used for meeting needs in a different manner, in substitution the resources are *redirected* to other providers, mostly newly established service providers. For Macedonia, it is appropriate to use a mixed model: in regions where institutions already exist, new services would be established by conversion of institutions into new service provider. Where institutions do not exist, or where they are too small, new community services would be created and residents originating from the region would be resettled back into the community by local providers.

91. In the deinstitutionalisation process, all the residents would *move to the community*. The majority will *live independently*, with support by and from the staff and professionals from the transformed institution as well as with support from other social service providers. Some residents would move to their *original home environments* outside the region covered by the institution. The staff of the care home would *retain* their *employment* and would *work in the community*, either with former residents or with other users living in the area.

92. The community should not merely be a passive recipient of the home coming former residents, but should also play an active part in creating and providing services by means of micro-community projects or initiatives which establish effective responses to needs of community members. Local government will be encouraged to actively participate in this aspect.

93. The programme of transition to the community will take into account the virtues of the present system, the experience of introducing innovations and resettlement in recent years, and will upgrade those good practices with the necessary changes.

94. The main risks of the process of deinstitutionalisations are related to decline or loss of political will for deinstitutionalisation, inconsistency in its implementation, resistance from employees in institutions or the community environment. Solutions that reduce those risks are: consistent and good management and an effective on-going monitoring process, a broad coalition of actors for change, dialogue with the community and all stakeholders and support for the change.

Risk	Possible ways for risk and harm reduction
Lack of political will or interest of decision makers	Coalition for deinstitutionalisation involving a diversity and a large number of stakeholders from the public and civil sector, the profession, the academic community, experts, etc.
Inconsistent process of implementation	External monitoring of implementation, involvement of various stakeholders
Resistance of institutions	Dialogue, support and engagement to and with institutions and staff, encouragement, determination in implementation of Strategy and Action Plan,
Resistance to change	Dialogic introduction of change, connecting stakeholders, education and awareness raising
Dependency on EU or other donor funding	Effective national budgeting for the deinstitutionalisation process with expeditious and consistent implementation.
Incorrect assessment of needs	Monitoring, training of service providers and support on the site.
Community resistance	Dialogue & awareness raising with the local communities
Uncertain sustainability system	Targeted services, strengthening the informal care and support system, systematic monitoring, effective national budgeting for the deinstitutionalisation process
Off-label use of funding	Relevant information, careful monitoring of the process.
Reproducing of institutional culture in community service delivery	Education, advocacy, sensitivity about institutionalism and the risks of re-institutionalisation, effective training and monitoring of community social service providers.
Delay in legislative reform	Promotion and awareness raising of the benefits of deinstitutionalisation among legislators, decision makers and the public, identification of priority measures for legislative reform to facilitate DI, political will of decision makers.
High threshold, skimming (i.e. resettlement of residents with lesser support needs)	Training, coordination, funding for community services supporting persons with complex and high level support and care needs.
Re–institutionalisation & trans–institutionalisation	A moratorium on admissions to residential institutions, irreversible change of the status of users, enhancing capacities of community services to support users effectively, reform to budget and financial allocations in favour of community based services

95. Implementation of change requires an intensive cooperation and mobilisation of actors at all levels. At the level of the *user* and the *community,* it is necessary to activate the relevant stakeholders, to set up *local initiatives* and *plans for new services* and *community projects*. Existing services and service providers must have a stronger contact and relationship with the community, to be present there at local level and in constant dialogue with the community members.

96. At *local* and *regional* levels, *centres for social work, existing institutions* and *day centres* (which need to become more community oriented and propulsive) and, of course, CSOs all have a pivotal role in the deinstitutionalisation process. These stakeholders should be oriented towards the community and will have to change their ways of working in order to respond to the needs of users effectively and efficiently.

97. Actors at the *national* level have to establish a more pro-active attitude towards change, rallying the structures at the local and national level to contribute to deinstitutionalisation. The MoLSP is to lead the process of transition but with inter-ministerial cooperation and coordination, to ensure implementation of the changes and support the education and training of certain groups of professionals who will not be directly involved in the process, but can play an important role in the implementation of the deinstitutionalisation process (e.g. judges, doctors, medical and health practitioners).

98. With policies for promotion of social care, the Ministry of Labour and Social Policy and involved structures at national level should actively maintain sufficient level of political *force of change*, with support from domestic and international organisations, networks and institutions. Continuous monitoring of measurable indicators (number of resettled residents, decommissioned institutions, services created, people who live independently) must be provided in order to monitor the effects and steer the process.

5.1 DYNAMICS OF TRANSITION

99. Deinstitutionalisation is a holistic and inclusive process cutting across the age ranges and social divisions. There are more similarities, common general issues to be addressed than differences between the way the deinstitutionalisation process should proceed in respect of the different kinds of institutions and different target groups. Yet there are notable differences, arising from, among other, different age groups – for children attention to child development and education, learning and socialising through play is essential, for adults independent living, having a role in the community and being valued, family, employment are the focus and for old people celebrating life achievements, relating their experiences with others, family and health is what matters. The difference is also to be reflected in the respective institutions and services.

100. While resettlement into the community is the goal for all children and adults who are residents of institutions it might not be the goal for all the residents of old age homes. Also certain types of services to be developed are, for some age groups relatively more important (e.g. home help is often more important to old people, while the foster care is more applicable to children). Besides the main pillars of transformation and policy measures of general importance, there will be three '*streams*' of deinstitutionalisation:

    a. for children,
    b. for adults under 65 years of age, and
    c. for old people over 65 years of age.

101. Other differences among the various groups of users should also be taken into account. For children there should be at least two 'sub streams' – one for children with disabilities and one for children experiencing predominantly issues of social deprivation (children without parental care, in conflict with law, children with educational difficulties). For adults (in the 'adults stream') there is a need to distinguish between persons with disabilities and persons with mental health difficulties. There is of course an option to form *ad hoc* 'sub streams' for still more specialised issues (e.g. relating to persons with dementia, persons with autism, persons with a physical disability etc.).

102. There will be *two phases or stages* of transition in the time period covered by this strategy.

    a. The first stage will be dedicated to and marked by resettlements and resettlement activities for children (all groups of users) and persons with disability. Residents living in the respective institutions for

children and for children and adults with disability will be resettled into the community in the first six years of Strategy implementation (i.e. until the end of 2023). Institutions where these categories of users are accommodated in will end the process of transformation. More detailed sub strategies for old age persons and persons with mental health difficulties will be prepared. Simultaneously, community based services will be developed, primarily focused on municipalities (or regions) where users will be resettled.

b. In the second stage (2024-2027), the process will intensify for the two other groups of users (the elderly and persons with long-term mental health difficulties) and throughout the other regions in the country. Experience and knowledge acquired in the first stage will be used for improving the process.

103. Priorities for the transformation are children institutions and Demir Kapija special institution. Being detained in institutions is most harmful to children, and children institutions are relatively small and easy to transform. Demir Kapija special institution should be priority since there are the worst conditions for residents and staff. The other reason is that Demir Kapija special institution is by far the largest social care institution in the country. Transforming such an institution will have the biggest impact on the creation of new community services and will deliver a positive message about the commitment and means to deliver the transition from institutionalisation to community based care and service provision.

6

KEY STRATEGIC AREAS (PILLARS) OF THE TRANSFORMATION OF INSTITUTIONS

6.1 TRANSFORMATION AND CLOSURE OF INSTITUTIONS

6.1.1 OVERVIEW OF THE SITUATION AND ACHIEVEMENTS UP TO DATE

104. Macedonia has a *low rate of institutionalisation* – 1,1 residents per 1000 inhabitants, which is a half the EU average (2/ 1000) and much less than neighbouring countries. There are, altogether, 34 residential institutions that accommodate about 2400 long-stay residents.

105. Most of institutions lie near the centre of urban areas, but are still visibly *separated from the wider community environment*. Most of the buildings are casern type. Life in an institution is organised by 'ward system', which homogenises, divides, classifies and grades the residents according to categories in a spatial progression. Some residents are 'parked' in their beds since accessories and assistive or mobility devices at hand are often not used.

106. Mostly staff have good *relationships* with residents. However, a clear *division* between staff and residents exists (uniforms, addressing, sub-ordinance). To make choices is severely limited in an institution. The residential setting discourages personal development on account of the absence of meaningful activities, lack of privacy and personal space. Residents associate only with other residents, the staff, sometimes with relatives, but not with the community outside the institution.

107. In spite of efforts of institution transformation, the institutions remained more or less as they were and none of institutions were actually transformed. The institution's transformation was interrupted as funding for the deinstitutionalisation process ran out and political will for change dwindled. The result was a stale-mate in subsequent developments.

108. The present organisational model is dysfunctional and completely unsuited for transformation into community services. Teamwork, project work, users' participation and care coordination (e.g. keyworkers) are lacking. Management is hindered by constraints and dependence on top down decisions and international agencies.

6.1.2 CHALLENGES

109. The main challenge is to *demonstrate that full transformation of institutions is possible* and achievable. It is also important to demonstrate that all the residents can live outside the institution in the community and will positively benefit from community based living. Some will require *intensive support* to make the transition.

110. Every institution should formulate its own *vision and transformation plan*. The vision must contain the kind of services the transformed institution will perform as a public service in the future. The transformation plan has to provide practical directions of how the process of transformation will proceed and has to determine all the important parameters and provide the road map for action. It has to establish the *date of final closure* of the institution, the *dynamics* of resettlement for each year, types of resettlement, *money flow* and additional resources and provisions needed, *new skills and knowledge* and type of training needed by staff. It must also provide and reform the *organisational structure* so that it would support transformation and present a good base for the future operation of the transformed institution and new community service provider. The transformation plans of each institution have to foresee the *future use of the institution's premises* (e.g. for sale, rental or community use, etc.). The transformation plan is to be drawn-up in a *participative approach* involving all the staff, residents and other stakeholders. Such an approach will assure a good design of the transformation plan as well as motivation *common consent* on the vision and future of the institution.

Time frame

111. Transformation of institutions will start immediately. Due to the low institutionalisation rate and with, for the most part, relatively small sized facilities or institutions, the resettlement and transformation process will take a relatively *short time*. Smaller institutions are easier to transform and to resettle residents, but they are also less institutional, so there is less pressure to vacate the institution. The process of transformation of the children institutions and the special institutions will start immediately. The process in Demir Kapija will require special attention since it will take more time to complete and the *expected impact* on the whole system will be a greater one. The reason for expeditious action relates to the financial and moral and ethical costs that occur as a consequence of not closing institutions while the resettlement process is taking place. The parallel costs of maintaining two separate systems should be curtailed as well as the impression that institutional and community care complement each other must be prevented. Children institution will be transformed by 2020, while those of persons with disability by 2022 the latest.

Preparation and democratisation

112. In order to perform transformation and prepare the staff for a role in delivery of community services, the existing *hierarchical relationships* (in the organisation of social care) *have to change*. Divisions across staffing structures and between staff and residents should be softened, uniforms taken off and partnerships developed. This is important on a symbolic and actual level of interaction. To *counter disciplinary and depersonalised relationships* improvements that were already made in some institutions must be introduced, such as for e.g. keyworkers, non (age) homogenous groups, methods of intensive interaction, personal planning and similar. Small improvements are also important: personal closets, personalised laundry, organisational changes (teamwork). *New methods* are possible to introduce while residents are still living in the institution.

113. *Participation of residents in decision-making* should be developed on various levels: consultation, participation in decision-making, independent advocacy, self-advocacy, inclusion in governing bodies, ownership

of services, and similar. Moving residents out of the wards and taking them on trips and visits outside the institution is necessary for *the preparation of both residents and staff for community living and the community service orientation*. By *exercising choice* while still living in the institution residents will prepare for the life outside in the community. Staff should learn to support and be sensitive to user or resident choices and decisions. In the process of transition to the community one of the first steps is *to open the institution to the community*, invite volunteers as a means to encourage everyday relationships, introduce new activities, advocacy and to support or assist residents to *go out into the community* (citizen advocacy, community membership).

Reorganisation

114. Whatever the model of change the *institutions must reorganise*. The existing organisational model is not functional even now and will be even less so in the process of transformation. The ward system needs to be broken down before the resettlements start. Accommodation units have to become heterogeneous, gathered on sociometrist and other value free principles. Teamwork and presence of professionals in units (where residents live) must be promoted. They should sponsor common projects, with users included, which is good groundwork for development of *future community teams*. These new organisational models and improvements should contribute to a stable environment and stable organisation framework.

Leadership

115. To conceive and implement transformation a *strong and dedicated leadership* is needed. The management of change needs to be local and anchored in the processes at hand. Institutions must be leaders of the change and outside bodies (including national authorities) must be perceived and must act as the support and mediators. The process must attract and welcome outside interest and support that will encourage innovation and creative activities. Students, locals and the civil sector must take part in the change to contribute to the process and to learn from it. In order that the change will not create resentment, resistance and attacks on leaders of change, there should be *clear support and commitment to the process from Government and professional authorities showing clearly and unmistakably what the intention is, that the cause is worthwhile and not to be abandoned.* Monitoring of transition and transformation is also about giving support to the local leadership.

Conserving resources

116. There are many *resources* available in institutions (material, financial, human). These have to be *used* into the system of community care. Material resources should be activated for the development of new services and for improving life of the ex-residents. The real estate of the institution may be used for public, communal or commercial purposes, after transformation and closure, but, in no case, should be used for re-institutionalisation. Future use of such real estate should be clearly presented in the individual transformation plans of each institution. Options may include sale or rental of the premises and in this way procure the financial means for acquisition of small property (houses, flats) for community social housing for residents and also to provide development funds for community services.

117. The *human resources* should be preserved too and *enhanced*. There should be a retraining of the existing staff in skills needed for the transformation process and for their new role of community service work. There will

be a need for re-enforcement of the staff – employing new, able and dedicated workers and professionals.[25] It is important to note that participation in the transformation process is *per se* an important and valuable experience and will make the participating staff the pivotal element of social care workforce.

6.1.3 PRIORITIES AND EXPECTED OUTCOMES

118. For the *transformation and closure of institutions*, the Strategy presents the following priorities and expected outcomes:

Priority I. Participatory planning of transformation of residential institutions

1.1. Transformation plans for each residential institution for children and children and adults with disabilities developed, including a containing vision regarding its future role and function, roadmap (action plan), use of premises and property, staff development, timeframe and budget;
1.2. Sub-strategy of deinstitutionalisation of old age homes developed;
1.3. Sub-strategy of deinstitutionalisation of mental health facilities;
1.4. Transformation plans, as above, separately for each old age home and long-stay mental health facility developed;
1.5. Established transformation task force within each institutions ensuring adequate representation of staff and users (or their families, where appropriate).

Priority II. Strengthen capacity of residential institutions for transformation

2.1. Managerial staff of residential institutions equipped with new management skills with focus on organisational transformation and change management and users empowerment;
2.2. Trained and enabled personnel, dedicated to change and human rights, selected and instated on the leading posts; with an authority for autonomous, but collaborative, decision-making;
2.3. New organisational structure of residential institutions enabling participation of staff and users, delegation of power and responsibilities and new functions of the institutions established;
2.4. Team work and project cycle management established in transforming institutions as main tools of organisation;
2.5. Coordinated care, person centred planning (case management) established as model of working with users;
2.6. Staff in institutions have good knowledge of deinstitutionalisation process, new methods and approaches in organising care, working with users.

Priority III. Transform residential institutions

3.1. Training, retraining and professional reorientation for institutions' staff provided, as in the transformation plans;
3.2. Reconstruction, adaptation and equipment for premises and properties of institutions provided, as in the transformation plans;

[25] There may be some staff not able to adapt to the new ways of working and new concepts and methods of community service delivery. In these cases staff will need support in finding alternative jobs.

3.3. Organisational structure and internal procedure for delivery of new social services in place, as in the transformation plans.

6.2 RESETTLEMENT OF RESIDENTS

6.2.1 OVERVIEW OF THE SITUATION AND ACHIEVEMENTS UP TO DATE

119. The deinstitutionalisation has been going on in Macedonia in a *start and stop fashion* since 2000. There were *two waves of resettlement*, mainly involving the Demir Kapija institution. Over hundred residents were resettled. *Intermediate structures* (group homes[26]) were most frequently used and have become a metonymy of deinstitutionalisation. The second most frequent resettlement (i.e. a quarter of all resettlements) was to *foster care families*. 'Moving on' from group homes and foster care is impeded by the lack of options for independent living and other alternative service support. *Adoption* and resettlement to *original families* were also used as resettlement destinations.

120. *Reception* of resettlement in community has been mainly positive, even though there are exceptions to this. Most social care workers, in principle, agree with deinstitutionalisation, but some still adopt a 'medical model' and approach to care and consider that residents are taken better care of inside institutions. However, there is nothing that is provided in an institution that cannot be provided in community settings. Furthermore, it has been demonstrated that such provision is more efficient and effective than institutionalised care.

121. Residents that were resettled in the past were mainly the ones that were easy to resettle. However, such a *'skimming'* approach is discriminative and causes many practical problems including interruption of the deinstitutionalisation process and continuation of two systems running in parallel as well as a fatalistic and sceptical attitude of staff.

6.2.2 CHALLENGES

122. In the first stage there will be resettlements from adult institutions and from children institutions amounting to *500 residents to be resettled in total*. At the second stage of the process can expect about 600 long-stay patients to return to the community from psychiatric hospitals and provision of intensive rearrangements of the residential care for old people living in old age homes.

123. The main challenges are to start to resettle residents with *intense support needs* and to develop the technology or mechanisms for resettling of individuals (directly) *to independent living*. This implies the intensive development of *personal services* which are currently lacking, such as personal assistance, home help or care and personal care packages; and intensive development of *new methods* such as intensive interaction, personal planning, etc.

[26] The legal term is 'organised living with support'

Resettlement to original environment.

124. Resettlement usually means going back to one's original environment. *Returning to the original environment* should be a leading principle in the future resettlements, but it must allow the resident leaving institution to decide whether he or she wants to return to his or her original home environment or not.

125. One of the obstacles in resettlement is 'ownership of residents' – a (misplaced) notion that residents are institution's responsibility when they reside in one. When they move out, are resettled or discharged from an institution, the concern for them is then considered to be 'owned' by somebody else. However there is a s*hared responsibility* – resettlement is a *common project* involving various actors through continuous, coordinated and managed care and support.

Use of diverse types of resettlements

126. In the past two main tools or destinations were used to resettle residents, those being foster care and group homes. In the next phase of resettlements foster care and group home services will still be used, while an emphasis will be given to *independent living*. This will allow for a *wider choice* of community services and resettlement options according to individual user needs, encouraging a flexible and pragmatic approach. There is also need to nurture a creative approach, piloting with alternative types of resettlement and community level support (e.g. living with ex-staff, board and lodging opportunities, care and support with another family, care of and by distant relatives, mutual support, housing communities etc.). The intermediate structures should, in the process of transition, provide an intermediate stage between institutional care and independent living. Also the care has to be taken and support provided in order to resettle the present residents of existing group homes so they may live independently.

127. For children a primary goal should be for children to *return to their own family* (and for adolescents to prepare for independent living), requiring material and professional support of original families. Another option for children is *adoption*. Procedures and organisation capacity should be improved to allow for the adoptive parents to be those waiting for children to adopt and children should be experiencing a speedy adoption process. The option of 'open adoption' should be explored (when adopters and the original family stay in contact). When returning to one's own family (including care of more distant relatives or relative's foster care) or when adoption is not possible, only then should a child be placed in foster family. Placements in group homes for young children should be avoided. Placements should be open, meaning that there should be collaboration of all the parties involved, including parents or other relatives. They should be proactive, future orientated on the basis of a child's needs and wishes, a personally tailored, unique 'project' should be constructed for the child and collaboratively implemented.

