RESEARCH REPORT

Eurofound

Living conditions and quality of life

Paths towards independent living and social inclusion in Europe

Paths towards independent living and social inclusion in Europe

Eurofound

European Foundation
for the Improvement of
Living and Working
Conditions

When citing this report, please use the following wording:
Eurofound (2024), *Paths towards independent living and social inclusion in Europe*, Publications Office of the European Union, Luxembourg.

Authors: Sanna Nivakoski and Marie Hyland (Eurofound), Chapters 1 to 4 and 7; Nienke Boesveldt (Research Institute Nienke Boesveldt and University of Amsterdam), Chapter 5; Sophie Thunus and Héline Zabeau (UCLouvain), Chapter 6

Research manager: Sanna Nivakoski

Research project: Paths towards independent living in Europe (230402)

Contributor: Elo Uzor (Eurofound)

Providers: Network of Eurofound Correspondents (see Annex 3)

Peer reviewers: Femmianne Bredewold (University of Humanistic Studies, Utrecht) and Jan Šiška (Charles University, Prague)

Acknowledgements: The authors are grateful for feedback received from colleagues at the European Commission, the European Parliament, the European Union Agency for Fundamental Rights, the European Disability Forum, the European Network on Independent Living, the European Expert Group on the Transition from Institutional to Community-based Care, Eurochild, Mental Health Europe, the European Social Network and Inclusion Europe.

With reference to Chapter 5, data collection was carried out between 2018 and 2023 with the help of students and researchers in the team; the authors would like to thank in particular Merel Otto, Nikkie Buskermolen and Annie Berendsen, who are, at the time of writing, still part of the team. Experts with lived experience acted as peers in interviewing clients, the current experts being Thijs Kuiling, Peggy Demilt and Stan Coldewijn. Ivy Drysdale, an Urban Lab intern, helped in the practical creation of the draft of the chapter. Finally, the author thanks all client and professional participants for their genuine and honest stories.

With reference to Chapter 6, the authors would like to express their gratitude to the members and workers of Brussels' Alternative Spaces, or *lieux de lien*, for their trust and participation in the research. Data collection was carried out from January to April 2024 with the help of students and researchers. In particular, the authors would like to thank Naomi Ohura and Célestine Cochinaux for their participation in the research, Alain Loute for his careful reading of the first draft of this report, and Maya Duverdier and Caroline Godart for their contribution to the discussion of the research findings.

Luxembourg: Publications Office of the European Union, 2024

Print: ISBN 978-92-897-2440-1 doi:10.2806/0075329 TJ-01-24-006-EN-C
PDF: ISBN 978-92-897-2439-5 doi:10.2806/4798019 TJ-01-24-006-EN-N

This report and any associated materials are available online at https://eurofound.link/ef23018

Research carried out prior to the UK's withdrawal from the European Union on 31 January 2020, and published subsequently, may include data relating to the 28 EU Member States. Following this date, research only takes into account the 27 EU Member States (EU28 minus the UK), unless specified otherwise.

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.

European Foundation for the Improvement of Living and Working Conditions

Telephone: (+353 1) 204 31 00
Email: information@eurofound.europa.eu
Web: https://www.eurofound.europa.eu

Contents

Executive summary

Introduction

Social inclusion is fundamental to ensuring that everyone can participate fully in community life, enjoying their rights and freedoms while being valued and respected. How care and services are provided has direct impacts on personal independence and social inclusion.

Long-stay residential institutions, such as care homes and assisted living facilities, offer support to individuals with significant care needs. However, institutionalisation poses major risks to care recipients. Institutionalisation and institutional culture have been shown to result in isolation, depersonalisation, a lack of autonomy, alienation, disempowerment and social exclusion.

Deinstitutionalisation entails a shift to community-based care and support services, prioritising individualised approaches, social inclusion and independence. It should involve planning for and creating family- and community-provided care and services that enable individuals to live independent lives within regular communities.

This report presents evidence on institutional living in the EU and the transition towards family- and community-based care and services. It discusses the thinking behind and evidence on deinstitutionalisation, strategies and practices for the provision of family- and community-based care and services, and the challenges involved. The report also presents case studies illustrating user and stakeholder experiences of efforts to achieve independent living.

Policy context

The principles of independent living and social inclusion are central to many EU-level recommendations and regulations. The European Pillar of Social Rights emphasises that supporting independent living for individuals with disabilities (Principle 17), affordable long-term care services (Principle 18), and the right to housing and assistance for the homeless (Principle 19) are crucial for social inclusion.

The European Child Guarantee emphasises the importance of family living for children's well-being and of children's involvement in decision-making to enhance their social inclusion and welfare. The European Care Strategy stresses the importance of person-centred care, promoting opportunities for individuals requiring care to participate fully in society and advocating for a mix of long-term care services and support for informal carers. The Strategy for the Rights of Persons with Disabilities emphasises social inclusion and independent living, advocating for policies to increase access to affordable housing, personal assistance and community-based support services. The European Commission's Green Paper on Mental Health stresses the need for an integrated approach to care, including community-based care.

The European Structural and Investment Funds – including the European Social Fund Plus and the European Regional Development Fund – support family- and community-based care services, with funds directed towards construction or renovation of facilities, capacity-building initiatives for informal carers and professionals, and schemes for the dissemination of best practices in the provision of community-based care and services.

Key findings

- The lack of comprehensive and comparable data on care and services and their recipients undermines the efforts of the EU and its Member States to develop care and services that foster independent living and social inclusion.
- The living conditions and lived experience of institutionalised people (and people at risk of institutionalisation) are underresearched. This is especially apparent in relation to children in residential care and people seeking emergency shelter because of homelessness or domestic abuse.
- Although most Member States have deinstitutionalisation strategies, in the 10 years up to 2022–2023 the numbers of children, adults with disabilities and older people in residential institutions have increased in the EU as a whole. The number of psychiatric care beds in hospitals has decreased marginally.
- Institutional culture entails isolation, depersonalisation, lack of participation in society, lack of control, rigidity of routine, block treatment, mobility restrictions, social distance and paternalism. Such a culture can be present in any setting but is often found in residential institutions and shelter accommodation, potentially resulting in limited privacy and personal freedom, insufficient services, inadequate living conditions and social exclusion.

- A lack of affordable and accessible housing with security of tenure and a shortage of foster care places impose severe limitations on Member States' ability to provide family- and community-based care and support.
- A shortage of public funding for family- and community-based care and services imposes limits on independent living and social inclusion. The delivery of these services is compromised by underresourcing, understaffing, lack of training and administrative issues.

Policy pointers

- Ensure that people with care or support needs are involved in the development and review of policies that concern them.
- Adopt a person-centred approach, offering a mix of family- and community-based care and services.
- Ensure that service users have maximal control over their situation, with supported decision-making when necessary.
- Prioritise preventive measures that reduce the risk of institutionalisation.
- Seek to minimise duration of stay in residential institutions and ensure transition to community- and family-based care and services.
- Ensure provision of emergency shelter accommodation for people experiencing crisis situations such as homelessness or domestic abuse, and make permanent, independent housing available to enable timely transitions from shelters.
- Acknowledge the challenges of deinstitutionalisation processes. Carefully plan individuals' transitions, maintaining continuity of support and daily activities.
- Increase the availability of affordable, accessible, inclusive and secure housing options in regular communities to prevent homelessness and facilitate independent living.
- Provide diverse family- and community-based care and services, including employment services, healthcare services, social services and services focused on social inclusion, ensuring adequate staffing and staff training.
- Improve the accessibility of mainstream services and facilities.
- Address institutional culture in all care settings by maximising individual autonomy in decision-making, minimising mobility restrictions, fostering social interaction and unlearning stereotypical client–staff roles.
- Support informal caregivers by providing training, respite care, counselling, technological aids and financial assistance.
- Ensure EU-wide data collection on care and service provision and the situations of carers and care recipients to monitor living conditions, policy implementation and trends over time.

Introduction

Social inclusion entails ensuring that individuals who are at heightened risk of being marginalised or excluded from mainstream society have equal opportunities to participate fully in community life and enjoy their rights and freedoms. Social inclusion is crucial for societies in which every individual is valued, respected and heard. By embracing diversity and ensuring equality in terms of opportunities, access to resources and participation in community life, inclusivity creates more just and compassionate societies.

Certain population groups, including people with care or support needs, face heightened risks of marginalisation and social exclusion, which result in reduced access to personal rights and diminished freedom to make choices on an equal basis with others.

The ways in which care and services are provided in societies have important implications for personal independence and freedom, as well as social inclusion and participation in the wider community and society. For these reasons, it is of vital importance to design and implement public policies, especially in the areas of care and services, that maximise social inclusion and independence. A crucial aspect of policymaking is involving people with care or support needs, along with those close to them, to understand how these policies affect their daily lives and experiences, with the aim of achieving the best outcomes for recipients of care and services.

A process known as deinstitutionalisation – the transition from the use of residential institutions to family- and community-based care and services – is central when reforming care services to ensure that they are person-centred and socially inclusive. Deinstitutionalisation has the potential to benefit individuals with care or support needs by affording them greater autonomy and social inclusion. It may also result in broader benefits such as increased provision of community-based care and services for the wider population, reduced need for health and social care services due to improvements in service users' health and well-being, and the spillover effects of enhanced social inclusion. However, deinstitutionalisation efforts are hampered by lack of investment in family- and community-based care and services and by many practical hurdles in policy implementation.

The demand for care and support services is rising in the EU, presenting significant challenges to policymakers. This growing demand is driven by an increase in children needing alternative care, a higher prevalence of disabilities and long-term health issues, an ageing population, and a surge in homelessness and domestic abuse. As this demand escalates, policy considerations on service delivery have increasingly substantial consequences for the care and services received by the individuals who need them.

Aims of the report

This report presents evidence on deinstitutionalisation in the EU: the scale of residential living and the transition from institutional to family- and community-based provision of care and services, national-level deinstitutionalisation strategies and practices, and challenges faced in providing family- and community-based care and services. It also presents person-centred case studies that illustrate the benefits of and challenges encountered in efforts towards deinstitutionalisation and greater social inclusion.

The population groups included in the reporting comprise people with care or support needs who are at risk of institutionalisation: children, adults with disabilities, adults with mental health issues and older people. The report also examines the situations of people experiencing homelessness and victims of domestic abuse, in terms of being housed – sometimes for prolonged periods of time – in congregated settings such as shelters and other emergency accommodation. The distinction between residential institutions and emergency shelter accommodation in the context of deinstitutionalisation is discussed further in Box 1.

It should be noted that the population groups discussed in this report should not be viewed in isolation or as independent of each other. Intersecting vulnerabilities across groups manifest when individuals are faced with multiple challenges, compounding the hardships they face. For example, many people who experience homelessness also have disabilities, health problems or addiction issues. Vulnerabilities can relate to each other in a temporal way over someone's life course, for example in the case of a person who is discharged from a residential institution at the age of 18 and subsequently becomes homeless. The likelihood of having a disability increases with age, with more than half of people aged 65 or over having a disability (Eurostat [hlth_silc_12]). These interlinked and overlapping vulnerabilities highlight the critical need for comprehensive support systems that are able to address these complex needs.

The evidence presented includes the latest national estimates of numbers of people living in institutional settings in the EU Member States and compares these figures with those from roughly 10 years earlier. The report also maps the strategies of Member States to coordinate the deinstitutionalisation of different population groups and highlights policies that have been implemented to support independent living. Furthermore, the report presents evidence from Member States about challenges that emerge in the provision of family- and community-based care and services.

The report incorporates two illustrative case studies that present novel evidence on the lived experience of providers and users of community-based services. The case studies were selected with the aim of presenting service users' and stakeholders' experiences of relatively recent practices of deinstitutionalisation in Member States, representing a range of settings in terms of geographical location and target group for services. The specific initiatives or policies were selected to offer insights from national contexts in which demonstrable progress has been made in recent years in fostering independent living and social inclusion.

The first case study offers a perspective on deinstitutionalisation of people housed in emergency shelter accommodation for people experiencing homelessness in the Netherlands. The case study highlights the difficulties encountered during the different phases of the transition and the lessons learned with regard to ensuring a successful transition to independent living and minimising the reoccurrence of homelessness. The discussion is enriched with quotes from people with lived experience of the situation.

The second case study examines the deinstitutionalisation of people with mental health problems in Belgium. It focuses on Alternative Spaces, which are low-threshold mental health support initiatives that are open to everyone and cater for a wide range of creative activities. These spaces have been established in the Brussels-Capital Region as a tool to support the deinstitutionalisation of mental health care by decreasing reliance on psychiatric hospitals and creating community resources that support independent living. The analysis incorporates the voices of service users and stakeholders. The final chapter of the report offers pointers to support the successful implementation of deinstitutionalisation policies.

Residential institutions

A widely cited early description of 'total' institutions is:

> *place[s] of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.*
>
> (Goffman, 1961, p. xiii)

Goffman described institutions as being situated on a continuum from closed to open, with no exact list of features determining the position on this continuum, but with closed institutions being characterised by batch living, binary management, the inmate role and the institutional perspective. These dimensions of institutional culture are discussed in more detail below.

While informal care was the predominant model in past centuries, residential institutions began to be established in greater numbers in Europe and North America in the 1800s. Following developments in understanding of child welfare, the decline of institutions for children continued throughout the 1900s in western Europe, although they remained the prevalent form of care in former Soviet Union countries (Dozier et al, 2012). For people with disabilities, the rise in institutionalisation took place later, with steep increases during the first half of the 20th century; the use of institutions began to decline from the 1960s, with speeds of decline varying between countries (Walmsley, 2005; McCarron et al, 2019).

Long-stay residential institutions have traditionally been provided for, for example, orphaned, abandoned and maltreated children, people with disabilities or other long-term health issues, and older people with care or support needs. While in the past such institutions were seen as evidence of a caring society that provides food, shelter, clothing and treatment for people who need it, a contemporary assessment recognises the importance of non-material aspects, such as social inclusion and person-centred individual approaches, in the provision of care and services (European Commission, 2009).

A residential institution cannot be defined by a set of characteristics such as function, location or size. While larger facilities are less likely to be able to provide individualised services or ensure community inclusion of their residents, the same situation can prevail in small-scale facilities. Therefore, institutions have often been defined as facilities that exhibit an institutional culture that results in isolation from and lack of participation in society and the wider community and is characterised by depersonalisation, which involves the removal of personal possessions and the absence of signs and symbols of individuality and humanity.

Box 1: Crucial role of emergency shelters

It is important to distinguish emergency shelter accommodation from residential institutions and to recognise the temporary and urgent nature of the services that these shelters deliver. Adequate provision of such shelter services is crucial for individuals experiencing crisis situations such as homelessness or domestic abuse, addressing immediate needs for safety and basic necessities. The ultimate policy objective should be to move individuals and families from emergency shelters to stable, permanent and independent housing – combined with the provision of community-based care and services – as soon as the people in question are ready for the transition. Nevertheless, such shelters serve a vital temporary function in ensuring that people in crisis situations can rebuild their lives with security and dignity. These issues are discussed in the case study on the deinstitutionalisation of people experiencing homelessness, presented in Chapter 5 of this report.

Such an institutional culture limits personal control over life choices and day-to-day decisions, partly owing to the rigidity of routine and fixed timetables. Block treatment or 'batch living' is the opposite of independence; it entails processing people in groups, without privacy, individual treatment or a person-centred approach. Institutional culture may also involve imposing restrictions on mobility. 'Binary management' in institutions means that there is a distance and a status imbalance between staff and residents, with staff holding power, while a person entering the institution is reduced from someone with many roles to someone with only one, that of resident (Jones and Fowles, 2023; European Commission, 2009).

In the same spirit, the 2009 *Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care* defined institutions as

> *any residential care where:*
>
> - *users are isolated from the broader community and/or compelled to live together;*
> - *these users do not have sufficient control over their lives and over decisions which affect them;*
> - *the requirements of the organisation itself tend to take precedence over the users' individualised needs.*
>
> (European Commission, 2009, p. 9)

Alternatives to residential institutions

There exists a spectrum of services designed to enable individuals with care or support needs to live within communities and, in the case of children, to be raised in a family environment rather than in an institutional setting. These family- and community-based alternatives emphasise person-centeredness, independence and social inclusion. Examples of the delivery of such services in Member States are discussed in Chapter 3.

In the case of children, alternatives to institutionalisation include strategies such as keeping families intact through early preventive and support services, as well as kinship care, foster care and adoption, which aim to provide children with stable family-based solutions (Dozier et al, 2012; Goldman et al, 2020).

In the case of adults with care or support needs, alternatives to institutionalisation involve community-based models that prioritise independence and social inclusion. Increasingly, provision has shifted towards a deeper integration of care recipients into communities through the provision of supported living in regular housing. Services are provided separately from accommodation and through small-scale community-based models in which people, although not owning or renting their own accommodation, live in ordinary housing within the community (Mansell, 2006; Šiška and Beadle-Brown, 2020).

First and foremost, any family- or community-based alternative to institutionalisation must be free from segregation or isolation from the community and free from other aspects of institutional culture (EEG, 2022). Assisted living facilities offer a combination of autonomy, care and services. Shared living arrangements, such as group homes and co-housing communities, provide home-like environments with communal resources, while supportive housing integrates support services, and independent living communities cater to individuals with minimal support needs. Foster care for adults provides family-based care. Mainstream community-based services (such as housing, healthcare, education, employment, culture and leisure services) should be accessible to all, and specialised services (such as those provided by home health aides, visiting nurses and personal care assistants) provide support within the individual's home. In addition, technological solutions such as telehealth and smart home technologies can be used for support. Community inclusion programmes aim to promote social engagement and reduce isolation.

Providers of informal care and support – especially family caregivers – play a crucial role in enabling people to live independently within their communities. Services aimed at informal caregivers, such as community-based adult day-care centres and respite care services, offer social activities and breaks from care and support duties.

Quality of care, institutional culture and outcomes

Institutional living has been shown to have negative outcomes. These outcomes are widely documented in existing research, including survivor accounts, which began to be recorded in the late 20th century, offering a different perspective from earlier published materials in the forms of institutional records and staff memoirs (Walmsley, 2005).

Many Member States recognise children in alternative (foster or residential) care as one of the most disadvantaged groups of children (Unicef and Eurochild, 2023). In relation to the well-being of children in institutional care, research – including randomised controlled trials – has found that in the absence of primary caregivers (for example, in institutional settings where rotating staff work in shifts) a child's development is harmed. Institutional care of children has been found to lead to negative outcomes in all examined domains of a child's development: physical growth (including brain development and head circumference), cognition, attention, socioemotional development and mental health. The length of stay in an institutional setting is related to the severity of these damaging outcomes, and the longer the period of institutionalisation, the lower the likelihood of recovery on transition to a non-institutional setting (Nelson et al, 2007; Dozier et al, 2012; Bick et al, 2015; Allen et al, 2020; van IJzendoorn et al, 2020). These detrimental consequences of institutionalisation are particularly pronounced in infants and young children, owing to the influence that stable relationships with caregivers have on important developmental stages during the early years of life. While residential institutions vary in their staffing levels and other quality considerations, all institutional settings have harmful effects on children's development (Dozier et al, 2012). For these reasons, the institutionalisation of children is particularly alarming (European Commission, 2009).

In the case of adults in institutional care, it has been shown that community-based models in general produce better outcomes than institutional settings, in terms of adaptive behaviour (effective responses to environmental demands and changes), challenging behaviour, community participation, interaction with staff, contact with family and friends, and degree of satisfaction of the client (Mansell, 2006). Furthermore, existing research provides evidence that a transition from an institutional setting to community living improves quality of life for people with intellectual disabilities. The transition to community-based living has been found to increase quality of life by increasing financial and general freedoms, decision-making capacity, and sense of privacy and physical space, and by reducing noise levels (McCarron et al, 2019).

Similar findings have been reported in studies examining the implications of deinstitutionalisation of people with mental health problems and older people with care or support needs (Newton et al, 2000; Compton et al, 2020).

The COVID-19 pandemic laid bare some of the increased risks faced by individuals living in institutions, particularly those residing in overcrowded facilities (see Box 2).

It needs to be borne in mind that institutional culture and poor quality of care and services can prevail in any setting. Therefore, family- and community-based settings do not guarantee better outcomes for the person with care or support needs, although they are a necessary condition for independence and social inclusion (Mansell, 2006; Šiška and Beadle-Brown, 2020). To achieve these goals, a person-centred approach to the provision of high-quality care and services needs to be taken, while maximising social inclusion and minimising institutional culture in their delivery. The challenges entailed in this include inadequate provision of foster care, a shortage of community-based housing for people with care or support needs, lack of provision of community-based care and services, issues with staffing, lack of preparation for transitions out of residential institutions, shortcomings in the coordination of services in the community, the stigma and discrimination faced by individuals, and lack of support for informal carers.

Box 2: The COVID-19 pandemic and residential institutions

In spring 2020, once the first cases of COVID-19 were confirmed in Europe, the virus spread rapidly in residential institutional settings, such as nursing homes, due to people living in close proximity, shared spaces and a lack of appropriate measures to prevent infection. As a result of these issues, residents in institutions faced a heightened risk of contracting the virus and increased mortality rates, as well as worse outcomes in terms of social isolation and loneliness (Simard and Volicer, 2020; Thompson et al, 2020).

The crisis emphasised the detrimental consequences that institutional culture has on the quality of life of people in institutionalised settings, including isolation from wider society and lack of social interaction. It also brought to fore the problems of inadequate staffing levels, limited access to healthcare resources and insufficient infection control measures. Addressing these issues is paramount to ensure person-centred responses to future crises.

1 Deinstitutionalisation

This chapter examines the process of deinstitutionalisation, defined as the transition from reliance on residential institutions to the adoption of family- and community-based care and services. The discussion begins by outlining various international treaties and declarations that emphasise the importance of independence, social inclusion and a person-centred approach to care and services. It then discusses the concept of deinstitutionalisation, exploring the motivations behind it, the progress being made across the EU, and the factors that drive or hinder this policy approach and its successful implementation. In addition, the chapter considers the broader benefits of deinstitutionalisation beyond its direct impact on service users, and the challenges that may be encountered in making efforts towards deinstitutionalisation. The chapter concludes by detailing the EU's role in supporting deinstitutionalisation through directives, recommendations and funding mechanisms.

Rights declarations

Many international treaties have affirmed the importance of independence, social inclusion and the adoption of a person-centred approach to the provision of care and services. They have recognised the crucial importance of listening to the voices of the people involved when it comes to the process of decision-making at individual level and at the level of society when policies are being formulated and reformed.

The Charter of Fundamental Rights of the European Union declares children's rights to protection and care in accordance with their best interests (Article 24), the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life (Article 25) and the right of persons with disabilities to participate in community life (Article 26).

The United Nations Convention on the Rights of the Child (which has been ratified by all EU Member States) declares that every child should be able to enjoy a standard of living that is adequate for their physical, mental and social development and to grow up in a family environment in an atmosphere of happiness, love and understanding.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) – to which the EU became a party in 2010, and which all 27 Member States have ratified – emphasises the right to independent living. In this regard, the UNCRPD declares the rights of persons with disabilities to live and participate in the community; to have the opportunity to choose their place of residence and where and with whom they live; to have access to a range of in-home, residential and other community support services and personal assistance; and to be protected from isolation or segregation from the community (Article 19). In addition, the related 2022 UNCRPD *Guidelines on deinstitutionalization, including in emergencies* emphasise the right to independent community living and the right to legal capacity.

In 2019, the health ministers of World Health Organization (WHO) member states updated the Comprehensive Mental Health Action Plan 2013–2030, which includes the objective of the provision of comprehensive, integrated mental health and social care services in community-based settings.

The United Nations Principles for Older Persons (adopted in 1991) specify that older people should have access to family and community support, care and protection, and also to the educational, cultural, spiritual and recreational resources of society. They state that older people should be able to reside at home for as long as possible; live in environments that are adaptable to personal preferences and changing capacities; and utilise appropriate levels of institutional care that provide protection, rehabilitation, and social and mental stimulation in a humane and secure environment. Older people should enjoy human rights and fundamental freedoms, including full respect for their dignity, beliefs, needs and privacy, and the right to make decisions about their care. The principles also state that older people should remain integrated in society and participate actively in the formulation and implementation of policies that concern them.

When it comes to people experiencing homelessness and victims of domestic abuse, the Lisbon Declaration on the European Platform on Combatting Homelessness (2021) includes among its commitments that, by 2030, no one will live in emergency or transitional accommodation longer than is required for a successful move to permanent housing and no one will be discharged from an institution (such as a prison, hospital or care facility) without an offer of appropriate housing.

The 2014 Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) states that member states of the Council will provide shelters for victims of domestic violence in sufficient numbers to provide safe accommodation, as well as implementing measures to ensure that victims have access to services facilitating their recovery from violence, including counselling, financial assistance and housing.

Progress on deinstitutionalisation

In general, over the past few decades in many countries and at EU level, there has been increased emphasis in policymaking on deinstitutionalisation. Efforts to address the negative effects of institutionalisation have led to a shift towards greater provision of community-based care that prioritises individualised support, social inclusion and independence. These community-based approaches aim to provide support and services that enable people to live in their own homes or in small community-based settings, while maintaining connections to their families, communities and social networks.

While there is no single definition of deinstitutionalisation, the process involves a transition from residential care provided in institutional settings to family- and community-based care and support. The Office of the United Nations High Commissioner for Human Rights, in relation to people with disabilities, has described deinstitutionalisation as

> *a process that provides for a shift in living arrangements for persons with disabilities, from institutional and other segregating settings to a system enabling social participation where services are provided in the community according to individual will and preference.*
>
> (Office of the United Nations High Commissioner for Human Rights, 2014, p. 8)

In addition, the *Common European guidelines on the transition from institutional to community-based care* state that deinstitutionalisation also entails the creation of preventive measures, with the aim of reducing or eliminating reliance on institutional care (EEG, 2012).

For successful deinstitutionalisation, the closing down of institutions is insufficient without the parallel development of high-quality, accessible community-based services. The lack of such systems of care and service provision within communities prevents the further closure of institutions in many instances (Dozier et al, 2012). The definition of deinstitutionalisation provided by the United Nations Children’s Fund (Unicef) emphasises the importance of careful planning and the creation of a range of compensatory services, describing it as ‘the full process of planning transformation, downsizing and/or closure of residential institutions, while establishing a diversity of other child care services regulated by rights-based and outcomes-focused standards’ (Unicef, 2010, p. 52).