Methods of resettlement

128. The democratisation process and changing of relationships between staff and residents, as well as changing attitudes are part of this process of resettlement. On the personal level of an individual resident, preparation means being included in preparing for the journey, choosing where and with whom to live, participating in arranging the departure, deciding on the new abode – choosing furniture, appliances, colours, curtains etc. Imagining life in a new environment, getting to know the new environment, community, the neighbours etc.

Successful and unsuccessful resettlements – criteria

129. There are at least three different types of criteria of what constitutes a success in resettlements. First, the *number of resettled* residents, or conversely the diminished number of residents living in an institution ending into *closure of the institutional compound* itself. Second, how many residents *return back* or get re-*admitted to another institution*. Third, and most important, is the change in *quality of life experienced by the ex-resident*. Group homes are the most efficient mode of resettlement, but their effectiveness is limited by the fact that it is still a collective way of living and that residents still feel they are guests in 'staff territory' and, as a consequence, still under the guardianship of the staff. Other ways of resettlement (for e.g. foster families or independent living with support) can be more effective, yield results of greater empowerment or encouragement of users, greater inclusion and services that are more tailored to suit individual user needs.

Factors of success

130. Group homes need to become more effective in terms of resettling people with intensive support needs, if the *funding system* is allowing this. The present system of financing does not allow funding that would provide adequate support to meet user needs. There is a need to change and reform the funding system. Also *housing* should be provided in accordance with user for the purpose of more efficient and effective resettlement. A pool of housing units should be available but, besides the premises, it is important to observe other needs related to housing such as secure tenure (permanent address), support in house maintenance and housework, adapting the house for personal requirements, choice of co-residents or living alone, privacy and intimacy concerns, social life and visits, need for temporary accommodation (transition, rehabilitation, respite, crisis), new forms of cohabitation such as shared household, housing communities and cooperatives.

131. *Collaboration* of and between various actors and services is of vital importance in resettlement. In the future transformed institutions can be a resource of support and monitoring to the foster carers. This kind of networking, collaboration and common effort for the well-being of a user is necessary. *Centres for social work* should have a prime role in organising and participating in such processes of collaboration since they are embedded in the community service, have a good knowledge of the community and its resources. Staff in the centres have to be relieved of paperwork and start applying the methodology of 'coordinated care'.

132. To be effective resettlement needs *good management* at organisational level as well as micro-management on the personal level of individual users. It requires a *different funding* logic that would secure funds *according to the needs* of users. It also needs a *resettlement plan* expressing the needs and wants and wishes of the user, foreseeing the services needed, but also documenting the *costs* of the services and serving as a guidebook for *involving other actors* other than the original provider. Such plan outlines tasks needed to be performed before the actual resettlement and serves as an assistance tool for helping the user and supporters to find best solutions of everyday problems after the resettlement. Such a plan is supplemented by a risk analysis, if needed, to empower the user to take risks that everybody in everyday life takes.

6.2.3 PRIORITIES AND EXPECTED OUTCOMES

133. For the *resettlement of residents*, the Strategy presents the following priorities and expected outcomes:

Priority I.: Allow continuous, pragmatic and non-discriminative resettlements

1.1. 'Resettlement time-table' drafted with indicators stating how many residents will leave an institution on annual level (as a part of transformation plan and observed in transformation process);
1.2. Priority to resettle children set;
1.3. Residents with intense support needs are represented in the first echelon of the resettlements;
1.4. Established funding allocations that would recognise the differences in the intensity and level of needs.

Priority II. Promote resettlements to independent living and original families

2.1. Resettlement to independent living set as a medium term priority mode;
2.2. Independent living for residents of group homes made available;
2.3. Means for children to be resettlement back to their families secured;
2.4. Faster adoption process by better recruitment of potential adoption parents and organisation of the process and procedures;
2.5. Possibilities for open adoption investigated.

Priority III. Improve the resettlement methodology

3.1. Methodology of personal resettlement plans set as a basic requirement;
3.2. Variety of different types of resettlement implemented including less used, 'unorthodox' or creative varieties of resettlement;
3.3. Availability of other services (other than housing) in the community where the user will resettle, according to their needs;
3.4. Methods suitable for resettling residents with intense support needs developed.

Priority IV. Improve preparations and resettlement procedure

4.1. Individual resettlement allowed according to personal choice of user;
4.2. Users prepared for resettlement through a participative preparation process.

6.3 DEVELOPMENT OF COMMUNITY SERVICES

6.3.1 OVERVIEW OF THE SITUATION AND ACHIEVEMENTS UP TO DATE

134. Basic community services in social care are centres for social work (in existence since 1960s). In last two decades, as a part of deinstitutionalisation process, there was a development of community care services, mainly day centres, group homes, foster care and some counselling services. Personal services like personal assistance and home care are only in the inception, personal care packages and personal budgets not known, advocacy, mobile and tele care yet to be introduced.

135. Centres for social work cover the entire territory very well, day centres are well dispersed with some need for adult and old age day centres. Foster care and group homes are, however, concentrated in very condensed areas. Personnel of community services is on average of slightly more qualified, foster carers are on average of lower education and also economic status. The new community services have developed a pleasant way of working and usually have an amicable relationship with users and their relatives, however their style (or

model) is more pedagogic and is missing proper support for social inclusion. A focus on improvement of a person and not on improving his or her situation and quality of life leads also, in conjunction with inadequate funding of the services, to raising the access threshold – demanding ‚entry level eligibility requires to access these services , accepting more able/more independent users and not users with higher support needs and referring them to institutions.

6.3.2 CHALLENGES

136. The main challenges regarding development of community services are: a) to develop services that will really respond to *local needs*, b) to *lower the threshold* of the services, c) to develop *person centred services and support*, d) *to improve the service coverage* and provide even dispersion of various services across the country.

137. Assessment of the needs and the resources in the community will be performed regionally and locally involving users, providers and important people in the community. The existing experience of *social mapping* practiced in Macedonia should be upgraded and calibrated to serve the deinstitutionalisation process and community care development.

138. Lowering of the service entrance *threshold* (requirements) is to be done with various instruments. The first is to unequivocally assert the *right to live in the community* and the duty of not only national but also local governments to enable and facilitate that right. Second is to provide an arm‘s length *support of mobile services* and *resources centres* (e.g. former institutions) to enable service providers to deal with complex and intense situations by providing expertise and resource. Then, to provide crisis and *respite accommodation* at regional level. Very important is to provide *good personal plans* that will give a solid idea what a person needs and wants and how to provide it. Also a *change of funding* is needed so that the services given can correspond to the needs of the user. A good *advocacy* service will also help people to get the service they need.

139. *Personalised services* need to be developed first. In the process of resettlement and transformation of the residential institutions there will be many opportunities for development. Special attention has to be given to the application of this approach in improving existing community services and also in creating new personal services. Such community services could be delegated to the centres for social work, the civil sector or the transforming institutions.

140. Precise need for *dispersion of services* will be known when the needs assessment will be made. Until then, it can be suggested that obvious discrepancies are corrected. Foster care should become available throughout the country and should provide proper geographical dispersion of crisis accommodation centres.

141. Reorientation of centres for social work is needed to provide *more services* and *coordination of services*, in order to generate new community services, especially personal services by personal care planning. Having a leading role in community centres for social work will have a leading role in *local needs assessment* and planning of responses. In connection with this and the issue of prevention, centres for social work have to (re)develop *community work and community action*.

142. *Foster care* should be better dispersed by strengthening the support to foster families by means of *outreach and mobile services*, more *proactive work* regarding the child’s future also by *inclusion of the child’s parents* and means to keep in contact with the parents. Foster care should not be used in the same form for adults. Whilst adults do not need parents as children do, many residents or service users could benefit from accommodation and even care and support from and inside a family setting. Family care for adults seems to

be appropriate for the Macedonian milieu and should be developed. Special forms of foster care and care by the family (similar to "home-family").

143. *Day centres* provide activities and care for users during the day, to relieve and provide respite to parents, as well as opportunity for employment. They have to put efforts in the future to organise more *inclusive activities*, introduce more variety of activities, emphasise *productive, developmental and rehabilitation activities*, activities involving other people from community and in the community. Day centres for children should and must connect with pre-schools and mainstream schools as well as with special needs schools and resource centres to support a more integrated and inclusive approach in education. Day centres could be transformed into *community centres* and meeting points for all the community. The idea of *social clubs* should be expanded and used as continuous sources of mutual support and self-help. Special care should be directed also to the *needs of parents* e.g. the provision of longer working and opening hours, allow drop-in and respite visitors and organise respite care at home etc.

144. *Group homes*, in the transition process, will provide still an important function. In the future there may well be *less need* for such accommodation as more tailored community services develop but there will be still transition places needed to bridge the gap and provide the support required by users who are making the transition between being dependent on parental support to an independent living situation, or those who need to recuperate after a prolonged crisis or a particularly distressing event etc. *Care and housing* provision and services need to become *separated* and to be provided by different providers. Experimentation or pilot testing with *diverse forms of accommodation* and accompanying services should be encouraged. Besides the board and lodging provision, caring families, there should be piloting of services such a cohabitation, housing cooperatives and housing communities.

145. Civil society organisations with status of social service providers should be equal with the status of the public providers. Parents and users should be encouraged to become founders of a service providing organisations.

6.3.3 PRIORITIES AND EXPECTED OUTCOMES

146. For the *development of community services*, the Strategy presents the following priorities and expected outcomes:

Priority I.: Implement local and regional plans for enhancement of social services provision

1.1. Developed methodology for assessment of local and/or regional needs, resource assessment and response planning with regards to social services;
1.2. Performed local and/or regional needs assessment and resource mapping with regards to social services;
1.3. Developed local or regional action plans for enhancement of social services provision;
1.4. Support provided (training, mentoring, resources, funds, etc.) to municipalities and/or regions for implementation of local and/or regional action plans for enhancement of social services provision.

Priority II. Lower service entrance threshold

2.1. Legal framework in place asserting the right to community living for persons in need of social care and housing and obliges state authorities to ensure this right;
2.2. Established mobile services and resources centres at local or regional level;
2.3. Established local, regional or national crisis and respite centres, as per determined needs;

2.4. Developed funding system for community-based social services provision, responsive to personal needs of users;
2.5. Establish personalised advocacy services (i.e. services for personal advocacy).

Priority III. Develop personalised services

3.1. Personalised services such as home based care, personal assistance and personal care packages introduced;
3.2. Institutional and organisational framework and network for personal services in place involving centres for social work, ex-residential institutions and civil organisations;
3.3. Developed and established methods of personal planning and person centred practice in the community service provision system;
3.4. System of social care and community support established.

Priority IV. Improve capacity of key local stakeholders in community service provision

4.1. Improved practice and strengthened capacity of centres for social work to perform in the system of personalised and community based social services;
4.2. Strengthened capacity of relevant civic organisations to deliver community social services;
4.3. Upgraded and enhanced system of foster care, including family (foster) care for adults;
4.4. Day centres upgraded to provide service and lower threshold for entrance;
4.5. Availability of variety of personalised community services promoted.

6.4 PREVENTION OF INSTITUTIONALISATION

6.4.1 OVERVIEW OF THE SITUATION AND ACHIEVEMENTS UP TO DATE

147. Prevention of deinstitutionalisation for Macedonia it is one of the most important issues. A low institutionalisation rate indicates that there exists informal support systems which work to prevent institutionalisation. Theses mechanisms and systems should be more specifically identified and supported in the future.

148. *Best prevention of institutionalisation is the deinstitutionalisation itself.* But in the initial phases, this is a major issue: on one hand there are moratoria on admissions in residential institutions, and on the other, the services are not yet fully developed.

149. The issue of prevention needs to be addressed by *administrative* measures such as *moratoria* on admissions and refurbishment of institutions, except interventions for providing security and health of users. It is necessary to act on *social factors* contributing to institutionalisation (e.g. poverty, lack of housing, lack of social support and solidarity) by *measures of economic or social policy* and by establishing 'crisis' *services* able to deal with *emergency situations.* These measures should be implemented through direct action *strengthening the community* and increasing its *solidarity* and ability to deal with complex and serious situations.

150. *Moratoria* on admissions were put in place in the previous deinstitutionalisation strategy, but were not fully observed. In addition to new admissions, re-institutionalisation and trans-institutionalisation cases have been observed.

151. The *institutionalisation rate* significantly *varies across various regions*. From the highest in Pelagonia region (11,3 residents in all social institutions per 10.000 inhabitants) and Eastern region (6,8) to as low as 0,7 in Polog region and 2,0 in the Southwest (national rate for social care institutions is 4,3). The variance of the institutionalisation rate can partly be attributed to the vicinity of an institution or its presence, partly also to the style of working of centres for social work who refer residents to an institution, but in substantial measure it can be attributed to *structural and cultural characteristic* of an area.

152. The low institutionalisation rate in the country indicates that *informal care or community response is important care provider* and the major factor of prevention of institutionalisation. It is based on the values of family solidarity and the imperative to care of one's own people, but also reflective of the shame and fear of stigmatisation that families experience. It can provide good care but also lead to social isolation and deprivation, in some cases even to abuse. Often it is the duty of one (usually female) family member to organise consistent care, which can lead to resentment, feelings of being left alone, burn out of the main carer, with simultaneous resentments and guilt feelings of other relatives.

6.4.2 CHALLENGES

153. Main challenge in prevention is to get *more knowledge on how the informal care and support system functions* and what are the *factors that prevent institutionalisation.* In this aspect research has to combine the economic and other statistical data with the data of social services. It has to investigate the caring and solidarity processes and the attitudes to formal help in various communities. Only based on this knowledge we will be able to design productive interventions including more structural – antipoverty measures.

154. For local intervention *action research* is needed. These interventions may include on one hand indirect community intervention – community support, community micro projects, encouragement of neighbourhood exchanges, local action groups, mutual help and similar. On the other hand it may involve adaptations of services and new provision like: support to the carer, training, remuneration, family assistance, family care grants, third person support and monitoring, and similar. The informal care system needs to be approached *carefully and sensitively.*

155. Introduction of *moratoria* remains a challenge in the next period, but can be overcome gradually by establishing community services. In addition to moratorium on admissions, there should be moratorium on renovation of institutions (except for interventions providing security and health of users). If the public policies on mental health will not opt for total and radical transformation of hospitals there should be a time limit on admissions to hospitals. For old age homes there should be a ban on admissions of people under 65 years of age.

156. A strict divide should be imposed on the status of resident of the institution and user (including an ex-resident) of the community services. This should be applied also for residents leaving the institution but who remain users of the outreach and community services provided by this same organisation or former institution. With the act of resettlement the formal status of the user must change and this change must be, in accordance with the moratorium, irreversible in order to avoid circulation of users in and out of the institution. Accordingly there should be a legal distinction between community residential care and institutional care.

6.4.3 PRIORITIES AND EXPECTED OUTCOMES

157. For the *prevention of institutionalisation*, the Strategy presents the following priorities and expected outcomes:

Priority I.: Investigate cultural patterns of informal care and structural factors of institutionalisation

1.1. Research conducted related to informal care, its base in cultural values and structural social and economic variables;
1.2. Community actions (projects) implemented to support positive features of traditional solidarity and informal care in and by the community, and for promoting new, culturally adequate responses, as per the research findings, conclusions and recommendations;
1.3. Culturally sensitive adaptations of existing and new services or other instruments of formal care and support introduced, as per the research findings, conclusions and recommendations;
1.4. Training conducted for centres for social work to change working style and communication adjusted to communities' needs and culture.

Priority II. Introduce administrative measures preventing (re)institutionalisation

2.1. Moratoria on admissions to all existing institutions introduced;
2.2. Moratoria on new construction and adaptations of institutional buildings and facilities, except for safety and health related interventions, introduced;
2.3. Ban on re-admission of a user's after discharge (after change of status) or resettlement from any residential institution in place.

7

STRATEGIC TOOLS OF POLICY IMPLEMENTATION

7.1 COORDINATED AND COMPLEMENTARY PUBLIC POLICIES

7.1.1 IMPROVING PUBLIC POLICIES IN OTHER AREAS

Overview of the situation and achievements up to date

158. The National Deinstitutionalisation Strategy 2008 –2018 was adopted and was *implemented only partially* in terms of its scope of actions – number of resettled residents and types of services developed. The stakeholders did not get to 'own' the strategy and policy, there was some resistance which also contributed to the lack of successful completion of the planned resettlements. Seen from today's perspective, it can be seen that some important measures were inadequately planned for, and some aspects of the change were not addressed.

Challenges

159. A big challenge is also to lay the path for *long-term care system*. In many ways deinstitutionalisation is its prerequisite and it will pave the way for establishing new responses and measures needed for a new system.

160. This new Strategy on Deinstitutionalisation 2018-2027 is consistent in stating and implementing the basic postulates of deinstitutionalisation as a policy and practice. It allows flexibility and dynamic development in the ways how to attain these goals and put the principles in practice regarding the local specificities and other implementation contingencies.

161. Successful implementation of this Strategy depends on the coordination of the goals of public policies in other sectors, including education, health, decentralisation, economic policies for poverty alleviation, etc. Public institutions from other sectors should get informed about the deinstitutionalisation and identify how they can support the process through their public policies and practice.

162. The implementation of the new Strategy should involve diverse sectors, including top national and international experts, representatives of various users' groups and well trained professionals providing guidance and support. There will be *annual deinstitutionalisation conferences* assembling all the actors involved in order to attain maximum transparency of the process, to discuss achievements and provide ideas for future action.

Priorities and expected outcomes

163. For the *coordinated and improved policies*, the Strategy presents the following priorities and expected outcomes:

Priority I. Harmonisation with other policies and development of supporting policies

1.1. Inconsistencies of policies related to deinstitutionalisation removed and agencies responsible for implementation of these policies notified;
1.2. Annual National Deinstitutionalisation Conference(s);

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7.1.2 RECOMMENDATIONS FOR LEGISLATIVE REFORM

Overview of the situation and achievements up to date

164. The legislative provision for the deinstitutionalisation is mostly located in the social protection legislation. A general perception that sole ownership of deinstitutionalisation lies with the social protection sector leads to fragmented connections with the regulations of other systems such as health care, education, housing and other.

Challenges

165. The developments of the service provision throughout the years are reflected in the legislation. This is a very important progress and contribution towards deinstitutionalisation, decentralisation and pluralisation of the social protection system. This trend has to be continued with the new Social Protection Act, which is being drafted in 2018.

166. The State is still dominant service provider. There is already legal possibility for CSOs, the private sector or individuals to provide social services and to be supported by the state system for service providers is not precisely defined and is not based on quality standards. Funding of non-state service providers is done through projects or annual calls, failing to provided sufficient sustainability of services. In future, the state of the art has to improve so that accreditation is based on the capacity of providers to deliver good quality service and will allow accredited providers to perform the service delivery on equal terms.

167. Relating the definitions and regulation of services in the law, all needed community based support services should be adequately envisaged in the new Social Protection Act. Also there must be the following provisions included in the new Social Protection Act:

- Moratoria on new admissions to institutions.
- *Personal assistance services* must be advanced as a right to service within the social protection system.
- Wider conception of a *family assistant* or *family cares*, which is at the moment missing in the legislation.
- Further description of the *home care* and *mobile support services*. The current definition is provides the legal basis but does not define the scope and the way of delivering this service to the people in need.
- Introduction of explicit reference to *coordinated care* (case or care management).
- The role and functions of centres for social work and other services need to be restructured. The Law should include reference to personal centred planning and person centred plans as core instruments

of social care. It should also introduce new procedures determining entitlement for personal and other services.
- Change to the definition of residential care in the aspect of providing community based care (rather than institutional).
- The concept of direct funding should be introduced i.e. the funds to follow the user not the service.
- Introduction of special circumstances for implementation of pilot-services and innovative services as best response to identified personal and local needs.

168. Many people living in poverty are at risk of institutionalisation because of the lack of possibilities to manage and cover the extra costs arising from the disability or the intensive support needs. Also, people that will be resettled from institutions will need additional support in organising their lives, besides the needed services. Hence, strengthening is needed of the financial support measures for prevention of institutionalisation.

169. It is essential that service provision process is planned, structured and controlled by set of regulatory mechanisms, starting with mapping the needs on national and local level, developing gate-keeping procedures for orientation of user to services (i.e. clear referral systems to services), licensing and accreditation for service providers, developing quality standards and procedures for funding services. CSO service providers have to be encouraged and the sustainability of their services has to be guaranteed by the state.

170. The quality of the services is one of the crucial points that needs to be included in revising the national legislation. So far, the quality assurance of the support services has been neglected in legislation too. The existing standards and norms, regulated by rulebooks, are mainly technical and are not taking into account the important dimensions of service delivery process.

171. Decentralisation in social protection is lacking. The Social Protection Act and the Local Self-Government Act initiated a move towards local community service provision. The existing legal provision enables, but does not oblige the municipalities to perform social protection activities and services. Generally, municipal services are rarely developed because of lack of capacity and local budget constraints.

172. In order to change the system, it is necessary to change the legislation, in particular the fundamental laws and by-laws in social protection and social care. The new Social Protection Act gives open possibilities to include necessary provisions to support effective deinstitutionalisation:

- Further regulation of the service delivery,
- Further pluralisation of the service delivery,
- Further decentralisation of the service delivery,
- Inclusion of the possibility of piloting new innovative services,
- New standards of quality of the services, focusing not only on the norms and standards of the facilities, but more on the process of service delivery.

173. It is necessary to start working on the strategic amendments to the legislation regarding the matter of *deprivation of legal capacity and guardianship* that need to be harmonised with international documents on human rights, protecting persons from involuntary admissions and minimising the measures of restraint and custody. Adoption of an Advocacy Act should be taken into consideration (e.g. legal advocacy support of and to persons with disabilities or from other vulnerable groups), which will introduce supported decision making for people with disabilities and advocacy representation in legal or administrative procedures, especially those which constrain human freedom and rights.

Priorities and expected outcomes

174. For the *legislative reform*, the Strategy presents the following priorities and expected outcomes:

Priority I. Reform social protection legislation so it supports deinstitutionalisation and provision of community based services

1.1. Clear distinction of the social protection allowances and the community based service provision in the new Social Protection Act;
1.2. Clear definition and regulation of all needed community based support services in the new Social Protection Act;
1.3. Introduction of coordinated care (case management) and personal planning as basic tools in community care;
1.4. Financial support measures for prevention of institutionalisation strengthened;
1.5. Analysis completed on possibilities for introduction of financing services according to the assessed need and possibility of personal budgets and direct service funding.

Priority II. Enhance pluralisation of the community based service provision

2.1. Introduce licencing and accreditations for all service providers, based on fulfilment of quality standards;
2.2. Introduce system of financing of actual services provided instead of organisational financing of service providers;
2.3. Project funding available for innovative and pilot projects for development of services.

Priority III. Stimulating decentralisation

3.1. Legal changes (in the Social Protection Act) to stimulate municipalities to perform services and support to vulnerable groups of citizens in the new Social Protection Act;
3.2. Service provision by the local self-governments encouraged by allocation of budget block grants to local governments in order to provide community based support services;
3.3. Recommendations drafted for legal amendments for the local self-government to improve its role in social services provision.

Priority IV. Change other legislation to support deinstitutionalisation

4.1. Legal changes regarding deprivation of legal capacity and guardianship, in accordance with relevant international documents, also to allow supported decision making for people with disabilities;
4.2. Supplementary housing legislation (housing provision);
4.3. Employment and disability legislation revised (equal pay for equal work, flexible status of disabled persons e.g. user of social assistance as well as status as employee and similar);

7.1.3 NEW STANDARDS OF QUALITY AND MONITORING

Overview of the situation and achievements up to date

175. The existing standards and norms contained in the by-laws of the national legislation regulating the community provision (day centres, group homes, foster care) are mainly technical, regulating the space, staffing and equipment, and neglecting the quality assurance in the service delivery process.

176. Monitoring of the social care services is done by the MoLSP (inspection) and Institute for Social Care (professional work). Public Health Institute is monitoring the mental health services and to some extent the services for old people. Internal monitoring schemes in general are lacking and the external monitoring schemes are insubstantial. The lack of systematic and effective (internal and external) monitoring and evaluation structures can be regarded as one of the reasons for the limited success of previous strategy

Challenges

177. The paradigm shift to individual support and person-centred planning requires a shift in how services are evaluated and how the standards are used. The personal plans themselves will provide a basic monitoring and quality assurance tool. On the personal level achievement of goals set in the plan is the main criterion of successful implementation of the plan. Revision of the plan can provide a record of the obstacles in the plan's implementation and service provision.

178. The choice and definition of quality principles, standards or indicators is one of the key steps towards establishing an efficient regulatory system for services in the community. Such standards must be linked to the rights and quality of life of service users, rather than focus on technical issues. Especially during transition, accountability and being able to maintain a level of quality service across the service spectrum are important. This includes both budget monitoring, and a system for evaluating any support and services provided. In defining quality standards, the use of personal outcomes determined by people that use the services has, in many countries, emerged as the preferred option. In addition, it is not enough for evaluation to simply track what service providers are doing. Effective evaluation systems have to include mechanisms for both assuring and improving the quality of service and outcomes for people using the services.

179. A very important challenge is to strengthen the monitoring by establishing high professional structures or bodies. One such should be the body which will deal with the deinstitutionalisation strategy and action plan, another such body should be dedicated to the monitoring and evaluation of the services, based on the quality standards of or for particular services. The monitoring procedures and quality standards will be clearly defined and accepted by all services providers. The definition of quality standard will be thus performed as a joint exercise of decision makers, monitoring agencies, care and support providers with a principal role of service users. The service providers, both public and CSO services, have to be encouraged to undertake their own internal monitoring and evaluation.

Priorities and expected outcomes

180. For the *new standards of quality, monitoring and development*, the Strategy presents the following priorities and expected outcomes:

Priority I. Development of new standard of quality for the community based services

1.1. New standards of quality of the services based on quality of living, focusing not only on the norms and standards of the facilities, but more on the process of service delivery; including user's rights, involvement, methods, staff training, monitoring and evaluation, ethics, complaints procedures etc. developed and put in place through participative action involving all the stakeholders;
1.2. Mechanism (system) for monitoring and evaluation of quality of services delivered in place;
1.3. Internal service quality monitoring and evaluation procedure mandatory for service providers introduced.

7.1.4 CHANGE IN FINANCING (REDIRECTING FROM INSTITUTIONS TO COMMUNITY SERVICES)

Overview of the situation and achievements up to date

181. Allocating sufficient financial and material resources is one of the crucial steps. The financing of services is centralised and inadequate for the new services.

182. Financing of community based services is uniform and indiscriminate regarding the amount of support received. This reinforces the 'skimming' process and leads to re-institutionalisation. It also penalises the community services and sends a wrong message about the nature of community care – that they are lesser support.

Challenges

183. In the transition from institutional to community care there four main challenges regarding management of financial resources. First is to *preserve the resources* that are used in the institutions for the community use (*ring fencing*). There is a possibility or risk that these resources could be put to another use (for e.g. services that are not directly linked with transition or even moved to another service sector). Second is to secure *funds for the transition process* (temporary costs of running two parallel systems and start-up costs for establishing new services including preparation of them and changing the system), and to employ them effectively. Third challenge is to *change the system of financing* so it will respond to the needs of the people and be available for them no matter where in the system the services are provided – the principle of *money follows the user*. Fourth challenge is a likely *increase of the number of users* through the years and the need to secure resources for this.

184. After the resettlement the cost of services for some users will increase and for some it will be smaller. On average or overall cost will remain the same. The sum of present costs for residents currently living in institutions should be sufficient to provide for the same number of residents in the community. The challenge is to keep these resources available during the course of the change of allocation system.

185. The transformation of the system towards community requires new financial resources. New costs occurring in the transition period are of two kinds: *bridging costs* and *start-up costs* (including unforeseen costs - hump and bump costs). *Bridging costs* occur, whereas at the time of the transition, two systems must be financed in parallel, such as old building and the new facilities in the community (energy and water, current and investment maintenance, material for the maintenance and rentals, as well as the costs of double work i.e. double staff costs). These costs are greater, if the time of transition is longer.

186. *Start-up costs* will be needed for developing and launching new services and for the introducing the necessary changes into the system. In the first instance these costs may be for preparation and launching of the services that will directly supplant the residential services (sheltered housing, group homes, personal assistance and care packages for ex-residents, and other) and will entail material costs for acquisition of property, furniture, fittings, personal items that were not needed in the institution, etc. Also, in the initial period some staff costs occur because of the need of more intensive support to users (and staff) just after the resettlement. On the system level there is need for piloting, preparatory research and studies, re-training, awareness raising etc.

187. The 'extra' funds must be earmarked for co-financing of investment in the development of new services, and the State budget will continue to cover operating costs of institutions until the last resident is resettled from the institution. All investments in new services must be based on a clear vision of the future system of care, on the principles and values of international human rights documents.

188. The 'extra' funds and other resources needed will be secured by: a) more efficient management of the present financial, material and human resources (in the institutions, but also in community services) and by mobilising the 'dormant' resources (real estate, informal help, community solidarity), b) by securing new means from the national budget, and c) by mobilising the development and donor community and possibilities for use of IPA EU funds.

189. The funding of the new services is to be decentralised. As the process of deinstitutionalisation develops, the funds spent on institutional care will be gradually, with the residents, shifted to community based care. Deinstitutionalisation and the dispersion of services requires new models and way of financing. One of the main principles of transformation should be that *the money follows the user*. Therefore, when a user resettles in the community the money he was receiving for the institutional care will follow him into the community. Like the care provision, the funding will also be transformed from a standardised form of delivery, where everyone's care, no matter what their needs, is funded at the same amount, to a personalised funding approach where the user receives funding level more in line with level and intensity of the support need. As people resettle into the community personal packages would be established and they should be receiving the amount of funding as they need to provide for their care.

190. There are three possible ways of ensuring that the 'money follows users":

    a. *direct funding of services* – the user receives money and purchases or *creates* personal services;
    b. *commissioning the services* — funds are received by care coordinators and they procure services to the user according to their needs;
    c. *allocation of funds to territorial units* based on a local needs assessment and plan of the response.

A new way of governance should combine all three methods listed above.

191. The direct funding model will be piloted – both for people resettling from the institutions and those living at home but at risk of institutionalisation.

192. Overall financial aspect of this Strategy is that the present financial resources will suffice for the same amount or number of users. Transitional costs will occur and there is a likelihood that new services will attract an increased number of users. These cost can be diminished with a shorter duration of transition and by strengthening the informal support networks (in this way there will be less new users of formal care thereby reducing costs).

Priorities and expected outcomes

193. For the *changes in financing*, the Strategy presents the following priorities and expected outcomes:

Priority I. Preserve existing institutional resources and convert them into community use

1.1. In the initial phase, before a new system of financing is put in place, funding of the services for ex-residents stays with institution paying for the care and services of potential providers, while institutions in transformation will be entitled to payments for their services provided to their 'new' users from other funds (such as grants, for instance);
1.2. For the new users, coming afresh and exceeding the current quota of users, special dedicated funds will be provided in order to prevent institutionalisation and to enable independent living;
1.3. A fund to support community actions as indirect or collective provision of care, will be made available. Initially, these funds will be placed at the national level with the intention of devolving them to regional or local levels;
1.4. After an initial period (3–5 years) and after a thorough review this initial system will be integrated into a possible long-term care scheme or integrated community care fund that would ensure stable and sustainable funding for community based services in the future;
1.5. The value of the institution's premises and facilities will be ring–fenced for future deinstitutionalisation measures and will be managed for maximum benefit of the development of the community services and well-being of the users.

Priority II. Secure budget needed during the transition period

2.1. The state will allocate sufficient earmarked funding explicitly meant for deinstitutionalisation (i.e. for transition costs);
2.2. The new, additional sources of funding (including EU and other donor funds) will be made available for development of new community based services;
2.3. All international and domestic donors will be coordinated, donations and funds to be fully used for action completely in line with this Strategy and action plan;
2.4. After the period of establishment and funding of the new services, the state will provide the sustainability of the services.

Priority III. Establish a new system of financing

3.1. Introducing and piloting of the *direct funding* for people that will be resettling from the institutions and those living at home but at risk of institutionalisation;
3.2. Introducing and piloting of commissioning of services;
3.3. Introducing and piloting of *allocation of funds to territorial units* based on a local needs assessment and plan of the response (intervention).

7.2 SOCIAL INCLUSION

7.2.1 SOCIAL INCLUSION AND ENABLING THE MAINSTREAM SERVICES

Overview of the situation and achievements up to date

194. Deinstitutionalisation is one of the crucial instruments in promoting social inclusion in its own right. It introduces measures are based on the social inclusion of the institutions' residents as well as other people in need of services.

195. Living in an institution is exclusion. People with disabilities and other people identified as people in need are excluded on the account of poverty, their social situation, prejudice, physical access barriers among others. They are insufficiently included in education activities, marginalised in respect of employment, have problem in access of health and other services, from using public (and owning private) transport, from participation in community activities and events and are often misunderstood and stigmatised.

Challenges

196. Accessibility to all mainstream services needs improvement. All professionals in public service activities (teachers, general practitioners, nurses, culture workers and others) need on the job training for users' involvement. Community care and users do not need specialist services and specialist professionals, they need professionals to do their work without discriminating.

197. Stigma and shame needs to be overcome. Deinstitutionalisation in its own right will relieve the relatives of the burden of stigma and guilt they experience as well as the shame of putting a family member in an institution. Awareness raising about disability rights to combat stigma, the inclusion of children with disabilities into ordinary, regular schools and the abolition of the two tiered schooling system, as well as development of working possibilities (social enterprise etc.) and measures promoting full access for all into social and cultural life will change social attitudes.

198. Uneasiness, misunderstanding, labelling and discomfort in everyday interaction is to be overcome by inducing the notions of respect and ‚strengths perspective' or empowerment of users to be understood, valued and accepted as community members on the very micro level. This will be supported by inclusion measures into the mainstream education, labour market, cultural life.

199. For social inclusion, centres for social work will have to provide the model to other service providers. This entails a change in their approach and their role. Their action must be absolutely inclusive, respectful and avoid categorisation. Their role will be more of a coordinating one, becoming a broker of needed services and proactive gate-keeper ensuring the access to needed response. Their community presence must increase – instead of office work there will be more field work undertaken by centres for social work in actual support to users and the community.

Priorities and expected outcomes

200. For the *social inclusion and enabling the mainstream services*, the Strategy presents the following priorities and expected outcomes:

Priority I.: Ensure access to mainstream education for social service users (with disability)

1.1. School-aged service users enrolled in ordinary schools;
1.2. Personal or educational assistance for children and persons with disabilities attending educational facilities provided;
1.3. Inclusion of children with complex needs into mainstream schools piloted.

Priority II. Ensure access to mainstream health services for social service users (with disability)

2.1. Ensured access to health insurance and health protection, as a precondition for accessing mainstream health services in the community;
2.2. Outreach mobile health services for social services users with disabilities with complex needs provided;
2.3. Doctors and nurses, and medical practitioners, trained for working with persons with disabilities.

Priority III. Ensure access to mainstream cultural organisations and events for users of social services (with disability)

3.4. Local cultural organisations supported in involving social service users;
3.5. Initiatives for cultural productions of persons with disabilities (and other social services users) designed and implemented.

Priority IV. Combat stigma and exclusion in everyday interaction

3.1. Respect and a ‚strengths perspective' approach Induced in everyday contacts of users and the service providers and the general public;
3.2. Public transport adapted to the needs of people with disabilities, community transport initiated and personal transportation enabled where needed or possible;
3.3. Centres for social work improved to serve as a model of inclusive service.

7.2.2 PROVISION OF HOUSING

Overview of the situation and achievements up to date

201. General public housing agencies provide housing to people in need of housing. However, there are little or no priorities for the ex-residents and other recipients of support and care services. These agencies do not have sensitivity and experience of working with the target groups of deinstitutionalisation.

Challenges

202. Housing is one of the prerequisites for transition and needs special attention and concerted effort from housing and social services. To successfully implement the resettlements a large number of housing units will be necessary. A thorough assessment of housing needs of residents of institutions and other (prospective) users of the community services must be performed and a special housing action plan constructed including a business model on how adequate, sustainable and affordable housing should be made accessible.

203. The strategic orientation is that people with disabilities need ordinary housing (i.e. housing in the community). Creating congregated housing or ghettos must be avoided and also other circumstances that would

segregate the service users from the rest of the population. However, there are frequently physical and social adaptations of given premises that are required.

204. Public housing agencies will provide the housing initially (for the first cohorts of the resettlements). They need to be better equipped for this operation and supported in being aware and sensitive to situations at hand. A special unit public housing agency, could be created that could serve this purpose.

205. Housing stock needed should be generated from existing capacities for social housing and by transforming the existing assets of the institutions into a resource for ordinary social housing. As well as by introducing a quota system in new contracting and building ventures. The latter would require legislative changes in construction legislation.

206. A model of housing provision is to be developed, which would involve public and private partnership, housing cooperatives, users as (partial) owners or tenants. In future, on the basis of the needs survey results, the creation of an umbrella organisation of diverse accommodation providers which would be able to generate the resources and sufficient potential to create housing capacity for vulnerable groups in general, should be considered. It should operate according to the principles of good governance and transparent management, as well as the principles of inclusion and activation of users, its function could also be wider and at the same time a powerful factor of the integration of the new network of services.

Priorities and expected outcomes

207. For the *housing provision*, the Strategy presents the following priorities and expected outcomes:

Priority I. Housing needs assessment

1.1. Comprehensive housing assessment of the housing needs of residential and other social services users conducted;
1.2. Housing action plan related to community care development developed.

Priority II. Establish ordinary housing for users of community services and ex-residents

2.1. Existing social housing stock for the first cohort resettlements mobilised;
2.2. Conducted adaptations and alterations to ensure accessibility;
2.3. Sensitised and equipped public housing agencies for the deinstitutionalisation process and the needs of users.

Priority III. Develop new housing provision model that enables public-private partnership, cooperative housing and users' participation

3.1. Analysis on introducing quota system in constructing legislation conducted (so that every new building contracting development will have a quota of awarded housing or will have to contribute to the social housing fund);

3.2. Analysis on establishing an organisation and building model (umbrella organisation) conducted based on good governance and transparent management, as well as the principles of inclusion and activation of (active participation of) users.

7.2.3 Users' participation and services lead by users

Overview of the situation and achievements up to date

208. There is a long tradition formal organisation of people with mobility and sensory disabilities, of relatives of people with intellectual disabilities and older people in Macedonia. Overall users' involvement in the provision and organisation of services is not developed. Mostly it is believed that people living in institution should not be making decisions or participating in decision making because they have a poor judgment and, due to the challenges of intellectual disabilities do not have the capacity for decision making. It is believed that it is right for professionals to make decisions in their best interest.

Challenges

209. According to the Common European Guidelines users should be involved and have control in every step of deinstitutionalisation; planning, implementation and monitoring. The main two challenges in Macedonia regarding users' involvement are the inclusion of users as important creators and decision makers of the existing services and to set up a range of users' led services.

210. Within the existing CSOs, centres for social work and residential institution users' boards are to be formed that will advocate for the users' rights, their needs and wishes in the organisation and to be equal partners in decision making. In the everyday functioning of the organisation, assemblies are to be established as a main tool of democratic decision making.

211. Another way to involve users in the existing services to a greater extent is to employ them as co-workers. Some can become *peer-support workers*. Some can be trained, some already have adequate training for work positions like nurses, carers, social workers, educators etc.