Developments in deinstitutionalisation have been uneven across Member States, with significant variation in the scale and quality of the provision of community-based services. Overall in the Western world, the progress has been described as having two phases: the deinstitutionalisation phase, in which large institutions are replaced by group homes and supported housing in the community; and the ‘home turn’ phase, during which family- and community-based care and services are developed, and the rights to a home and to inclusion in society are recognised (Hall et al, 2021). Some countries have moved ahead with closing large institutions and developing community-based alternatives, while others lag behind, maintaining more traditional institutional care models. This disparity arises from differences in national policies, funding priorities and levels of commitment to social inclusion. In addition, cultural attitudes towards disability and mental health, as well as the availability of trained professionals and appropriate infrastructure, contribute to this uneven progress. Developments in deinstitutionalisation across Member States are discussed further in Chapter 2.

Potential for wider positive outcomes

Deinstitutionalisation has the potential to improve outcomes not only for individuals with care or support needs but also for society at large. For the individuals directly affected, family- or community-based settings afford greater autonomy, allowing them to exercise more control over their lives and make personal choices that are often restricted in institutional settings. It also promotes social inclusion by enabling people to live in their communities, participate in social activities and build diverse relationships. This integration can lead to improvements in mental and physical health, as individuals experience a sense of belonging and purpose. The provision of permanent housing for people experiencing homelessness, for example, has resulted in reductions in emergency hospital visits and hospital admissions and shorter hospital stays, demonstrating that investment in housing has wider benefits as a health intervention (The Lancet, 2024). This effect can ease the burden on healthcare systems.

Beyond the individual benefits, deinstitutionalisation can lead to increased provision of community-based care and services for society at large, enhancing the overall quality and accessibility of care (Bredewold et al, 2018).

There are also possible spillover effects of enhanced social inclusion. Individuals with care or support needs being more visibly included in their communities can foster a more inclusive and accepting society, breaking down stereotypes and reducing stigma. In addition, the community at large can benefit from the contributions of these individuals, through employment, volunteer work or social engagement.

EU initiatives

At EU level, components related to deinstitutionalisation and the right to independent living have been included in many initiatives and policies. The European Pillar of Social Rights (2017) aims to promote fair and inclusive societies throughout the EU. Social inclusion and independent living are key components of the Pillar, which reflects the EU's commitment to ensuring equal opportunities for all to participate fully in society and lead autonomous lives. Its principles include support for the independent living of individuals with disabilities (Principle 17), affordable long-term care services (Principle 18) and the right to housing and assistance for the homeless (Principle 19).

The European Child Guarantee (2021) and the related monitoring framework aim to address child poverty and social exclusion by means of policy action, including national action plans and targeted funding mechanisms. The guarantee recognises the importance of family living as a fundamental aspect of children's well-being and development, and it emphasises the importance of listening to children and involving them in decisions that affect their lives, thus contributing to their well-being and social inclusion. Furthermore, the 2024 European Commission recommendation on developing and strengthening integrated child protection systems in the best interest of the child proposes that Member States prioritise family- and community-based care for children, accelerate national deinstitutionalisation strategies and invest in non-residential family- and community-based quality services.

The European Care Strategy (2022) emphasises that people requiring care need to have access to opportunities for full participation in society and supports a person-centred approach to care that takes into account individuals' preferences, needs and experiences. The strategy underlines the concept of ageing in place and stresses the importance of offering a mix of care services while supporting informal carers.

The Strategy for the Rights of Persons with Disabilities (2021), including the European Disability Strategy 2021–2030, incorporates social inclusion and independent living as key pillars of its approach to advancing the rights of persons with disabilities. The strategy aims to promote the full and effective participation of persons with disabilities in society and recognises their right to live independently and be included in the community. It advocates for policies that support independent living arrangements, including through access to affordable housing, personal assistance, assistive technologies and community-based services, while enabling people with disabilities to make choices about where and with whom to live.

The European Commission's Green Paper on Mental Health (2005) states that efforts are necessary to build an integrated, cross-sectoral approach to mental health that includes the integration of mental health services into primary care and a shift to community-based care. The 2023 Commission communication on a comprehensive approach to mental health highlights the overlaps between disabilities and mental health problems and emphasises the importance of developing good deinstitutionalisation practices in this field.

In 2024, the European Council adopted a directive to combat violence against women and domestic violence. The directive contains measures to support victims (including children) in accessing appropriate social and health services, including information on access to housing and other support.

EU funding mechanisms direct resources to support the provision of family- and community-based care. The Common Provisions Regulation states that funds from the European Structural and Investment Funds, including the European Social Fund Plus and the European Regional Development Fund, must be implemented in a way that supports good-quality care services, including family- and community-based care. Besides directly funding care services provision, investment is also directed to the construction or renovation of facilities such as day-care centres, respite care facilities and assisted living accommodation. Capacity-building initiatives and training programmes for informal carers and professionals in addition are financed to enhance their skills and competencies in providing person-centred care, promoting independence and supporting individuals in community settings. EU funds also facilitate and promote the dissemination of best practices in the provision of community-based care services.

2 Recent changes in institutional living in the EU

Despite the international declarations advocating for the independence and social inclusion of individuals with care or support needs, large-scale congregated living is commonplace in many Member States. In many cases, efforts to close residential institutions while increasing the availability of community-based alternatives fall short due to a variety of factors, including perceptions and misperceptions, societal stigma, inadequate funding, problematic incentives and a lack of infrastructure.

Societal perceptions play a role in the progress towards deinstitutionalisation. Funders of residential institutions may perceive the model to be superior to community-based solutions or may be unaware of the impacts of institutionalisation. Funding models also play a role, as resistance to close residential institutions can arise when government agencies receive funding based on the number of individuals receiving institutional care. Coordination is also complicated in cases where, for example, institutional care is financed at national level, but community-based care is organised at local level (Dozier et al, 2012).

While acknowledging that social inclusion and quality of life are generally better for individuals living in community-based settings than in residential institutions, merely moving the location of service provision does not ensure these better outcomes. Furthermore, a reduction in institutional care provision does not automatically lead to a parallel increase in family- and community-based solutions. With these limitations in mind, this chapter summarises previous findings on the size of institutionalised populations in the EU. It provides up-to-date national estimates from EU Member States of the percentage changes in the numbers of people in residential institutions and in emergency shelter accommodation over the preceding 10 years or thereabouts. For the majority of Member States, the most recent data available are from 2022 or 2023, and the past estimate is from 2012 or 2013.[1] Annex 1 (Tables A1–A6) contains the detailed tables of figures used to compute these percentage changes, along with the years of data collection. While these statistics cannot be considered to provide a comprehensive picture of the progress of deinstitutionalisation, they provide some indication of developments in the use of residential institutions across the EU.

Lack of a harmonised definition

The reporting in this chapter acknowledges the difficulties that arise from the differences between countries when it comes to definitions, age cut-offs and the time point of measurement. Furthermore, and more importantly, the concept of a residential institution is not well defined and not uniform across countries, or across time within countries. Given this limitation, the main added value of the analysis is in the estimates of change over time, allowing (in most cases) the percentage change in the size of the institutionalised population in each Member State to be reported; Annex 1 presents the absolute numbers that the analysis is based on. While, in theory, relative numbers – such as proportions of the total population of a certain age – would allow for cross-country comparison, in practice such comparison would be misleading because Member States' definitions of residential institutions are not uniform.

For the purpose of this reporting, residential institutions are defined as 'congregated institutions where multiple people are housed together, and where staff provide care or support, either continuously or occasionally', including group homes, residential homes, special homes, care homes and nursing homes.[2]

Included in the analysis are three groups of people living in residential institutions: children, adults with disabilities and older people. In addition, the capacity of psychiatric hospital inpatient care for people with mental health issues is assessed by examining statistics on the number of psychiatric care beds in hospitals. Finally, the change in the numbers of people housed in emergency shelter accommodation for people experiencing homelessness and victims of domestic abuse is examined. As highlighted in the introduction to this report, it should be borne in mind that emergency shelter accommodation is devised as a temporary measure to meet the urgent needs of individuals in crisis situations such as homelessness or domestic abuse. Therefore, the closure of such shelters should not be considered a goal of any deinstitutionalisation strategy. On the contrary, the importance of strengthening shelter services has been highlighted in the Istanbul Convention.

---

[1] These data were provided by members of the Network of Eurofound Correspondents, listed in Annex 3.

[2] Examples of children's residential institutions are those used by Unicef and Eurochild (2021), including *maisons d'enfants à caractère social*, *hébergement éclaté* and *foyer de l'enfance* (in France), *Heimerziehung* (in Germany), *accoglienza in comunità residenziale* (in Italy), *instytucjonalna piecza zastępcza* (in Poland) and *acogimiento residencial* (in Spain).

Existing estimates

The European Expert Group on the Transition from Institutional to Community-based Care (EEG) has provided estimates of the numbers of people living in residential institutions in the EU. The EEG's first report in 2009 highlighted that institutional care still accounted for more than half of public care expenditure in many countries, especially in central and eastern Europe (EEG, 2009). Drawing on the findings of several studies, the EEG concluded that 150,000 children and nearly 1.2 million people (children and adults) with disabilities lived in institutions across Europe; the EEG emphasised the incomplete and fragmented nature of the estimates.

The 2020 EEG report highlighted that, while some countries had significantly decreased their institutionalised populations, others had seen little change or even an increase (Šiška and Beadle-Brown, 2020). The report estimated at least 1.44 million people living in institutions in the EU. Key factors influencing these trends include differing national policies, levels of investment in community-based services, and the degree of political and public support for deinstitutionalisation. Countries with strong legislative frameworks and robust funding mechanisms have generally made greater strides in transitioning individuals to community-based care. Conversely, countries with weaker support systems and less financial commitment continue to rely heavily on institutional care.

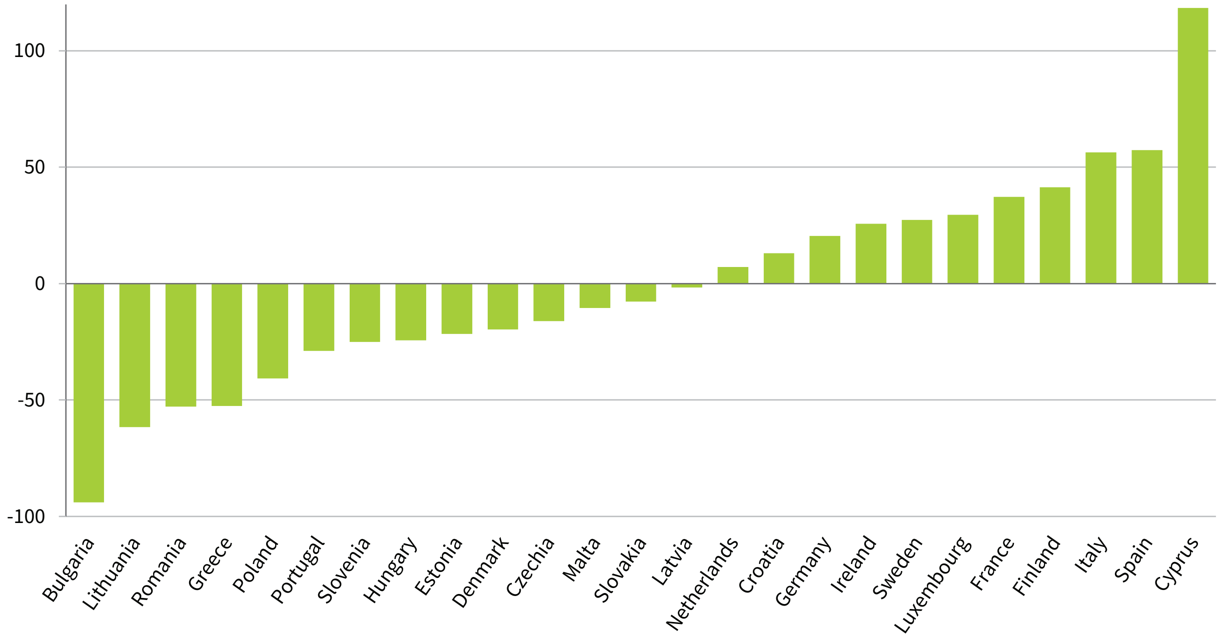
A relatively recent data collection exercise carried out between 2020 and 2021 estimated that the total number of children living in residential care settings in the EU (excluding Austria) was 302,979 (Unicef and Eurochild, 2021).

Latest estimates of changes over time

Children in institutional care

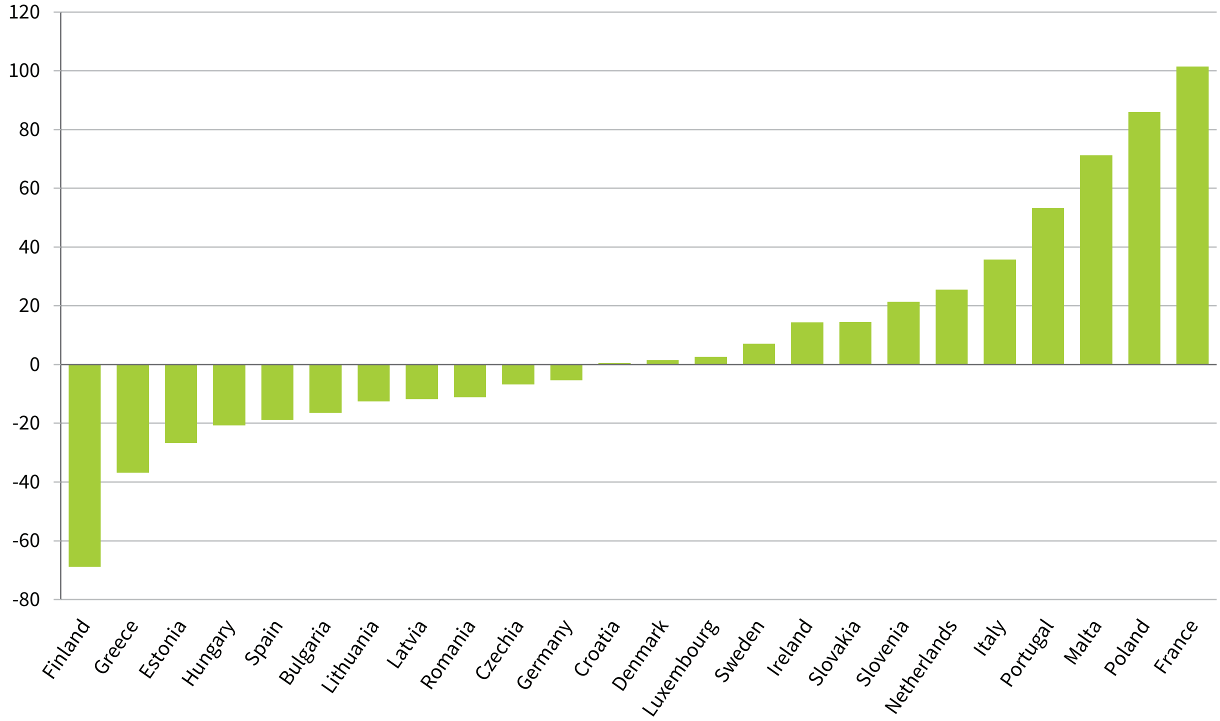
With regard to children, Figure 1 presents the most recent national estimates available of the percentage change in the number of children living in institutional settings in each Member State. While unavailability of data prevents the temporal analysis for Austria and Belgium, it is evident that the number of children in residential institutions has increased in 11 Member States, most notably in Cyprus, Spain and Italy. Conversely, the number has declined in 14 countries, especially in Bulgaria, Lithuania, Romania and Greece. Taken together, across the 25 Member States where comparison over time is possible, the number of children in residential care is estimated to have increased by 14% (from 410,126 to 466,807).

Figure 1: Change in the population of children in residential institutions over the 10 years preceding the most recent estimate, EU Member States (%)



Notes: *No past data available for Austria or Belgium. The intervals over which these changes occurred vary depending on country; see Table A1 in Annex 1 for specific years and other data.*
Source: *Network of Eurofound Correspondents*

Figure 2: Change in the population of adults (aged 18–64) with disabilities in residential institutions over the 10 years preceding the most recent estimate, EU Member States (%)



Notes: *No past data available for Austria or Cyprus. No data available for Belgium. The intervals over which these changes occurred vary depending on country; see Table A2 in Annex 1 for specific years and other data.*
Source: *Network of Eurofound Correspondents*

Adults with disabilities in institutional care

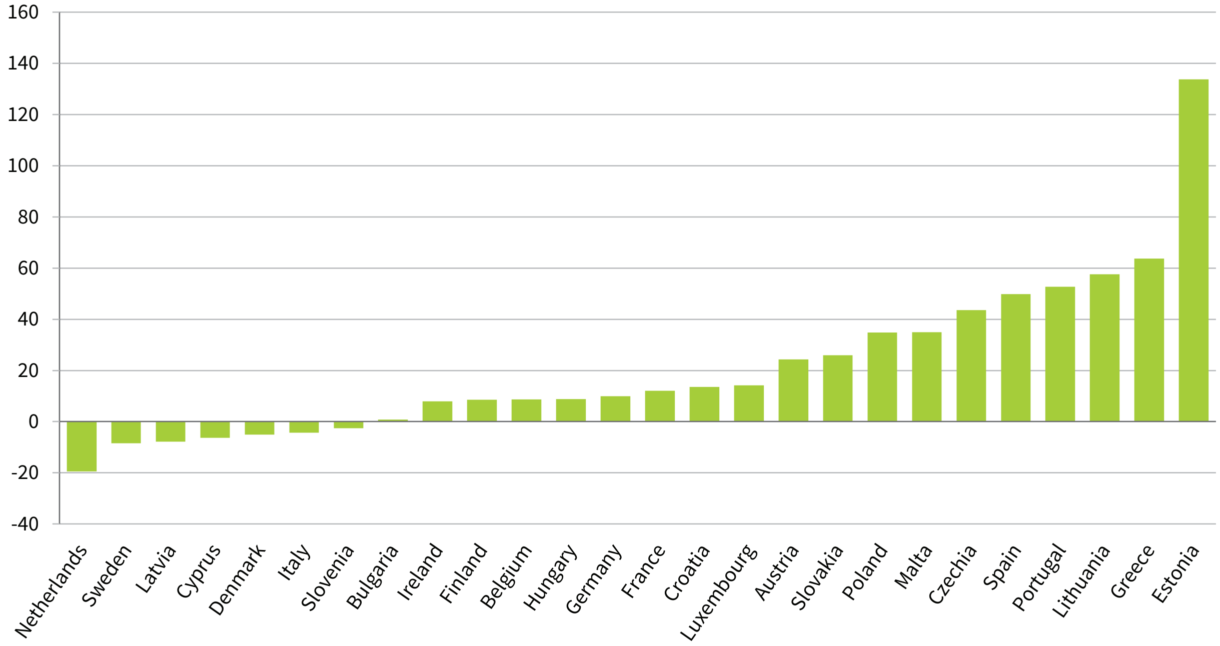
Figure 2 presents the corresponding data for adults aged 18–64 with physical, sensory or intellectual disabilities. Also in this case, for the countries for which analysis of data over time is possible, the number of people in residential institutions increased in 13 Member States. The percentage increases were particularly pronounced – exceeding 50% – in France, Poland, Malta and Portugal. Reductions were seen in 11 Member States, most notably in Finland, Greece, Estonia and Hungary. Across the 24 Member States where comparison over time is possible, the number of adults with disabilities living in residential institutions increased by 29% (from 709,682 previously to 916,385 in the most recent estimate).

Older adults in residential care

In relation to older adults, the Organisation for Economic Co-operation and Development (OECD) provides estimates of numbers of people receiving formal (paid) long-term care in institutions (other than hospitals) for 19 EU Member States. For the remaining eight Member States, supplementary data were provided by the Network of Eurofound Correspondents where available. No data were available for Romania from these sources.

Partly driven by the ageing of the EU population, the number of people aged 65 and over in residential institutions increased in the vast majority of Member States (19 in all) (Figure 3). This was especially the case for Estonia, Greece, Lithuania and Portugal. A decline in the older population in residential care was evident in only seven Member States, with the Netherlands being the only Member State with double-digit percentage declines in the size of the institutionalised population. Collectively in the EU, according to these estimates, the number of older adults in institutions increased by 11% (from 2,355,292 to 2,609,193).

Figure 3: Change in the population of older people (aged 65+) in residential institutions over the 10 years preceding the most recent estimate, EU Member States (%)

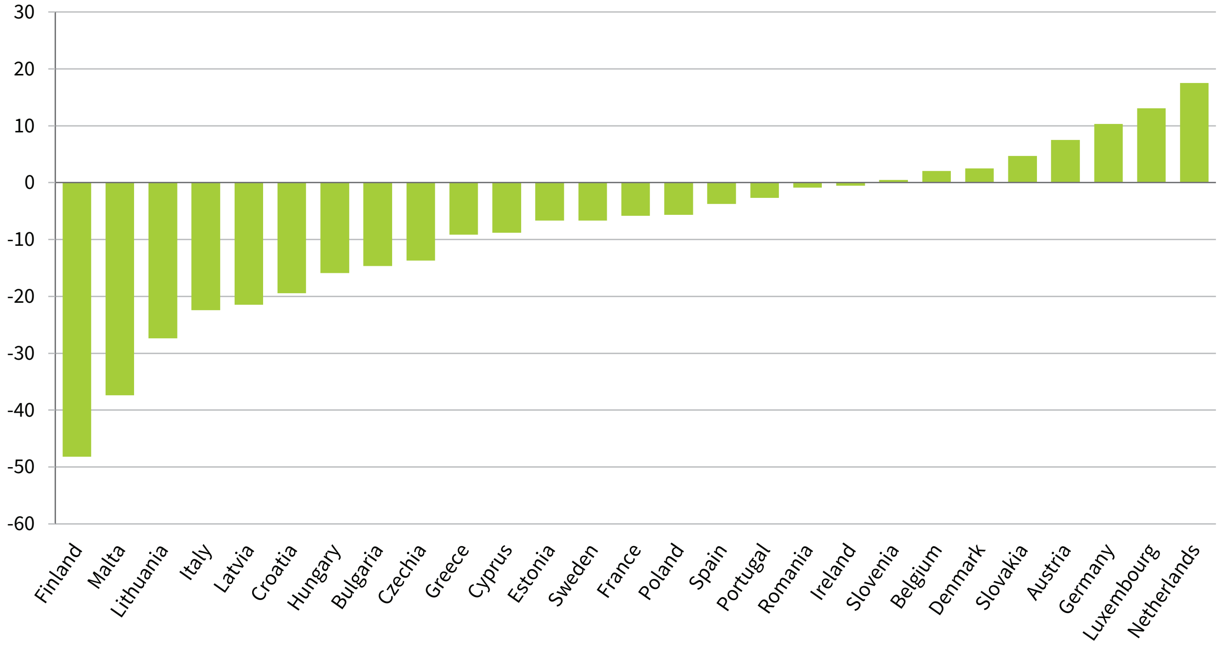


Notes: *No data available for Romania. The intervals over which these changes occurred vary depending on country; see Table A3 in Annex 1 for specific years and other data.*
Sources: *Network of Eurofound Correspondents (Austria, Bulgaria, Croatia, Cyprus, Greece, Italy, Malta and Romania); OECD, 2024 (all other Member States)*

Adults with mental health conditions in hospital care

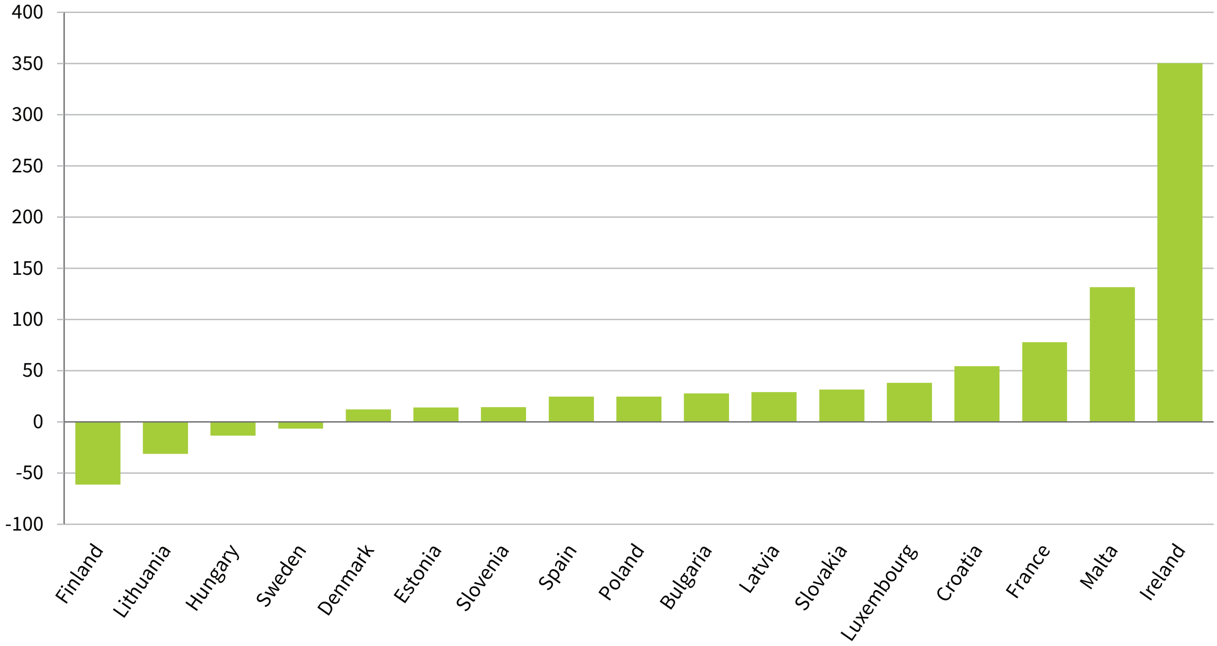
Figure 4 presents Eurostat data on the number of psychiatric care beds that are available in hospitals in EU Member States. The data are available for all Member States, with most having data available for 2011 and 2021, allowing a comparison over time. The number of psychiatric hospital beds declined in the majority of Member States (19). This was especially the case for Finland, Malta, Lithuania, Italy and Latvia.