212. During the development of the new services such as housing, day centres, work and employment providing units, advocacy and self-help groups, several user led pilots should be tried out (such as shared ownership (housing cooperatives) and user participation in building construction or refurbishment. Advocacy and self-advocacy centres and initiatives should be supported in organisational and financial terms.

213. Peer support workers are an important profile of professional both in the transition to community and in the community services. Their advantage is that they have a life experiences and thus more empathy. They are usually much more committed and available for the users because they know how it is to be in their position.

214. In order to provide quality peer support, self-advocacy, user management and other services, users should be trained for their work and a users' knowledge base developed.

Priorities and expected outcomes

215. For the *users' participation and services lead by users*, the Strategy presents the following priorities and expected outcomes:

Priority I.: Increase users' control and power

1.1. Users trained in empowerment, management and self-advocacy;
1.2. Creation of self-advocacy programmes and initiatives;
1.3. Established users boards in residential organisations and in community services;
1.4. Peer-support workers trained and employed (engaged) in transforming institutions and community services;
1.5. Legal framework that requires social service providers to ensure users' participation in decision making introduced;
1.6. Favourable legal framework for employing peer support workers at social service providers.

Priority II. Pilot users led organisations and initiatives

2.1. Initiative on shared ownership and participation in house construction designed and piloted;
2.2. Initiative in establishing user led group home and day centre designed and piloted;
2.3. Initiative in establishing user led personal assistance organisation designed and piloted.

Priority III. Support the development of users' knowledge base

3.1. Users led research designed and piloted;
3.2. Users led training programmes for social service providers' staff developed and delivered.

7.3 CAPACITY BUILDING

7.3.1 STRENGTHENING NEW APPROACHES (PERSONALISED SERVICES)

Overview of the situation and achievements up to date

216. New approaches and overall change in working with service users such as empowerment, strengths perspective, users perspective, advocacy, contextual sensitivity and person centred care have been introduced and been developing in the last decades. However, the medical approach as well as the ‚charitable approach' of a guardian still prevail.

217. Personal planning is a basic element of the person centred services. In Macedonia, the notion 'individual planning' is adopted as a formal requirement in the service provision. The way it has been applied is predominately 'service' based and oriented, treating the persons as object of care or service user only (not as a whole person in his or her context). The authentic personal planning is focused on the person's perspective, wishes and goals, putting the person in the centre of the process and the action.

Challenges

218. The main strategic challenge in the area of methods and approach to working with service users is to personalise the provision, enhance person centred approach along with promoting the advocacy stance of professionals and other service workers, encouraging risk taking instead of risk avoiding methods of risk assessment, acknowledgement of the importance of the users' life-world and resources it provides, and along

with transforming formal procedures into user friendly ones, promoting and celebrating positive changes in the user's life.

219. The main tool of personalisation or person centred care is *personal planning* (formerly termed also as individual planning). Therefore, the individual plans have to be replaced by personal plans. Individual plans as they are written at the moment are not tailored to the user but are mainly a list of the impairments or so-called ‚defects' of the users and how each of the professionals will be trying to correct them. Community care requires a paradigmatic shift to the social model of disability that will take into consideration a persons' ambitions, needs, wishes and goals in consideration. Some elements of adequate personal planning can be found in the methodologies of the CSO service providers, however, there is a need for improvement.

220. The main features of the method are that it is proactive, empowering, setting the goals rather than reacting to 'problems', taking the user's perspective and introducing the user from the strengths perspective, seeing the user as competent and able and seeking the ways of enabling him or her, taking the life-world perspective and whole life into account. A personal plan is the expression of the user's will, but also a work plan for the providers of what support is needed to achieve the quality of life set by the user. Personal plans are often also the basis for the planning of services and the organisation and establishment of services.

Priorities and expected outcomes

221. For the *strengthening new approaches*, the Strategy presents the following priorities and expected outcomes:

Priority I. Introduce the personal planning method

1.1. Personal planning introduced as a key methodology in the work of social care professionals;
1.2. An extensive training of trainers module on personal planning developed and delivered;
1.3. Systematically trained social protection and social service provision professionals in implementing and evaluating personal plans.

Priority II. Ensure critical change in the patterns of working with people.

2.1. User empowerment, users' perspective, contextual sensitivity, advocacy approach introduced as fundamental principles in service delivery (in legislation, by-laws, Code of Ethics, quality assurance and the transformation plans and other services' strategic documents);
2.2. Enacted regulation requiring that new approaches are a required part of all the new developments, services, pilot projects and other transforming activities;
2.3. Training in these approaches provided adequately for relevant staff at all levels of social protection and social service system;
2.4. Existing referral procedures reviewed in order to transform them into user friendly procedures;
2.5. Participation of users and relatives ensured in these abovementioned activities.

7.3.2 CAPACITY OF THE WORK FORCE AND TRAINING

Overview of the situation and achievements up to date

222. Working in the community requires quite a different set of skills and knowledge for all professions and retraining is a major operation to be accomplished in the transition. Most of the workforce has been exposed to training and education. The past development of the workforce lacked *continuity and coordination.* The institutional, 'medical' model and the distrust of users is still quite strong between professionals. A substantial knowledge and skills in deinstitutionalisation have been developed but they are often not used everyday practices.

Challenges

223. *New competencies and training.* The main challenge is to develop a comprehensive and well-coordinated programme for all involved in deinstitutionalisation. It is not just the staff working in institutions and social care who need to be educated and further trained, but also professionals working in the justice, health, education and other sectors need training and adaptation to new conditions.

224. Special attention needs to be paid to develop *good leadership for change*. Apart from the directors of institutions, agencies and authorities, also other advocates and main protagonist of innovation need to be educated and trained in order to have good leadership teams in every region. On the national level key civil servants at the MoLSP, MoH and MoES need to be trained as well.

225. *Users* need to be involved in the development of the workforce as trainers and they need to be trained to become peer-support workers, carers, researchers etc. Users involvement is crucial and the transformation of the perception of users as passive recipients of care to active colleagues of change. Apart from training the existing workforce, there will be a need to develop *new profiles* such as care coordinators, personal assistants, social carers, community nurses, community attendants, advocates, and others.

226. Skills and knowledge, methods and concepts of deinstitutionalisation need to be developed: the ethics, teamwork, personal planning, risk analysis, empowerment, shared and supported decision-making, recovery, crisis intervention.

227. The whole process of education and retraining needs to be monitored and coordinated by a structure that will steer the transition to community services as a network for mutual training, thus spreading knowledge in a capillary fashion. Strategically, however, it is necessary to establish an updated, progressive education programme at the level of higher education and for professional qualifications. All the training activities of international organisations need to work in a coordinated manner also regarding their on-site work and organisation of training.

Priorities and expected outcomes

228. For the *Capacity of the work force and training*, the Strategy presents the following priorities and expected outcomes:

Priority I. Training delivery in deinstitutionalisation to professionals from the social protection and other relevant sectors

1.1. Training programme for deinstitutionalisation developed, with different modules for professionals from different sections;
1.2. Training of trainers in deinstitutionalisation conducted;
1.3. Training for social care staff conducted;
1.4. Training for the staff in other sectors (education, health, employment, etc.) conducted.

Priority II. Include deinstitutionalisation in the academic sphere and curricula

2.1. Conducted analysis of coverage of deinstitutionalisation and related topics in relevant high education institutions;
2.2. Increased coverage of deinstitutionalisation and related topics in graduate and post-graduate studies of relevant high education institutions.

7.3.3 AWARENESS AND ADVOCACY – PROMOTION OF DEINSTITUTIONALISATION IN THE PROFESSIONAL PUBLIC AND GENERATING GENERAL PUBLIC AWARENESS

Overview of the situation and achievements up to date

229. The general public is only marginally aware of the problem of institutions and the deinstitutionalisation process. Professional audiences are more informed, but many are also misinformed, often unaware of the benefits of the transformation and of the opportunities to enhance their professional efficacy.

230. There are good examples and experience of good public awareness campaigns in Macedonia related to disability rights, children rights and protection, as well as inclusion in general. The deinstitutionalisation and the institutional malpractices, however, were not brought to public attention.

Challenges

231. Public awareness is an important part of the transformation – communication is needed with interested public (users, staff, management, staff in institutions, community services, social workers, doctors, judges, relatives, etc.) and communication with the general public: politicians, government, media, culture, civil movements, associations, CSOs and the interested public.

232. The communication is to include general topics to combat exclusion and promote inclusion, promote users' rights and fight against discrimination, supporting a shift from the medical to the social model. However, the accent of the awareness raising will be on educating and making the audiences more aware of the problem of institutions and the advantages of the deinstitutionalisation. The message needs to be conveyed that institutional care is harmful, ineffective, unethical solution, which violates human rights. The myth of the necessity of institution, that 'some people will always need institutional care' has to be dispelled and the idea that all people have the right to live in the community regardless the intensity of disability to be asserted. Institutional malpractices should be denounces and made public. The benefits to users and, also to the community, need to be demonstrated and a plea to the cultural values and norms of hospitality, generousness and compassion has to be made, as well values of inclusion and solidarity.

233. Besides general campaigns there will be focused campaigns on specific issues that need a special attention (legal capacity, sensitising health, social, public administration and others), promoting learning how wider communities live with and include vulnerable groups (e.g. learning the sign language, knowing how to deal with intense needs) and as groundwork to enhance certain provision (e.g. increase availability of adopting parents, making adopting parents more prone to adopt children with disabilities and Roma children, promoting fostering, creation and implementation of a person centred plan).

234. Deinstitutionalisation must be widely and publicly discussed, form part of the public debate, to broaden and deepen understanding about it and help with a successful implementation. An ongoing information on the process is needed that will ensure and build understanding that deinstitutionalisation is everybody's responsibility and at everybody's advantage. There should be clear and wide communication and information dissemination to the public, providing good examples of successful resettlements and promoting communities (and local authorities) who successfully cooperated in resettlement and establishing a good community response.

235. Besides traditional and new media, other avenues of making public conscious and mobilising it for collaboration in this genuinely social endeavour will be used since personal experience and contacts are more meaningful to attract an active attention. Hence the users, ex-residents, relatives and actively involved field workers must participate in design and implementation of all the promotion activities, especially those based on the direct contact and community dialogue.

Priorities and expected outcomes

236. For the *awareness raising and advocacy*, the Strategy presents the following priority and expected outcomes:

Priority I. Promote deinstitutionalisation properly

1.

1.1. Annual plans developed for promotion of deinstitutionalisation and establishment of personalised and community social services (benefits and advantages of) to the general public;

1.2. Annual information campaigns conducted on deinstitutionalisation and establishment of personalised and community social services;

1.3. Users involvement ensured in the awareness raising and promotional activities.

7.3.4 Research, pilots and learning sites

Overview of the situation and achievements up to date

237. There is a substantial number of research on the topics related to deinstitutionalisation, mostly of social policy and service organisation kind, less on social work and methods of working with people. Systemic changes were in the past often implemented without piloting them. The consequence was that there were good nominal solutions but not supported by operative measures which would legally and organisationally warrant their implementation in practice. A lot of valuable knowledge that was produced in various projects was lost and forgotten, even on the sites where it was created.

Challenges

238. Research activities are needed to provide required information and data, and pilot-projects as well to test the foreseen solutions and to modify them in order to fit into the evolving system. New knowledge and experiences need to be documented, preserved and by systematic and constant dissemination made available where needed.

239. Several types of research are foreseen: *Basic research* that would address important but still open questions of the contextual factors influencing the process and particularly on the role of informal support and care. *Needs assessment* is needed – either for specific geographic areas or for specific aspects of deinstitutionalisation (e.g. housing needs). *Evaluation studies* are important part to upgrade monitoring and to evaluate pilot experiences and various practices (existing and newly introduced). *Preparatory studies*, especially of legal kind will precede the pilots and new legal solutions that will set the piloting and provide the conceptual dimension of the changes. *Integrative research* activity in order to analyse the research results from a wider perspective and to provide syntheses needed for subsequent action needs to complement the basic research activities, as well as reflection of immediate experiences and results on the ground. The basis for comprehensive analysis and development of the process is, however, *documentation of the process*.

240. Three types of *pilots* are needed. Some will introduce, develop and test new *methods* of working (personal planning, risk taking, intensive interaction etc.), others will set up and evaluate *new forms of care provision* (personal assistant, personal budgets, family care and accommodation for adults, home help etc.), while there will be also need to *test the systemic solutions* in a delineated geographic areas before putting them into legislation and nationwide use. The latter will be performed in pilot areas, while the former in transforming institutions and other sites. The pilots will follow the pattern of: *conceptualisation* of the pilot project (defining the scope, variables observed, methods etc.), *applying* it into *action*, and *evaluating* the *outcomes* and analysing the *process*. They will be disseminated partly in the implementation phase and finally after the evaluation and analysis will be completed.

241. For effective dissemination a system of *resource centres* or *learning sites* is foreseen. Every institution in transformation will have its topic – a method or form of provision to develop, sustain and to transmit to other actors in the field. Typically, a working group would be formed consisting of some professional and other staff and users of the institution but with participation of workers of some other institutions, so that dissemination will be happening while development will be taking place.

242. Besides the promotion and awareness raising described above there will be dissemination of published professional work – one to two publications a year for monographic publications, five in domestic periodicals and three in international journals.

Priorities and expected outcomes

243. For the *research, pilots and learning sites*, the Strategy presents the following priorities and expected outcomes (the concrete research and pilots are listed under the motions that are regulating the content of the research or pilot topic):

Priority I. Research activities that support good implementation of deinstitutionalisation

1.1. Research on the contextual impacts on deinstitutionalisation, institutionalisation rates and informal care conducted;
1.2. Research conducted on existing and newly developed types of care and their effectiveness and impact;
1.3. Studies on documenting the deinstitutionalisation process, its experiences, achievements and challenges completed and published;
1.4. Expert debates conducted to ensure higher level integration of monitoring and research data, providing recommendations for subsequent action in the field of deinstitutionalisation.

8

IMPLEMENTATION, MONITORING AND EVALUATION

244. *GoRM* is responsible for implementation of the Strategy. The MoLSP has the responsibility for immediate implementation of foreseen measures, monitoring the effects and achievements, proposing necessary amendments and improvements, and operative coordination of all involved stakeholders.

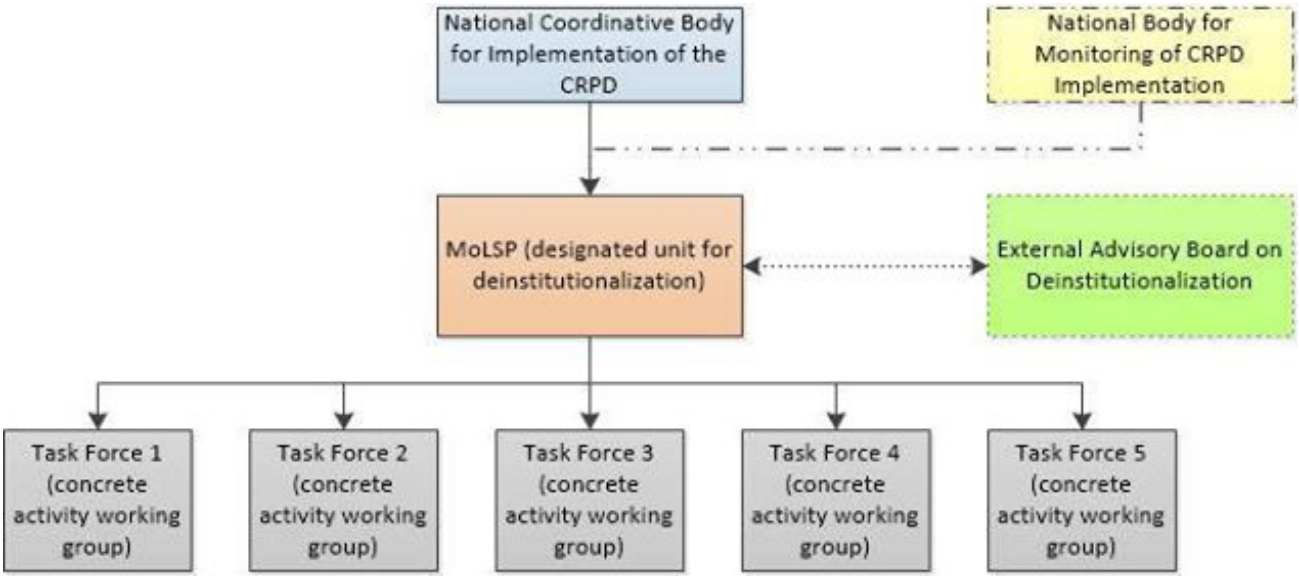
245. Coordination at the highest level will be a responsibility of the *National Coordinative Body for implementation of the CRPD* within the Office of the President of the GoRM. Key tasks of this body would include providing the highest level of political will and support for the deinstitutionalisation; facilitating inter-sectoral coordination; ensuring measures undertaken for implementation of the Strategy are in agreement with the provisions of the CRPD; providing guidelines for improvements and similar actions.

246. Monitoring of the implementation of the Strategy will be a responsibility of the *National Mechanism (body) for monitoring the implementation of CRPD within the Ombudsman Office*, with participation of representatives of people with disabilities and relevant civil organisations. Obligations of this body would include monitoring of achievements; monitoring the degree of harmonisation of the Strategy implementation with the CRPD; drafting periodical progress reports and offering recommendations for improvements; informing the public on Strategy implementation monitoring and similar actions.

247. The MoLSP will establish an organisational unit (department) with appropriate human resources, with the following duties: execution of foreseen activities; operative coordination with different stakeholders; documentation of steps undertaken and effects achieved; drafting periodical progress reports, proposing measures for improvements, etc.

248. The MoLSP will establish a separate advisory body consisting of representatives of public institutions, international organisations, CSOs, persons with disability, users of social services, experts, etc., who will be assigned with a task of critically monitoring and evaluating the implementation of the Strategy and, on ground of national and international experience, to offer proposals and alternatives for improvements.

Illustration 1: Mechanisms for implementation and monitoring of the Strategy



249. The implementation of this Strategy will undergo two formal external evaluations: at the beginning of 2021 (following the first three years of implementation) and at the beginning of 2024 (following the second three years of implementation). External evaluators will be hired, who will need, through a participatory process, to critically evaluate achievements, offer guidelines for implementations of the Strategy in the upcoming period and to draft detailed action plans for the periods 2021-2023 and 2024-2027, respectively.

Action plan

The Republic of Macedonia
Ministry of Labour and Social Policy

Action plan on implementation of the National Deinstitutionalisation Strategy 2018-2027 "Timjanik"

Skopje, October 2018

INTRODUCTION

The goal of this Action plan on implementation of the National Deinstitutionalisation Strategy 2018-2027 "Timjanik" is to be used as a practical and operative guide for implementation of deinstitutionalisation in the country:

On one hand, the Action plan is a practical tool to be used in managing and implementing the Strategy, by offering a detailed review of activities to be undertaken in order to meet the targets and priorities. Even though key responsibility for Strategy implementation lies with the Ministry of Labour and Social Policy, this document, in the spirit of the participative process of drafting, clearly allocates responsibility and emphasises the inclusion of different stakeholders in the implementation.

On the other hand, by setting up performance indicators and sources of verification in advance, this Action plan is becoming grounds for monitoring and evaluation of the degree of success in implementing the deinstitutionalisation process. Hence the document will also encourage systemic learning from the process and will contribute to informed decision making and policy creation.

The Action plan and the National Deinstitutionalisation Strategy 2018-2027 "Timjanik" were developed with financial and technical support by the European Union and within a participative and consultative process which included numerous meetings, discussions, debates and conferences. Communication and cooperation with different stakeholders in the drafting process contributed to enhanced possibilities for collaborative and successful implementation of the deinstitutionalisation process, in the interest of respecting human rights and strengthening the dignity of citizens in need of social care and support.