Figure 4: Change in the number of psychiatric care beds in hospitals over the 10 years preceding the most recent estimate, EU Member States (%)



Notes: *The intervals over which these changes occurred vary depending on country; see Table A4 in Annex 1 for specific years and other data.*
Source: *Eurostat, Hospital beds by function and type of care [hlth_rs_bds1]*

Figure 5: Change in the number of people housed in temporary shelters or emergency accommodation for people experiencing homelessness over the 10 years preceding the most recent estimate, EU Member States (%)



Notes: *No past data available for Austria, Belgium, Czechia, Germany, Italy, the Netherlands, Portugal or Romania. No recent data available for Greece. No data available for Cyprus. The intervals over which these changes occurred vary depending on country; see Table A5 in Annex 1 for specific years and other data.*
Source: *Network of Eurofound Correspondents*

An increase in the number of beds was recorded in eight Member States, especially in the Netherlands, Luxembourg and Germany. Overall in the EU, according to these estimates, the number of psychiatric care beds declined over time by 1% (from 329,204 to 327,180).

Use of emergency shelters by people experiencing homelessness

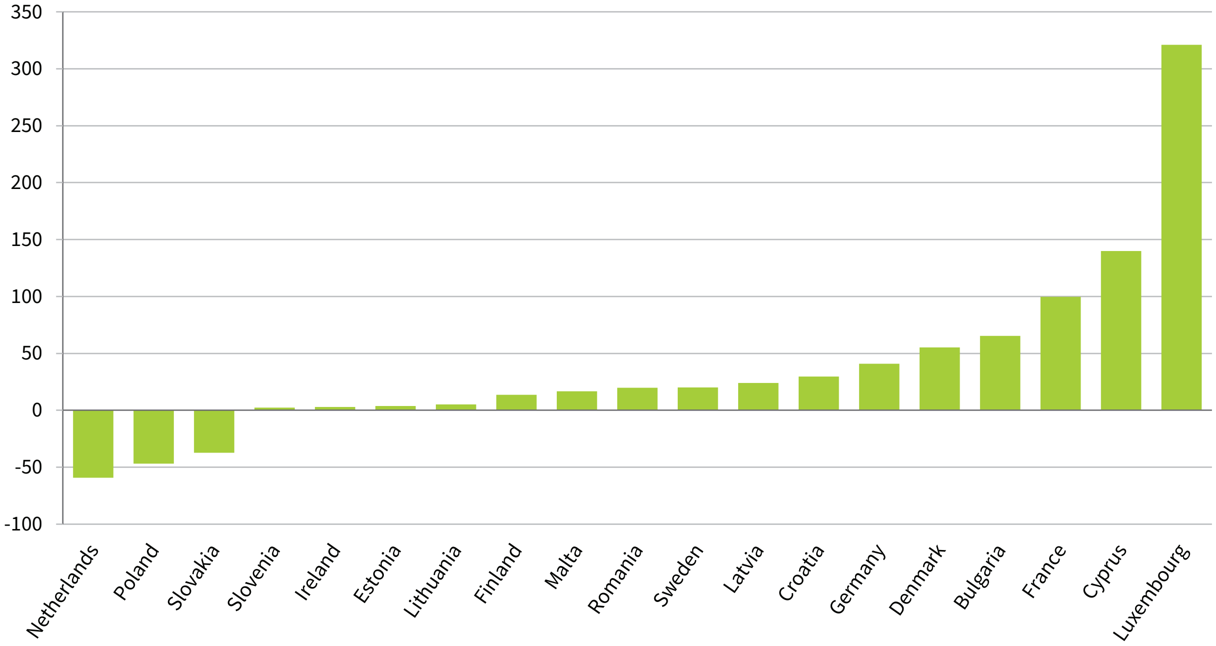
Figure 5 presents the estimated numbers of people housed in emergency or temporary accommodation for people experiencing homelessness in EU Member States. Depending on the Member State, some entries represent the total number of times that a person sought help from the services, whereas, in other cases, unique annual users were recorded. In some instances, census data from a specific date were collected.

Although the unavailability of data prevents a comprehensive overview, it is evident that the numbers of people being housed in emergency accommodation for the homeless have increased dramatically. Cases increased in 13 out of the 17 Member States where time trend analysis is possible. The percentage increases were particularly pronounced – exceeding 50% – in Ireland, Malta, France and Croatia. Reductions were recorded in only four Member States (Finland, Lithuania, Hungary and Sweden). Collectively, in the countries where comparison over time is possible, the number of people housed in shelters for the homeless increased by 56% over roughly a decade (from 189,705 to 296,483).

Use of emergency shelters by victims of domestic abuse

A very similar picture to that of homeless shelters is evident in the case of emergency accommodation for victims of domestic abuse (Figure 6). In many cases, national-level data are lacking, but from the available information it is clear that the numbers of people being housed in shelters have risen over time. Out of the 19 Member States for which comparison over time is possible, 16 have seen increases in shelter use, whereas declines have been evident only in three (the Netherlands, Poland and Slovakia). The percentage increases exceeded 50% in Luxembourg, Cyprus, France, Bulgaria and Denmark. Among the countries with time series data, the number of people housed in emergency accommodation for victims of domestic abuse increased by 11% (from 63,981 to 70,794).

Figure 6: Change in the number of people housed in temporary shelters or emergency accommodation for victims of domestic abuse over the 10 years preceding the most recent estimate, EU Member States (%)



Notes: *No past data available for Czechia, Greece, Hungary, Italy, Portugal or Spain. No data available for Austria or Belgium. The intervals over which these changes occurred vary depending on country; see Table A6 in Annex 1 for specific years and other data.*
Source: *Network of Eurofound Correspondents*

3 Supporting independent living: Strategies and practices

Strategies for deinstitutionalisation in the Member States

This chapter maps the national-level deinstitutionalisation strategies that are in place in EU Member States for the different population groups; these include umbrella strategies that cover multiple groups. It also notes groups for whom there is no national-level deinstitutionalisation strategy.

As highlighted by the 2019 Academic Network of European Disability Experts (ANED) report, across Europe, much higher levels of expenditure continue to be allocated to institutional care than to community care. However, the report also highlights a trend away from care provision in large institutional settings and towards care in the community. In several countries, there are strategies or action plans underlying this trend.

In some countries, a single strategy coordinates the deinstitutionalisation of several groups. For example, in Bulgaria, the Social Services Act coordinates the deinstitutionalisation of children, adults with disabilities, older people and people experiencing homelessness. There are, however, complementary policies in place, including the National Long-term Care Strategy and Action Plan. In Czechia, the National Strategy on Social Services Development was identified as a key tool for coordinating deinstitutionalisation for children, adults with disabilities and older people, again with complementary policies in place. In Sweden, the Act concerning Support and Services for Persons with Certain Functional Impairments coordinates deinstitutionalisation for adults with disabilities and people with mental health problems. Estonia is an extreme example of this, with only one policy – the Welfare Development Plan – identified, which addresses deinstitutionalisation of children, adults with disabilities, people with mental health problems and older people. For homeless people and victims of domestic abuse, no national-level strategy on deinstitutionalisation was identified in Estonia. There are also certain groups for whom, in many Member States, deinstitutionalisation tends to be coordinated by a separate policy instrument, particularly victims of domestic abuse.

In other countries, for example Denmark, Portugal and Romania, there is a separate strategy for each of the six groups under consideration in this report.

Member States are also at various stages in terms of the implementation of deinstitutionalisation policies. While some countries are already following through on their strategies – for example, Romania has a strategy that covers 2022–2024 – other countries, including Spain, are in the process of developing one.

Member States' strategies for different population groups are listed in Annex 2 (Tables A7–A12).

Examples of initiatives to support independent living

This section of the report describes approaches taken to achieve independent living and deinstitutionalisation across Member States. It highlights common approaches and unique avenues. Available evidence on user costs and policy evaluations are presented.

Across Member States, a wide range of policies have been adopted to promote and support independent living for the specific groups identified in this report. While there are many differences between Member States in how these policies are designed and implemented, they can be broadly grouped into five main types of policies (Figure 7). There are policies that seek to ensure that accommodation is provided, ensure that (often subsidised) in-home care and services are provided by professionals, support informal (often, but not always, family) carers, provide support services in the community and, finally, directly provide financial assistance.

Figure 7: Typology of policies to support independent living

- **Accommodation** (e.g. foster care, adapting physical environments to increase safety and accessibility, shelters for those in danger)
- **Professional care at home** (e.g. personal assistants, mobile mental care teams)
- **Informal care at home** (e.g. recognising and improving the conditions of informal carers)
- **Support services in the community** (e.g. day-care centres, counselling services)
- **Financial assistance** (e.g. allowances, rent subsidies, interest-free loans)

The sections that follow describe initiatives aimed at (i) children, (ii) adults with disabilities, (iii) people with mental health problems, (iv) older people and (v) victims of domestic violence. For a relatively recent overview of policies to support independent living of people experiencing homelessness, see Eurofound (2023). While the policies in this section are discussed separately for each group, some of the policies support or target several of these groups.

Children

Examples of initiatives to support the deinstitutionalisation of children in care are evident in almost every Member State. Options for children to live in family environments, as alternatives to institutional care, are facilitated by support to birth families – including parental education programmes, financial assistance, access to social services, access to health services and family counselling – kinship care, foster care and adoption.

Foster care

Across Member States, the most common approach to providing accommodation for children is to place children with foster families. For example, in Bulgaria, the effort to place children with foster families was operationalised through the Action Plan implementing the European Child Guarantee. This initiative has led to the closure of institutions for children and ensured the placement of a large number of children in foster care or with relatives. In Spain, a programme coordinating the placement of children in foster care has been in place since 1996, and at the end of 2022 there were 18,177 children in foster care, compared with 17,061 children in residential care.

A similar approach to foster care – albeit with important differences – is the use of 'family homes' in the Flanders region of Belgium. These homes are similar to foster care in that children and young people are placed with 'family home parents' – people with professional training who are paid to care for those who are in need of the service. This service is offered to children or young people who need intensive care and professional help. This novel initiative has been in place for less than a year and, to date, there is no evidence available of its effectiveness. In Daugavpils, Latvia, a 'family house' has been established, catering for children aged from 8 to 17 years who have previously lived in a social care centre. The house has been in operation since 2022 and currently there are 20 children living in it. Its aims are to provide a more family-like environment for children and to prepare them for independent life in society.

Likewise, in the regional state of Burgenland in Austria, a modified version of the traditional foster care model has been in use since 2022. Under this new model, foster parents are employed and receive full social insurance coverage as well as a salary of up to €2,408.96 per month (gross, paid 14 times a year) plus a monthly allowance of €550 per foster child under the age of 14 years.

Alternatives to traditional foster care

There are also examples of initiatives that centre around families but are separate from the traditional foster care model. For example, in Denmark, a non-governmental organisation (NGO) called Mentorbarn connects children and young people who live in foster care or residential institutions with a 'friendship' or 'mentor' family. This gives children the opportunity to participate in daily family life outside the system, to form close relationships and gain social skills. In Estonia, a programme coordinates placement in 'crisis substitute families' and 'specialised substitute families', the former being short-term placement in emergencies, while the latter are short- or long-term placements for children with additional care needs.

In Finland, a programme of aftercare provides social and healthcare services to children and young people who have been removed from their home as a result of a custody order or in the case of an emergency in the home. The aftercare helps them to reintegrate into society after a temporary placement in an institutional setting (THL, 2024).

In the Netherlands, an initiative that has been in place since 2019 focuses on maintaining family ties for children in alternative care. The aim is to ensure that children can return to their family home in a sustainable and safe manner as quickly as possible, and there is an emphasis on ensuring that siblings in alternative care are not separated. This project appears to be largely successful, as the results from the pilot study suggest that family ties were strengthened in 93% of cases, and in 92% of cases the child returned to their family home.

Youth accommodation

For older young people, there are also promising initiatives to facilitate deinstitutionalisation. For example, in Italy, the Appartamenti per l’autonomia (Apartments for Autonomy) programme has, since 2001, been providing housing to young people aged 18 or older who had previously been in foster care. A similar initiative in Portugal, the Apartamentos de Autonomização (Autonomisation Apartments), consists of single-family homes in the community that aim to support the autonomy of young people aged 15 and over, in particular to prepare them to live independently.

Support services in the community

In Lithuania, the Transition Service provides services and facilities for young people aged 16–24 currently or previously living in alternative care or with a family at social risk. Services provided under this programme include psychological and psychotherapeutic support, development and maintenance of daily living skills, and development of work skills.

In Cyprus, there has been a programme in place since 2020 specifically to support young migrants between the ages of 16 and 21 with the transition to adulthood. The users of the services have access to social services and are provided with semi-independent housing. As of December 2022, 137 unaccompanied migrant teenagers had received aid under the programme.

In France, the Young Adult Contract provides material, educational and psychological support to young adults between the ages of 18 and 21 who experience severe challenges in terms of social integration and are without family support. The contract can cover a young person for between six months and two years, and evidence suggests that those who have access to this support for a longer period are more likely to be able to find their own accommodation and employment. As of the end of 2022, approximately 34,100 young people had benefited from this programme.

Adults with disabilities

Initiatives to support adults with disabilities to live independently can be found in all Member States. Examples of such initiatives are described below.

Providing and adapting housing

Programmes are in place across several Member States that provide housing or adapt existing housing for people with disabilities. In Malta, Supported Independent Living Opportunities is a pilot programme that works directly with people living in a state-run institution or with their parents or guardians to help them to look for alternative independent living arrangements within the community. Through this pilot project, which has been in place only since late 2023, people with disabilities are involved in decision-making about their own lives, including choosing the location of their apartment, refurbishing their apartment, and choosing their support system and personal assistants. In Czechia, the city of České Budějovice also promotes an approach to help adults with disabilities live independently while providing them with comprehensive support. In Poland, the For Life programme provides housing and training for independent living for adults and children with disabilities. In Ireland, there is a programme in place to move people with disabilities from congregated settings to their own homes in the community and provide them with the support they need. As of 2021, 2,200 people had made use of the programme.

Personal assistants

A significant number of Member States provide support for personal assistants for people with disabilities, which allows people with disabilities to live in their own homes and facilitates their engagement with the wider community. The costs to service users vary across Member States. For example, a programme in Denmark provides personal assistance at no cost to the user, while in Estonia the user cost is 2.5% of the overall service cost. In Austria, funding for personal assistants is provided at 50% of the cost per hour of assistance incurred by the service user. In Sweden, the services are either provided for free or subsidised, depending on which municipality is running the programme.

Community support services

In Germany, in 2018, an independent counselling service for people with disabilities was introduced. The aim of this service is to ease the administrative burden on people with disabilities who are trying to understand and apply for the different benefits available to them. An independent evaluation of the service found that around 15,000 consultations per month have taken place throughout Germany. Users of the service are highly satisfied because it helps them to clarify their needs, assess how their living situation can be improved and find out what services are available to them (Heimer et al, 2023). This service is provided at no cost to the user.

Financial assistance

In Gipuzkoa, Spain, and in Romania, programmes have been implemented to provide financial support to people with disabilities. Personal finance is also an important part of the policy Perspectiefplan 2020 for people with disabilities in Belgium. This gives recipients a personal budget, fully financed by the government, that allows them to make their own choices regarding how they organise their care. In France, adults with disabilities can apply for financial aid in the form of the Disability Compensation Benefit. In Slovenia, a deaf, blind or deafblind person can apply for a communication allowance, and with this they can apply for personal assistance for up to 30 hours per month or claim a monetary allowance of €173.56 per month.

People with mental health problems

For people with mental health problems, several types of programmes across the Member States provide support and facilitate deinstitutionalisation.

Accommodation

Housing is provided to people with mental health problems in several Member States. For example, in Hungary, accommodation in supported housing is available to women with addiction problems who have young children or are pregnant. Support from social workers is also offered to the users but is not mandatory. Though the programme is small in scale (15 adults and 16 children received support between 2017 and 2020), the evidence suggests that it has been effective in preventing children from being taken into care.

In Czechia, deinstitutionalisation is supported by a housing-first approach. The project aims to find standard accommodation and provide support for its long-term maintenance, as well as providing personal development support, for people with serious mental illnesses who are in need of comprehensive and intensive care and also in need of accommodation. The project is in the process of being implemented and is currently providing support to 51 people.

In Portugal, there is a programme in place to provide housing (at a subsidised cost) to people with mental health problems. In Cyprus, the Assisted Living Guesthouse is staffed by mental health professionals and houses patients with mental health problems who were former residents of Athalassa Psychiatric Hospital. Users are housed temporarily, pending their integration into the community.

Ireland is another example of a Member State that aims to support the deinstitutionalisation of people with mental health problems by providing them with housing. This is carried out through the National Housing Strategy for Disabled People 2022–2027, which includes people with intellectual disabilities, psychosocial disabilities and mental health difficulties.

In Greece, since 2018, supported living homes have facilitated the deinstitutionalisation of people with physical, psychosocial, intellectual or sensorial disabilities. Twenty-eight organisations operate 65 supported living arrangements.

The process of moving from an institutional environment to independent living can be challenging. To address this, in Malta, since late 2023, a pilot project has offered a transitionary placement to people before they proceed to a semi-independent or independent living arrangement. The placement is in a small residential setting, away from the institution or group home. In addition to accommodation, users receive an individualised support plan, assistance in their search for employment, and help to build support networks and to enhance their independent living skills.

Professional care at home

Several Member States have programmes that provide assisted living arrangements to people with mental health problems. For example, in Estonia, people with mental health problems can claim two hours per week of assisted living services. The service assists users in household management and tasks such as budgeting. If the person is living in their own home, there is no fee associated with the service. As of January 2024, 1,073 adults were using the service. Similar home support services are provided in Sweden, and in most municipalities these services are provided at no cost to the user.

An interesting initiative in Denmark is the Ambulatory Crisis Resolution Team, which provides free emergency psychiatric care to people with mental health problems in their homes. This initiative, which ran as a pilot from 2015 to 2018 and was subsequently expanded, has been deemed generally successful, with service users highly satisfied with the care they receive.

Care is also provided in the home by mobile teams in Belgium. The mobile teams are multidisciplinary and provide specialised care in the home environment. They are responsible for the aftercare of people who were previously admitted to an institution. Likewise, in Slovenia, multidisciplinary mobile teams were established in 2023 and consist of a psychologist or specialist in clinical psychology, a social worker, a registered nurse, and a representative of the Red Cross, Caritas or a local NGO.

Support services in the community

In the Basque Country of Spain, day centres provide individualised and comprehensive care during the day for people with chronic mental illness. This service, which is provided for users at a fee based on their income, allows people to maintain or increase their autonomy. A similar service is provided in Slovakia by a network of psychiatric day-care centres. These centres aim to avoid or at least shorten the residential treatment required by people with mental health problems, as well as increase their quality of life and foster their social inclusion. In Finland, the city of Helsinki provides people who are struggling with mental health symptoms with day ward services in a psychiatric day hospital. Treatment can include cognitive and behavioural therapy. In Latvia, an initiative under way in the Riga region has established day-care centres where people can receive support.

In Croatia, the Operational Plan for Deinstitutionalisation, Prevention of Institutionalisation and Transformation of Social Service Providers, in place since 2022, targets several vulnerable groups. Regarding adults with mental health problems, the plan has created a centre for the provision of services in the Osijek community, a home for adults in the city of Trogir and a home for adults in the city of Rijeka. In total, around 230 care recipients have been included in the process of deinstitutionalisation. While the initial goal was to target adults with less severe mental health problems, the process of deinstitutionalisation included all users, regardless of the level of support required. This has led to increased costs of implementation as well as delays.

Older people

Across Europe, a wide variety of services are in place to facilitate the deinstitutionalisation and independent living of older people.

Accommodation

While not directly providing accommodation, there are programmes in several Member States that deliver technologies and services that help older people to live in their homes, in good health, for longer. For example, in Hungary, technology is being deployed to increase the physical security of older people living at home. Since April 2022, the state has provided older people with a device with a single button that they can press in the case of an emergency. The device, which is free to eligible users, connects users to a continuously operated dispatch service. A similar technology (the tele-alarm) is available for those aged over 65 in Luxembourg. However, in Luxembourg, there is an installation cost of €75 and a monthly subscription fee of €31. There are social rates available to those on low incomes.

In Ireland, the Healthy Age Friendly Homes programme provides a range of support to older people to help them live in good health in their own homes. As part of the programme, a local coordinator visits the applicant to carry out an assessment of their needs across the domains of health, housing, community and technology. Following the assessment, the coordinator works with the older person to design a personalised action plan. Over the course of the two-year pilot, which commenced in 2021, nearly 3,000 older adults were provided with support. The national rollout of the programme aims to support up to 10,000 older adults annually.

Professional care at home

All Member States provide home help services. For example, in Spain, access to home help has been guaranteed by law since 2006 to those who need it. Enshrining the right in law has made this form of help much more accessible, as previously it was available on an ad hoc and unequal basis. The costs of the service are subsidised by local governments, and users pay based on their economic means. According to data from 2022, users paid, on average, 9.4% of the hourly cost of the service. In Lithuania, care services are also provided in a person's home (or in an institution), with the hours of care provided based on the needs of the user. In Bulgaria, assisted support is available for older people in need in their homes. Austria's programme subsidises the cost of hiring a live-in carer for people who need long-term, around-the-clock care. The proportion of the costs funded under this programme depends on the determined need for care of the user, as well as their financial means.

In Greece, the Help at Home programme provides domestic assistance to older people who live alone. Services provided include counselling and emotional support, nursing care and physiotherapy, and assistance with day-to-day life, including shopping and paying bills.

An interesting innovation is under way in Sweden to ensure more consistent care services for home care users. A 2023 report found that older people who use home care services meet, on average, 16 different staff members during a two-week period. The new initiative aims to address this by ensuring that the service users have the right to permanent contact with a licensed assistant nurse. It is hoped that this will promote more personalised care and increase feelings of security among the care users. As the project was initiated in 2023, no results on its success are available yet.

In Denmark, an initiative was established to improve the quality of existing services. Since 1998, meal services have been provided at a subsidised rate to older people in need of them, and since 2013 recipients have been able to use meal choice vouchers to choose their own providers of the service, in theory enhancing the dignity and independence of individuals. In 2022, 40,215 people received the meal service, but there are no data available on how many service users made use of the meal choice vouchers. Home-delivered meals are also provided to older people in need of this service in other countries, including Finland.

Informal care at home

In Germany, Portugal and Romania, initiatives have been put in place to improve the conditions of informal or family carers of older people. In Romania, since 2022, informal carers of older people are formally acknowledged as working a part-time schedule and receive an allowance equal to half the gross basic salary of a home carer. This initiative is fully funded by the state. In Portugal, since 2019, people who provide permanent or regular care to others can apply for the recognition of informal carer status and receive a carer's allowance. At the programme's initiation, the informal carer status was limited to the family members of the person being cared for, but on 12 January 2024 the Portuguese Parliament approved a proposal to extend informal carer status to eligible people without family ties but who live with the cared-for person and provide regular care. In Germany, all employees can apply for 10 days of caregiver leave if they need to provide or organise nursing care for a close relative. In addition to being entitled to leave, employees can also apply for wage replacement from their statutory care insurance.

Support services in the community

A pilot project in the Nijmegen municipality of the Netherlands saw professional social workers with expertise in the care of older people manage the coordination of care across doctors, neighbourhood nurses and other care providers to ensure that older people with memory problems could live independently for longer. Results from the pilot showed that, after six months, the older people who participated had better social functioning and less severe memory problems. Furthermore, they lived at home for an average of seven months longer than those who had not received that support.

In Croatia, as part of its national plan accessing funding from the EU's Recovery and Resilience Facility, centres for older people are being constructed and equipped. In these centres, older people who live alone will be able to have meals and spend time in the company of others. For older people who lack the physical mobility to travel to these centres, regular visits from personal assistants or healthcare professionals will be arranged.

Financial assistance

In Malta, financial support, up to a maximum of €8,000 per year, is provided to eligible people over the age of 60 who employ carers in their own homes. The initiative has been in place since 2016, and the number of people using this service increased from 56 in 2016 to 865 by the end of 2023.

Victims of domestic violence

Across Member States, a variety of programmes have been established in an effort to achieve safe, independent living for victims of domestic violence.

Accommodation

In many Member States, emergency shelter accommodation is provided to women and children who are victims of domestic violence. For example, in the Murcia region of Spain, three types of shelters are available: emergency centres where the average length of stay is between 15 days and 1 month; shelter homes where victims typically spend between 3 and 6 months; and shelter homes where self-sufficient women victims of abuse and their children live together in a partially self-managed regime, for an average stay of between 6 and 12 months. These services are provided free of charge.

The National Organisation for Women's Shelters and Young Women's Shelters in Sweden has provided services for free to victims of domestic violence since 1984. According to the most recent data, in 2017, 4,054 women and 6,788 girls received support. Historically, the shelters have had to turn some applicants away due to a lack of resources. However, since 2017, the service has received additional government financing and, as a result, fewer applicants have been turned away. In Austria, there are 33 women's shelters located around the country, the first of which has been in operation since 1978. In 2022, the services provided care for 1,498 women and 1,520 children.

In Bulgaria, the state finances the provision of shelter housing centres for victims of domestic violence. In total, there are 32 crisis centres that provide services to 658 users. In Finland, emergency shelters for victims of domestic violence must be provided by law. They are funded by the state but are typically run by NGOs or the newly established 'well-being services counties' (regional divisions of the country responsible for organising healthcare, social welfare and rescue services).

In Croatia, women and children who are victims of domestic violence are provided with temporary accommodation in shelters. As of 2022, 18 shelters were providing accommodation for 280 women and children.

There are also examples of accommodation being provided on a smaller scale through 'crisis apartments'. In Czechia, since March 2024, this service has been available to women victims of domestic violence. These women are able to avail themselves of seven nights' accommodation at no cost. A similar initiative has been under way in the town of Cascais in Portugal since 2017 in the form of a 'transition apartment'. Women using this service can also make use of supplementary services, including support with finding employment and housing. Since 2017, the service has housed 10 women and 15 children. Crisis apartments have recently been established in Latvia, providing women and children with emergency accommodation for up to 30 days, which can, in exceptional circumstances, be extended to 180 days. Under this initiative, it is envisaged that emergency accommodation would be provided to approximately 100 people per year.

Support services in the community

Another initiative in place across several Member States is national helplines for victims of domestic violence. In Slovakia, for example, this service is provided free of charge to users and operates around the clock. In 2022, the service received 2,678 incoming calls and, while the service provision is considered adequate, the hotline is to be further promoted and its capacity will be increased through EU funding. In Romania, a national helpline operates continuously at no cost to the user. It provides primary legal and psychological counselling to victims of domestic violence. In Denmark, also, there is a service that provides free counselling services and legal advice to victims of domestic violence. The service targets women who are unwilling or unable to move to a shelter. As of 2022, 1,314 victims had contacted the service.

In Belgium, family justice centres are in place for families in which there are serious, repeated conflicts that lead to violence. Victims cannot directly contact these centres; rather the police refer families to these centres. An interesting feature of these centres is that they are intended for not only the victims of domestic violence, but also the perpetrators. The centres aim to create a strong support system around the families and tackle the problems that may have led to the violence. In the event that a victim needs to move out of their home because of violence, the centres also provide support for this.

In Cyprus, social services are made available to victims of domestic abuse. These services cover the cost of essential items, including household equipment (furniture, electrical appliances and so on), and aim to connect the service users to the labour market, by referring them to specialised training programmes, helping them to prepare a CV and collaborating with nurseries, kindergartens and schools. These services are provided for free to users, and the programme has been in place since 2021.

Financial assistance

Rent subsidies

In Greece, women who are accommodated in hostels for victims of violence and who do not have access to housing are eligible to participate in the Housing and Work for the Homeless programme. The programme includes a rent subsidy for a period of up to 24 months, provision of psychosocial support and links to supplementary social benefits and services, including services supporting activation, training and access to the labour market. Overall, the results have been deemed particularly positive for homeless beneficiaries of the programme. In Ireland, too, a rent subsidy is provided for victims of domestic violence. For the first three months, the subsidy is provided without a means test; thereafter, a means test is performed to determine if the subsidy is to be extended.

Other forms of financial assistance

In France, through a recent initiative (in place since December 2023), financial aid is provided to victims of domestic violence. The aim of this aid is to allow victims to leave their homes immediately and find an alternative place to stay.

A unique service that has been provided in Italy since 2020 is the Freedom Income service. Through this initiative, female victims of domestic violence who have difficulty accessing traditional bank credit can, subject to eligibility criteria, apply for interest-free loans. In addition to providing women with financial credit, it supports them through financial education.

Conclusion

The mapping of national deinstitutionalisation strategies suggests the existence of coordinated efforts in some Member States, such as Bulgaria, Czechia and Sweden, but a relative lack of coordination in others, such as Estonia, where fewer comprehensive strategies exist. Implementation also varies, with some countries still developing strategies for deinstitutionalisation.

Various practices and policies across Member States to support independent living and family- and community-based care and services can be identified, including examples of foster care, in-home services, support for informal carers, community support services and financial assistance.

Despite the ambitious strategies for deinstitutionalisation adopted by Member States across the EU, the transition to family- and community-based care and services is lacking in scope and quality in many instances, as demonstrated in this chapter. The gaps between strategy aims, policy implementation and outcomes underscore the challenges of and shortcomings in deinstitutionalisation. The following chapter focuses on these issues, shedding light on the causes of challenges and exploring potential solutions.

4 Challenges with family- and community-based care and services

Many hurdles can prevent the successful delivery of person-focused care and services and the availability of community-based options for people with care or support needs. This chapter examines the challenges encountered in providing family- and community-based care and services that aim to support social inclusion and independent living among groups that are at risk of social exclusion and marginalisation. The analysis draws on studies from EU Member States and reviews of existing literature. The discussion is divided into three sections: limited resources, suboptimal processes and shortcomings identified from lived experience.

Limited resources

The **lack of funding** directed towards relevant policies prevents Member States from establishing, and maintaining, adequate levels of family- and community-based care and services. As a result, in the majority of Member States, the scale and adequacy of these services are reported to be insufficient for many of the population groups covered in this report. The scale of services is lacking, for example, in programmes for older young people (discussed in the preceding chapter of this report). This is also evident in a survey of services carried out in Lithuania in 2023, which indicated that the services were not yet available in 27 of the country's 50 municipalities, with a lack of funding being among the reasons for this. A further example of how a lack of funding limits opportunities for independent living can be seen in Greece, where the budget for the rent subsidy programme for victims of domestic abuse has been too low. In Ireland, it has been highlighted that the effectiveness of its rent subsidy programme has been impacted by the housing crisis and the lack of rental accommodation available (Irish Examiner, 2022).

When it comes to the deinstitutionalisation of children, the **shortage of foster care places** is a widely shared obstacle. The lack of foster families limits the availability of stable and tailored family care options for children, maintaining reliance on institutional facilities for children without adequate parental care. It has been reported, for example in the case of Hungary, that even very young children are placed in temporary children's homes because of the priority to keep siblings together and the lack of suitable foster families (Vígh, 2015). Some Member States (such as Germany, Greece, Poland and Sweden) have implemented initiatives to provide funding to foster families. However, the problem of an insufficient number of foster families persists. While there are no national data available, certain regions in Sweden highlight the magnitude of the problem. For example, in 2019, there were more than 130 children in the queue for foster care in Gothenburg and 100 children in the queue in Malmö. Likewise, according to data from 2023, 30 and 20 children were waiting for foster care in Linköping and Norrköping, respectively. The employment model of foster care being deployed in Austria aims to make foster care more attractive to potential foster parents, to address the shortage of foster families. In Germany, in some states, child and youth welfare offices lack sufficient personnel to adequately support foster families (van Santen et al, 2019).

The **shortage of accessible and affordable housing** in regular communities poses challenges to the desired progress in deinstitutionalisation being achieved. For example, while the provision of shelter accommodation is crucial as a form of emergency support to people experiencing homelessness and victims of domestic abuse, the Lisbon Declaration and the Istanbul Convention, discussed in Chapter 1 of this report, emphasise the importance of minimising time spent in emergency shelters and prioritising the offer of permanent housing solutions. A further goal set in the Lisbon Declaration is that no one is discharged from an institution (such as a prison, hospital or care facility) without an offer of appropriate housing. There are reports from Member States that people's discharge from institutions such as prisons and psychiatric hospitals is delayed because of a shortage of suitable housing on offer and that (hidden) homelessness is common after discharge (Hrast et al, 2023; Teale et al, 2024). The lack of availability of housing and the limited scale of Housing First-type schemes is also highlighted in recent reporting by Eurofound (2023) and discussed in detail in the case study on the deinstitutionalisation of people experiencing homelessness presented in Chapter 5 of this report. In such schemes, providing homeless people with housing is a starting point rather than an end goal (Housing First Europe Hub, 2024). This approach is in contrast with 'staircase models', which first provide non-housing support.

The **inadequate scale of services** is a common shortcoming among initiatives in several Member States. For example, in Estonia, while there were 1,073 adults with mental health issues making use of the assisted living service at the start of 2024, almost one-third of this number (350 people) remained on a waiting list. In Sweden, the level of service provided under the assisted living service, which can be as little as one hour per week, is not sufficient. In Portugal, the programme that provides subsidised housing to people with mental health problems has been criticised for its small scale, with only 26 people receiving support in 2020. In Greece, too, the relevant programme has been criticised for its small scale, with services reaching only a very small percentage of people with disabilities living in the community.

An issue that has been reported in many Member States (such as Cyprus, Estonia and Ireland) in reference to adults with disabilities is that they have, in some instances, been housed in care homes for older people. As a further indication of fundamental insufficiency in care resourcing, in France, owing to a shortage of services for adults with mental health problems, people are sometimes sent to Belgium, isolated from their family and familiar surroundings, which becomes a further barrier to their autonomy and integration into society (France Assos Santé, 2017).

The inadequate scale of services can have far-reaching and unexpected implications. Analysis of survey data collected from older people in Finland (using models that control for confounders such as age, health status and income) found that people living in old-age care homes reported higher levels of subjective well-being than their home-living peers – a finding that the authors of the study hypothesised to stem from the lack of care-home beds and the lengthy waiting lists to access them (Böckerman et al, 2012).

Constraints on the choices available can have adverse outcomes for people seeking to use services. When it comes to people with disabilities, a report from the Danish Institute for Human Rights highlights that, while, in theory, people can choose their type of housing (for example, independent or accessible housing or a residential institution), in practice many people have little choice in the matter. In turn, this means that they have limited influence on issues such as the people they live with or how close to friends and family they live. The lack of choice is a result of how local municipalities have organised housing for people with disabilities and how different residential institutions target different disabilities. As residential institutions are typically organised as communal living institutions, where the residents share staff and common areas, people have no option but to live in shared accommodation to ensure they get the support they need (Institut for Menneskerettigheder, 2021). Research has found that having a choice about whom one lives with (in the case of shared accommodation in the community) and compatibility with housemates are important determinants of quality of life (McCarron et al, 2019).

Another key barrier to independent living is **limited access to mainstream services**, notably employment and education services that are fundamental for people to successfully integrate into societies and gain freedom, independence and self-expression.

Understaffing is an issue that affects the delivery of family- and community-based care and services in many instances. Existing research highlights the importance of staff support in community-based living for improving individuals' quality of life. Low staff turnover and a core of permanent staff ensures familiarity with service users' individual interests and preferences (McCarron et al, 2019). A shortage of personal assistants has been highlighted as an obstacle in many Member States, including Bulgaria, Denmark and Portugal. In Denmark, municipalities are supposed to fund the services of personal assistants, but financial constraints have meant that availability has been curtailed. In Cyprus, personal assistants are supervised by staff with a nursing degree, with the associated salary expenditure limiting the size of the programme. A challenge that has been highlighted in Sweden is that, while the number of users receiving home support is growing, the increasing demand is leading to delays in applicants receiving the service. In France, the growing number of children under state care (an increase of 43% in 10 years) has created a pressing need for social workers to assess their situations. However, there is an insufficient number of social workers available (DREES, undated). **Waiting times to access services** are problematic. For example, in Belgium and France, people with disabilities are facing excessive waiting times to receive personal financing.

Examples of **inadequate resourcing of shelters and services** across the EU for victims of domestic abuse and homeless people are described in Box 3.

Box 3: Underresourcing of shelters

Several examples illustrate the capacity constraints in shelters for victims of domestic abuse. In Austria, in 2022, 353 women could not be admitted to the shelter where they first sought refuge – an issue also reported by women's shelters in Germany (Association of Women's Shelters, 2023). In Bulgaria, there are several districts where a shelter service is not available. As a result, there are currently 479 children and 295 adults who are victims of violence or trafficking and who remain in need of support. In Croatia, while the existing shelters have no waiting lists, five counties have no shelters. In Greece, the number of beds in shelters for abused women barely exceeds 400; however, the goal of a minimum of 1,000 beds was set by the 2014 Istanbul Convention.

In France, the conditions in homeless shelters (such as curfews, space limitations and poor maintenance) mean that 26% of homeless people report never seeking help from them (Fondation Abbé Pierre, 2021).

The low ratio of staff to residents in homeless shelters in Belgium means that the staff workload is too high for them to provide help and assistance tailored to the individual's needs. As a result, the support in shelters is described as being limited to basic 'bed, bath and bread'. Similar findings are reported about homeless shelters in Spain, where services are focused on basic emergency care instead of the promotion of autonomy and support to rebuild a life in the community (Ministerio de Derechos Sociales, 2023).

Capacity issues can also hinder the delivery of counselling services. For example, the legal and psychological counselling service for victims of domestic violence in Denmark has a waiting list of between three and seven months. The longest waiting times are in Copenhagen. Lack of links to other related bodies can also cause a problem – for example, a criticism of the job-seeking support measures that are available in Greece is that the public employment service is not involved in the work integration process.

In Bulgaria, a lack of funding is reported to hamper the sourcing of medical supplies, legal aid, educational supplies and entertainment for child victims of domestic abuse in shelters (BFW, 2022).

Suboptimal processes

For people who move from a residential institution to a family- or community-based setting, the **moment of transition** is fraught with risks. Various Member States in their Child Guarantee national action plans refer specifically to children leaving alternative care (including residential care) (Unicef and Eurochild, 2023), with some plans mentioning specific measures to support such children in successfully transitioning to independent living. In an example that highlights how the trajectories of young people leaving institutional care can be hampered by lack of support around the transition, research findings from Austria show that expectations of staff regarding the school performance of children who leave institutional care (in most cases at the age of 18) are low. These children are generally advised to pursue qualifications that can be achieved quickly so that they can secure employment (Sting et al, 2018). The lack of research into practices that help children and adolescents who transition from institutional to family-based care means that interventions are lacking or sometimes not evidence based. Transitioning children are in need of psychological support, the establishment of structure and routines, language stimulation, and behaviour management (Dozier et al, 2012). The importance of the transition out of institutions and into community living is discussed in detail in the case study presented in Chapter 5, along with suggestions for ways in which the associated risks could be mitigated.

As discussed in the introduction to this report, **institutional culture** can prevail in any setting, even in community-based alternatives. The persistence of the institutional mindset therefore needs to be overcome for deinstitutionalisation efforts to be successful. However, transferring practices used in institutional settings into the community may reinforce the persistence of that culture (Mansell et al, 2007). For this reason, family- and community-based care and service provision needs to be accompanied by a cultural change among service providers (Ilinca et al, 2015).

For successful policy implementation, it is essential to **empower the service users** affected by the policies in question by actively involving them in the process and ensuring that their voices are heard. Individuals' insights into their own needs, preferences and lived experience form a basis of a person-centred approach in provision. The approach of considering the service user (rather than the service provider) to be in the best position to judge their care and service needs and to steer their engagement with these services is a manifestation of the move away from a damaging institutional culture. Existing research suggests that the achievement of better social inclusion through deinstitutionalisation is hampered by the lack of service user involvement (Hall et al, 2021). The ethos of separation of housing and services in Housing First-type schemes for people experiencing homelessness emphasises the importance of personal agency. This issue has been discussed, for example, in relation to cases in which people experiencing homelessness have been offered independent housing only on the condition that they accept counselling (Eurofound, 2023), and it is also revisited in the case study presented in Chapter 5.

Some studies highlight that, while anti-discriminatory practices and the promotion of the right to individual choice are of paramount importance, some people with intellectual disabilities may need **help with decision-making** or need others to make decisions on their behalf, and therefore deinstitutionalisation efforts need to acknowledge the degree of impairment that people have (Mansell, 2006).

The provision of effective community-based care and services faces challenges that require planning and **coordination between service providers**, such as housing agencies, social services, healthcare services and social support networks, to avoid fragmented service provision that makes it difficult for individuals to access the support that they need. A fragmentation of service provision and a lack of coordination among service providers can create barriers to people accessing care and services. The phenomenon of 'revolving doors' within the service-delivery framework is particularly problematic for people with complex needs (Pratt et al, 2006). The coherent coordination of community-based care and services, for example by means of case management and single-entry-point systems, can help to avoid scattered provision.

Onerous application processes and bureaucracy in community-based services have been highlighted as issues. In Finland, a criticism of the supported living programme for people with disabilities is that it is not always clear who is eligible. Sometimes the criteria for accessing support can pose a challenge to those who may need it. For example, the Young Adult Contract in France is only accessible to those without a family to support them. This criterion complicates the reintegration of young adults into society, particularly as many of the individuals who would be eligible for the programme were originally placed under the care of the French state due to their family's inability to support them. If conditions within these families have not improved over time, teenagers who return to their families at the age of 18 may find themselves reintegrating into dysfunctional households, hindering their integration into society (INED, 2018).

Research highlights the importance of considering the **specificities of community-based solutions**, such as the fostering of meaningful activities and social relationships of service users in the training and appraisal of staff who work in this sector (Mansell, 2006). Suggested actions to be incorporated in the development of training include the consultation of national experts to ensure that training is based on community-focused principles, and the provision of training to staff and stakeholders to ensure organisational readiness to integrate community-based services and care systems (George et al, 2021).

Box 4: Suboptimal processes in shelter accommodation

The effectiveness of services provided in shelters may be limited if their focus is too narrow and does not account for the wider threats to victims of domestic abuse. For example, a policy in France focuses on the material needs of women who have experienced violence, but their social needs also need to be taken into account. As the perpetrators are often people to whom they are related (such as husbands and partners), keeping these women and children safe is very challenging. Furthermore, it has been highlighted that the stigma of being a victim of domestic violence can make these women more susceptible to further attacks (Fondation des Femmes, 2021).

The lack of gender-specific facilities is an issue that has been reported in relation to shelters for people experiencing homelessness across many Member States. For this reason, women (and their children) are often prevented from accessing homeless services.

A concern about being housed in temporary shelters is the risk of long-term institutionalisation. For example, as reported in Denmark, many people experiencing homelessness stay in shelters for prolonged periods due to a lack of resources to support the residents to move to permanent housing. While most homeless shelters do not offer halfway housing and almost half never offer opportunities for permanent housing, they do, however, play an important role in connecting homeless people to support services that may enable them to gain access to more permanent housing (Institut for Menneskerettigheder, 2017). To combat some of these issues, Housing First was implemented in 2023 as a national priority in combating homelessness, prioritising permanent independent housing solutions in combination with establishing support systems with public services (Socialstyrelsen, 2022).

Challenges with achieving independent living

While the aim of deinstitutionalisation and the provision of family- and community-based care and services is to enhance the social inclusion and independence of service users, and while the general conclusion of research carried out in this area has been that deinstitutionalisation improves outcomes, certain risks have been identified. For example, research evidence highlights cases of worsening of health and well-being outcomes, increased substance abuse, undetected health problems, social isolation, increased risk of becoming a victim of crime and increased burden on informal carers (Bredewold et al, 2018).

Mixed evidence is presented about the 'hydraulic hypothesis', which suggests that closure of some institutions leads to increased admissions into other institutions. For example, a meta-analysis of homelessness and imprisonment following deinstitutionalisation after long-term psychiatric care found sporadic evidence of such events and a post-deinstitutionalisation increase in criminal behaviour among people with intellectual or psychiatric disabilities (Winkler et al, 2016; Bredewold et al, 2018).

Independent living can foster a sense of needing to manage life's challenges without asking for help. This phenomenon, referred to as the 'Superman complex' in the case study presented in Chapter 5, raises the risks of deteriorating situations for people. While deinstitutionalisation aims to promote independent living, safety and safekeeping pose challenges in community settings. Managing the front door and ensuring personal safety can be problematic, and individuals with care or support needs are at heightened risk of victimisation, complicating their journey towards independence and limiting the success of such transitions.

General stigma and discrimination can create barriers to the provision of community-based care, giving rise to social isolation, reluctance to seek support, and exclusion from employment and housing. Enabling people to be included in community life and participate in wider society is central to the aims of deinstitutionalisation.

Stigmatisation of people at risk of marginalisation and social exclusion is highlighted as an important issue, leading to experiences of loneliness and the inability to live a fulfilling life. The stigma experienced by people with experiences of homelessness is discussed in the case study presented in Chapter 5, along with the potential for people to achieve 'role exit'. This can be facilitated by, for example, offering the opportunity for building new social relationships outside the homeless network or by housing people from different backgrounds together. In addition, healthcare professionals can make the status of 'homelessness' less central in their contact with their clients and place more emphasis on other identities, such as being a parent. As the social integration of population groups at risk of marginalisation and social exclusion has been shown not to always arise spontaneously, initiatives that foster inclusion and reduce stigma and prejudice are promising (Bredewold et al, 2018). An example of such an initiative is described in the case study presented in Chapter 6.

The transition towards more community-based provision of care and services increases the demand for informal care provision, often carried out by family members facing significant pressures, including physical and emotional strain and financial burden. Without adequate support and resources, this can lead to undue stresses and unsustainable situations for many families (Bredewold et al, 2018).

Conclusion

The evidence presented above highlights many challenges that have been identified in the delivery of family- and community-based care and services in the EU. Many of the issues are explored in more detail in the case studies presented in the two chapters that follow. Chapter 5 offers an examination of stakeholders' and service users' experiences of transitions from institutional settings to independent housing among people experiencing homelessness in the Netherlands. Chapter 6 discusses the deinstitutionalisation of mental health care in Belgium and presents stakeholder, staff and participant experiences of community-based initiatives that bridge the gap between psychiatry and mental health care, on one hand, and society in general, on the other.

5 Case study: Transitions from homelessness in the Netherlands

This chapter presents a case study investigating the operation of a policy that aims to transition people experiencing homelessness into independent housing in the Netherlands. Policy challenges are discussed, and protective factors and risk factors are described. The analysis incorporates the perspectives of clients and former clients of social care shelters and protected housing services, as well as those of professional stakeholders.

This case study builds on a longitudinal research project that studies deinstitutionalisation and decentralisation of shelters and protected housing across seven Dutch regions.[3] The participants were interviewed a number of times (ranging from two to five times) on a yearly basis between 2018 and 2023. The longitudinal follow-up of the participants sheds light on their personal trajectories over time, including the transition to independent housing and the events that unfolded afterwards. The analysis also includes reflections on particular policy challenges that arise in rural contexts.

Homelessness in the Netherlands: Trends, policies and evaluations

The issue of homelessness in the Netherlands has become more prominent in recent years. Although greater policy attention was paid towards homelessness in the 2000s, with the number of homeless people reaching a low of 17,800 in 2009, that figure subsequently increased to 27,000 in 2012 and 39,000 in 2018, before declining again to 32,000 in 2021 (Tuynman and Planije, 2014; Statistics Netherlands, 2021). Particularly pronounced among young people and people with a migration background, the increase in homelessness in the Netherlands has been traced to the international financial crisis of 2007–2008, decentralisation that increased municipal responsibilities for the provision of protected housing and youth care, and the gradual dismantling of the social housing sector (Statistics Netherlands, 2019).[4]

In the Netherlands, homelessness usually results in institutionalisation, with people staying in shelters or longer-term institutions such as protected housing. In recent years, shelters have shifted from offering night and emergency accommodation (where people may, for example, stay for a maximum of seven days or are allowed to stay only during night-time) to providing 24-hour accommodation, where people can stay until they are able to move to independent housing. Increasingly, it has become accepted that a stay in a shelter should not exceed three months. Recently, municipalities have seen an increase in homelessness – not yet reflected in statistics – despite a policy objective to increase provision of independent housing. As a result, and contrary to this aim, municipalities have called for measures to facilitate emergency responses (shelters), instead of longer-term investments in housing.

Box 5 provides definitions of forms of accommodation and housing that are central to policies regarding homelessness in the Netherlands, as well as other terminology used in this case study. Protected housing is accessible only to individuals with a diagnosis based on the *Diagnostic and statistical manual of mental disorders* (DSM). People cannot apply for protected housing themselves; they require a care professional to do so for them. The responsibility for protected housing was partly decentralised to municipalities in 2015, with the objective of deinstitutionalising two-thirds of the people residing in protected housing. The ministries responsible for health and justice provide additional financing to cover individuals with greater care needs and requiring longer-term residence in protected housing. Because of these policy transitions, the people residing in protected housing are increasingly those with more complex support needs.

---

[3] A description of the research project is available at nienkeboesveldt.com

[4] For more context, see Boesveldt (2024).

Box 5: Definitions

(Social care) shelters provide accommodation for people experiencing homelessness. The shelters vary in terms of accessibility (for example only allowing access during the day or at night). In addition, length of stay may be limited (for example to one week, to several months or to up to a year).

Protected housing is a form of clustered housing in which people with a psychiatric diagnosis live, with the objectives of recovering and participating in society as much as possible. There is 24-hour supervision, and people living in protected housing are assessed as having urgent care needs.

Independent housing refers to a housing unit with an individual lease, where the occupants are not required to live with unrelated individuals (Boesveldt and Loomans, 2023).

Mixed living comprises residential projects (including independent housing units with individual leases) in which different groups of people live together in an organised context, maintain contact and sometimes undertake joint activities. The projects consist of a combination of 'regular' tenants (and in some cases homeowners) with, for example, former homeless people, young people with a mild intellectual disability, people with psychological vulnerabilities and older people with care needs.

Client participants are clients and former clients of shelters or protected housing aged 23 or older, excluding families and undocumented homeless people. Inclusion criteria include being part of the local municipal target group for shelters or protected housing. Client participants include people who have experienced homelessness due to addiction problems, mental health issues or debt.

Professional participants include councillors; municipal policymakers involved in shelter and protected housing, community care, work and income policies, or housing; staff of the Municipal Health Service; staff from insurance companies; and stakeholders active in urban and rural contexts in the fields of mental health care, addiction care, social work, social care, housing associations, protected housing, policing, informal care and welfare.

To make housing more affordable, low-income households in the Netherlands are eligible for social housing.[5] The housing stock is mostly owned by housing associations. These associations are semi-private organisations with the state-mandated task of delivering affordable housing for low-income groups. Access to social housing is through a waiting list, although priority access is possible for groups such as people leaving homeless shelters and refugees (Boesveldt and Loomans, 2023).

In the Netherlands, rental agreements for priority access groups are set up in a variety of ways. The most commonly used are intermediate rental agreements whereby the contract is initially (during the first year or two) with the ambulatory care provider. After that initial period, the contract is registered in the tenant's name, while the ambulatory care is continued, gradually phased out or terminated. During the initial period, the liability for rent arrears is with the ambulatory care provider, and the rental agreement can be terminated if the care organisation feels that the tenant is no longer cooperating. In this set-up, the tenant has no rental rights.

Another commonly used solution is a three-party structure, where there is a direct relationship between the tenant and the housing association, but there is also a role for the ambulatory care organisation. In some regions, it is standard process to follow intermediate contracts with three-party contracts. In other regions, a regular rental contract can include an appendix drafted by the housing association, setting out the condition of the tenant having to accept ambulatory care for a certain period. As in the case of a three-party contract, the care organisation is involved but in a less formal way. The role of the care organisation in these structures varies, with additional conditions in rental contracts, including not being allowed to live with another person; restrictions related to visitors, pets, cleanliness, drugs and alcohol; minimum income requirements that ensure the tenant's ability to pay the rent; and limits on debt levels. These examples illustrate that these are situations in which care provision and housing provision are intertwined.