Support by international stakeholders is contributing to the efforts by the Republic of Macedonia to meet obligations taken with the ratified international conventions and protocols, as well as to harmonise its own social care system with standards and practices of the European Union.

LIST OF ACRONYMS AND ABBREVIATIONS

Academic institutions	Higher education institutions relevant for social care
GoRM	Government of the Republic of Macedonia
CSO	Civil society organisation
OAH	Old Age Homes (for persons over 65 years of age)
EU	European Union
ISC	Institute for Social Care
Inspectorate	State Labour Inspectorate
consultants	External consultants to be additionally hired for implementation of deinstitutionalisation
CRC	UN Convention on the Rights of the Child
CRPD	UN Convention on the Rights of Persons with Disability
MoH	Ministry of Health
MoC	Ministry of Culture
MoES	Ministry of Education and Science
MoJ	Ministry of Justice
MoTC	Ministry of Transport and Communication
MoLSP	Ministry of Labour and Social Policy
RI	Residential social institutions: • Home for Children without Parents and Parental Care '11 October' • Home for Infants and Small Children (Bitola) • Institute for rehabilitation Banja Bansko • Institute for protection and rehabilitation of children and youth Topaansko Pole • Public institution for fostering children with behavioural and social problems '25 May' • Special Institution Demir Kapija • Institute for fostering children and youth with behavioural problems 'Ranka Milanovik'
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
CSW	Centres for Social Work

1. TRANSFORMATION OF INSTITUTIONS

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
1.1	**Plan transformation of residential institutions in a participatory fashion**				
1.1.1	**Transformation plans developed for every institution for children without parental care and persons with disability**	**Each residential institution (7) has developed and adopted a transformation plan**	**Adopted transformation plan by every residential institution**	**2019**	**MoLSP, RIs**
1.1.1.1.	Selection of external consultants for preparation of transformation plans for residential institutions	Consultants hired in every institution	Agreements for hiring consultants in every institution	2018	MoLSP, UNICEF, UNDP
1.1.1.2.	Implementation of a participatory process of drafting transformation plans	Staff and users of institutions, as well as other stakeholders, participate in the planning process	Reports on meetings, interviews and other forms of consultations held	2018-2019	Consultants, RIs, MoLSP
1.1.1.3.	Adoption of transformation plans	Transformation plans adopted by management bodies of institutions	Decision on adoption of transformation plans by management bodies of each institutions	2019	RIs
1.1.2	**Developing a sub-strategy for deinstitutionalisation of old age homes**	**Sub-strategy approved for deinstitutionalisation of old age homes**	**Government decision on adoption of the sub-strategy for deinstitutionalisation of old age homes**	**2021**	**MoLSP**
1.1.2.1.	Establishing a workgroup for drafting a sub-strategy for deinstitutionalisation of old age homes	Workgroup for drafting a sub-strategy for deinstitutionalisation of old age homes established	Decision on establishing a workgroup	2021	MoLSP
1.1.2.2.	Selection of external consultants for drafting a sub-strategy for deinstitutionalisation of old age homes	Consultants hired	Agreements for hiring consultants	2021	MoLSP
1.1.2.3.	Situation analysis on old age homes and possibilities for deinstitutionalisation	Completed situation analysis on old age homes and possibilities for deinstitutionalisation	Report on the situation analysis on old age homes and possibilities for deinstitutionalisation	2021	MoLSP, Consultants
1.1.2.4.	Participatory drafting of a sub-	Staff and users of old age homes,	Reports on meetings, interviews and other	2021	MoLSP,

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
	strategy for deinstitutionalisation of old age homes	as well as other stakeholders participate in the planning process	forms of consultations held		consultants
1.1.3	**Developing sub-strategy for deinstitutionalisation of institutions for persons with mental health difficulties**	**Adopted sub-strategy on deinstitutionalisation of institutions for persons with mental health difficulties**	**Government decision on adoption of the sub-strategy for deinstitutionalisation of institutions for persons with mental health difficulties**	**2021**	**MoLSP, MoH**
1.1.3.1.	Establishing a work group for developing sub-strategy for deinstitutionalisation of institutions for persons with mental health difficulties	Work group established to develop sub-strategy on deinstitutionalisation of institutions for persons with mental health difficulties	Decision on establishing a work group	2021	MoLSP, MoH
1.1.3.2.	Selection of external consultants for drafting a sub-strategy for deinstitutionalisation of institutions for persons with mental health difficulties	Consultants hired	Agreements for hiring consultants	2021	MoLSP
1.1.3.3.	Situation analysis on institutions for persons with mental health difficulties	Completed situation analysis on institutions for persons with mental health difficulties and possibilities for deinstitutionalisation	Report on the situation analysis on institutions for persons with mental health difficulties and possibilities for deinstitutionalisation	2021	MoLSP, MoH Consultants
1.1.3.4.	Participatory drafting of a sub-strategy for deinstitutionalisation of institutions for persons with mental health difficulties	Staff and users of institutions for persons with mental health difficulties, as well as other stakeholders participate in the planning process	Reports on meetings, interviews and other forms of consultations held	2021	MoLSP, MoH Consultants
1.1.4	**Transformation plans developed for old age homes and institutions for persons with mental health difficulties**	**Transformation plans for old age homes and institutions for persons with mental health difficulties adopted**	**Decision on adoption of Transformation plans for old age homes and institutions for persons with mental health difficulties**	**2022**	**MoLSP, MoH, RIs, OAH**
1.1.4.1.	Participatory development of transformation plans for all public old age homes	Transformation plans developed for all public old age homes Staff and users of old age homes, as well as other stakeholders participate in the planning process	Individual transformation plans for all public old age homes Reports on meetings, interviews and other forms of consultations held	2022	MoLSP, OAH

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
1.1.4.2.	Participatory development of transformation plans for institutions for persons with mental health difficulties	Transformation plans developed for institutions for persons with mental health difficulties Staff and users of institutions for persons with mental health difficulties, as well as other stakeholders participate in the planning process	Individual transformation plans for institutions for persons with mental health difficulties Reports on meetings, interviews and other forms of consultations held	2022	MoLSP, MoHRIs
1.1.5	**Work group on transformation of every institution established and operative**			**2018-2027**	**MoLSP, MoH, RIs, OAH**
1.1.5.1	Establishing work groups to regularly work on transformation of institutions for children (without parents or parental care, with behavioural problems, etc.) and children and persons with disability	Work group established in each institution Work groups in each institution have adopted decisions and conclusions	Decision on establishing work groups in each institution	2018-2023	MoLSP, RIs
1.1.5.2	Establishing work groups to regularly work on transformation of public old age homes and institutions for persons with mental health difficulties	Work group established in each old age home and institutionfor persons with mental health difficulties	Decision on establishing work groups in each institution	2022-2027	MoLSP, MoH, OAH, RIs
1.2	**Strengthening the capacity for transformation of residential institutions**				
1.2.1.	**Institutional management staff capacity strengthened for managing changes and organisational transformation**	**Management staff of all institutions trained to manage the process of transformation of institutions**	**Reports on the course of implementation of transformation plans of institutions**	**2018-2027**	**MoLSP, RIs, OAH**
1.2.1.1.	Providing training for managing changes and organisational transformation for the management staff of social institutions, old age homes, and institutions for persons with mental health difficulties	Management staff of all institutions and homes in transformation have attended training for managing changes and organisational transformation	Reports from training events (at least 3, one for each type of institution: social institutions; old age homes; and institutions for persons with mental health difficulties	2018-2023	MoLSP, RIs, OAH
1.2.1.2.	Providing mentoring support for the management staff of social institutions, old age homes,	Management staff of all institutions and homes in transformation are provided	Reports from the mentoring support provided	2019-2027	MoLSP, RIs, OAH

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
	and institutions for persons with mental health difficulties	mentoring support in the process of transformation			
1.2.1.3.	Organising study visits (at least 7) for presenting good practice of transformations of social institutions, old age homes, and institutions for persons with mental health difficulties	Management staff of all institutions and homes in transformation have participated at least one study visit for presenting good practice of transformation of a related institution or home	Reports from study visits (at least 7, one for each type of institution:institutions for children without parents and parental care; children (parents) with social and behavioural problems; children with disability; persons with disability; old age homes; and institutions for persons with mental health difficulties)	2019-2027	MoLSP, RIs, OAH
1.2.2.	**Trained and skilled staff, dedicated to changes and human rights, selected and appointed at leading positions**	**Institutional management staff dedicated and supports transformation of institutions**	**Reports on the course of implementation of transformation plans of institutions**	**2018-2027**	**MoLSP, RIs, OAH**
1.2.2.1.	Implementing transparent procedures for selection and promotion of management staff of institutions, based on merit and dedication to the transformation of institutions	Selection and promotion of management staff of institutions is transparent and based on merit and dedication of candidates to the transformation of institutions	Documentation on the procedures of selection and promotion of management staff of institutions		MoLSP, RIs, OAH
1.2.3.	**New organisational structure established at residential institutions, allowing for staff and user participation, delegation of power and duties, and new functions of institutions (according to the transformation plans)**	**Staff and users participate in decision making within the institutions** **The new organisational structure is appropriate for the new functions of the institutions**	**Rulebooks on systematisation of institutions**	**2019-2021**	**MoLSP, RIs, OAH**
1.2.3.1.	Participatory development of the new organisational structure at residential institutions	Staff and users participate in the development of the new organisational structure The new organisational structure allows for new functions and participation of staff and users participate in decision making	Reports on meetings, interviews and other forms of consultations held Draft rulebooks on systematization and other relevant internal acts of institutions	2019-2021	MoLSP, RIs
1.2.3.2.	Adopting the new organisational structure at residential institutions	The new organisational structure at residential institutions adopted	Decisions on adopting the new organisational structure at residential institutions	2019-2021	MoLSP, RIs
1.2.4.	**Team work and project management introduced**	**At least one functional internal team designated to a particular (specific) issue in each institution**	**Reports on the work of internal work groups in institutions** **Project documents and reports**	**2019-2021**	**MoLSP, RIs, ISC**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
		established **At least 5 institutions are implementing or participating in projects in their specific scope of work**			
1.2.4.1.	Organising training on team work for staff at residential institutions	At least 25% of staff at residential institutions have undergone training on team work	Reports on training events held, lists of participants	2019-2021	MoLSP, RIs, ISC
1.2.4.2.	Organising training on project management for staff at residential institutions	At least 3 staff in each residential institution have undergone training on project management	Reports on training events held, lists of participants		MoLSP, RIs, consultants
1.2.5.	**Coordinated care (case management) and personal planning introduced**	**Residential institutions are applying the methods of coordinated care and personal planning in their work**	**Personal files of users kept by institutions** **Personal plans of users**	**2018-2020**	**MoLSP, ISC, consultants, RIs**
1.2.5.1.	Organising training for trainers on coordinated care (case management)	At least 20 experts from the social protection system have acquired knowledge and skills for delivery of training on coordinated care	Reports on training events held, lists of participants	2018	MoLSP, consultants
1.2.5.2.	Organising training on coordinated care (case management) for staff at residential institutions	Professional staff at residential institutions have undergone training on coordinated care (case management)	Reports on training events held, lists of participants	2019-2020	MoLSP, ISC , trained trainers, RIs,
1.2.5.3.	Organising training for trainers on personal planning	At least 20 experts from the social protection system have acquired knowledge and skills for delivery of training on personal planning	Reports on training events held, lists of participants	2018-2019	MoLSP, consultants
1.2.5.4.	Organising training on personal planning for staff at residential institutions	Professional staff at residential institutions have undergone training on personal planning	Reports on training events held, lists of participants	2019-2020	MoLSP, ISC , trained trainers
1.3.	**Transformation of residential institutions**				
1.3.1.	**Training, re-training and professional re-orientation of staff at institutions provided**	**Staff are trained to perform new functions of institutions**	**Reports on the course of implementation of transformation plans of institutions**	**2018-2022**	**MoLSP, ISC, RIs, consultants**
1.3.1.1.	Analysis completed on the structure of current and needed staff, according	A clear overview of available and needed staff for institution to be	Analysis of the structure of current and needed staff	2018-2019	MoLSP, RIs

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
	to the new function of institutions (stated in the transformation plans)	properly responding to new functions obtained			
1.3.1.2.	Organising training and re-training for staff at institutions	All staff members have undergone trainingto be able to perform new functions at the institution	Reports on training events, lists of participants	2018-2022	MoLSP, ISC, RIs, consultants
1.3.1.3.	Providing support for professional re-orientation of staff at institutions that need the support	Staff at institutions that need the support have received support on professional re-orientation	List of staff members who have received support for professional re-orientation	2019-2020	MoLSP, ISC, RIs
1.3.2.	**Reconstruction, adaptation and equipping the premises and properties of institutions completed** **Note:** this refers to the seven residential institutions stated in this Strategy; in old age homes and institutions for persons with mental difficulties, this activity will commence in 2023	**Premises and property allow for uninterrupted performance of the new functions of institutions that are not residential**	**Reports on the course of implementation of transformation plans of institutions**	**2019-2025**	**MoLSP, RIs**
1.3.2.1.	Developing a survey and calculation for reconstruction, adaptation and equipping the institutions	Survey, calculation and design plans developed for each of the seven residential institutions	Survey, calculation and design plans for each residential institution	2019-2021	MoLSP, construction planners
1.3.2.2.	Performing reconstruction, adaptation and equipping of institutions, according to the new function stated in the transformation plans	Reconstruction, adaptation and equipping are performed according to the defined survey and calculation at each institution	Report from the supervision body	2019-2025	MoLSP, RIs, contractors, supervision
1.3.3.	**Establishing internal procedures on delivery of new social services**	**Internal procedures adopted allow for high quality delivery of new services**	**New internal procedures (and work protocols) for institutions**		
1.3.3.1.	Participative development of new internal procedures (and work protocols) to enable delivery of new social services by institutions	Staff and users participate in developing new internal procedures	Reports on meetings, interviews and other forms of consultations held Draft internal procedures of institutions	2019-2021	MoLSP, RIs, consultants
1.3.3.2.	Adopting new internal procedures (and work protocols) to enable delivery of new social services by institutions	New internal procedures (and work protocols) adopted	Decisions on adopting new internal procedures (and work protocols)	2019-2021	MoLSP, RIs

2. RESETTLEMENT OF USERS

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
2.1	Enabling continuous, pragmatic and non-discriminatory resettlement				
2.1.1.	Schedule defined for resettlement of users of institutions	At least 500 resettled users by 2023 are provided with regular support in the new forms of care	Reports on resettlement of users	2018-2027	MoLSP, MoTC, RIs, contractors, service providers

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
2.1.1.1.	Developing personal plans for resettlement of users of the seven residential institutions stated in the Strategy	Personal plans for resettlement of all users of the institutions, with defined needs for support following the resettlement	Personal plans for users	2018-2022	MoLSP, RIs
2.1.1.2.	Providing public housing or renting housing units to accommodate users of institutions	At least 120 publicly owned flats provided	GoRM decisions on awarding entitlement to use publicly owned flats	2018-2027	MoLSP, RIs
2.1.1.3.	Adaptation (especially providing accessibility) and equipping the homes for users to move in	At least 160 flats adapted, accessible and equipped for users to move in	Reports from supervisory body on construction work List of equipment and furniture procured	2022-2023	MoLSP, contractors
2.1.1.4.	Resettling users in small group homes (or housing communities for organised living with support in the community, hereafter: housing communities)	At least 500 users resettled at small group homes (or housing communities)	Reports on resettlement of users of institutions	2018-2023	MoLSP, RIs, service providers
2.1.1.5.	Continuous care and support of resettled users in small group homes (or housing communities) provided	At least 500 users are regularly provided with support at small group homes (or housing communities) Service providers for small group homes (or housing communities) exist in at least 6 of the 8 statistical regions	Reports from service providers who provide care for users following the resettlement	2018-2027	MoLSP, service providers
2.1.2.	**Enabling resettlement of children from institutions**	**All children from institutions resettled by 2020**	**Reports on resettlement of children from institutions**	**2018-2027**	**MoLSP, RIs**
2.1.2.1.	Developing personal plans for resettlement of children from institutions	Personal plans for resettlement of children from institutions developed	Personal plans for children from institutions	2018-2020	MoLSP, RIs

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
2.1.2.2.	Providing foster families and resettlement in small group homes for children from institutions (those without the possibility to be returned to biological families) **Note:** only costs for allowances for foster families are presented; costs for resettlement of children into group homes are presented in activity 2.1.1.5.	At least 100 children are resettled into foster families At least 50 children are resettled into small group homes	Reports on resettlements of children from institutions	2018-2027	MoLSP, RIs
2.1.3.	**Enabling resettlement of users in need of intensive support**				
2.1.3.1.	Inclusion of users in need of intensive support from the very beginning of the resettlement process	At least 1/3 of resettled users in the course of a year are persons in need of intensive support	Reports on resettlements of users of from institutions	2018-2023	MoLSP, RIs, service providers
2.1.3.2.	Establishing small group homes (or housing communities) with users in need of intensive support from the beginning of the resettlement process to set a role model example **Note**: Costs for this activity are presented in activity 2.1.1.5.	At least 2 small group homes (or housing communities) with users in need of intensive support established	Reports on resettlements of users of from institutions	2018-2019	MoLSP, RIs, service providers
2.1.4.	**Establishing financial allocations taking into account the differences in the intensity of needs of users**	**Different amounts identified for social services provision regarding support and care for users with different intensity of needs**	**Cost price of social services for support and care for users with different intensity of needs**	**2018-2019**	**MoLSP, consultant**
2.1.4.1.	Developing and adopting acosting methodology for identifying the price of social services taking into account the differences in the intensity of needs of users	Costing methodology for identifying the price of social services taking into account the differences in the intensity of needs of users adopted	Decision on adoption of costing methodology for identifying the price of social services taking into account the differences in the intensity of needs of users	2018-2019	MoLSP, consultant
2.2.	**Promoting resettlement towards independent living and biological families**				
2.2.1.	**Resettling into independent living enabled**	**Practice of resettlement of users of institutions towards independent living piloted**	**Report on experiences and satisfaction of users following resettlement into independent living**	**2018-2019**	**MoLSP, CSW, RIs, donors, ISC**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
2.2.1.1.	Enabling resettlement towards independent living of users of institutions for persons with disability from the very beginning of the resettlement process (by covering 'transitional' costs by donor organisations)	At least 2 resettlements of users of institutions for persons with disability (including intellectual disability) into independent living in the first year of resettlement process	Reports on resettlements of users of from institutions	2018-2019	MoLSP, RIs, donors
2.2.1.2.	Monitoring and documenting the success of the concept of independent living for ex-users of institutions	Experiences and satisfaction of users following resettlement into independent livingare documented and analysed	Report on experiences and satisfaction of users following resettlement into independent living	2018-2019	MoLSP, CSW, ISC
2.2.2.	**Enabling independent living for adult ex-residents resettled into small group homes**	**Piloted practice of resettlements of users of small group homes (or housing units) towards independent living**	**Recommendations developed for promoting the concept of independent living for persons in need of long-term care**	**2018-2020**	**MoLSP, CSW, RIs, donors, ISC**
2.2.2.1.	Enabling resettlements towards independent living of users of small group homes (by covering 'transitional' costs by donor organisations)	At least 4 users of small group homes (or housing communities) resettled into independent living in the first year of the resettlement process	Reports on resettlements of users of small group homes (or housing communities)	2018-2019	MoLSP, RIs, donors
2.2.2.2.	Monitoring the success of the concept of independent living for ex-users of small group homes (or housing communities)	Experiences and satisfaction of users following resettlement into independent livingare documented and analysed	Report on experiences and satisfaction of users following resettlement into independent living	2018-2019	MoLSP, CSW, ISC
2.2.2.3.	Conducting analysis and drafting recommendations for promotion of the concept of independent living (with appropriate support)	Recommendations drafted to intensify resettlement towards independent living (with proper support)	Analysis and recommendations for promotion of the concept of independent living (with proper support)	2019-2020	MoLSP, ISC
2.2.3.	**Providing support for resettlement of children in theirbiological families**	**Practice of returning children to their biological families piloted**	**Recommendations provided for enhancing opportunities for resettlement of children into their biological families**	**2018-2020**	**MoLSP, CSW, RIs,** ISC
2.2.3.1.	Strengthening the contacts of children from institutions with their biological families, prior and following resettlement	Steps toward strengthening the contacts of children from institutions and their biological families are included in the personal plans	Personal plans of children from institutions	2018-2019	MoLSP, RIs

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
2.2.3.2.	Enabling resettlement of children from institutions into their biological families	At least 4 children from institutions resettled into their (biological) families in the first year of the resettlement process	Reports on resettlements of users of institutions	2018-2019	MoLSP, RIs
2.2.3.3.	Monitoring the success of the concept of resettlement of children from institutions into their biological families	Experiences and satisfaction of users and their families are documented and analysed	Report on experiences and satisfaction of users and their families	2018-2019	MoLSP, CSW, ISC
2.2.3.4.	Conducting analysis and drafting recommendations for promotion of the concept of resettlement of children from institutions into their biological families (with appropriate support)	Recommendations drafted to enhance opportunities for return of children into their biological families	Analysis and recommendations for enhancing opportunities for return of children into their biological families	2019-2020	MoLSP, ISC
2.2.4.	**Establishing accelerated, clear and efficient adoption procedure**	**Adopted changes in the legal framework for adoption are in line with international standards and good practice**	**Adopted changes in the legal framework for adoption**	**2019-2020**	**MoLSP, consultants**
2.2.4.1.	Conducting a comparative analysis on the adoption procedure in RM and positive international practice	Necessary steps identified for improving the legal framework on adoption in RM	Report on the comparative analysis on the adoption procedure in RM and positive international practice	2019	MoLSP, consultants
2.2.4.2.	Improving the legal framework on adoption on grounds of the recommendations of the comparative analysis	Draft amendments to the legal framework on adoption developed	Draft amendments to the legal framework	2019-2020	MoLSP, consultants
2.2.5.	**Researching the possibilities for introduction of open adoption**	**Recommendations for the possibilities for introduction of open adoption in RM drafted**	**Report on the comparative analysis(2.2.4.1)**	**2019-2020**	**MoLSP, consultants**
2.2.5.1.	Conducting analysis on the possibilities for introduction of open adoption (within the Comparative analysis foreseen in 2.2.4.1)	Necessary steps identified for introduction of open adoption in RM, including necessary changes to the legal framework (if this option is considered desirable)	Report on the comparative analysis (2.2.4.1)	2019-2020	MoLSP, consultants
2.3.	**Improving the user resettlement methodology**				

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
2.3.1.	**Methodology introduced for drafting personal plans for resettlement as a prerequisite for resettlement**	**Resettlement of users is performed according to the proscribed methodology on personal planning and completed personal plans**	**Personal plans of users**	**2019-2027**	**MoLSP, ISC, RIs**
2.3.1.1.	Formally proscribing the methodology on personal planning as a prerequisite for resettlement of users of institutions	Written instructions introduced on application of the methodology on personal planning at residential institutions	Written instructions on application of the methodology on personal planning at residential institutions	2019	MoLSP, ISC
2.3.1.2.	Application of the methodology on personal planning upon resettlement of users of institutions	Institutions develop personal plans for their users	Personal plans of users	2019-2027	MoLSP, RIs
2.3.2.	**Different types of resettlement developed, including less used 'unconventional' or creative types of resettlement**	**At least 10% of users in institutions are resettled into different types of arrangements other than small group homes (or housing communities)** **Not more than 20% of children younger than 15 are resettled into small group homes**	**Report on the resettlement of users in institutions**	**2018-2027**	**MoLSP, CSW, ISC, RIs, CSOs**
2.3.2.1.	Participative research into all possible options when drafting personal plans for resettlement of users of institutions, including cooperation with local service providers and available local resources at the place of resettlement	The personal planning methodology includes researching into different types of resettlement and available local resources at the place of resettlements	Written instructions on application of the methodology on personal planning at residential institutions	2018-2027	MoLSP, ISC, CSW, RIs
2.3.3.	**Providing access to services in the community (outside the housing limits) according to the user needs**	**Users resettled in the community have access to necessary health, education, culture and other services in the new community**	**Report from the service provider of housing with support**	**2018-2027**	**MoLSP, CSW, RIs**
2.3.3.1.	Providing necessary services for the user in the community prior to his/her resettlement in the community	Personal planning methodology includes measures for providing necessary services and support at the place of resettlement	Personal plans of users Memorandums of understanding or other type of confirmation of availability of services and support by other providers (outside the housing limits)	2018-2027	MoLSP, CSW, RIs
2.4.	**Improving preparations and procedures for resettlement**				

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
2.4.1.	**Individual resettlement provided according to personal choice of users**	**Users actively participate in planning and implementing the resettlement from institutions**	**Personal plans for resettlement of users of institutions Reports on resettlement of users of institutions**	**2018-2027**	**MoLSP, RIs, service providers**
2.4.1.1.	Including personal choice of user for the place of resettlement and, if relevant, persons who will live together in a small group home or housing community	Resettled users of institutions have opportunities to personally choose the future place of living, and if relevant, persons who will live together in a small group home or housing community	Personal plans for resettlement of users of institutions Reports on resettlement of users of institutions	2018-2027	MoLSP, RIs, service providers
2.4.1.2.	Including users in equipping and decorating the flat (house) they will be resettled in	More than 75% of users actively participate in equipping and decorating the flat (house) they will be resettled in	Personal plans for resettlement of users of institutions Reports on resettlement of users of institutions	2018-2027	MoLSP, RIs, service providers
2.4.2.	**Users prepared for resettlement in a participatory process of preparations**	**Less than 10% of resettled users require change of place and form of resettlement in the first year of the resettlement process**	**Reports from service providers for supported living in the community**	**2018-2027**	**MoLSP, RIs, CSOs, service providers**
2.4.2.1.	Continuing the application of the method of intensive interaction in working with users	More than 75% of users (with intellectual disability) participate in the work based on applying the method of intensive interaction	Periodical reports on the work with users by applying the method of intensive interaction	2018-2020	MoLSP, RIs, CSOs
2.4.2.2.	Organising visits of users to theirfuture home and community, for meetings and initiating contacts	More than 75% of users have visited their future home and community at least two times prior to resettlement	Personal plans for resettlement of users of institutions Report on resettlement of users of institutions	2018-2027	RIs, service providers
2.4.2.3.	Organising workshops and training for self-determination for users with intellectual disability in institutions	More than 75% of users with intellectual disability in institutions have participated at workshops and training for self-determination	Personal plans for resettlement of users of institutions Reports by CSOs involved in the delivery of workshops and training for self-determination	2018-2020	MoLSP, RIs, CSOs
2.4.2.4.	Organising workshops and training for self-advocacy for users in institutions	More than 50% of users in institutions have participated at workshops and training for self-advocacy	Personal plans for resettlement of users of institutions Reports by CSOs involved in the delivery of workshops and training for self-advocacy	2018-2027	MoLSP, RIs, CSOs

3. DEVELOPMENT OF COMMUNITY SERVICES

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
3.1.	**Implementation of local and regional plans on improving social service provision**				
3.1.1.	**Methodology developed on assessment of local and/or regional needs, mapping of resources and response planning (interventions) regarding social services**	**Capacities strengthened in all statistical regions on application of harmonised methodology on planning the development of social services at local and/or regional level**	**At least two representatives from each statistical region (either from the regions, from municipalities or from CSOs) have undergone training on methodology on needs assessment, resource mapping and planning of social services**	**2019**	**MoLSP, consultants**
3.1.1.1.	Developing methodology on assessment of local and/or regional needs, mapping of resources and response planning regarding social services	Methodology developed on assessment of local and/or regional needs, mapping of resources and response planning regarding social services	Methodology on assessment of local and/or regional needs, mapping of resources and response planning regarding social services	2019	MoLSP, consultants
3.1.1.2.	Organising training on introduction of the methodology on assessment of local and/or regional needs, mapping of resources and response planning regarding social services	At least 2 training events held for at least 30 representatives of municipalities, statistical regions and civil society organisations on application of the harmonised methodology	Reports on training events	2019	MoLSP, consultants
3.1.2.	**Assessment conducted of local and/or regional needs, mapping of resources and response planning regarding social services**	**The assessments cover all statistical regions in the country (at least by assessing and mapping on municipal level in each region)**	**Reports on assessments and mapping completed**	**2019-2020**	**Statistical regions, municipalities, CSOs, consultants**
3.1.2.1.	Conducting assessment of local and/or regional needs, mapping of resources and response planning regarding social services	At least 10 assessments conducted of local and/or regional needs and mapping of resources	Reports on assessments and mapping completed	2019-2020	Statistical regions, municipalities, CSOs, consultants
3.1.3.	**Developing local and/or regional action plans for improving social service provision**	**10 developed local and/or regional action plans, out of which at least one for each planning region**	**Local and/or regional action plans for improving social service provision**	**2019-2020**	**Statistical regions, municipalities, CSOs, consultants**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
3.1.3.1.	Participative development of local and/or regional action plans for improving social service provision	Active participation of local stakeholders provided in planning social services	Reports on meetings, workshops, interviews and other forms of consultations held	2019-2020	Statistical regions, municipalities, CSOs, consultants
3.1.4.	**Support provided to municipalities and/or regions to implement action plans**	**At least 6 regions (out of 8) supported in developing social services** **At least 75% of the municipalities supported in developing social services according to action plans**	**MoLSP decisions for supporting municipalities in development of social services**	**2018-2027**	**MoLSP, consultants**
3.1.4.1.	Developing encouraging legal framework for promotion of municipal and/or regional participation in social services provision, including devolving competencies and authorities for social care provision to municipalities (and CSOs)	The legal framework encourages municipalities and regions to actively participate in social services provision	Changes to relevant legislation (Social Protection Act) and by-laws adopted	2018-2019	MoLSP, consultants
3.1.4.2.	Providing transparent financial and technical support to municipalities by MoLSP in their social services provision	Publishing annual calls by MoLSP for financial and technical support to municipalities for social services provision	Documentation relating to annual calls by MoLSP for financial and technical support to municipalities for social services provision	2019-2027	MoLSP
3.2.	**Reducing the threshold on eligibility for entrance into services**				
3.2.1.	**Legal framework adopted to guarantee the right of life in the community for persons in need of social care and housing and to impose an obligation to the state bodies to provide this right**	**The legal framework guarantees the right of life in the community for persons in need of social care and housing and offers possibilities for providing the needed support**	**New Social Protection Act** **Auxiliary secondary legislation (by-laws)**	**2018-2019**	**MoLSP**
3.2.1.1.	Introducing legal guarantee of the right of life in the community for persons in need of long-term social care	The legal framework in view of the right to life in the community, is fully harmonised with the provisions of the UNCRPD	Changes in the legal framework adopted (primarily in the Social Protection Act)	2018-2019	MoLSP
3.2.2.	**Mobile services and resource centres established at local and regional level**	**At least 200 persons are using mobile services and resource centres services at local and**	**Reports by service providers**	**2018-2027**	**MoLSP, service providers**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
		regional level			
3.2.2.1.	Establishing a legal framework for introducing mobile services and resource centres at local and regional level	The legal framework provides for establishing of mobile services and resource centres at local and regional level	New Social Protection Act	2018-2019	MoLSP
3.2.2.2.	Establishing mobile services and resource centres at local and regional level	Different types of mobile services and resource centres have been established in at least 4 statistical regions	List of licensed service providers (MoLSP)	2019-2027	MoLSP, service providers
3.2.3.	**Crisis centres and respite centres established**	**At least 50 persons use crisis centre services annually** **At least 50 persons use respite centre services annually**	**Reports by service providers**	**2018-2027**	**MoLSP, service providers**
3.2.3.1.	Introducing legal grounds for establishing crisis centres and respite centres	The legal framework provides grounds for establishing crisis centres and respite centres	New Social Protection Act	2018-2019	MoLSP
3.2.3.2.	Establishing crisis centres and respite centres	At least 1 crisis centre and 1 respite centre are established	List of licensed service providers (MoLSP)	2019-2027	MoLSP, service providers
3.2.4.	**Introduction of personal advocacy services**	**At least 30 persons use the service of personal advocacy annually**	**Reports of service providers**		**MoLSP, service providers**
3.2.4.1.	Introducing legal grounds for establishing personal advocacy services	The legal framework provides grounds for establishing personal advocacy services	New Social Protection Act	2018-2019	MoLSP
3.2.4.2.	Establishing personal advocacy services	At least one service provider established for personal advocacy services	List of licensed service providers (MoLSP)	2019-2027	MoLSP, service providers
3.3.	**Development of personalised services**				
3.3.1.	Personalised services such as home care, personal assistants and similar services introduced	**Personal assistance used at least by 250 persons annually** **Home care used by at least 250 persons annually**	**Reports of service providers**	**2018-2027**	**MoLSP, service providers**
3.3.1.1.	Introducing a legal framework on establishing home care and personal assistance services	The legal framework provides grounds for establishing home care and personal assistance services	New Social Protection Act	2018-2019	MoLSP

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
3.3.1.2.	Establishing personal assistance service	Personal assistance available in all statistical regions and in more than 75% of the municipalities	List of licensed service providers (MoLSP)	2018-2027	MoLSP, service providers
3.3.1.3.	Establishing home care service	Home care available in all statistical regions and in more than 75% of the municipalities	List of licensed service providers (MoLSP)	2019-2027	MoLSP, service providers
3.4.	**Strengthening the capacity of existing service providers**				
3.4.1.	**Strengthened capacity of centres for social work and for acting within the system of personalised community services**	**At least 3 representatives from each CSW trained to act within the system of personalised community service**	**Reports from training events, list of participants**	**2018-2020**	**MoLSP, ISC, consultants**
3.4.1.1.	Organising training for strengthening the capacity of CSW on social work and action in the community	At least 10 training events held on social work and action in the community for representatives of CSW	Reports from training events, list of participants	2019-2020	MoLSP, ISC, consultants
3.4.1.2.	Organising training for strengthening the capacity of CSW on assessment of social needs in the community and planning social interventions	At least 10 training events held on assessment of social needs in the community and planning social interventions for representatives of CSW	Reports from training events, list of participants	2019-2020	MoLSP, ISC, consultants
3.4.1.3.	Organising training for strengthening the capacity of CSW on case management and coordination of services	At least 10 training events held on case management and coordination of services for representatives of CSW	Reports from training events, list of participants	2018-2019	MoLSP, ISC, consultants
3.4.2.	**Capacity of relevant civil organisations strengthened for community service provision**	**Civil society organisations provided personalised social services in the community in each statistical region**	**List of licensed service providers (MoLSP)**	**2019-2021**	**MoLSP, ISC, consultants**
3.4.2.1.	Organising training for CSOs on the concept and principles of provision of personalised social services in the community	At least 5 training events held on the concept and principles of provision of personalised social services in the community	Reports from training events, list of participants	2019-2020	MoLSP, ISC, consultants
3.4.2.2.	Organising study visits for CSOs to present successful examples of CSOs that provide personalised social services in the community	At least 3 study visits organized to present successful examples in the country and internationally	Reports from study events	2019-2021	MoLSP, ISC, consultants
3.4.3.	**Strengthened and improved system**	**Improved care quality in foster**	**Report on annual evaluation performed on**	**2018-**	**MoLSP, ISC,**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
	for fostering, including family (foster) care for adults	**families for children and for adults**	**care quality in foster families**	**2027**	**UNICEF, CSOs**
3.4.3.1.	Introducing encouraging legal framework on fostering, including fostering of adults	The legal framework provides grounds for appropriate support, including financial support and access to training and services for the fostering families	New Social Protection Act Relevant secondary legislation (by-laws)	2018-2019	MoLSP
3.4.3.2.	Introducing a possibility for fostering by relatives	The possibility for adoption by relatives legally introduced	New Social Protection Act	2018-2019	MoLSP
3.4.3.3.	Establishing centres for support of foster carers	At least 2 centres for support of foster families established At least 100 foster families annually are provided with professional support and training by the centre	New Social Protection Act Annual reports on the work of centres for support of foster families	2019-2027	MoLSP
3.4.3.4.	Organising periodic information campaigns for motivating potential foster families	At least 3 information campaigns for motivating potential foster families completed	Reports from campaigns completed	2018-2027	MoLSP, UNICEF, CSOs
3.4.4.	**Capacity of day centres offering inclusive services and lower threshold for entry of users strengthened**	**Increased number of day centre users (i.e. community centres) by 50% compared to the current number** **At least 30% of the total number of users of day centres (i.e. community centres) use development and rehabilitation services**	**Annual reports on the work of day centres ((i.e. community centres)**	**2018-2027**	**MoLSP, ISC, day centres, consultants**
3.4.4.1.	Transformation of day centres into inclusive community centres (according to recommendations from the UNICEF report on day centres)	All day centres transformed into inclusive community centres	Decisions on transforming day centres into inclusive community centres	2018-2027	MoLSP, day centres
3.4.4.2.	Training for representatives of day centres on provision of new types of services	At least 10 training events on provision of new types of services for representatives of day centres	Reports on training events	2019-2027	MoLSP, ISC, consultants
3.4.5.	**Availability of variety of community services promoted**	**At least 500 visits of the website per month**	**Report on the number of website visits**	**2019-2027**	**MoLSP**
3.4.5.1.	Establishing and regularly updating a website on available community	A website on available community services and community service	A website on available community services and community service providers	2019-2027	MoLSP

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
	services and community service providers	providers constructed			

4. PREVENTION OF DEINSTITUTIONALISATION

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
4.1.	**Research of cultural customs for care and structural factors of institutionalisation**				
4.1.1.	**Research conducted on informal care and its basis in the culture values and social and economic variables**	**Factors identified contributing to informal care and contributing to institutionalisation**	**Reports on research completed**	**2019-2024**	**MoLSP, CSOs**
4.1.1.1.	Conducting research related to informal care	At least 1 research related to informal care completed annually	Reports on research completed	2019-2024	MoLSP, CSOs
4.1.2.	**Projects implemented in the community to support positive aspects of traditional solidarity and informal care in and by the community**	**At least 100 direct users covered annually by supporting and promoting informal care**	**Project reports**	**2020-2025**	**MoLSP, CSOs municipalities**
4.1.2.1.	Implementation of projects promoting traditional solidarity and informal care in and by the community	At least 3 projects implemented annually in different statistical regions	Project reports	2020-2025	MoLSP, CSOs municipalities
4.1.3.	**Culturally sensitive adaptations of services introduced, in line with research conclusions and recommendations**	**Increased level of satisfaction of users by the undertaken culturally sensitive adaptations of services**	**Report on the analysis of the satisfaction level in users by the undertaken culturally sensitive adaptations of services**	**2021-2025**	**MoLSP, CSOs, CSW, service providers**
4.1.3.1.	Conducting analysis on the degree of harmonisation of individual services offered by the social protection system and findings from research and projects related to informal care	Recommendations developed for needed for culturally sensitive adaptations in the manner of social service provision	Report on the analysis on the degree of harmonisation of individual services offered by the social protection system and findings from research and projects related to informal care	2021-2025	MoLSP, ISC
4.1.3.2.	Changes and adaptations, if necessary, to certain services offered by the social protection system	Social services adapted to the culture and the traditional informal care in certain communities	Reports on the evaluation of piloted adaptations of certain social services	2021-2025	MoLSP, ISC, CSW, service providers
4.1.3.3.	Organising training for CSW and service providers to adapt the style of work and communication in line with the needs and culture of users	At least 10 training events held on adaptation of the style of work and communication in line with the needs and culture of users	Reports on training events, lists of participants	2021-2025	MoLSP, ISC, CSW, service providers
4.2.	**Introduction of administrative measures preventing (re)institutionalisation**	**No cases of institutionalisation or re-institutionalisation have been recorded**	**Annual reports on the work of residential institutions** **Reports on resettlement of users of institutions**	**2018-2027**	**MoLSP, CSW, RIs**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
4.2.1.	**Moratoria introduced for admissions in residential institutions for children without proper care and for persons with disability**	**No cases of admissions in institutions for children without proper care recorded** **No cases of admissions in institutions for persons with disability recorded**	**Annual reports on the work of residential institutions for children without parents and parental care and for persons with disability**	**2018-2027**	**MoLSP, CSW, RIs**
4.2.1.1.	Moratoria introduced for admissions in residential institutions for children without proper care	Moratoria for admissions in residential institutions for children without proper care is in place	Decision on introducing moratoria for admissions in residential institutions for children without proper care	2020-2027	MoLSP, CSW, RIs
4.2.1.2.	Duration extended of the moratoria on admissions in institutions for persons with disability	Moratoria for admissions in institutions for persons with disability is in place	No decision on withdrawal or termination of the moratoria	2018-2027	MoLSP, CSW, RIs
4.2.2.	**Moratoria introduced on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users**	**No measures have been undertaken to construct or adapt institutional buildings and facilities**	**Annual reports on the work of residential institutions**	**2018-2027**	**MoLSP, RIs**
4.2.2.1	Introducing moratoria on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users	Moratoria on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users in place	Decision on introducing moratoria on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users	2018-2027	MoLSP, RIs
4.2.2.2.	Conducting basic interventions on adaptation of institutional buildings and facilities related to safety and health of users	Minimal conditions provided in institutions to protect safety and health of users and staff	Annual reports on the work of residential institutions	2018-2020	MoLSP, RIs
4.2.3.	**Ban introduced for re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution**	**No user has returned to the institution following resettlement (dismissal)**	**Annual reports on the work of residential institutions** **Reports on resettlement of users from institutions**	**2018-2027**	**MoLSP, CSW, RIs**
4.2.3.1.	Introducing a ban on re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution	A ban on re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution is in place	Decision on introducing a ban on re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution	2018-2027	MoLSP, CSW, RIs