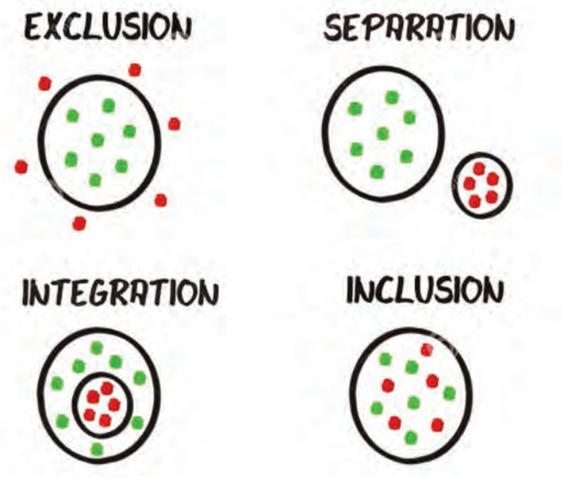
In 2015, following insights gained from research into the Housing First model (Tsemberis, 2010) and an increase in societal support for maintaining the independence of people with psychiatric and social problems with the

---

[5] In 2024, the annual income limit to qualify for social housing is €47,699 for a single-person household and €52,671 for a multiperson household. For housing allowance, maximum monthly limits for rent and service costs vary by age. In 2024, the limit for people aged 18–23 is €454.47; for those aged 24 or over, the limit is €879.66.

timely provision of appropriate support at home, the Association of Dutch Municipalities (VNG) requested advice on this topic from scientific and societal partners including former councillors, programme leaders of knowledge networks in healthcare and administrative lawyers. The consultation resulted in the report *From protected living towards a protected home* by the Advisory Committee on the Future of Protected Housing (2015). The report argued that the majority of individuals residing in institutions would be better off in a supportive environment in a regular neighbourhood. Figure 8 (used in the report) illustrates four potential scenarios for how a society can support individuals in vulnerable situations, ranging from exclusion to inclusion. Along this continuum, protected housing situated in regular neighbourhoods could be characterised as integration. The report paid attention to challenging policy issues, such as a lack of affordable housing, that needed to be addressed to pursue the proposed way forward. Therefore, a 15-year transition period was suggested.

Figure 8: Four scenarios for how a society can support individuals in vulnerable situations



Source: *Advisory Committee on the Future of Protected Housing, 2015*

The consultations undertaken for the report were with various stakeholders, primarily with care and services organisations. In the years that followed, housing actors have increasingly taken a role, and, gradually, deinstitutionalisation in the Netherlands has been reframed from primarily a health issue to one relating to housing. Subsequent policy documents illustrate this trend, as detailed below.

In 2020, the Council for Public Health and Society issued an advisory report in which initial ideas about a right to housing took shape (Council for Public Health and Society, 2020). The report focused mainly on preventing future increases in homelessness and reducing the current level, and it prompted the government to rethink its approach to housing people in vulnerable situations.

The Ministry of the Interior and Kingdom Relations, responsible for housing, published an advisory report in 2021. This report was produced by an interadministrative working group tasked with strengthening housing policy for certain groups, including adults in vulnerable situations, such as homeless people and people departing institutions. Illustrating the increased focus on housing solutions, the report discusses efforts to reduce evictions and highlights opportunities such as utilising the existing housing stock and transforming offices that have become vacant (due to an increase in telework, for instance) into housing (Ministry of the Interior and Kingdom Relations, 2021).

The evidence on Housing First had already been mentioned in the 2015 advice; it also informed a 2022 multiministerial National Action Plan on Homelessness, with close alignment between the national approach to homelessness and the national housing strategy (van Ooijen, 2022). According to the plan, 250,000 new social housing units are to be built by 2030, addressing the needs of low-income people and people experiencing homelessness. Furthermore, municipalities are required to include a vision for people at risk of experiencing homelessness in their housing strategies. For these tasks, additional funding has been made available from 2023 to 2027 by the Ministry of Health, Welfare and Sport (€325 million) and the Ministry of the Interior and Kingdom Relations (€1.5 billion).

The policy challenges envisaged in 2015 continue to provoke discussion at different levels of government and remain partly unsolved in 2024. The full decentralisation of responsibility for protected housing to the municipalities has been postponed year after year, and the shortage of affordable regular housing amounts to a widely felt housing crisis in 2024. The country is facing this shortage of affordable housing because the social housing market has been restructured (Van Gent and Hochstenbach, 2020). Since the 1990s, the share of social housing has decreased from around 41% to 34% in 2022 (Priemus, 1995; Statistics Netherlands, 2023). The waiting time for social housing often exceeds 7 years, and in some municipalities even 17 years (NOS, 2021). The prioritisation of the right to housing for groups in vulnerable situations is still much debated. National agreements have been made, but execution is at the discretion of the municipalities.

Independent interest groups, organised in the coalition Together at Home 2030, have been positive about the direction of the National Action Plan on Homelessness. In its recent evaluation, however, the coalition concluded that the lack of guidance about a partially decentralised system remained a real concern and that specific goals had still not been established.

Administrative parties from different governmental departments and the VNG have made mutual agreements to give substance to the plan, but these are best-effort obligations with no consequences for lack of action.

In 2023, a dashboard showing progress on the national action plan was presented by the VNG (Wolf and van den Dries, 2023). Together at Home 2030 has been sceptical about the dashboard, as it consists mainly of progress indicators, with no quantitative and little qualitative monitoring information (for example, the actual number of housing units for people experiencing homelessness, how many are temporary and how many permanent, and how often people use the plan to get a rental contract in their own name) (Samen Thuis 2030, 2023).

Studies in two regions using ETHOS Light

Two ETHOS Light[6] counting studies in the south of the Netherlands, applying a broad definition of homelessness, provide insights into the numbers and profile characteristics of homeless people in the participating municipalities. In addition to visible homelessness, the counts identified hidden homelessness. The studies revealed homeless people in various living situations, homelessness affecting the lives of many children, a large number of homeless young people and homelessness being more widespread than was expected. The first region counted 1,008 homeless people, including 223 children. In its largest municipality, 453 homeless people (0.4% of the population) were identified. The second region counted 490 homeless people, of whom 123 were children, with the largest city in this region counting 146 homeless people (0.2% of its population) (Schel et al, 2023; Wewerinke et al, 2023).

State of homeless shelters

In 2023, an evaluation by the umbrella organisation for shelter providers concluded that the trend towards offering short-term 24-hour shelters (instead of night shelters) appeared to be continuing. Simultaneously, the decrease in the use of night shelters is limited. In addition, a trend that started in 2021 towards smaller-scale shelters appeared to be stagnating in 2023. There is a tension between the desire to reduce the number of emergency shelters on the one hand and the increasing demand for shelters' services from more service users on the other (Akkermans et al, 2023). This issue is also discussed in Chapter 2, where the evidence from the majority of Member States highlights that the use of emergency shelter accommodation by people experiencing homelessness or domestic abuse has been increasing over the past decade.

Case study evidence: Clients' and professionals' experiences

This case study draws on data gathered during interviews conducted as part of a wider longitudinal research project into deinstitutionalisation and decentralisation of shelters and protected housing in the Netherlands.

Methods

The study took place in in seven Dutch regions, encompassing 7 larger municipalities (including The Hague and Utrecht) and 27 smaller municipalities.[7] Traditionally, the four biggest cities (Amsterdam, Rotterdam, Utrecht and The Hague) have more (and more specialised) service provision, including for people requiring shelter accommodation or protected housing. Although each city has its own specificities, the inclusion of the cities of The Hague and Utrecht in the study makes the collected data relevant also to other larger Dutch cities such as Rotterdam and Amsterdam. The inclusion of smaller (rural) municipalities makes the evidence relevant for eastern and northern areas of the Netherlands.

Study participants were interviewed annually between 2018 and 2023, with the number of interviews ranging from two to five. The interviews continued during the COVID-19 pandemic, taking place online when necessary. The interviews collected information on the perspectives of clients and former clients of shelters and protected housing ('client participants') and professional participants from related services ('professional participants'). In total, 1,299 interviews with 757 participants took place: 414 client participants and 343 professional participants. Of the client participants, 255 (62%) resided in a homeless shelter at the time of the first interview, while 159 (38%) resided in protected housing.

Re-interviewing the same people over a period of time makes it possible to gain insights into personal trajectories that span transitions to independent housing and to follow people as they establish independent living in the longer term. The longer-term follow-up is a crucial aspect of the research, as relapses into homelessness occur frequently (McQuistion et al, 2014).

---

[6] The European Typology of Homelessness and Housing Exclusion (ETHOS) is increasingly being used to draw attention to the multiple dimensions of homelessness. ETHOS seeks to provide comparable measures of homelessness in the EU (Edgar, 2012). ETHOS Light is a harmonised definition of homelessness for statistical purposes.

[7] In the Netherlands, there are 342 municipalities, consisting of 44 larger municipalities and 298 smaller ones.

All participants gave their written informed consent prior to participation.[8] Client participants were interviewed about their housing and homelessness pathways, care networks, needs and experiences. The interviews were conducted with the support of trained peer-interviewers to democratise knowledge-making, enhance the validity of the data collected and help to gain access to hard-to-reach populations (Boesveldt, forthcoming). Professional participant interviews covered policy development and implementation. Specific questions addressed the drivers of policy, the instruments used to implement policies and any barriers to achieving policy goals.

Preparation for transition to independent housing

Client participants from both shelters and protected housing indicated that they would have liked to have been involved to a greater extent in the process of applying for a home. They would have liked to have more influence on the speed with which applications progressed and to be able to choose housing that suited their individual (or anticipated family) situation. While during initial interviews some client participants did not have direct responsibility for their children, they often anticipated recovering the relationship and therefore wished to receive housing with an extra bedroom. More often than not, housing requirements were incorrectly communicated or paperwork went missing. Improvements in this groundwork could make individuals better prepared (mentally) for the transition in a timelier manner. Many indicated that they had experienced a lot of uncertainty about the time frame for receiving an offer of a home. Many were left waiting for long periods of time, while others received unexpected offers of housing. This made preparing for the transition difficult.

When preparing for a move to independent housing, risks factors include the feelings of elation combined with little prior insight into risks, changing support needs and facing bureaucracy during a transition to another municipality. Because applications for support services can be made only after a person has actually moved, the person may be placed on a waiting list, being left without support in the first few weeks or months in the new home. Protective factors, however, are timely guidance and preparation for independence, stabilisation of debts, clarity about the steps in the process, timely application for benefits and having an up-to-date action plan to prevent homelessness recurring.

In comparison with client participants housed in shelters, participants in protected housing were more likely to indicate that they agreed with the duration of their programme. Some of the participants moving from a protected housing facility to an independent home indicated that the transition had not been a specific focus in the guidance, and that instead they had progressed towards it naturally. These participants said that the original plan had been to stay at the protected housing facility for between six and nine months. In many cases, the stay turned out to be more than two years in duration. Some participants felt that they had been ready to live independently, but did not mind that their stay in a facility had lasted longer. Other participants did not yet dare to live independently. This might be because of earlier bad experiences of living alone, a lack of practical preparation (for example, for doing groceries, cooking one's own meals or cleaning responsibilities) or experiences of housemates returning to protected housing facilities after failed attempts at living on their own. In some instances, the transition was experienced as an efficiency measure that did not serve the person's interest. Client participants staying in protected housing facilities often said that they were working on goals that were not necessarily aimed at transition out of the facility.

Professional participants representing municipalities and healthcare providers mentioned that moving out was being prevented by external barriers, such as a lack of availability of housing or appropriate support in the neighbourhood. Some long-term residents of protected housing indicated feeling that they had little or no prospect of transition. For example, Dennis was staying in a protected housing facility against his preference, with the stability of his place of residence uncertain, while, for James, a shortage of housing prevented him from transitioning to independent living. Parts of their stories are told in Box 6.

Role of the social network

In preparation for a move to an independent home, there is often little attention paid to the client's social network. Contact with family and (previous) friends appears to be a complex and charged subject, and professionals may find the topic difficult to bring up. Network-oriented care empowers people within their own environment (Tjaden et al, 2021).

---

[8] The researchers explained the content of the consent form and emphasised the anonymous and voluntary nature of participation, and that participants could decline to answer any questions or stop their participation at any time. Different semi-structured questionnaires were used, depending on the role of the respondent. All interviews were audiotaped and transcribed using Atlas.ti.

Box 6: Trajectories during transition

At the time of his first interview, Dennis had only just moved into protected housing for group living. Previously, he had lived in a similar facility at another location. He did not explain why he had changed his protected housing location. He did not participate in the third round of interviews in the study. During the fourth round, he explained that he had had a relapse in drug addiction at the time of the third round. He said that his current protected housing, a group living situation, was to be converted into independent studios, with the number of studios fewer than the number of rooms currently occupied. He wanted to be considered for one of the studios. It was not clear where he and his fellow residents would stay during the renovation, who would qualify for the studios or who would end up in a group home elsewhere. Dennis was looking forward to a more independent life and had found paid work near his place of residence.

In the run-up to the fifth round of interviews, it became clear that he had been admitted for detoxification. Dennis later said that he had worked for a number of weeks but that the first salary payment had been deposited into his current account instead of that of his administrator. He immediately spent the money on 'drugs and women'. This episode turned into a longer relapse into addiction, including a threatened suspension from the programme. According to Dennis, his admission to a clinic was voluntary and arranged within two weeks. He explained how his stay in the clinic had ultimately lasted 10 months:

> *It went well, but then they said I had become psychotic. Then I had to go to the clinic again. That took about two months. Besides, they said, ... they might not even want to take me back, there was also renovation work in the hallway, that it was only wise to return after the renovation. Yes, and some people had holidays and this and that, this and that. I know, a lot. In the end it just turned into 10 months.*

During the fourth round of interviews, Dennis had indicated that he would like to be considered for an individual studio. He continued to indicate this during his stay at the clinic. Independent living with outpatient housing support remained a goal in his guidance plan:

> *I wanted to, but suddenly there was no room for me any more. I thought it was a shame. When I look at it, when I walk past it and I see those houses … Too bad. But I can also identify with [living] in a house like that. … A house for yourself is a bit better in terms of family, friends, girlfriend.*

Unpredictability of a person's housing situation prior to placement in a clinic is a risk factor for an unstable trajectory. Dennis experienced a lot of uncertainty around his stay in a protected housing facility.

In the case of James, there were other reasons why he did not move into independent housing. He had a paid job and wanted to leave protected housing but was faced with a housing shortage. Until recently, the protected housing where he resides had no formal agreements (between care providers and housing providers) about housing being made available for people transitioning from care institutions. As discussed above, in 2022 it was agreed at national level that municipalities were required to include a vision for people at risk of experiencing homelessness in their housing strategies, and in some municipalities that vision does not include specific agreements to deliver priority housing.

Various professional participants in multiple regions indicated that a number of protected housing buildings were to be converted from group living facilities to independent studios without communal areas. The reasons for this were outpatient arrangements and the current group of clients being less suitable for group living.

Among client participants residing in shelters, contact with family members is often poor, especially among participants who are preparing to transition to independent housing. Many of them have completely broken off contact with family members, while others still have contact with one or two family members, often a sibling or a mother. However, contact is often superficial in nature. Previous conflicts, disappointments and shame about their situation often prevent intensive contact. The vast majority of participants also indicated that they had had a difficult childhood in a family that had not always been able to take good care of them due to, among other things, psychological problems, addiction, poverty, violence or abuse, and, as a result, they had come into contact with youth care at an early age. Furthermore, family members of participants often lived abroad. Consequently, many participants were on bad terms with their family, as the following quote illustrates:

> *I have no family at all any more. That's over and done with. My father passed away in '78 and we had a lot of commotion and trouble in the family about the inheritance. And my mother said to my girlfriend at the time: 'I no longer have a son.' And I was not allowed to take a step on the property, not any more, and I have been completely denied [my] inheritance.*

Most participants had stayed with friends or acquaintances for a period of time before registering with a shelter. Staying with these contacts had often been temporary, and, in most cases, participants talked about being a burden, invading others' privacy or conflicts. Once someone is staying in a shelter, contact with friends or acquaintances often fades away. Participants frequently felt that their world was very different from the life they previously shared with their network, which made maintaining contact difficult. For example, a participant staying in a night shelter commented, 'Old acquaintances. What do you talk about with them? About nothing. That's difficult. They have a good life.'

These experiences differ from those of client participants who are transitioning to independent housing from protected housing. A number of participants residing in protected housing indicated that they had a good relationship with a limited number of family members or friends. In several cases, participants received support from this network in dealing with psychological problems or addiction issues.

For a number of client participants, the death of a parent, especially if they provided a lot of support, led to great confusion and stress, causing them to lose control over their circumstances. This led to an accumulation of other issues in the short term, such as problems with paying bills or rent, or addiction issues. For them, the death was a strong trigger for (repeated) homelessness.

Many people (in both shelters and protected housing) indicated that they had difficulty building new social contacts in preparation for the transition to independent living. They felt that they were unable to meet new contacts on an equal basis because they were conscious of the stigma caused by their past. Although conversations on this topic with professionals are complex, and often avoided by the client, they should be facilitated because a person's social network can play an important role in driving or preventing recurring homelessness. The lack of a supportive social network sometimes makes people who leave institutions more vulnerable to risky or criminal contacts.

While the policy responsibility for shelters and protected housing lies with the larger (urban) municipalities, a significant share of people residing in these facilities originate from the surrounding rural areas. Whether they wished to stay in an urban area or to return to their area of origin varied among participants, influenced by positive and supportive social ties on the one hand and feelings of shame on the other. When a participant stays in an urban facility for such a long time that initial ties with their social network in their place of origin have weakened, they may not wish to return there. Social ties also varied among professional participants. In smaller municipalities, professional participants repeatedly mentioned having close ties with professionals in adjacent areas (such as working in housing or social welfare). This may lead to client participants being able to receive support that is more customised or provided more rapidly.

Housing availability

While housing is scarce in all regions, different barriers and opportunities emerge across regions. Smaller municipalities report more housing availability but have less provision of specialised care. In addition, smaller municipalities often have fewer single-person apartments and more family housing. Housing associations and providers of shelters and protected housing may agree on a certain number of apartments being made available to individuals residing in institutions, but there is no clear relationship between the number of inhabitants in a region and the number of social housing units being made available. For example, a city with 360,000 inhabitants has 385 social housing apartments, while a municipality with 57,000 inhabitants has 30 apartments.

In addition, the scale of social housing provision that is agreed upon is not always realised for a number of reasons. First, supply can be restricted due to demand from other groups (such as refugees) or too few transitions (a lack of people moving out of social housing). Second, available housing is not always taken up if units are made available to care organisations in an ad hoc manner, meaning they are unprepared, without enough residents who are ready to move out.

Urban providers of specialised ambulatory care in the form of shelters or protected housing are often not active in the smaller municipalities. This means that client participants have often needed to change service provider when moving from an urban to a rural area. Similarly, client participants who leave a smaller municipality to live in a shelter or protected housing in a city often end up relocating more permanently by moving to independent housing in that city. In some cases, however, agreements are made between an urban care provider, a rural municipality and the local rural housing association about housing being made available. Sometimes, though, this option is not viable, for instance because staff would need to travel (at a cost) to be able to support the person after the transition.

In some instances, individuals on a waiting list for social housing lose their place in the queue if temporarily residing in a shelter or protected housing outside the municipality. This risk arises especially in rural contexts without shelter or protected housing services; it is not a risk that client participants from urban areas faced.

Care provision

The provision of care is often connected to the social housing offer that a person transitioning from institutional care receives. In the urban context, in general, it is agreed that the same service provider that offered institutional care will also offer this ambulatory care for two years. There are local variations, however, whereby the care is provided for only one year or by another (less specialised) team. In addition, there are specialised mental health teams, such as those offering flexible assertive community treatment (discussed below). The provision of ambulatory care is not necessarily limited to situations in which a person is transitioning from an institution.

Care providers specialising in ambulatory mental health or addiction support are scarce in smaller municipalities. Ambulatory social care and care after protected housing are also scarce because of the travelling time from urban areas. In some regions, however, there have been interesting innovations. One example is the provision of small-scale shelters in rural areas. Another is the Salvation Army's pit-stop facilities, which are volunteer-hosted shelters offering several advantages, including that people do not need to leave their home town, do not lose their place on a social housing waiting list, and can maintain their formal and informal contacts.

Actual transition to independent housing

This section discusses findings on the actual moment of deinstitutionalisation. The analysis distinguishes between planned transitions (often to housing specifically made available to people leaving institutions) and unplanned transitions (which entail higher risks and fewer protective factors than planned transitions).

Planned transitions

In a planned transition from an institution, there are two phases: the actual moment of leaving and a 'changeover period' of about three months.

At the moment of transition, risks arise because of the many changes taking place, administrative issues and the new responsibilities that relate to renting and household maintenance. Tsemberis (2010) identifies what is known as the 'dip in the mood' that follows the initial happiness that stems from receiving housing. The realisation of what has happened to oneself during the time of homelessness or while living in an institution may be challenging. In addition, previous trauma from youth may present itself more prominently when someone is housed independently, and there is less of the 'hustle and bustle' of an institutional setting.

The new housing situation may result in a lack of clarity about what help can be requested. This may be combined with changes in guidance or support, due to a geographical move or different financing of residential and ambulatory care.

Protective factors at this critical moment include the offer of intensive guidance preceding the transition, during the transition and shortly after the transition. Preferably, such guidance should be provided close to the person's new home and flexible in scale (in terms of the number of hours offered). An example of such care for this group is flexible assertive community treatment (FACT), a multidisciplinary recovery-oriented model used to provide long-term outreach care and integrated treatment to people with severe mental illness (van Veldhuizen, 2007). In interviews, professional participants also mentioned the relevance of at least three months of 'warm cooperation' between the previous professional and the new social professional involved with a person's care. In some regions, plans are drawn up with the client before the transition. As many things change rapidly during and just after the transition, updating this plan can be very useful. Benefits are also seen when social workers pay attention to the emotional impact of the move, and when there is input from people who have already made the transition. Finally, it is vital that attention is paid to the continuity of daily activities, workshop attendance and (volunteer) work, and the meaning that is attributed to these activities.

For Dave, shortly after moving from a shelter to independent housing provided by a housing association, it became clear how vulnerable he was during this phase. Owing to financial difficulties, he almost did not manage to keep his housing. His social care supervisor quit. Dave eventually received guidance from a social worker that helped him to avoid losing his home. This situation, at the time, caused a lot of stress for Dave, who was afraid of becoming homeless again.

Unplanned transitions

An unplanned transition from a shelter to independent housing carries with it a big risk of repeated homelessness. An unplanned transition takes place when a person in a shelter or protected housing looks for alternative solutions on the private housing market. In these cases, and unlike with intermediate rental contracts in social housing, no ambulatory support is organised or financed.

As discussed above, a lack of suitable social housing was described as a barrier in many interviews with both client and professional participants. Some client participants indicated that the housing that becomes available is not suited to their personal situation.

Box 7: Evaluation of the Living Lab ‘First a Home’ project, Utrecht, 2021–2023

The Living Lab ‘First a Home’ project (set up by the Utrecht region together with municipalities, housing associations and healthcare organisations) provided homes – a combination of mixed living and scattered-site housing – for more than 200 previously homeless people.

Interviews used for this case study covered 66 residents of the project. Most residents indicated that they had made progress in their recovery, with many experiencing more peace and stability and seeing improvements in relation to addictions or other aspects of their mental health. They mentioned that they had undertaken social activities more often, had meaningful daily schedules and had built up new supportive social networks.

They reported that the recovery process involves trial and error and takes time. Stability, peace and structure are necessary to ‘get out of survival mode’ and be able to participate in society again. A lack of confidence in care services and in the future, in terms of being able to continue to live in their home permanently, hinders recovery. Dissatisfaction with the home, stressful life events (such as the death of a loved one or a lawsuit), trauma and health problems also play a role.

After moving into their First a Home residence, residents had experienced positive developments in at least one area, but generally in several areas, of life, such as personal well-being, social contacts, daily activities and finances. Almost all residents emphasised that having their own permanent home had been crucial for this (Eerst een Thuis, undated).

Owing to the limited supply of social housing, staff working in shelters often strongly encourage client participants to settle for any living space available, including a room. Client participants are generally not positive about this because they view it as a temporary arrangement. Housing that suits their personal situation is therefore not a luxury but a necessity to create the stability that they need.

Client participants who looked for independent housing on the private market themselves were subject to associated risks, leading to unstable living situations in some cases. The private rental sector is more likely to use temporary rental contracts or offer informal housing, and it includes semi-legal and illegal housing options, such as campsites, mobile homes and holiday parks. When clients leave a shelter or protected housing on their own initiative, it is more difficult to organise guidance and care providers, and the municipality can easily lose track of clients, risking relapse into homelessness. Take, for example, the experience of Frits. He had left a shelter four years before, and had been living in, in his own words, ‘a very small room’. He was sometimes frustrated that he was unable to find his own home and believed that the housing market in his region had simply come to a standstill. He was thinking about moving back to living in a chalet park.

‘Denial-of-service lists’ are increasingly used by housing associations, hindering people from obtaining affordable housing. Housing associations use these punitive practices in the cases of renters with a history of payment arrears or eviction. Some associations take a case-by-case approach, while others refuse to accept listed renters for a period of five years. In some cases, lists are shared with other housing associations in the region. Some housing associations describe the practice on their websites.

Support from social networks

Most client participants indicated that they had a positive view of their new living environment. For many, their preferences for living in certain neighbourhoods or municipalities had been met, meaning that they could live near family members, including children, or other important contacts, or away from high-risk contacts.

During institutional stays, people in protected housing appear to have maintained regular contact with relatives and some friends, while shelter residents tended to minimise contact with loved ones because of conflicts or feelings of shame. This seems to have changed slowly after the transition to independent housing. For a number of client participants, the positive news of having their own home and leaving behind a stressful period created an opportunity to discuss lighter topics, providing a sense of optimism that helped in rebuilding and normalising social contacts. This was especially true in cases in which shame (rather than conflict) had caused disruption to contacts.