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
4.1.	**Research of cultural customs for care and structural factors of institutionalisation**				
4.1.1.	**Research conducted on informal care and its basis in the culture values and social and economic variables**	**Factors identified contributing to informal care and contributing to institutionalisation**	**Reports on research completed**	**2019-2024**	**MoLSP, CSOs**
4.1.1.1.	Conducting research related to informal care	At least 1 research related to informal care completed annually	Reports on research completed	2019-2024	MoLSP, CSOs
4.1.2.	**Projects implemented in the community to support positive aspects of traditional solidarity and informal care in and by the community**	**At least 100 direct users covered annually by supporting and promoting informal care**	**Project reports**	**2020-2025**	**MoLSP, CSOs municipalities**
4.1.2.1.	Implementation of projects promoting traditional solidarity and informal care in and by the community	At least 3 projects implemented annually in different statistical regions	Project reports	2020-2025	MoLSP, CSOs municipalities
4.1.3.	**Culturally sensitive adaptations of services introduced, in line with research conclusions and recommendations**	**Increased level of satisfaction of users by the undertaken culturally sensitive adaptations of services**	**Report on the analysis of the satisfaction level in users by the undertaken culturally sensitive adaptations of services**	**2021-2025**	**MoLSP, CSOs, CSW, service providers**
4.1.3.1.	Conducting analysis on the degree of harmonisation of individual services offered by the social protection system and findings from research and projects related to informal care	Recommendations developed for needed for culturally sensitive adaptations in the manner of social service provision	Report on the analysis on the degree of harmonisation of individual services offered by the social protection system and findings from research and projects related to informal care	2021-2025	MoLSP, ISC
4.1.3.2.	Changes and adaptations, if necessary, to certain services offered by the social protection system	Social services adapted to the culture and the traditional informal care in certain communities	Reports on the evaluation of piloted adaptations of certain social services	2021-2025	MoLSP, ISC, CSW, service providers
4.1.3.3.	Organising training for CSW and service providers to adapt the style of work and communication in line with the needs and culture of users	At least 10 training events held on adaptation of the style of work and communication in line with the needs and culture of users	Reports on training events, lists of participants	2021-2025	MoLSP, ISC, CSW, service providers
4.2.	**Introduction of administrative measures preventing (re)institutionalisation**	**No cases of institutionalisation or re-institutionalisation have been recorded**	**Annual reports on the work of residential institutions** **Reports on resettlement of users of institutions**	**2018-2027**	**MoLSP, CSW, RIs**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
4.2.1.	**Moratoria introduced for admissions in residential institutions for children without proper care and for persons with disability**	**No cases of admissions in institutions for children without proper care recorded** **No cases of admissions in institutions for persons with disability recorded**	**Annual reports on the work of residential institutions for children without parents and parental care and for persons with disability**	**2018-2027**	**MoLSP, CSW, RIs**
4.2.1.1.	Moratoria introduced for admissions in residential institutions for children without proper care	Moratoria for admissions in residential institutions for children without proper care is in place	Decision on introducing moratoria for admissions in residential institutions for children without proper care	2020-2027	MoLSP, CSW, RIs
4.2.1.2.	Duration extended of the moratoria on admissions in institutions for persons with disability	Moratoria for admissions in institutions for persons with disability is in place	No decision on withdrawal or termination of the moratoria	2018-2027	MoLSP, CSW, RIs
4.2.2.	**Moratoria introduced on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users**	**No measures have been undertaken to construct or adapt institutional buildings and facilities**	**Annual reports on the work of residential institutions**	**2018-2027**	**MoLSP, RIs**
4.2.2.1	Introducing moratoria on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users	Moratoria on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users in place	Decision on introducing moratoria on construction or adaptation of institutional buildings and facilities, except for interventions related to safety and health of users	2018-2027	MoLSP, RIs
4.2.2.2.	Conducting basic interventions on adaptation of institutional buildings and facilities related to safety and health of users	Minimal conditions provided in institutions to protect safety and health of users and staff	Annual reports on the work of residential institutions	2018-2020	MoLSP, RIs
4.2.3.	**Ban introduced for re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution**	**No user has returned to the institution following resettlement (dismissal)**	**Annual reports on the work of residential institutions** **Reports on resettlement of users from institutions**	**2018-2027**	**MoLSP, CSW, RIs**
4.2.3.1.	Introducing a ban on re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution	A ban on re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution is in place	Decision on introducing a ban on re-institutionalisation of the status of users following resettlement (dismissal) from a residential institution	2018-2027	MoLSP, CSW, RIs

5. COORDINATED AND COMPLEMENTARY PUBLIC POLICIES

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
5.1.	**Harmonisation with other relevant public policies and development of new policies for supporting deinstitutionalisation**				
5.1.1.	**Inconsistent parts in the policies related to deinstitutionalisation removed**	**Interventions in at least 5 different areas (public policy papers) due to removal of inconsistent parts related to deinstitutionalisation**	**Decisions of relevant bodies on changing public policies aimed at supporting and promoting deinstitutionalisation**	**2019-2027**	**GoRM, MoLSP, other ministries**
5.1.1.1.	Analysing public policies (health, education, justice, etc.) related to deinstitutionalisation and identifying inconsistencies	Inconsistencies in relevant public policies related to deinstitutionalisation identified	Reports of the analysis of public policies related to deinstitutionalisation	2019-2027	GoRM, MoLSP, other ministries
5.1.1.2.	Developing proposals for improving other relevant public policies for the purpose of supporting and promoting deinstitutionalisation	Proposals onimproving other relevant public policies for the purpose of supporting and promoting deinstitutionalisation developed	Draft proposals on improving other relevant public policies for the purpose of supporting and promoting deinstitutionalisation	2019-2027	GoRM, MoLSP, other ministries
5.2.	**Changes in other legislation to support deinstitutionalisation**				
5.2.1.	**Changes in legal capacity deprivation and guardianship, in accordance with international documents to allow for supported decision making**	**The national legal framework related to legal capacity deprivation and guardianship is harmonised with international documents to allow for supported decision making**	**Review of changes in the legal framework related to legal capacity deprivation and guardianship**	**2020-2021**	**MoLSP, MoJ, consultants**
5.2.1.1.	Conducting a comparative analysis on the degree of harmonisation of the Macedonian legal framework related to legal capacity deprivation and guardianship and relevant international documents	Gaps identified between the national legal framework and relevant international documents in relation to legal capacity deprivation and guardianship	Report on the comparative analysis on the degree of harmonisation of the Macedonian legal framework related to legal capacity deprivation and guardianship and relevant international documents	2020-2021	MoLSP, MoJ, consultants
5.2.1.2.	Developing proposals for harmonising the legal framework related to legal capacity deprivation and guardianship with relevant international documents to allow for supported decision making	Proposals for harmonising the legal framework related to legal capacity deprivation and guardianship with relevant international documents to allow for supported decision making developed	Draft proposals for harmonising the legal framework related to legal capacity deprivation and guardianship with relevant international documents to allow for supported decision making	2020-2021	MoLSP, MoJ

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
5.2.2.	**Revising the legislation on social housing**	**The revised legislation allows for different forms of promoting social housing**	**Review of changes in legislation related to social housing**	**2021-2022**	**MoLSP, MoTC, consultants**
5.2.2.1.	Conducting an analysis of the legal framework on social housing (including public-private partnership, cooperative housing and participation of users)	Possibilities identified for improving the legal framework to promote social housing	Report on the analysis of the legal framework on social housing	2021-2022	MoLSP, MoTC, consultants
5.2.2.2.	Developing proposals for improving the legal framework on social housing	Proposals for improving the legal framework for promoting social housing developed	Draft proposals for improving the legal framework on social housing	2021-2022	MoLSP, MoTC
5.2.3.	**Revising legislation on employment of persons with disability and other vulnerable groups**	**The revised legislation on employment of persons with disability and other vulnerable groups encourages their participation at the open labour market**	**Review of the changes in the legislation on employment of persons with disability and other vulnerable groups**	**2019-2020**	**MoLSP, consultants**
5.2.3.1.	Conducting analysis on the legal framework on employment of persons with disability and other vulnerable groups	Possibilities identified for improving the legal framework on employment of persons with disability and other vulnerable groups	Report on the analysis of the legal framework on employment of persons with disability and other vulnerable groups	2019-2020	MoLSP, consultants
5.2.3.2.	Developing proposals for improving the legal framework on employment of persons with disability and other vulnerable groups (to encourage their access to the open labour market)	Proposals for improving the legal framework on employment of persons with disability and other vulnerable groups (to encourage their access to the open labour market) developed	Draft proposals for improving the legal framework on employment of persons with disability and other vulnerable groups	2019-2020	MoLSP

6. LEGISLATIVE REFORM

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
6.1.	**Reforming the legislation on social protection for the purpose of supporting deinstitutionalisation and providing services in the community**				
6.1.1.	**Clearly defined and regulated social services in the community required**	**A new Social Protection Act adopted** **Necessary by-laws adopted**	**The new Social Protection Act published in the Official Journal of RM** **Decision on by-laws coming into force**	**2018-2020**	**MoLSP**
6.1.1.1.	Defining required social services in the new Social Protection Act	Each foreseen social service is clearly defined	Draft social protection act	2018	MoLSP
6.1.1.2.	Drafting by-laws on standards (and forms, etc.) on each social service foreseen in the new Social Protection Act	Standards are based on quality of living of the user	Draft by-laws	2018-2020	MoLSP, consultants
6.1.3.	**The methods of coordinated care (case management) and personal planning introduced as basic tools for care in the community**	**A new Social Protection Act adopted**	**The new Social Protection Act published in the Official Journal of RM**	**2018**	**MoLSP**
6.1.3.1.	Introducing legally binding application of case management as a method of work in the field of social protection	Clear provision in the Social Protection Act on legally binding application of case management in the field of social protection	Draft Social Protection Act	2018	MoLSP
6.1.3.2.	Introducing legally binding application of personal planning as a method of work with users of social services	Clear provision in the Social Protection Act on legally binding application of personal planning as a method of work with users of social services	Draft Social Protection Act	2018	MoLSP
6.2.	**Strengthening pluralisation in community service provision**				
6.2.1.	**System on licensing and accreditation introduced for social service providers**	**A new Social Protection Act adopted** **Necessary by-laws adopted**	**The new Social Protection Act published in the Official Journal of RM** **Decision on by-laws coming into force**	**2018-2019**	**MoLSP**
6.2.1.1.	Introducing provisions to the draft Social Protection Act to establish a system on licensing of social service providers	Clear provisions in the draft Social Protection Act to establish a system on licensing of social service providers	Draft Social Protection Act	2018	MoLSP
6.2.1.2.	Drafting required by-laws on regulating the system on licensing of	By-laws allow for clear and efficient procedure on licensing of social	Draft by-laws	2018-2019	MoLSP, consultants

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
	social service providers	service providers			
6.2.2.	**A system introduced for financing actual services provided**	**A new Social Protection Act adopted** **Necessary by-laws adopted**	**The new Social Protection Act published in the Official Journal of RM** **Decision on by-laws coming into force**	**2018-2019**	**MoLSP, consultants**
6.2.2.1.	Introducing provisions to the draft Social Protection Act to establish a system on financing the services delivered by licensed service providers	Clear provisions in the draft Social Protection Act to establish a system on financing the services delivered by licensed service providers	Draft Social Protection Act	2018	MoLSP
6.2.2.2.	Drafting required by-laws on regulating the financing of the services delivered by licensed service providers	By-laws allow for clear and efficient procedure on regulating the financing of the services delivered by licensed service providers	Draft by-laws	2019	MoLSP, consultants
6.2.3.	**Project financing established for innovative and pilot projects for development of social services**	**A new Social Protection Act adopted** **Necessary by-laws adopted**	**The new Social Protection Act published in the Official Journal of RM** **Decision on by-laws coming into force**	**2018-2019**	**MoLSP, consultants**
6.2.3.1.	Introducing provisions to the draft Social Protection Act for project financing of innovative and pilot projects for development of social services	Clear provisions in the draft Social Protection Act for project financing of innovative and pilot projects for development of social services	Draft Social Protection Act	2018	MoLSP
6.2.3.2.	Drafting required by-laws (and methodology) on selection and financing of innovative and pilot projects for development of social services	By-laws allow for clear and efficient procedure on selection and financing of innovative and pilot projects for development of social services	Draft by-laws	2018-2019	MoLSP, consultants
6.3.	**Encouraging decentralisation in social service provision**				
6.3.1.	**A system introduced of budget block grants to local self-government units for social service provision**	**A new Social Protection Act adopted** **Necessary by-laws adopted**	**The new Social Protection Act published in the Official Journal of RM** **Decision on by-laws coming into force**	**2018-2019**	
6.3.1.1.	Introducing provisions to the draft Social Protection Act for encouraging municipalities to provide social services	Clear provisions in the draft Social Protection Act for encouraging municipalities to provide social services	Draft Social Protection Act	2018	MoLSP
6.3.1.2.	Drafting by-laws (and methodology) on selection and financing (through budget block grants) of municipalities in social service provision	By-laws allow for clear and efficient procedure on selection and financing of social service provision delivered by municipalities	Draft by-laws	2018-2019	MoLSP, consultants

7. STANDARDS FOR QUALITY AND MONITORING

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
7.1.	**Development of new quality standards for community services**				
7.1.1.	**New quality standards established on community social services based on the quality of living**	**Application of the new quality standards for community services**	**Reports from the monitoring of quality standards for community services**	**2019-2027**	**MoLSP, ISC, inspectorate, consultants**
7.1.1.1.	Developing of new quality standards on community social services, based on the quality of living	New quality standards on community social services developed	By-laws on quality standards on community social services, based on the quality of living of users	2019-2027	MoLSP, ISC, inspectorate, consultants
7.1.1.2.	Adopting new quality standards on community social services, based on the quality of living	New quality standards on community social services adopted	Decision on by-laws on new quality standards on community social services, based on the quality of living coming into force	2019-2027	MoLSP
7.1.2.	**Mechanism (system) introduced on monitoring and evaluation of quality of social services**	**Regular monitoring and evaluation of the quality of social services and applying corrective measures as necessary**	**Annual reports on monitoring and evaluation of the quality of social services, including recommendations for improvements**	**2019-2027**	**MoLSP, ISC**
7.1.2.1.	Developing mechanism (system) on monitoring and evaluation of quality of social services	Mechanism (system) on monitoring and evaluation of quality of social services designed	Document describing the mechanism (system) on monitoring and evaluation of quality of social services	2019-2020	MoLSP, ISC, consultants
7.1.2.2.	Establishing structures and building the necessary capacities for application of the mechanism (system) on monitoring and evaluation of quality of social services	Required structures are established and have the necessary capacity	Decisions on establishing required structures Report on measures applied for building the capacities(instructions, information events, training events, etc.)	2019-2020	MoLSP, ISC
7.1.2.3.	Introducing mandatory internal monitoring and evaluation of the quality of services delivered by social service providers	An act introducing mandatory internal monitoring and evaluation of the quality of services delivered by social service providers adopted	Act on mandatory internal monitoring and evaluation of the quality of services delivered by social service providers adopted	2020	MoLSP, ISC, consultants

8. CHANGES IN FINANCING: REDIRECTING FROM INSTITUTIONS TOWARDS COMMUNITY SERVICES

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
8.1.	**Providing the necessary funds during the transition period**				
8.1.1.	**Funds provided from the state budget for covering transitional costs related to deinstitutionalisation**	**Appropriate funding provided from the state budget (via MoLSP) for implementation of the National Deinstitutionalisation Strategy 2018-2027**	**Financial review of expenditure for implementation of the National Deinstitutionalisation Strategy 2018-2027**	**2018-2027**	**GoRM, MoLSP**
8.1.1.1.	Allocating the required funds for implementation of the National Deinstitutionalisation Strategy 2018-2027 in the MoLSP annual budget	Required funds from the state budget intended for implementation of the National Deinstitutionalisation Strategy 2018-2027 are planned on time	RM Budget Act	2018-2027	GoRM, MoLSP
8.1.2.	**Coordination provided for all activities and funds by international donors and by CSOs (and other stakeholders) related to Strategy implementation**	**At least 20% of funds necessary for implementation of the National Deinstitutionalisation Strategy 2018-2027 are provided from sources other than state budget**	**Financial review of expenditure for implementation of the National Deinstitutionalisation Strategy 2018-2027**	**2018-2027**	**MoLSP**
8.1.2.1.	A coordination group led by the MoLSP established to coordinate activities of international donors and relevant CSOs relating to the implementation of the National Deinstitutionalisation Strategy 2018-2027	Regular meetings of the group for coordination of activities relating to the implementation of the National Deinstitutionalisation Strategy 2018-2027	Minutes from meetings of the coordination group, list of participants	2018-2027	MoLSP
8.3.	**Establishing a new financing system**				
8.3.1.	**A system piloted for direct financing of users**	**Possibilities for establishing a system for direct financing of users practically tested**	**Report on piloting the system fordirect financing of users**	**2023-2024**	**MoLSP, ISC, consultants**
8.3.1.1.	Piloting the system for direct financing of users	At least 50 users per year have an opportunity to be directly financed	Reports on the effectiveness and the impact the system for direct funding has in the lives of users	2023-2024	MoLSP, ISC, consultants
8.3.1.2.	Analysing the effects of piloting and possibilities for permanent	Advantages and challenges of the system for direct financing of users	Report on the analysis of the effects of piloting and possibilities for permanent establishment of	2024	MoLSP, ISC, consultants

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
	establishment of a system for direct financing of users	identified	a system for direct financing of users		
8.3.2.	**A system piloted for commissioning social services**	**Possibilities for establishing a system for commissioning social services practically tested**	**Report on piloting the system for commissioning social services**	**2023-2024**	**MoLSP, ISC, consultants**
8.3.2.1.	Piloting the system for commissioning social services	At least 50 users per year have an opportunity to get support to commission social services	Reports on the effectiveness and the impact the system for commissioning social services has in the lives of users	2023-2024	MoLSP, ISC, consultants
8.3.2.2.	Analysing the effects of piloting and possibilities for permanent establishment of a system for commissioning social services	Advantages and challenges of the system for system for commissioning social services identified	Report on the analysis of the effects of piloting and possibilities for permanent establishment of a system commissioning social services	2024	MoLSP, ISC, consultants

9. SOCIAL INCLUSION AND PROVIDING REGULAR SERVICES

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
9.1.	**Providing access to regular education for users (with disability) of social services**				
9.1.1.	**School age users of social community services are enrolled at school**	**Children who are users of social services regularly go to school**	**Personal files of users**	**2018-2027**	**MoLSP, MoES, service providers**
9.1.1.1.	Enrolling at school all school age users of social services	All children users of social services are enrolled at school	Personal files of users	2018-2027	MoLSP, MoES, service providers
9.1.1.2.	Piloting inclusion of children with complex needs at regular schools, by support of education assistants and support of professional staff from special schools	At least 10 children with complex educational needs included Identifying recommendations for establishing education assistance service for inclusion of children with complex educational needs in regular education	Report from piloting the service	2021-2022	MoLSP, MoES, service providers
9.2.	**Providing regular access to health services for users of social services**				
9.2.1.	**Access provided to health insurance, health care and health services to users of social services**	**Users of social services have access to health insurance, health care and regular health services**	**Personal files of users**	**2018-2027**	**MoLSP, ISC, MoH, service providers**
9.2.1.1.	Ensuring access of social service users to health insurance and health care	All social service users have health insurance and can use health care series	Personal files of users	2018-2027	MoLSP, ISC, MoH, service providers
9.2.1.2.	Organising training for doctors, nurses and health workers on working with persons with disability	Developing training programme for health workers on working with persons with disability Organising at least 3 training events per year for at least 60 health workers	Training programme for health workers on working with persons with disability Reports on training delivered, lists of participants	2019-2027	MoLSP, ISC, MoH
9.2.2.	**Outreach (mobile) health services developed for social service users with disability or complex health needs**	**At least 50 users with disability or with complex health needs use outreach (mobile) health services**	**Annual reports by service providers**	**2019-2027**	**MoLSP, MoH**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
9.2.2.1.	Introducing proper legal framework for developing outreach (mobile) health services for social service users with disability or complex health needs (or combined social and health services)	The new Social Protection Act foresees combined social and health services By-laws introduce standards and procedures for establishing and providing combined social and health services	New Social Protection Act Adopted by-laws on standards and procedures for establishing and providing combined social and health services	2019-2020	MoLSP, MoH
9.2.2.2.	Establishing combined social and health services	At least 2 providers offer combined social and health services	Decision on launching operations of a service provider	2021-2027	MoLSP, MoH
9.3.	**Providing access for users of social services to regular culture organisations and events**				
9.3.1.	**Support provided for local culture initiatives for inclusion of persons with disability (and other social service users)**	**Persons with disability (and other social service users) are actively involved in local culture initiatives**	**Reports on implementation of supported culture initiatives**	**2020-2027**	**MoLSP, MoC, CSOs, culture organisations**
9.3.1.1.	Providing support for local culture initiatives for inclusion of persons with disability (and other social service users)	At least 5 supported local culture initiatives for inclusion of persons with disability (and other social service users)	List of supported local culture initiatives for inclusion of persons with disability (and other social service users)	2020-2027	MoLSP, MoC, CSOs, culture organisations
9.3.2.	**Designed and implemented culture activities of persons with disability (and other social service users)**	**Persons with disability (and other social service users) are provided with opportunities to design and implement culture activities**	**Reports on implementation of supported culture activities of persons with disability (and other social service users)**	**2020-2027**	**MoLSP, MoC, CSOs, culture organisations**
9.3.2.1.	Providing support for culture activities of persons with disability (and other social service users)	At least 5 supported initiatives for culture activities of persons with disability (and other social service users)	List of supported initiatives for culture activities of persons with disability (and other social service users)	2020-2027	MoLSP, MoC, CSOs, culture organisations

Total funds required for 9. Social inclusion: 1.120.000 EUR

10. PROVIDING PLACES FOR HOUSING

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
10.1.	**Providing housing in relation to development of community care**				
10.1.1.	**Action plan developed for housing provision in relation to development of community care**	**Action plan adopted for housing provision in relation to development of community care**	**Decision on adopting the action plan for housing provision in relation to development of community care**	**2020-2021**	**MoLSP, MoTC**
10.1.1.1.	Conducting research on the housing needs of users of residential and other social services	Housing needs of users of residential and other social services identified	Report on research findings on housing needs of users of residential and other social services	2020	MoLSP, MoTC
10.1.1.2.	Developing an action plan for housing in relation to development of community care	Identified priorities on promoting housing for users of residential and other social services	Action plan for housing provision for users of residential and other social services	2021	MoLSP, MoTC

11. USER PARTICIPATION AND USER LED SERVICES

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
11.1.	**Increasing control and power of users**				
11.1.1.	**Implementing programmes and activities for self-advocacy**	**At least 3 different groups of users have implemented self-advocacy initiatives**	**Reports on implemented self-advocacy initiatives**	**2020-2027**	**MoLSP, ISC, CSOs, consultants**
11.1.1.1.	Organising training events for users on managing and self-advocacy	At least 2 training events held annually, each with at least 12 users	Reports on trainings, lists of users	2020-2027	MoLSP, ISC, CSOs, consultants
11.1.1.2.	Providing support for self-advocacy initiatives	Support provided for at least 1 self-advocacy initiative per year	List of supported self-advocacy initiatives	2021-2027	MoLSP, CSOs
11.1.3.	**User boards established at residential institutions and community services**	**User boards participate in decision making in every residential institution and community service provider**	**Reports on meetings of management boards of residential institutions and community services**	**2019-2027**	**MoLSP, RIs, service providers**
11.1.3.1.	Foreseeing a legal obligation for establishing user boards at residential institutions and community service providers	The legal framework introduces mandatory establishment of user boards at residential institutions and community service providers	Social Protection Act By-laws (secondary legislation)	2018-2019	MoLSP
11.1.3.2.	Establishing user boards at residential institutions and community service providers	Each residential institution or service provider (especially residential) has established user board	Decisions of each residential institution or service provider for establishing user boards	2019-2027	MoLSP, RIs, service providers
11.1.4.	**Peer support workers trained and employed (hired) in residential institutions and community services**	**Employed (hired) peer support workers are payed salary (fee)**	**Reports by residential institutions and community service providers on type and manner of employment (hire) of peer support workers**	**2020-2027**	**MoLSP, RIs, service providers**
11.1.4.1.	Developing a legal framework encouraging employment of peer support workers at RIs and social service providers	The legal framework encourages employment of peer support workers at RIs and social service providers	Relevant legislation and by-laws	2020	MoLSP
1.1.4.2.	Organising training for users interested in providing peer support	At least 50 users trained for providing peer support	Reports from training events, lists of participants	2020-2021	MoLSP, RIs, service

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
					providers
11.1.4.3.	Employing (hiring) users to provide peer support at residential institutions and social service providers	At least 20 users employed for providing peer support at residential institutions and social service providers	Reports by residential institutions and community service providers on type and manner of employment (hire) of peer support workers	2021-2027	MoLSP, RIs, service providers
11.2.	**Implementation of pilot projects for organisations and initiatives led by users**				
11.2.1.	**Initiative piloted on establishing service providers led by users**	**Possibilities identified and recommendations provided for establishing and support of service providers led by users**	**Report on the analysis of effectiveness and impact of piloted initiatives on establishing service providers led by users**	**2023-2027**	**MoLSP, users**
11.2.1.1.	Designing and piloting initiatives on establishing a group home, day centre and/or personal assistance provider led by users	At least 3 implemented initiatives on establishing a group home, day centre and/or personal assistance provider led by users	Plans on the initiatives Reports on implementation of initiatives	2023-2027	MoLSP, users
11.3.	**Development of user knowledge base**				
11.3.1.	**User led research conducted on a topic related to deinstitutionalisation**	**The perspective of users regarding the success of deinstitutionalisation presented**	**Report on the research conducted**	**2023-2027**	**MoLSP, ISC, trained users, CSOs**
11.3.1.1.	Training of users for conducting research	At least 12 users per year trained to conduct research	Reports from training events, lists of participants	2023-2027	MoLSP, ISC
11.3.1.2.	Deinstitutionalisation related research conducted led by users	At least 1 research annually led by users (on an issue of their choice)	Report on research conducted	2023-2027	MoLSP, trained users, CSOs
11.3.2.	**Training programmes developed and delivered for training of staff at user led social service providers**	**At least 30 staff employed at social service providers participate in at least 2 user led training events per year**	**Reports from training events, lists of participants**	**2021-2027**	**MoLSP, ISC, service providers**
11.3.2.1.	Organising training for trainers for social service users (on topics of their choice)	At least 12 users are trained in training delivery (on topics of their choice)	Reports from training events, lists of participants	2021-2027	MoLSP, ISC, service providers

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
11.3.2.2.	Developing user led training for staff at service providers	User led training programme developed for staff at service providers	Training programme	2021-2027	MoLSP, ISC, service providers
11.3.2.3.	Delivering user led training for staff at service providers	At least 2 user led training events for staff at service providers	Reports from training events, lists of participants	2022-2027	MoLSP, ISC, service providers

12. INTRODUCING NEW APPROACHES AND METHODS IN SOCIAL CARE

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
12.1.	**New approaches and methods of work introduced in the social care system**				
12.1.1.	**Professionals in the field of social protection are systematically trained for applicationof personal planning**	**Professional workers in the social care system apply the personal planning method**	**Personal files of users Annual work report of social institutions Supervision reports by ISC**	**2019-2027**	**MoLSP, ISC**
12.1.1.1.	Organising training on personal planning for professional workers in the social care system	Professional workers in the social care system have undergone personal planning training	Reports on training events, lists of participants	2019-2021	MoLSP, ISC, trained trainers (see: 1.2.5.3)
12.1.2.	**Training implemented for professionals in the social care system on empowerment of users, perspective of users, and advocacy approach**	**Social institutions apply the approaches of empowerment of users, perspective of users, and advocacy**	**Annual work report of social institutions Supervision reports by ISC**	**2019-2027**	**MoLSP, ISC**
12.1.2.1.	Implementing training for trainers on the topics of empowerment of users, perspective of users, and advocacy approach	At least 20 professional workers in the social care system have acquired knowledge and skills on delivery of training related to the stated topics	Reports on training events, lists of participants	2019	MoLSP, ISC, consultants
12.1.2.2.	Organising training for professionals in the social care system on empowerment of users, perspective of users, and advocacy approach	At least 2 professional workers from each social institution have undergone training on the stated topics	Reports on training events, lists of participants	2019-2023	MoLSP, ISC, trained trainers

13. STRENGTHENING THE CAPACITY OF THE WORK FORCE AND TRAINING PROVISION

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
13.1.	**Implementation of training on deinstitutionalisation for professionals in other relevant sectors**				
13.1.1.	**Delivery of training on deinstitutionalisation for professionals in other relevant sectors**	**At least 180 professionals in other relevant sectors have been trained to act in support of deinstitutionalisation**	**Reports on training events, lists of participants**	**2019-2022**	**MoLSP, ISC**
13.1.1.1.	Developing training programmes for deinstitutionalisation for professionals in other relevant sectors (health, education, culture, justice, internal affairs, etc.)	Training programmes developed take into account transfer of deinstitutionalisation related knowledge and skills to enable them to support the process through their work	Training programmes for deinstitutionalisation for professionals in other relevant sectors	2019-2022	MoLSP, ISC
13.2.	**Inclusion of deinstitutionalisation in the academia and curricula**				
13.2.1.	**Recommendations developed for enhanced coverage of deinstitutionalisation and related topics in undergraduate and postgraduate studies at relevant higher education institutions**	**Enhanced coverage of deinstitutionalisation and related topics in higher education institutions**	**Revised curricula and programmes of relevant higher education institutions**	**2019-2020**	**MoLSP, MoES, higher education institutions**
13.2.1.1.	Conducting analysis on the degree of coverage of deinstitutionalisation related topics in undergraduate studies at relevant higher education institutions	Recommendations developed for enhanced coverage of deinstitutionalisation related topics in undergraduate studies at relevant higher education institutions	Report on the analysis of the degree of coverage of deinstitutionalisation related topics in undergraduate studies at relevant higher education institutions	2019-2020	MoLSP, MoES, higher education institutions
13.2.1.2.	Conducting analysis on the degree of coverage of deinstitutionalisation and related topics in postgraduate studies at relevant higher education institutions	Recommendations developed for enhanced coverage of deinstitutionalisation related topics in postgraduate studies at relevant higher education institutions	Report on the analysis of the degree of coverage of deinstitutionalisation related topics in postgraduate studies at relevant higher education institutions	2019-2020	MoLSP, MoES, higher education institutions

14. PROMOTION OF DEINSTITUTIONALISATION IN THE PROFESSIONAL AND THE GENERAL PUBLIC

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
14.1.	**Promotion of deinstitutionalisation**				
14.1.1.	**Annual awareness raising campaigns on deinstitutionalisation and establishing community social services implemented**	**Raised awareness of the general public about the need and advantages of deinstitutionalisation and community social services**	**Reports on campaigns implemented, including coverage of the population and review of media announcements related to the campaigns (press clipping)**	**2019-2027**	**MoLSP, CSOs**
14.1.1.1.	Implementing awareness raising campaigns on deinstitutionalisation and/or the need of establishing/strengthening community social services (based on 'strengths perspective' of users and countering stigma)	At least 1 awareness raising campaign on deinstitutionalisation and/or the need of establishing/strengthening community social services	Reports on implemented campaigns	2019-2027	MoLSP, CSOs
14.1.1.2.	Enabling participation of users in annual awareness raising campaigns on deinstitutionalisation and/or the need of establishing/strengthening community social services	Users participate in designing, planning and implementing the annual awareness raising campaigns	Campaign plans Reports on campaigns implemented	2019-2027	MoLSP, CSOs
14.1.2.	**Annual national conferences on deinstitutionalisation held**	**Managing the deinstitutionalisation process includes recommendations given at national conferences**	**List of conclusions and recommendations from the national conferences** **Decisions made on application of recommendations from the national conferences in managing the deinstitutionalisation process**	**2019-2027**	**MoLSP, CSOs, academic institutions**
14.1.2.1.	Organising annual national conferences on deinstitutionalisation	At least 1 national conference held annually with participation of international experts to monitor the progress of deinstitutionalisation in the country	List of conclusions and recommendations from the national conferences Lists of participants at national conferences	2019-2027	MoLSP, CSOs, academic institutions

15. RESEARCH, PILOT-PROJECTS AND LEARNING

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
15.1.	**Research activities supporting good implementation of deinstitutionalisation**				
15.1.1.	**Research conducted on existing and newly developed types of care, their effectiveness and impact**	**Effectiveness and impact of existing and newly developed types of care as grounds for deinstitutionalisation related decision making documented**	**Reports on research studies completed Decisions made on strengthening the impact and improving effectiveness of existing and newly developed types of care**	**2020-2027**	**MoLSP, ISC, CSOs, academic institutions**
15.1.1.1	Conducting research on existing and newly developed types of care, their effectiveness and impact	At least 1 research on existing and newly developed types of care, their effectiveness and impact completed annually	Reports on research studies completed	2020-2027	MoLSP, ISC, CSOs, academic institutions
15.1.1.2.	Promoting the research reports on existing and newly developed types of care, their effectiveness and impact	At least 1 promotion event per year of research reports on existing and newly developed types of care, their effectiveness and impact	List of participants at the event List of media announcements about the event	2020-2027	MoLSP, ISC, CSOs, academic institutions
15.1.2.	**Studies on documenting the deinstitutionalisation process, experience, achievements and challenges implemented and published**	**Documented experience, achievements and challenges in deinstitutionalisation, as grounds for process related decision making**	**Reports on implemented research (studies) Decisions made on enhancing the achievements and overcoming challenges in the deinstitutionalisation process**	**2020-2027**	**MoLSP, ISC, CSOs, academic institutions**
15.1.2.1.	Research conducted on deinstitutionalisation, experience, achievements and challenges	At least 1 research on deinstitutionalisation, experience, achievements and challenges completed annually	Reports on research studies completed	2020-2027	MoLSP, ISC, CSOs, academic institutions
15.1.2.2.	Promoting the research reports (studies) on deinstitutionalisation, experience, achievements and challenges	At least 1 promotion event per year of research reports on deinstitutionalisation, experience, achievements and challenges	List of participants at the event List of media announcements about the event	2020-2027	MoLSP, ISC, CSOs, academic institutions
15.1.3.	**Expert debates completed to discuss monitoring and research data and to provide recommendations for further activities in the field of deinstitutionalisation**	**Deinstitutionalisation process management takes into account recommendations deriving from expert debates**	**List of conclusions and recommendations from expert debates Decisions made on application of recommendations from expert debates in the management of the deinstitutionalisation process**	**2019-2027**	**MoLSP, ISC, CSOs, academic institutions, municipalities**

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
15.1.3.1.	Organising expert debates to discuss monitoring and research data and to provide recommendations for further activities in the field of deinstitutionalisation	At least 1 national expert debates to discuss monitoring and research data and to provide recommendations for further activities in the field of deinstitutionalisation	List of conclusions and recommendations from expert debates List of participants at expert debates	2019-2027	MoLSP, ISC, CSOs, academic institutions
15.1.3.2.	Organising regional/local expert debates to discuss monitoring and research data and to provide recommendations for further activities in the field of deinstitutionalisation	At least 4 regional/local expert debates to discuss monitoring and research data and to provide recommendations for further activities in the field of deinstitutionalisation	List of conclusions and recommendations from expert debates List of participants at expert debates	2019-2027	MoLSP, ISC, CSOs, municipalities

16. IMPLEMENTATION, MONITORING AND EVALUATION

No.	Priorities/ Outcomes/ Activities	Indicators	Sources of verification	Deadline	Responsible
16.1.	First mid-term evaluation of the implementation of the National Deinstitutionalisation Strategy 2018-2027	First mid-term evaluation of the implementation of the National Deinstitutionalisation Strategy 2018-2027 completed	Report on the first mid-term evaluation of the implementation of the National Deinstitutionalisation Strategy 2018-2027	2020	MoLSP, ISC, consultants
16.2.	First revision of the Action plan on implementation of the National Deinstitutionalisation Strategy 2018-2027	Corrections for improving the successful implementation of the National Deinstitutionalisation Strategy 2018-2027 completed	Revised Action plan for 2021-2023	2020	MoLSP, ISC, consultants
16.3.	Second mid-term evaluation of the implementation of the National Deinstitutionalisation Strategy 2018-2027	Second mid-term evaluation of the implementation of the National Deinstitutionalisation Strategy 2018-2027 completed	Report on the second mid-term evaluation of the implementation of the National Deinstitutionalisation Strategy for the period 2021-2023	2023	MoLSP, ISC, consultants
16.4.	Second revision of the Action plan on implementation of the National Deinstitutionalisation Strategy 2018-2027	Corrections for improving the successful implementation of the National Deinstitutionalisation Strategy 2018-2027 completed	Revised Action plan for 2024-2027	2023	MoLSP, ISC, consultants
16.5.	Final evaluation of the implementation of the National Deinstitutionalisation Strategy 2018-2027	Achievements and challenges regarding the implementation of the National Deinstitutionalisation Strategy 2018-2027 documented	Report on the final evaluation of the implementation of the National Deinstitutionalisation Strategy 2018-2027	2027	MoLSP, ISC, consultants