It is evident that when client participants needed short-term practical help, they could count on support from family and friends. For many participants, the moment of moving was one of those occasions on which contacts could be re-established. In the case of people for whom social contacts had continued during an institutional stay, family members and friends provided support in various areas. In contrast, in the case of participants for whom contact with family or friends had been minimal during their stay in an institution, social contacts often increased with the transition, but the interactions were mainly superficial.

Most participants indicated that they had people with whom they could discuss difficulties. Parents especially were cited as people to whom participants felt they could 'open their hearts'. Family members, friends or partners sometimes provided support with financial matters (sometimes by lending money), finding a (temporary) place to stay or finding (voluntary) work.

Many participants also indicated that they regularly visited a church or a mosque to have contact with people within a religious community. For these participants, this provides an important source of meaning in life and a motivation for them to work on their recovery. As one client participant said:

> *I really lost myself completely for a few years. … Thank God I have found my religion again ... I [had] let go of it somewhat in my life, distanced myself and I have now found it again. I have discovered again that I just ... the pain inside that I don't want to talk about with you, but that I can leave to God.*

The second round of interviews in particular revealed that, for many client participants, social contacts are restored bit by bit after discharge from an institution. While (broken) social contacts with family, friends and their own children were often rebuilt and normalised again, many participants struggled with loneliness after moving into their own home. Many participants would have liked to make new contacts but were intimidated because they felt they had stood still for a while – 'stepping out of normal life' – and therefore felt distant from others in society. They had a feeling – and sometimes had also experienced – that many people had already 'filled their social circle', and often a positive first contact was not followed up. For example, Joost, who left protected housing a year ago, explained:

> *I would indeed like to meet other people, but I also find it nerve-racking ... because most people have a completely different life – work, fixed obligations – that's so diametrically opposed to my own life. [I get the impression that] many people don't really feel like it at all ... when people hear about your situation, you actually don't hear anything anymore.*

Several participants also indicated that they did not like to talk about their past or felt ashamed because of stigma. For example, Anna explained how this affected her social contacts:

> *Well, I think it's more just a bit of openness that I had less of, and that I had to chat around a bit or something. And that's just not very nice. But really hindered? No, I don't think so.*

Overall, many client participants experienced barriers to meeting people, suffered from (internalised) stigma and sometimes avoided making contacts (consciously or unconsciously). Many participants indicated that they felt that they could, or should be able to, meet new people. This strong conviction that you yourself are responsible for your life – and for dealing with its problems – is characteristic of the Superman complex.

Continuity of care and services

It was clear to municipal and non-municipal professional participants that continuity of care and services was important for a successful transition to independent housing. Shortages of healthcare staff, high staff turnover and temporary work contracts are obstacles to achieving this continuity. From the client participant perspective, Freek said:

> *I also notice that many substitutes often work in the office. They work a lot with temporary workers, and I know it. Then I think, 'Wouldn't it be better to have a few permanent supervisors? That works much better, doesn't it?' Temporary employees sometimes swear while doing their thing.*

In Freek's case, the housing association had stipulated in the rental contract that he must continue to receive support. If Freek wanted the housing but rejected the support, then he would not be eligible for the housing, making the situation coercive. A municipal stakeholder recognised this:

> *A case like this looks familiar to me. Somehow I think, 'if the client already wants that, how bad is it that it is demanded?' I understand that the coercion part is there. On the other hand, it is entirely possible that, due to a relapse, someone says after four months, 'I don't need it anymore.' This also helps the client in question to have this imposed. This is quite a dilemma.*

Although the aim of such practices is to promote continuity of support, with better monitoring of the client's situation, a dilemma is encountered. By obliging the client to receive care, the principle of separating the provision of housing and the provision of care is not followed. This principle, as described in the National Action Plan on Homelessness, is not complied with in the majority of deinstitutionalisation processes in the Netherlands.

The following section discusses the more promising practice of 'neighbourhood circles', whereby outpatient support is close at hand but not necessarily required by the rental contract.

Neighbourhood circles

The premise of a neighbourhood circle is that a group of people in vulnerable situations support each other based on their talents and strengths, so that they become more independent in their daily lives.
A neighbourhood circle aims to facilitate a situation in which professionals step back, a horizontal neighbourhood network is established, and informal care and support become more important. None of the client participants in this case study mentioned contact with a neighbourhood circle, although in one region

there were six such circles of 9 to 12 people active. Existing research into neighbourhood circles has found that they contribute to self-reliance because people can learn from each other in groups, and collaboration is fostered, enriching people's lives, with a major influence on emotional well-being (Weltevrede et al, 2017).

When discussing neighbourhood circles in a professional participant interview, a healthcare organisation worker highlighted the importance of the continuation of professional support, but noted that practical and institutional barriers stand in the way of facilitating the circles:

> *It is something that takes a lot of time, which is also a complicated thing in financing. Because if first of all your own clients are in that circle, you can claim that time. But if you run the neighbourhood circle, you also run the same for many clients. Not even your own clients. We take that for granted if it includes our own clients. But if those own clients flow out ... and you are still left with that neighbourhood circle, and you have to spend six hours a week on that, then at some point a manager comes along and says, 'Well, shouldn't your caseload be increased a bit?' And then you say, 'Yes, I'm too busy with my neighbourhood circle ...', but that doesn't accomplish anything.*

The risk of recurrent homelessness

In this case study, the risk of recurrent homelessness has been mentioned frequently. The data show that reports of addiction, a weak social network, criminal behaviour, physical health issues, psychopathology and intellectual disabilities – and in many cases a combination of these – are more common among repeatedly homeless participants. The vast majority have had a difficult childhood. Negative childhood experiences (a family unable to provide support due to poverty, psychiatric problems, abuse or addiction) often damage their trust in others, causing them to keep (new) social contacts at a distance or to need time to learn to trust people. Care avoidance is also a characteristic that stands out among repeatedly homeless participants. Many become overstimulated easily. When stressed, they quickly become overwhelmed, often causing them to 'freeze' and avoid care. They often do not ask for help: there is a strong belief that people are responsible for their own lives and must solve their problems independently (elements of the 'Superman complex'). Many people also avoid care due to a lack of trust or because of bad experiences in the past.

Independent housing in the long term

Role of the social network

In the long term, one of the challenges identified is difficulty in keeping risky contacts at a distance. Risky contacts include people with substance abuse issues or people from the homeless circuit. As discussed above, client participants often express no desire to receive support when it comes to managing their social contacts. In addition, loneliness is an issue that increases the risk of accepting these risky contacts. Distance from familiar amenities and social contacts can cause feelings of isolation, making people susceptible to addiction. Insufficient availability of services for dealing with addiction issues, including detox support, also play a role.

Protective factors that support independent living in the longer term are continuity of the rental contract, proactive and continuing welfare work, and long-term support from social networks. While most client participants do not have a large social network, pets – especially dogs or cats – are reported by many as important forms of company and good motivators for leaving the home regularly. Some participants actively seek social connections within the neighbourhood through informal initiatives. For instance, Lonneke mentioned that she had various contacts within her church community, with whom she regularly went walking. She did not explicitly mention that her church was nearby; it was more the shared faith that facilitated the connection.

Relationships with neighbours

Most client participants' experiences of contact with their neighbours were pleasant. For some participants, this contact consisted of short greetings or a chat in the corridor, while other participants had fostered friendships.

Particularly for those in 'mixed living' situations, where more attention is paid to the social component of living, enthusiasm was often expressed by client participants. This applies to John, who had been homeless twice. At the time of the interview, John was living in a new mixed living project, and, because of his enthusiasm and easy-going attitude, he had been given a voluntary position as administrator in the project:

> *It's very cosy. There is also a lot of organising going on. Unfortunately, that is a bit difficult due to the corona[virus], but despite that it is just a lot of fun, here in the apartment building where I also live. ... [T]here are 30 of us here and I know all the other 29. And if, for example, I have to go shopping and I can't, all I have to do is ask and it will be done for me.*

The interviews with client participants also highlighted the difficulties that arise when people do not identify with their neighbours, for example due to being in a different phase of life. When people encounter problems with each other, there is less tolerance, and it seems difficult to resolve issues. Some client participants indicated that because of this they feel less at home, misunderstood, irritated and sometimes stigmatised.

Three cases of friction with neighbours

A year ago, Rachid (who is in his late 20s) was given a home in an apartment where many young families live. He is bothered by the crying children, and, despite efforts to raise this issue with neighbours and the housing association, little appears to change. He is considering moving to an area outside the city, where it is less noisy.

Steven (mid-40s) moved into a senior apartment last year, when, to the great dissatisfaction of the senior residents, several units were released to younger residents. He does not feel welcome and is not greeted by his neighbours. He has received complaints about the home improvement works he has carried out in his new home, despite having communicated with his neighbours about these changes.

Thea (early 60s) left a protected housing institution a year ago and was looking forward to contact with her new neighbours. She invited her neighbour for a coffee via a note; however, the note was returned through her mailbox with the answer that the neighbour wanted to have nothing to do with her. Thea said:

> *I think that she has seen the car of [ambulatory protected housing organisation] here in front of the door at some point. Of course, she immediately must have thought, 'She comes from [housing organisation].'*

Life events

Acute risk factors – for example, life events such as the end of a relationship, a death, an illness, a relapse into addiction or a rapid accumulation of problems – are potential issues throughout the deinstitutionalisation process. These factors raise the risk of recurrent homelessness. When faced with problems, client participants are often seen to seek help only at a very late stage when there may be insufficient time to provide effective support. Many client participants felt that they were responsible for their situation, felt a lot of shame or faced major barriers to raising the alarm with a professional or in their informal networks.

Unequal treatment from care providers and the imbalance of power makes it difficult for participants to accept support. Goffman (1961) describes how interaction of this kind carries the risk that personal identity will be gradually replaced by an organisational identity, ultimately resulting in the transformation of the self into a new role, that of the patient. Interviews with client participants uncovered cases in which people sought to resist seeing themselves as 'a patient' or 'a former homeless person' and, as a result, refused to ask for help or accept care.

At the same time, continuity of outpatient support has been helpful for several client participants. Independent living can be interrupted at times, such as during a hospital admission or a rehabilitation programme, and, Freek, for example, living independently after leaving a protected housing facility, emphasised how important it was for him to have continuity of support when a life event took place:

> *I have a supervisor who has guided me for almost 10 years. He's been through everything. When my wife died, he came along. I called him in panic, and he was there within 10 minutes. He was just there for me. He also comforted me then. … He was afraid that I would completely panic there. My supervisor is really a great guy. He helped me very well with that grief. I'm proud of that. … The team that I receive guidance from already knows me very well. All those supervisors know me very well and I get along well with all those supervisors.*

Case study conclusion

As the evidence presented in this case study shows, transitioning from institutional care to independent housing is vital for the recovery process of people experiencing homelessness. The process of moving from an institutional setting to independent housing is a delicate transition that is fraught with challenges such as lack of housing availability, insufficient preparation for the transition, workforce shortages resulting in limited support, lack of continuity in provision of support and in daily activities, bureaucratic hurdles, the provision of housing being conditional on acceptance of care, a damaging institutional culture, fragile social networks and hesitancy to seek help. Effective policies must facilitate more transitions, and more successful transitions, by addressing the above challenges. Recommendations on formulating policies that address these issues are made in Chapter 7.

6 Case study: Community-based mental health care in Belgium

This chapter presents a case study that focuses on Alternative Spaces, low-threshold spaces that are open to everyone and cater for a wide range of creative activities in the Brussels Region of Belgium. These spaces have been set up as a tool to support the deinstitutionalisation of mental health care.

Alternative Spaces offer an opportunity to examine the process of deinstitutionalisation, by questioning the relationship between reductions in the number of psychiatric hospital beds and independent living. Deinstitutionalisation policies seem to rely on the tacit assumption that reducing psychiatric hospital beds, opening community mental health facilities and encouraging people to live in their own environment necessarily lead to independent living. However, evaluations of recent policies suggest that independent living is difficult to achieve and that deinstitutionalisation policies may also result in social exclusion that can lead to rehospitalisation. This case study presents the objectives and operation of Alternative Spaces and highlights members' and stakeholders' experiences of the initiative to offer insights into what people need to live independently and to feel socially included.

Mental health care in Belgium: Trends, policies and evaluations

In Belgium, psychiatric hospitals remained within the domain of justice until 1948, when responsibility for closed institutions was transferred to the public health ministry. This transfer is seen as a key moment in the development of the field of mental health care in Belgium, marking a shift towards medical psychiatry, which involved transforming asylums into hospitals, integrating psychiatric hospitals into the overall health system and recognising psychiatry as the dominant profession in treating mental illnesses (De Munck et al, 2003). This step also had strong symbolic significance, indicating that a desire to cure mental health problems, now viewed as mental illnesses, took precedence over the desire to protect society from madness. On a sociological level, it established a system of norms and professional hierarchies in which the medical psychiatrist holds expertise that they apply to a person in the role of a patient in a hospital, which is established as a privileged location for the application of medical knowledge (Thunus, 2015).

The integration of psychiatric hospitals into the field of healthcare also marked the beginning of a professionalisation process that led to the development of different types of facilities advocating psychological, social or functional rehabilitation approaches to mental health (Abbott, 1988). This process was punctuated by three major policy reforms, the first of which was the creation of community mental health services in 1974. The policy aimed to create outpatient services in which multidisciplinary teams addressed mental health problems from psychological and social perspectives, with functional links to psychiatric hospitals. However, these links were not established, and the reform led instead to an 'expansion of institutions', followed by an 'expansion of the clientele and an increase in consumption' of both hospital and outpatient care (Verhaegen, 1987, p. 49).

The second reform, in 1989, established psychiatric nursing homes and sheltered housing initiatives. The policy explicitly aimed at deinstitutionalisation, by reducing the number of psychiatric hospital beds and creating community-based alternatives focused on social inclusion. While the new services were welcomed, their creation was also met with some doubts. It became apparent that most chronically ill patients housed in these structures, despite no longer requiring hospital-based treatment, were unable to integrate into their living environments. As the WHO pointed out in 2008, Belgium still had the second largest number of psychiatric hospital beds per inhabitant in the EU, with 158 beds per 100,000 inhabitants (WHO, 2008).

The third reform ('Reform 107') began in 2010, informed by the idea that mental health issues affect all of us at some time in our lives. It aimed to foster deinstitutionalisation and social inclusion by developing care functions provided through local mental health networks of services relying on close collaboration between mental health and psychiatric services. These functions included mental health prevention and promotion, psychiatric mobile teams providing home care for both acute and chronic problems, and alternative housing facilities.

These policy reforms were part of a drive towards deinstitutionalisation, marked by the twin objectives of decreasing the importance of the psychiatric hospitals and creating community resources that contributed to enabling independent living. Evaluations of Reform 107 have found that mobile teams have allowed for a reduction in psychiatric hospital beds and increased provision of care at home. However, when outpatient mental health care services are overstretched, there is a lack of community-based alternatives to mobile teams through which people can find personal and social support. Crisis services and residential facilities are also oversubscribed. Crisis situations must therefore be managed at the level of primary care and through social services (Mistiaen et al, 2019; Smith et al, 2019; Thunus et al, 2019).

The reduction in psychiatric hospital beds achieved through these policies does not seem to have resulted in greater social inclusion. Instead, the people in the most vulnerable situations and those with the most complex trajectories, marked by a combination of social, physical and mental health problems, seem to suffer from social exclusion and exclusion from care.

Brussels mental health policy

The evaluations of Reform 107 prompted reflection in the Brussels Region, where the problem of access to mental health care for people in the most vulnerable situations was particularly acute. In the context of the sixth reform of the Belgian state, which transferred responsibilities for mental health care from the federal government to the regional and community governments, the Health and Social Observatory (Observatoire de la Santé et du Social) commissioned a study on how access to mental health and psychiatric care could be improved. The study, entitled Parcours.Bruxelles (Walker et al, 2019), argued that stigmatisation of mental health persisted at a societal level and concluded that trajectories of mental health service users indicated the importance of a holistic approach, as challenges occur at different times and in different areas of life, including school, work, family and social life, and housing. The study shed light on structures that facilitate social inclusion while reducing stigmatisation, termed ‘alternative spaces’ (*lieux de lien* in French), described as

> *spaces that are not formally associated with the mental health care system. They are often created at the initiative of or in collaboration with users or their relatives. They are inclusive and dissolve or at least offset socially constructed categories that stigmatise people with mental health problems. They are open to everyone and explicitly oriented toward the integration of people with experiences in mental health services. They offer opportunities to connect with society through cultural and social activities.*
> (Walker et al, 2019, p. 35)

Case study evidence: Members’ and professionals’ experiences

This case study draws on data collected in early 2024 and explores members’ and professionals’ experiences of Alternative Spaces.[9] Alternative Spaces are co-managed facilities that have been established in the Brussels Region of Belgium with the aim of enabling people to reconnect with themselves and with the community by taking an alternative look at social institutions and mental health.

Methods

The material presented in this section was collected in 2024. Three types of actors were consulted: policymakers, stakeholders including coordinators and permanent staff of Alternative Spaces, and people who frequent the spaces (‘members’). A range of data collection methods were used (semi-structured interviews, focus groups and observation), with the selection tailored to each type of actor. There were three Alternative Spaces coordinator interviews, one policymaker interview, three focus groups (with a total of 28 participants, of whom 19 were members) and observation of a meeting organised by a mental health services federation. The material collected is attributed in the analysis that follows to the various participants using codes: ‘E’ indicates a policymaker, stakeholder or staff member, for example E1; ‘FG’ indicates a focus group; and ‘P’ indicates a participant.

The interviews and focus groups were designed to collect data about five Alternative Spaces, which varied in terms of location (city centre or residential area), funding (regional government or community government subsidies) and impetus for creation.[10] Of the spaces studied, three were created as part of a post-COVID-19 recovery plan. Two of these have a structural link with a community mental health service and one with a psychiatric hospital.[11] The two other spaces had been created before the recovery plan was in place, but funding under the plan helped to support them.

Creation of Alternative Spaces

In the context of the COVID-19 crisis, the Brussels authorities took up the recommendations of the Parcours.Bruxelless study discussed above. The recovery plan included mental health funding, and the study was seen as ‘a privileged tool’ for policy decision-making (E1, interview with a policymaker). In addition, policymakers saw Alternative Spaces as ‘less

---

[9] More information on the 20 Alternative Spaces in Brussels is available in LBSM (2024).

[10] To compare different Alternative Spaces or to analyse the impact of factors such as location or funding type, further research would be needed. This research collected only the experiences of people currently engaged with the initiative and who generally share an enthusiasm for it. To address the challenges presented at the end of this report, further research could focus on the experiences of members who have stopped participating.

[11] A structural link means that the government subsidies are paid to the community mental health service or psychiatric hospital, which uses them to finance the Alternative Space, giving a great deal of autonomy to the team that coordinates the space.

standardised and less prescriptive spaces [than other mental health care services], where people can reclaim their lives' (E1). They also constituted a way to fill a gap in the existing care offer: 'In the Belgian system, we have things that work quite well in terms of care, [but] we lack a support system that goes beyond care' (E2, interview with an Alternative Space coordinator).

In this respect, Alternative Spaces seemed to open up a way of 'thinking about mental health in the broadest sense, and getting away from specialisation, which was showing its limitations' (E1). In addition, 'influential or respected people in the Brussels mental health sector' were aware of the study and their 'recognition of the legitimacy of the results' supported this political decision (E1). The political context of the recovery plan was 'tense', with 'everyone talking about COVID as being a disaster for people's mental health' (E1).

In 2020, policymakers opted for an open call for projects that defined Alternative Spaces as places where people could talk to therapists, social workers, educators and peer helpers; where they could be directed towards more specific local help and care services; and where cultural, social and sporting activities could be initiated by users and supported by staff. In the call for projects, the aim was said to be 'to strengthen the community approach to mental health, go beyond individual and stigmatising responses, and offer spaces for bonding and social inclusion'. It specified that social isolation had increased following the COVID-19 lockdowns and that individual therapy was not the ideal response. Instead, a more accessible community response was needed.

Many services responded to the call for projects. The selection was organised by a jury made up of scientific experts and government officials; the latter were responsible for ensuring the 'implementation capacity' (E1) of the project leaders, while the former ensured that the projects followed a destigmatising and community-based logic to avoid 'reinforcing what already existed' (E1).

At the end of the selection process, some existing projects were offered additional support and new ones were created. In total, nine Alternative Spaces were financed by regional or community government subsidies, or both. Overall research and coordination were financed through government funding, which made it possible to hold regular meetings to build connections between the spaces and to create a guide listing all the initiatives (LBSM, 2022).

Among the new Alternative Spaces, some took advantage of the call for projects to design the space in an organic way, without any preconceptions, except for the general guidelines given (E3, interview with a coordinator of and permanent worker in an Alternative Space). Others took as their starting point a preliminary definition prepared by a working group (E2).

As discussed below, these different starting points gave rise to very different realities. Since the beginning of 2024, Alternative Spaces have been gradually brought under a structural framework that is still subject to discussion (see 'Key challenges' below).

Members

He used to be a champion boxer. He had a company and was always busy. Her recovery was well established – seven years – then she became a caregiver. He was an engineer and there was a lot of pressure. She fell into alcoholism. He cannot live without music. She is of Vietnamese origin. Things became very difficult after his divorce. He makes tutorials on YouTube; it is a very lonely occupation. She had a major manic episode, then a deep depression. He was in a psychiatric hospital. She is in a nursing home and she's bored. He took medication and gained a lot of weight. Her spouse took their children away. Since he arrived in Belgium, his life has changed. She suffers from loneliness. He spent 16 hours a day behind his computer. He worked for a big company; it was a lot of stress. It took years for her to recover. He is bipolar.

This introductory text mixes fragments of journeys shared by the people in the focus groups, revealing the diversity of the Alternative Spaces members, while also having a familiar ring, as they echo the lives of many people. Members 'come from all walks of life', they are 'older people', 'neighbourhood ladies', 'the grandma who is bored in a nursing home' or 'the man with a long psychiatric history' (E2, E3 and E4, interviews with three coordinators of and permanent workers in Alternative Spaces). Sometimes they enter the spaces sporadically, as in the case of a man who goes there every time he goes to do his laundry. Sometimes they come 'for specific activities, or for entire days', or they make 'cyclical returns', such as those who 'spend time here for a while and then disappear for a year or two, then come back, then disappear … ' (E4).

Between 10 and 30 members visit one of these initiatives per day, depending on the Alternative Space in question. They are generally adults; sometimes they are accompanied by a child. One member described themselves, with a great laugh, as 'a handful' (FG3, P3); such statements emphasise that members share a form of human – social, psychological and financial – fragility:

> *It is often people who have social difficulties … housing, work or relational problems … Much more broadly, it is people who do not find their place, who do not find their place to hang on, to connect.*
>
> (E3)

Some workers insist on talking about 'fragility' rather than 'mental health problems', as this term can be 'confused with psychiatry, which deals with institutions that aim to treat psychiatric pathologies' (E4).

Members had arrived at Alternative Spaces in different ways. Word of mouth seems to work well: 'Our participants are very good at talking about us on the bus, everywhere … so there are more and more people' (E3). Some had first heard about the initiative from practitioners or care services, such as psychologists, mental health services, mobile teams or general practitioners. An Alternative Space worker observed:

> *It seems to have responded to a demand from the network. There are a lot of people who have sent us people … who were looking for a place to connect but not too much.*
>
> (E3)

More rarely, people had happened to pass the entrance and had walked in. 'Everyone is welcome' (E2); 'No one is excluded here. We do not talk about exclusion, we talk about "Come back tomorrow or come back when you feel better"' (E4). There are no conditions that must be met for someone to access Alternative Spaces, but there are behaviours that are incompatible with their values; for example, 'Violence is not part of our values' (FG1, P8). Behaviours that threaten the collective project are managed through discussion. If members are under the influence of drugs or alcohol, they may be invited to come back later.

Alternative Spaces: A tentative definition

> *What I like ... is that you have a kind of relief ... it's as if a series of obligations, not explicit but more like social, behavioural, appearance or belonging norms, as if all that was suspended a bit, in fact ... I think it's very important to have places where nothing is asked of you. You're welcome under any conditions, and nothing is asked of you.*
>
> (E2)

Others describe Alternative Spaces as follows: 'Alternative Space is free', 'Drinks are cheap', 'And there's a lot of noise' (FG1, P5). But 'What is an Alternative Space? Well, I don't know!' (E3).

Based on an analysis of the interview and focus group materials, three recurring characteristics of Alternative Spaces can be identified: their accessibility and openness to everyone for a wide range of activities, their position between care services and places of social life such as workplaces or cafés, and the adventure associated with the spaces' co-creation and co-management, in which both members and workers are involved.

Accessible and open to everyone and everything

First and foremost, Alternative Spaces are easily accessible. They may be located in the city centre or in a residential area, but they are always accessible by public transport. The spaces are set up either in houses or in former (work)shops, often rented by the municipal authorities for an affordable fee.

The spaces are characterised by their openness: 'The door is open and anyone who wants to can come in' (FG1, P8). In an Alternative Space, the door remains open, except in one case, where members have to ring the doorbell because the municipal authority has refused to adjust the door. This constraint is seen as an opportunity by those involved in this particular Alternative Space, where everyone who rings the bell is welcomed personally. Access is unconditional, but participation requires respect for basic values, and these are often set out in a charter. The spaces welcome everyone:

> *Whether you're unemployed, divorced or separated, or suffering from a serious illness, there's no age limit and no discrimination. All nationalities can drop in, discover, share, do activities, give suggestions that we accept or don't accept.*
>
> (FG1, P7)

The spaces thus open the door to social diversity: 'There are different cultures, different ideas; you see how people think, how their lives are going' (FG1, P2). The spaces are non-judgemental and welcome those dealing with a range of issues, including forms of fragility that are socially stigmatised: 'For example, if you have a few problems, I'll say psychological problems, you can talk about them' (FG1, P3).

Alternative Spaces invite people to meet others and offer an opportunity to learn to co-exist:

> *It's a bit of a school of life. Because we're confronted with people who are sometimes not doing so well, who are upside down. And as a result, you learn to live and accept that other people are ... just the way they are.*
>
> (FG2, P3)

In turn, these encounters foster an alternative view of one's own situation and greater tolerance of oneself; something that one participant calls a 'decomplexification of prejudices' (FG2, P3).

The openness extends to what people can do in the spaces:

> *You can do anything. That's it. ... I did my poetry exhibition, but I was also able to do my screening, so I was also able to express my art, ... even in a group that is ... totally outside cinema.*
>
> (FG1, P3)

Doing nothing is an option: 'The last activity, the "nothing at all", is also important' (E2). Members 'can keep quiet and not interact with others if they feel like it. There are no behavioural obligations on them' (E2). Therefore, with regard to physical space, participants emphasised that Alternative Spaces need to be sufficiently big and well organised to allow different activities to take place while maintaining quieter areas.

In-between places

Alternative Spaces are situated between the worlds of psychiatry and mental health care, on the one hand, and society in general, on the other. They are characterised by the absence of the medical and hierarchical relations that exist in psychiatric and mental health institutions: 'I feel good here. I think we're accepted as we are – that's it. And what's even better, I think, is that there's no medication' (FG3, P9). Nevertheless, the spaces can facilitate access to medical and social care and resources thanks to the presence of workers seconded from psychiatric, medical and social services. They also differ from outpatient psychiatric and mental health services, where 'there is an obligation to attend and take part in activities' (E4). In Alternative Spaces, by contrast, 'you are the actor of your own presence', meaning that members come and go freely (FG2, P3). Paternalism, the infantilising or dehumanising aspect of institutional culture that is prevalent in some care services, is also absent. As explained by a coordinator, 'there's really a question of ... fighting the paternalism' that is present in services where mental health professionals, who see themselves as normal people, are constantly asking the more fragile people to prove themselves (E2).

Alternative Spaces are characterised by a 'kind of automatic benevolence' that sets them apart from society in general or from other 'human communities [where] social barbarity is commonplace' (FG3, P3; FG2, P1). They are different 'from a café, where … there won't be this consideration of fragility' (E4). They are more like 'a youth centre for adults' (E3). Whereas, 'in youth centres, the focus is on young people, here, the focus is on human fragility' (E4).

The in-between position means that Alternative Spaces stand apart from both social norms and the norms of psychiatric institutions (which historically protect the former). This position is seen as a prerequisite for destigmatising mental health problems and adopting a non-judgemental attitude to human fragility.

A unique adventure of co-creation

Co-creation and co-management mean that workers and members are equally involved in the organisation and day-to-day running of Alternative Spaces, and this leads people to describe them as adventures or tapestries that 'can be sewn, unsewn and customised' (FG2, P5). People involved with the initiatives include permanent workers, peer support workers, workers seconded by other psychiatric, medical and social services, volunteers and members. A non-hierarchical, horizontal relationship between workers of all types and members is implied, so that activities and organisation emerge from their encounters, rather than being imposed from above. From the point of view of some participants, this way of working was encouraged by the conditions under which the Alternative Spaces were created. In the call for projects, 'the definition was just a few lines long ... And so, for me, it was a great adventure too. We don't really know what it will lead to' (E3). The openness of the call enabled the workers and members to build the spaces according to their preferences and the characteristics of the place in which the space was to be created and of the neighbourhood. This sense of adventure feeds into how Alternative Spaces are organised thanks to a willingness to go back to the drawing board and question the way the spaces work whenever there is a risk of hierarchical relationships developing (FG3).

A sense of adventure is also inherent in the day-to-day running of the spaces: 'You never know what's going to happen, who's going to walk through the door and offer what' (E3). Members can propose activities based on their talents and passions. In addition, they have willingness to take up a proposal even if it wasn't planned and requires a major effort (FG2, P1).

As each Alternative Space is renewed daily, 'each Alternative Space is unique' (FG1, P5). This uniqueness makes defining them difficult: 'We don't manage to define ourselves because in fact the members of each place ... have pulled in perhaps slightly different directions' (E3). When the range of Alternative Spaces in Brussels are viewed as a network, these unique identities can be seen as offering opportunities:

> *One place may offer activities that interest one person and not another ... and over the course of a week you can visit lots of different places and find activities that are there and not elsewhere.*
>
> (FG2, P2)

Purposes

The main objectives of Alternative Spaces are to provide a specific but not specialised welcome, to establish links at three levels, and to promote social inclusion and active citizenship, as described below.

The first objective is to ensure that the welcome is not specialised, meaning that it is not guided by medical criteria, such as a diagnosis, or oriented towards a clinical activity – it could even be described as de-specialised, or simply human. However, this human welcome is specific in the way in which it goes against the grain of 'social brutality' by 'taking into account everyone's difficulties and fragility' (E4).

> *We need to maintain a specific welcome because the members have experienced hard things in their lives … But we mustn't specialise too much in mental health problems, because then we lose all the other benefits of opening up to something else.*
>
> (E3)

The welcome is offered by workers or by members themselves. One person is generally responsible for welcoming members for a limited period (two to four hours).

The second objective is to create links. First, links are created 'between the members who come, who meet each other and who arrive isolated and find themselves going to the market together on Sundays' (E4). The links are not imposed, but rather hoped for. 'The link is about what is created ... whether it's an artistic object, ... a workshop or ... a meal' (FG2, P2). Second, links are fostered 'between members and professionals of the team here, but also professionals from the network' (E4). Workers in the spaces are responsible for welcoming people, but not as health professionals. They can nevertheless facilitate links between members and the care or social services they may need. Third, the spaces facilitate links 'between the professionals who meet here, between the workers seconded by a medical centre, by a community mental health service, by a sheltered housing initiative … it's all about networking' (E4).

The third objective of the spaces is active citizenship and social inclusion, through a connection 'with the outside world' and by being part of the city – that is, 'being a citizen of your town'(E4). In some cases, a central objective is that members move around the city, which is reflected in the short daily opening hours of the spaces in question, designed to 'avoid [members] living in isolation. Life is not limited to your house or to [this Alternative Space] ... there's life outside' (FG1, P8).

Rules and values

Alternative Spaces have rules that are both present and absent or 'suspended' (E2). They rely on a frame of reference identified as a charter or a set of values. They symbolise 'a floating framework' that results from the spaces' aim of reaching an equilibrium between total freedom and the adoption of operating rules (E4). Thus, the framework is not made up of rules that apply to every specific situation: 'We don't have any ready-made answers' (FG2, P1). 'It's not no, it's not yes. It's every time you have to discuss and decide' (E4). For example,

> *If violent behaviours arise, we take the time to discuss it with the person ... We mustn't forget that we are human beings. Everyone comes with their own baggage, their own emotions.*
>
> (FG1, P8)

An Alternative Space's charter tends to include a set of basic rules and values for living together, which are applied through discussion, with respect for each situation but also for the collective project. 'We wonder what is OK for the Alternative Spaces and what is not? ... And the idea of being able to do things together is more or less the basis' (FG2, P1). Accordingly, the spaces are not completely unregulated, but they operate a collective, negotiated and procedural form of regulation that focuses on the how rather than on the what. The 'floating framework' is embodied by people taking turns to have 'authority over the way things are going to happen' and to be 'responsible for the structure'. The fact that 'this responsibility circulates between the members … means that everyone in turn ... takes the measure of what we are committing ourselves to' (FG2, P2).

Both members and workers can propose activities. The organisation and coordination of the activities are discussed and decided on either at participatory assemblies or at members' meetings, which take place monthly or weekly, depending on the initiative.

Self-regulation emanates from each person's freedom to decide to be present and this

> *creates a safe space ... because even if there's a conflict between two people ... they've co-existed, they've co-acted ... and we still try to understand each other ... because we're free to come anyway, and so if you decide to come and the other person decides to come ... it means there's a choice ... and we're happy here.*
>
> (FG2, P3)

Workers

Workers in Alternative Spaces include occupational therapists, psychologists, specialised educators, social workers, social therapists and psychosocial workers. Permanent workers share the work of welcoming people with workers who are seconded for a few hours a week by psychiatric, medical and social services, with peer helpers and sometimes with volunteers. They are generally responsible for 'the framework' of ensuring that the basic rules and values of the group are respected. They also participate in the life of the spaces and coordinate practical and administrative tasks. Permanent workers shared their feeling of having unlearned certain formal aspects of interaction with clients that they had been taught during their training, including 'professional secrecy, therapeutic distance, all these big terms that are used during our studies, more or less incessantly' (E4). In the Alternative Spaces, which emphasise the importance of informality, proximity and horizontality between workers and members, they learn about 'human work' (E4).

When talking about their day-to-day work, one staff member commented:

> *I find that we have to walk a tightrope between many, many things, between this professional hat and just a human welcome, between therapy and letting people live, between the individual and the community.*
>
> (E4)

Another added, 'You have to know how to bounce back all the time', how to deal with constant uncertainty, saying, 'Sometimes it's tiring because I don't know whether 10 people are going to walk through the door or 30 ... Or what state people will be in' (E3). At the same time, this uncertainty guarantees a degree of liveliness in a context in which there can be 'something of the inertia and the heaviness of the mental health problems that are present here' (E3). The enjoyment of the human experience seems to take precedence: 'I say to myself every day, "But, still, it's quite phenomenal to laugh so much at work." So that's my little point of wonder ...' (FG3, P7).

Benefits of Alternative Spaces for members

> *The members here don't necessarily say they come to be more independent. They say they come to fight loneliness.*
>
> (E3)

Independent living as community living

Alternative Spaces are viewed as 'the best way to fight loneliness' (FG1, P3). 'I feel lonely, I get bored at home … I go to the Alternative Space … and we have fun, we laugh, we talk, we listen to each other' (FG1, P6). Within the space, members can express themselves, including their psychological suffering, without being stigmatised: 'Here, I feel good because when things aren't going well, I say so' (FG1, P7). Creative activities allow not only for social connection but also for self-assertion: 'I gained more confidence to assert myself … I am increasingly creative sometimes' (FG2, P6). The spaces offer the possibility of 'beautiful encounters … There are always people – people I know, people I don't know, different lives' (FG1, P4). They support learning about community life: 'I am learning here to live with people who, for the most part, have the same problem as I do. So there is an understanding that happens automatically' (FG3, P3). At the same time, coming up against differences promotes greater tolerance towards others and oneself:

> *I learn not only how to live but also to accept that others are … as they are. It is really a thing I had social difficulties in, and I had a lack of self-confidence before. Here, I am not complicated any more.*
>
> (FG2, P3)

Thanks to the options of choosing to be present or not, to propose activities or not, and to participate or not, the spaces allow for individual affirmation as an active citizen: 'I feel like an actor in my life … it is really participative and oriented towards citizenship' (FG2, P3). This freedom to be present or not is combined with the possibility of taking on responsibilities: 'I came here and I never left … There is a framework … and it has allowed me to learn … the sense of responsibilities. The contribution as a person … is absolutely phenomenal' (FG2, P4).

The spaces offer a sense of belonging and of safety: 'I appreciate a lot the feeling of belonging I have here' (FG2, P6); 'I am 100% sure that if there is a problem, I am not alone. And that is incredible. This, for me, it's priceless and it allows me to evolve' (FG2, P4).

In some instances, this feeling is described using the metaphor of family: 'Here, it's my family, it's a big family, we love each other enormously. If there is something that goes wrong, there is room for discussion' (FG3, P10).

Deinstitutionalisation: From dehospitalisation to social inclusion

There are people who

> *come here precisely because this place provides them with enough to not need to go to psychiatry. And that they can do things and interact with people. And they don't feel isolated.*
>
> (FG2, P4)

The contribution of the Alternative Spaces to dehospitalisation or social inclusion has not been scientifically or formally assessed, and it will be difficult to assess that contribution. However, stakeholders are aware of situations in which the spaces have contributed to preventing hospitalisation or rehospitalisation (E3). Several members affirmed that the initiatives had kept them out of psychiatric care: 'If I had continued to go downhill for a year or two, I would have gone to psychiatry' (FG2, P4).

Members explained that Alternative Spaces had stimulated them to explore roles other than the patient role implied by psychiatry. Unlike hospitals and medication, which can make people 'feel depersonified' (FG2, P1), the spaces foster self-affirmation and the experience of citizenship:

> *Even if you're really breaking down and have a hard time, you can receive support here and get your feet back on earth … I really think that the fact of being in a citizen space which is co-constructed allows people who have a hard time to put their feet back on the ground.*
>
> (FG2, P3)

The self-affirmation (as an active citizen) that the spaces stimulate is made possible by their acceptance of failure and the absence of judgement of personal and social skills. The importance attributed to success and the omnipresence of judgement in society have had an impact on some members' trajectories:

> *At some point, you no longer do anything. To no longer be responsible for what you do wrong ... because you can no longer stand being criticised when you do something ... Because it destroys you, literally, it's hell on earth.*
>
> (FG2, P4)

The absence of judgement opens the door to exploration and construction of one's identity, even if it diverges from dominant social norms:

> *It is truly a space of resilience here … Identity … it's something that lives … that evolves … This is something I didn't understand before coming here … that I could be totally at ease about the shifting of identity …*
>
> (FG2, P3)

Key challenges

Four main challenges emerge from participants' experiences of Alternative Spaces. First, at the structural level, the link with mental health is a topic of debate. The integration of Alternative Spaces into the same legal and regulatory framework as mental health services would allow them to benefit from long-term funding. However, given the social stigma of mental health problems, members and workers fear that a structural link between the spaces and mental health might alienate certain people, including those who suffer or have suffered from mental health problems but no longer want to hear about psychiatric treatment. At the same time, all Alternative Spaces claim openness to fragility and mental health issues in general. Therefore, the question remains: 'Should we talk about mental health to destigmatise it or should we not? Should you be part of the mental health sector? Or should you not?' (E3).

Regarding implementation, an issue that is debated is whether the design of spaces should be conceptualised before they are opened or whether it should evolve during their operation. Stakeholders who had studied other initiatives before starting their own were in favour of preparatory conceptualisation work. However, they noted the importance of carrying out this work with those who were to be responsible for launching and running the initiative. Otherwise, the conceptualisation risks being misunderstood and some ideas may be difficult to put into practice. For example, the idea of working with many seconded workers reflects a desire to stimulate networking. In practice, though, the more seconded workers there are, the more difficult it is to build team cohesion and to organise their work. By contrast, stakeholders who had not carried out preparatory conceptualisation were satisfied with this choice because they felt it had fostered true co-creation. However, three years after having launched their initiative, they felt the need to take stock of how they were working and to reflect on the conceptualisation of the space.

Stakeholders question the size of permanent worker teams, expressing the concern that closely bound teams of several permanent workers could undermine co-creation, leaving seconded workers and members feeling excluded. The teams themselves share this concern. However, they emphasise the need not to be alone in the face of the uncertainty that is inherent in the spaces. Organising permanent workers in small teams may offer a balanced solution.

Finally, the number of seconded workers is also a topic of discussion: on the one hand, more seconded workers means that Alternative Spaces are better connected to local networks; on the other hand, more seconded workers (who spend between two and four hours per week at the initiative) results in greater difficulty in managing the spaces and creating a collective identity.

Case study conclusion

The field of mental health in Belgium has been subject to a partial deinstitutionalisation process, resulting from policies that have aimed to reduce the number of psychiatric hospital beds, to create alternative services or both. However, these initiatives have not contributed to a sufficient reduction in psychiatric hospital beds, and they have led to social exclusion, particularly for people in the most vulnerable situations.

The experiences of those participating in the Alternative Spaces initiatives indicate that independent living cannot be achieved by those living in isolation. Social inclusion implies that people do not feel isolated; not feeling isolated means building meaningful links that rely on relationships with people from different social, economic and cultural backgrounds and sharing a form of human fragility. In this respect, the spaces enable their members to meet a diversity of people, providing them with opportunities to learn to live with different people and accept the differences of others, as well as their own differences. People also need places where they can express themselves, through conversation as well as creatively through a wide range of cultural, social and artistic activities, and they need to feel that they belong somewhere and that they have a role to play in society. The Alternative Spaces ensure voluntary participation and implement co-management and co-creation. They act as intermediary spaces that lie between psychiatry and mental health care (refusing its hierarchical organisation, role system and the dominance of medical expertise) and mainstream society (characterised by a culture of competition and stigmatisation of mental health problems).

7 Policy pointers

Based on the findings presented in this report, the necessity of ensuring social inclusion in the provision of care and services cannot be emphasised enough, especially with regard to individuals at risk of marginalisation. The persistence of institutional care across the EU – despite international declarations and national strategies advocating for an expansion of the provision of family- and community-based care and services – is concerning. Institutional culture and inadequate quality assurance processes contribute to shortcomings in living conditions and give rise to isolation, dependency and a loss of autonomy. It is imperative that policymakers ensure that individuals have access to a range of support services that empower them to live fulfilling lives within their communities.

The findings of this research, particularly the insights from the case studies, present evidence for policymakers seeking to facilitate successful transitions to family- and community-based care and services while promoting independent living and social inclusion. By highlighting the challenges and successes experienced by individuals and service providers alike, the findings offer insights that can help to shape effective policies.

Recommendations for policymakers and practitioners are as follows.

- Ensure that people with care or support needs are involved in the development and review of policies that concern them.
- Adopt a person-centred approach, offering a choice from a mix of family- and community-based care and services.
- Ensure that service users have maximal control over their personal situation, including a choice about where and with whom to live and how to spend allocated budgets. Support to exercise legal capacity should be provided, and supported decision-making should be used when necessary. Access to justice and complaints procedures should be ensured.
- Increase the availability of family- and community-based living options by providing kinship care, foster care and adoption services for children in need of alternative care. Ensure the provision of affordable, accessible, inclusive and secure housing options in regular communities. When providing housing, separate its provision from the provision of care and services.
- Ensure provision of emergency shelter accommodation for people experiencing crisis situations such as homelessness or domestic abuse, and make permanent, independent housing available to enable timely transitions from shelters.
- Address institutional culture in all care settings by maximising individual choice and autonomy in decision-making about daily life, minimising mobility restrictions, fostering social interaction, unlearning stereotypical client–staff roles and establishing adequate quality assurance mechanisms.
- Carefully plan and prepare for individuals' transitions to community living. As the transition is a high-risk period, ensure clear communication about the process, maximise continuity of support and of daily activities, and minimise all other changes.
- Provide services focused exclusively on the promotion of social inclusion and the strengthening of social networks, for example through network-oriented models such as resource groups and peer support.
- Ensure equal access to mainstream services (including employment, education, information and healthcare) and facilities such as transport, housing, public buildings and recreational and outdoor areas.
- Actively offer support to people living in community-based settings, as they may not overcome the hurdle of asking for help or seeking support, and problems could therefore escalate.
- Ensure adequate staffing and decent pay for care and social services workers.
- Improve the professional knowledge of staff working in community-based care and services, by providing education, internships and vocational training.
- Ensure coordination of community-based care and services by means of case management and single-entry-point systems, avoiding scattered provision and onerous application processes.
- Support informal caregivers by providing respite care, care leave, training, counselling, peer support, technological aids and financial assistance.
- Ensure EU-wide collection of data, comparable across time and between countries, on care and service provision and the situation of carers and care recipients, disaggregated by, for example, age and gender, to monitor living conditions, policy implementation and trends over time, with the aim of creating an evidence base to support the delivery of good-quality services for people with care or support needs.

References

All Eurofound publications are available at www.eurofound.europa.eu

Abbott, A. D. (1988), *The system of professions: An essay on the division of expert labor*, University of Chicago Press, Chicago, Illinois.

Advisory Committee on the Future of Protected Housing (2015), *From protected living towards a protected home*, VNG, The Hague.

Akkermans, C., Oudejans, A. and Antonio, M. (2023), *Rapportage Staat van de Nachtopvang*, Valente, Amersfoort, Netherlands.

Allen, S., Bulic, I., Rosenthal, E., Laurin-Bowie, C., Roozen, S. and Cuk, V. (2020), 'Institutionalisation and deinstitutionalisation of children', *Lancet Child & Adolescent Health*, Vol. 4, No. 11, e40.

ANED (Academic Network of European Disability Experts) (2019), *The right to live independently and to be included in the community in European States: ANED synthesis report*, European Commission, Brussels.

Association of Women's Shelters (2023), *Bundesweite Frauenhaus-Statistik 2022*, Berlin.

BFW (Bulgarian Fund for Women) (2022), *The invisible front line*, Sofia, available at https://bgfundforwomen.org/wp-content/uploads/2022/09/BWF-Nevidimata-Parva-Linia.pdf, accessed 27 August 2024.

Bick, J., Zhu, T., Stamoulis, C., Fox, N. A., Zeanah, C. and Nelson, C. A. (2015), 'Effect of early institutionalization and foster care on long-term white matter development: A randomized clinical trial', *JAMA Pediatrics*, Vol. 169, No. 3, pp. 211–219.

Böckerman, P., Johansson, E. and Saarni, S. I. (2012), 'Institutionalisation and subjective wellbeing for old-age individuals: Is life really miserable in care homes?' *Ageing & Society*, Vol. 32, No. 7, pp. 1176–1192.

Boesveldt, N. (forthcoming), 'Peer researchers in qualitative research on homelessness and mental health: A reflexive journey from validity into relations of ethical labour', in Busby, H. (ed.), *Qualitative research ethics*, Advances in Research Ethics and Integrity series, Emerald Publishing, Leeds.

Boesveldt, N. F. (2024), 'Governing homelessness in the Netherlands: Incremental change towards providing housing first', in Bevan, C. (ed.), *The Routledge handbook of global perspectives on homelessness, law and policy*, Routledge, Abingdon, United Kingdom, pp. 175–187.

Boesveldt, N. F. and Loomans, D. (2023), 'Housing the homeless: Shifting sites of poverty management in the Netherlands', *Urban Studies*, Vol. 61, No. 7, pp. 1393–1410.

Bredewold, F., Hermus, M. and Trappenburg, M. (2018), '"Living in the community" the pros and cons: A systematic literature review of the impact of deinstitutionalization on people with intellectual and psychiatric disabilities', *Journal of Social Work*, Vol. 20, No. 1, pp. 83–116.

Compton, R. M., Owilli, A. O., Caine, V., Berendonk, C., Jouan-Tapp, C., Sommerfeldt, S. et al (2020), 'Home First: Exploring the impact of community-based home care for older adults and their family caregivers', *Canadian Journal on Aging*, Vol. 39, No. 3, pp. 432–442.

Council for Public Health and Society (2020), *Herstel begint met een huis: Dakloosheid voorkomen en verminderen*, The Hague.

De Munck, J., Genard, J.-L., Vrancken, D., Delgoffe, D., Donnay, J.-Y., Moucheron, M. et al (2003), *Santé mentale et citoyenneté: Les mutations d'un champ de l'action publique*, Academia Press, Ghent, Belgium.

Dozier, M., Zeanah, C. H., Wallin, A. R. and Shauffer, C. (2012), 'Institutional care for young children: Review of literature and policy implications', *Social Issues and Policy Review*, Vol. 6, No. 1, pp. 1–25.

DREES (Direction de la recherche, des études, de l'évaluation et des statistiques) (undated), *Les bénéficiaires de l'aide sociale à l'enfance*, web page, accessed 26 June 2024.

Edgar, B. (2012), 'The ETHOS definition and classification of homelessness and housing exclusion', *European Journal of Homelessness*, Vol. 6, No. 2, pp. 219–225.

EEG (European Expert Group on the Transition from Institutional to Community-based Care) (2009), *Report of the ad-hoc expert group on the transition from institutional to community-based care*, European Commission, Brussels.

EEG (2012), *Common European guidelines on the transition from institutional to community-based care*, Brussels.

EEG (2022), *EU guidance on independent living and inclusion in the community*, Brussels.

Eerst een Thuis (undated), *Nieuwsbrief #18*, web page, accessed 21 June 2024.

Eurofound (2023), *Unaffordable and inadequate housing in Europe*, Publications Office of the European Union, Luxembourg.

European Commission (2009), *Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care*, Brussels.

Fondation Abbé Pierre (2021), *L'État du mal-logement en France 2021*, Paris.

Fondation des Femmes (2021), *Où est l'argent pour l'hébergement des femmes victimes de violences?* Paris.

France Assos Santé (2017), *Prise en charge de l'autisme et autres handicaps: La Belgique comme échappatoire*, web page, accessed 26 June 2024.

George, S., Silva, L., Llamas, M., Ramos, I., Joe, J., Mendez, J. et al (2021), 'The development of a novel, standards-based core curriculum for community facing, clinic-based community health workers', *Frontiers in Public Health*, Vol. 9, Article 663492.

Goffman, E. (1961), *Asylums: Essays on the social situation of mental patients and other inmates*, Anchor Books, New York.

Goldman, P. S., Bakermans-Kranenburg, M. J., Bradford, B., Christopoulos, A., Ken, P. L. A., Cuthbert, C. et al (2020), 'Institutionalisation and deinstitutionalisation of children 2: Policy and practice recommendations for global, national and local actors', *The Lancet Child & Adolescent Health*, Vol. 4, No. 8, pp. 606–633.

Hall, C., Raitakari, S. and Juhila, K. (2021), 'Deinstitutionalisation and "Home turn" policies: Promoting or hampering social inclusion?' *Social Inclusion*, Vol. 9, No. 3, pp. 179–189.

Heimer, A., Schütz, H., Wansing, G., Braukmann, J., Czichon, J-F., Deutschmann, C. et al (2023), *Evaluation der Ergänzenden unabhängigen Teilhabeberatung, Bundesministerium für Arbeit und Soziales*, Berlin.

Housing First Europe Hub (2024), *What is housing first?* web page, accessed 13 September 2024

Hrast, M. F., Pleace, N., O'Sullivan, E., Allen, M., Benjaminsen, L., Busch-Geertsema, V. et al (2023), *Leaving prison and homelessness*, European Observatory on Homelessness, Brussels.

Ilinca, S., Leichsenring, K. and Rodrigues, R. (2015), *From care in homes to care at home: European experiences with (de) institutionalisation in long-term care*, Policy Brief 12/2015, European Centre for Social Welfare Policy and Research, Vienna.

INED (Institut national d'études démographiques) (2018), 'Que deviennent les jeunes après l'aide sociale à l'enfance', press release, 13 December.

Institut for Menneskerettigheder (2017), *Hjemløse borgeres rettigheder i kommunerne*, Copenhagen.

Institut for Menneskerettigheder (2021), *Boligvalg og retten til et selvstændigt liv for mennesker med handicap*, Copenhagen.

Irish Examiner (2022), *Rent supplement support for domestic violence survivors hampered by housing dearth*, web page, 14 February.

Jones, K. and Fowles, A. J. (2023), *Ideas on institutions: Analysing the literature on long-term care and custody*, Routledge, Abingdon, UK.

The Lancet (2024), 'Housing: An overlooked social determinant of health', editorial, *The Lancet*, Vol. 403, No. 10438, p. 1723.

LBSM (Ligue Bruxelloise pour la Santé Mentale) (2024), *Guide des lieux de liens en Région de Bruxelles-Capitale*, Brussels.

Mansell, J. (2006), 'Deinstitutionalisation and community living: Progress, problems and priorities', *Journal of Intellectual and Developmental Disability*, Vol. 31, No. 2, pp. 65–76.

Mansell, J., Knapp, M., Beadle-Brown, J. and Beecham, J. (2007), *Deinstitutionalisation and community living – Outcomes and costs: Report of a European study. Volume 2: Main report*, University of Kent, Canterbury, UK.

McCarron, M., Lombard-Vance, R., Murphy, E., May, P., Webb, N., Sheaf, G. et al (2019), 'Effect of deinstitutionalisation on quality of life for adults with intellectual disabilities: A systematic review', *BMJ Open*, Vol. 9, No. 4, Article e025735.

McQuistion, H. L., Gorroochurn, P., Hsu, E. and Caton, C. L. (2014), 'Risk factors associated with recurrent homelessness after a first homeless episode', *Community Mental Health Journal*, Vol. 50, No. 5, pp. 505–513.

Ministerio de Derechos Sociales (2023), *Marco Estratégico de la desinstitucionalización para una buena vida en la comunidad*, Madrid.

Ministry of the Interior and Kingdom Relations (2021), *Een thuis voor iedereen: Adviesrapport interbestuurlijke werkgroep versterking beleid huisvesting aandachtsgroepen*, The Hague.

Mistiaen, P., Cornelis, J., Detollenaere, J., Devriese, S., Farfan-Portet, M-I. and Ricour, C. (eds.) (2019), *Organisation of mental health care for adults in Belgium*, KCE Reports 318, Belgian Health Care Knowledge Centre (KCE), Brussels.

Nelson, C. A., III, Zeanah, C. H., Fox, N. A., Marshall, P. J., Smyke, A. T. and Guthrie, D. (2007), 'Cognitive recovery in socially deprived young children: The Bucharest Early Intervention Project', *Science*, Vol. 318, No. 5858, pp. 1937–1940.

Newton, L., Rosen, A., Tennant, C., Hobbs, C., Lapsley, H. M. and Tribe, K. (2000), 'Deinstitutionalisation for long-term mental illness: An ethnographic study', *Australian and New Zealand Journal of Psychiatry*, Vol. 34, No. 3, pp. 484–490.

NOS (2021), *Sociale huurwoning? In zeker een kwart van de gemeenten wacht je meer dan 7 jaar*, web page, 24 April.

Office of the United Nations High Commissioner for Human Rights (2014), *Thematic study on the right of persons with disabilities to live independently and be included in the community*, Geneva.

Pratt, R., Clare, L. and Kirchner, V. (2006), '"It's like a revolving door syndrome": Professional perspectives on models of access to services for people with early-stage dementia', *Aging & Mental Health*, Vol. 10, No. 1, pp. 55–62.

Priemus, H. (1995), 'How to abolish social housing? The Dutch case', *International Journal of Urban and Regional Research*, Vol. 19, No. 1, pp. 145–155.

Samen Thuis 2030 (2023), *Geen woorden, maar daden. Één jaar Nationaal Actieplan Dakloosheid: Eerst een thuis*.

Schel, S., Kuijpers, M., Wewerinke, D., Scheepers, A., De Vries, J. and Van Doorn, L. (2023), *Iedereen telt mee. Resultaten eerste ETHOS telling van dak- en thuisloosheid in regio Brabant Noordoost-Oost*, Hogeschool Utrecht, Utrecht.

Simard, J. and Volicer, L. (2020), 'Loneliness and isolation in long-term care and the COVID-19 pandemic', *Journal of the American Medical Directors Association*, Vol. 21, No. 7, pp. 966–967.

Šiška, J. and Beadle-Brown, J. (2020), *Report on the transition from institutional care to community-based services in 27 EU Member States*, EEG, Brussels.

Smith, P., Nicaise, P., Neyens, I., Hermans, K., Thunus, S., Walker, C. et al (2019), 'Values and sets of possible organisational solutions: A choice-based stakeholder analysis survey', in Mistiaen, P., Cornelis, J., Detollenaere, J., Devriese, S., Farfan-Portet, M-I. and Ricour, C. (eds.) (2019), *Organisation of mental health care for adults in Belgium*, KCE Reports 318, Belgian Health Care Knowledge Centre (KCE), Brussels.

Socialstyrelsen (2022), *Housing First-tilgangen: Manual til hjemløshedsområdet*, Odense.

Statistics Netherlands (2019), *Homelessness more than doubled since 2009*, web page, accessed 23 September 2024.

Statistics Netherlands (2021), *Aandeel jongere daklozen in 5 jaar tijd gehalveerd*, web page, accessed 23 September 2024.

Statistics Netherlands (2023), *Steeds minder gereguleerde huurwoningen beschikbaar*, web page, accessed 23 September 2024.

Sting, S., Groinig, M., Hagleitner, M. W. and Maran, T. (2018), *Bildungschancen und Einfluss sozialer Kontextbedingungen auf Bildungsbiographien von Care Leavern*, Wissenschaftlicher Endbericht zum Jubiläumsfondsprojekt Nr. 16821, University of Klagenfurt, Klagenfurt am Wörthersee, Austria.

Teale, A-L., Morgan, C., Jenkins, T. A. and Jacobsen, P. (2024), 'Delayed discharge in inpatient psychiatric care: A systematic review', *International Journal of Mental Health Systems*, Vol. 18, Article 14.

THL (Terveyden ja hyvinvoinnin laitos) (2024), *Jälkihuolto ja itsenäistyminen*, web page, accessed 27 August 2024.

Thompson, D. C., Barbu, M. G., Beiu, C., Popa, L. G., Mihai, M. M., Berteanu, M. et al (2020), 'The impact of COVID-19 pandemic on long-term care facilities worldwide: An overview on international issues', *BioMed Research International*, Nov 4, 8870249.

Thunus, S. (2015), *The system for addressing personal problems – From medicalisation to socialisation: Shifts in Belgian mental health and psychiatric institutions*, University of Liège, Liège.

Thunus, S., Neyens, I., Walker, C., Hermans, K., Smith, P., Nicaise, P. et al (2019), 'Strengths, weaknesses, gaps, and overlaps in the current mental health care supply: A focus group study', in Mistiaen, P., Cornelis, J., Detollenaere, J., Devriese, S., Farfan-Portet, M-I. and Ricour, C. (eds.) (2019), *Organisation of mental health care for adults in Belgium*, KCE Reports 318, Belgian Health Care Knowledge Centre (KCE), Brussels.

Tjaden, C., Mulder, C. L., den Hollander, W., Castelein, S., Delespaul, P., Keet, R. et al (2021), 'Effectiveness of resource groups for improving empowerment, quality of life and functioning of people with severe mental illness: A randomized clinical trial', *JAMA Psychiatry*, Vol. 78, No. 12, pp. 1309–1318.

Tsemberis, S. (2010), *Housing First: The pathways model to end homelessness for people with mental illness and addiction manual*, Hazelden Publishing, Center City, Minnesota.

Tuynman, M. and Planije, M. (2014), *'Het kán dus!' Een doorbraak in het Nederlandse dakloosheidsbeleid. Evaluatie Plan van Aanpak maatschappelijke opvang in de vier grote steden, 2006–2014*, Trimbos-instituut, Utrecht.

Unicef (2010), *At home or in a home? Formal care and adoption of children in Eastern Europe and Central Asia*, Unicef Regional Office for Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS), Geneva.

Unicef and Eurochild (2021), *Better data for better child protection systems in Europe: Mapping how data on children in alternative care are collected, analysed and published across 28 European countries*, Geneva.

Unicef and Eurochild (2023), *Children in alternative care in the Child Guarantee National Action Plans – A summative analysis*, Geneva.

Van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Duschinsky, R., Fox, N. A., Goldman, P. S., Gunnar, M. R. et al (2020), 'Institutionalisation and deinstitutionalisation of children 1: A systematic and integrative review of evidence regarding effects on development', *The Lancet Psychiatry*, Vol. 7, No. 8, pp. 703–720.

Van Gent, W. and Hochstenbach, C. (2020), 'The neo-liberal politics and socio-spatial implications of Dutch post-crisis social housing policies', *International Journal of Housing Policy*, Vol. 20, No. 1, pp. 156–172.

Van Ooijen, M. (2022), *Nationaal Actieplan Dakloosheid: Eerst een Thuis*, Minstry of Health, Welfare and Sport, The Hague.

Van Veldhuizen, J. R. (2007), 'FACT: A Dutch version of ACT', *Community Mental Health Journal*, Vol. 43, No. 4, pp. 421–433.

Van Santen, E., Pluto, L. and Peucker, C. (2019), *Pflegekinderhilfe – Situation und Perspektiven. Empirische Befunde zu Strukturen, Aufgabenwahrnehmung sowie Inanspruchnahme*, Beltz, Weinheim, Germany.

Verhaegen, L. (1987), 'The evolution of Belgian psychiatry', *International Journal of Mental Health*, Vol. 16, No. 1–2, pp. 42–57.

Vígh, K. (2015), 'A befogadó otthonok szerepe és jellemzői a fővárosi gyermekvédelmi szakellátásban a 2014-től hatályos törvényi változások után', *Párbeszéd: Szociális Munka Folyóirat*, Vol. 2, No. 4.

Walker, C., Thunus, S. and Nicaise, P. (2019), *Parcours.Bruxelles: Évaluation qualitative du système de la santé mentale et des parcours des usagers dans le cadre de la réforme Psy 107 en Région de Bruxelles-Capitale*, Observatoire de la Santé et du Social, Brussels.

Walmsley, J. (2005), 'Institutionalization: A historical perspective', in Johnson, K. and Traustadottir, R. (eds.), *Deinstitutionalization and people with intellectual disabilities: In and out of institutions*, Jessica Kingsley Publishers, London.

Weltevrede, A., van den Heerik, A., Wolff, R., de Boom, J. and Seidler, Y. (2017), *Netwerken in de buurt. Een onderzoek naar het nieuwe zorgconcept Buurtcirkel*, Movisie, Utrecht.

Wewerinke, D., Schel, S., Kuijpers, M., Scheepers, A., De Vries, J. and Van Doorn, L. (2023), *Iedereen telt mee. Resultaten eerste ETHOS telling van dak- en thuisloosheid in regio Noordoost Brabant*, Hogeschool Utrecht, Utrecht.

WHO (World Health Organization) (2008), *Policies and practices for mental health in Europe: Meeting the challenges*, WHO Regional Office for Europe, Copenhagen.

Winkler, P., Barrett, B., McCrone, P., Csémy, L., Janoušková, M. and Höschl, C. (2016), 'Deinstitutionalised patients, homelessness and imprisonment: Systematic review', *British Journal of Psychiatry*, Vol. 208, No. 5, pp. 421–428.

Wolf, J. and van den Dries, L. (2023), *Het dashboard van het Nationaal Actieplan Dakloosheid*, Impuls, Nijmegen, Netherlands.

Annexes

Annex 1: Institutionalised population

Table A1: Population of children in residential institutions, EU Member States

Member State	Previous estimate	Recent estimate	% change	Year of previous estimate	Year of recent estimate
Austria		6,413			2022
Belgium		8,412			2021
Bulgaria	3,328	202	-94	2013/2014	2023/2024
Croatia	980	1,108	13	2015	2022
Cyprus	92	201	118	2013	2021
Czechia	7,621	6,394	-16	2005/2006	2017/2018
Denmark	4,754	3,819	-20	2012	2022
Estonia	1,123	880	-22	2015/2018	2022/2023
Finland	2,455	3,471	41	2013	2023
France	139,526	191,514	37	2012	2022
Germany[1]	100,627	121,273	21	2012	2022
Greece	2,850	1,351	-53	2014	2023
Hungary	8,031	6,073	-24	2012	2023
Ireland	452	568	26	2014	2023
Italy	14,781	23,122	56	2010	2020
Latvia	527	518	-2	2012	2023
Lithuania	5,625	2,159	-62	2012	2022
Luxembourg[2]	676	876	30	2014	2023
Malta	221	198	-10	2011	2021
Netherlands	19,037	20,385	7	2015	2020
Poland	27,953	16,572	-41	2012	2022
Portugal[3]	7,577	5,386	-29	2013	2022
Romania	23,240	10,976	-53	2011	2023
Slovakia	5,476	5,053	-8	2012	2022
Slovenia	1,530	1,147	-25	2014	2022
Spain	10,844	17,061	57	2008	2022
Sweden	20,800	26,500	27	2012	2022

[1] *Includes young adults up to age 27 if their personal development does not allow them to live a self-determined and independent life.* [2] *Children and young adults (2023).* [3] *Including people aged 18 and over.*
Notes: *Blank cells indicate data unavailability. Stock data (figures from a specific point in time) where available.*
Source: *Network of Eurofound Correspondents*

Table A2: Population of adults (aged 18–64) with disabilities in residential institutions, EU Member States

Member State	Previous estimate	Recent estimate	% change	Year of previous estimate	Year of recent estimate
Austria[1]		5,656			2021
Belgium					
Bulgaria[2]	5,606	4,685	-16	2012	2022
Croatia	5,308	5,335	1	2015	2022
Cyprus		170			2019
Czechia	11,815	11,016	-7	2016	2022
Denmark	5,123	5,201	2	2015	2022
Estonia	4,175	3,059	-27	2015	2022/2024
Finland	1,612	502	-69	2012	2022
France	144,100	290,280	101	2011	2018
Germany[3]	242,643	229,687	-5	2012	2022
Greece[4]	2,894	1,827	-37	2017	2021
Hungary	15,921	12,626	-21	2012	2022
Ireland[2]	8,000	9,147	14	2013	2023
Italy	51,591	70,000	36	2011	2021
Latvia	4,350	3,840	-12	2010	2021
Lithuania	2,054	1,797	-13	2018	2022
Luxembourg[5]	574	589	3	2012	2022
Malta	198	339	71	2011	2021
Netherlands[6]	93,570	117,460	26	2015	2021
Poland	34,409	63,976	86	2012	2022
Portugal[2]	4,583	7,025	53	2010	2021
Romania[7]	17,844	15,863	-11	2015	2023
Slovakia[8]	17,313	19,814	14	2012	2022
Slovenia	3,099	3,761	21	2014	2022
Spain[9]	9,000	7,300	-19	2008	2020
Sweden	23,900	25,600	7	2011	2021

[1] *People aged 15–64.* [2] *Beds.* [3] *People aged 15–59.* [4] *Social care units, also including children and older people.* [5] *Beds in group living homes.* [6] *People entitled to residential care. Includes people who receive funding for home care – across all age groups, this group was 12.5% of the total.* [7] *People aged 18 and over.* [8] *Total for 2022 is calculated as the sum of 12,627 residents in social services homes with mental disability, 6,437 with physical disability and 750 with sensory disability. However, the true total number of recipients is not equal to the sum of recipients with individual disadvantages, as one recipient may have several types of disadvantages.* [9] *People aged 6–64 years.*
Notes: *Blank cells indicate data unavailability. Stock data (figures from a specific point in time) where available.*
Source: *Network of Eurofound Correspondents*

Table A3: Population of older people (aged 65+) in residential institutions, EU Member States

Member State	Previous estimate	Recent estimate	% change	Year of previous estimate	Year of recent estimate
Austria[1]	52,165	64,866	24	2015	2022
Belgium	111,432	121,049	9	2010	2020
Bulgaria[2]	5,660	5,705	1	2012	2022
Croatia	17,141	19,458	14	2015	2022
Cyprus	1,436	1,346	-6	2013	2014
Czechia	38,493	55,248	44	2010	2021
Denmark	40,697	38,656	-5	2012	2022
Estonia	5,208	12,173	134	2011	2021
Finland	46,834	50,833	9	2011	2021
France	478,206	535,829	12	2011	2021
Germany	656,400	721,569	10	2011	2021
Greece	8,000	13,100	64	2008	2021
Hungary	50,529	54,956	9	2011	2021
Ireland	19,541	21,095	8	2011	2021
Italy	279,000	267,000	-4	2011	2021
Latvia	1,808	1,666	-8	2011	2021
Lithuania	36,287	57,170	58	2011	2021
Luxembourg	4,047	4,623	14	2012	2022
Malta	4,692	6,334	35	2011	2021
Netherlands	168,075	135,340	-19	2010	2020
Poland	41,934	56,519	35	2011	2021
Portugal	18,216	27,826	53	2012	2022
Romania					
Slovakia	23,781	29,944	26	2012	2022
Slovenia	17,088	16,643	-3	2011	2020
Spain	138,869	208,062	50	2012	2022
Sweden	89,753	82,183	-8	2011	2021

[1] *People aged 60 and over.* [2] *Beds.*
Notes: *Blank cells indicate data unavailability. Stock data (figures from a specific point in time) where available.*
Sources: *Network of Eurofound Correspondents (Austria, Bulgaria, Croatia, Cyprus, Greece, Italy, Malta and Romania); OECD, 2024 (all other Member States)*

Table A4: Number of psychiatric care beds in hospitals, EU Member States

Member State	Previous estimate	Recent estimate	% change	Year of previous estimate	Year of recent estimate
Austria	5,981	6,431	8	2011	2021
Belgium	16,012	16,342	2	2011	2021
Bulgaria	4,614	3,937	-15	2011	2021
Croatia	4,610	3,713	-19	2011	2021
Cyprus	182	166	-9	2017	2021
Czechia	10,417	8,991	-14	2011	2021
Denmark	2,967	3,041	2	2011	2021
Estonia	717	669	-7	2011	2021
Finland	4,039	2,091	-48	2010	2020
France	56,950	53,633	-6	2011	2021
Germany	98,719	108,898	10	2011	2021
Greece	8,145	7,401	-9	2011	2021
Hungary	8,933	7,512	-16	2011	2021
Ireland	1,624	1,615	-1	2011	2021
Italy	6,086	4,720	-22	2011	2021
Latvia	2,657	2,086	-21	2011	2021
Lithuania	3,368	2,446	-27	2011	2021
Luxembourg	452	511	13	2015	2021
Malta	596	373	-37	2011	2021
Netherlands	16,757	19,695	18	2015	2021
Poland	24,278	22,905	-6	2011	2021
Portugal	6,788	6,605	-3	2011	2021
Romania	16,653	16,503	-1	2011	2021
Slovakia	4,148	4,342	5	2011	2021
Slovenia	1,344	1,350	0	2011	2021
Spain	17,724	17,058	-4	2011	2021
Sweden	4,443	4,146	-7	2011	2021

Source: *Eurostat, Hospital beds by function and type of care [hlth_rs_bds1]*

Table A5: Number of people housed in temporary shelters or emergency accommodation for people experiencing homelessness, EU Member States

Member State	Previous estimate	Recent estimate	% change	Year of previous estimate	Year of recent estimate
Austria[1]		11,441			2020
Belgium[2]		8,582			2023
Bulgaria[3]	641	819	28	2012	2022
Croatia	391	604	54	2015	2022
Cyprus					
Czechia		5,981			2022
Denmark[4]	6,246	7,011	12	2012	2022
Estonia[4]	1,508	1,718	14	2015	2022
Finland	2,057	795	-61	2012	2022
France	111,000	197,300	78	2012	2021
Germany		372,060			2023
Greece	920			2009	
Hungary	10,018	8,675	-13	2012	2022
Ireland	3,000	13,514	350	2014	2024
Italy[5]		15,759			2021
Latvia	4,654	5,997	29	2010	2022
Lithuania	2,447	1,681	-31	2012	2022
Luxembourg	1,570	2,168	38	2013	2020
Malta	38	88	132	2011	2021
Netherlands[3]		10,559			2021
Poland	13,872	17,277	25	2012	2022
Portugal		9,604			2021
Romania		6,279			2022
Slovakia[6]	2,608	3,433	32	2012	2022
Slovenia	2,797	3,196	14	2014	2022
Spain	22,938	28,552	24	2012	2022
Sweden	3,920	3,655	-7	2011	2023

[1] *People registered in facilities for homeless people.* [2] *Flemish and Walloon regions only.* [3] *Beds.* [4] *People aged 18 and over.* [5] *Includes authorised camps and tolerated settlements.* [6] *Crisis intervention social services are provided to people in various life situations, including domestic abuse and homelessness.*

Notes: *Blank cells indicate data unavailability. Annual data on unique (individual) users of services, where available.*

Source: *Network of Eurofound Correspondents*

Table A6: Number of people housed in temporary shelters or emergency accommodation for victims of domestic abuse, EU Member States

Member State	Previous estimate	Recent estimate	% change	Year of previous estimate	Year of recent estimate
Austria					
Belgium					
Bulgaria[1]	185	306	65	2012	2022
Croatia	216	280	30	2015	2022
Cyprus[2]	15	36	140	2013	2024
Czechia[1]		90			2024
Denmark	3,400	5,279	55	2017	2022
Estonia	501	520	4	2016/2019	2022/2023
Finland[3]	4,550	5,163	13	2017	2022
France	5,100	10,185	100	2017	2022
Germany	22,055	31,070	41	2010	2022
Greece		513			2022–2023
Hungary[1]		200			2019
Ireland[1]	140	144	3	2016	2022
Italy[4]		4,820			
Latvia[5]	585	726	24	2019	2022
Lithuania	2,510	2,636	5	2012	2022
Luxembourg	38	160	321	2013	2020
Malta	18	21	17	2011	2021
Netherlands	16,500	6,695	-59	2009	2019
Poland[6]	1,695	900	-47	2012	2022
Portugal		1,478			2023
Romania	2,328	2,790	20	2016	2022
Slovakia[1]	1,091	684	-37	2012	2022
Slovenia	2,624	2,683	2	2014	2022
Spain		5,548			2020
Sweden	430	516	20	2011	2023

[1] *Beds.* [2] *Beds (2013), current residents (2024).* [3] *Visits to temporary accommodation.* [4] *Women housed in 2022.* [5] *Applications for assistance.*
[6] *Only data for homes for mothers with small children and pregnant women included.*
Notes: *Blank cells indicate data unavailability. Annual data on unique (individual) users of services, where available.*
Source: *Network of Eurofound Correspondents*

Annex 2: National deinstitutionalisation strategies

Table A7: National deinstitutionalisation strategies – children

Member States	Strategy	Years covered
Austria	No strategy identified	Not applicable
Belgium	No strategy identified	Not applicable
Bulgaria	План за действие за създаване на Европейска гаранция за детето (2030) (European Child Guarantee Action Plan (2030))	2022–2030
	Закон за социалните услуги (Social Services Act)	Since 2020, amended in 2023
Croatia	Operativni plan deinstitucionalizacije, prevencije institucionalizacije i transformacije pružatelja socijalnih usluga (Operational Plan for Deinstitutionalisation, Prevention of Institutionalisation and Transformation of Social Service Providers in the Republic of Croatia)	2022–2027
Cyprus	Θεσμός Ημιανεξάρτητης Διαβίωσης (Institution of Semi-independent Living)	Since 2016
Czechia	Národní strategie ochrany práv dětí 2021–2029 (National Strategy for the Protection of Children's Rights 2021–2029) Implemented by plans and strategies below	2021–2029
	Akční plán k naplnění Strategie ochrany práv dětí (2021–2029) (Action Plan for the Implementation of the National Strategy for the Protection of Children's Rights (2021–2029))	2021–2029
	Strategie rodinné politiky 2024–2030 (Strategy on Family Policy 2024–2030)	2024–2030
	Národní strategie rozvoje sociálních služeb na období 2016–2025 (National Strategy on Social Services Development for the Period 2016–2025)	2016–2025
	Dlouhodobý záměr vzdělávání a rozvoje vzdělávací soustavy České republiky 2023–2027 (Long-term Plan for Education and Development of the Education System of the Czech Republic 2023–2027)	2023–2027
Denmark	Børnene Først (Children First)	Since 2021
Estonia	Heaolu arengukava 2023–2030 (Welfare Development Plan 2023–2030)	2023–2030
Finland	Newly established well-being services counties are responsible for arranging housing services for people in need; this applies to the provision of services that help people live independently at home for as long as possible and services that could be referred to as institutionalisation, when the need arises. Thus, there is no need for national coordination of these services	Not applicable
France	Contrat Jeune Majeur (CJM) (Young Adult Contract)	Since 1974
	Allocation d'éducation de l'enfant handicapé (AEEH) (Education Allowance for Disabled Children)	2002
Germany	Social Code Book VIII (Sozialgesetzbuch VIII, SGB VIII)	Since 1990
Greece	Μέτρα για την προώθηση των Θεσμών της Αναδοχής και Υιοθεσίας και άλλες διατάξεις (Measures for the Promotion of the Institutions of Foster Care and Adoption and Other Provisions)	Since 2018
Hungary	Act 31/1997 on Child Protection	Since 1997, amended in 2014
	Gyermekvédelmi stratégia (Child Protection Strategy) was planned in 2019, but not completed	
	Digitális Gyermekvédelmi Stratégia (Digital Child Protection Strategy)	Since 2021
	In preparation: Gyermekvédelmi törvény (A New Child Protection Act)	
Ireland	Tusla Strategic Plan for Residential Care Services for Children and Young People 2022–2025	2022–2025
Italy	Legge 28 marzo 2001, No. 149 modifiche alla legge 4 maggio 1983, No. 184, recante «Disciplina dell'adozione e dell'affidamento dei minori» (Amendments to Law No. 184 of 4 May 1983 on 'Discipline of adoption and foster care of children'), and Title VIII of Book I of the Civil Code	Since 2001

Member States	Strategy	Years covered
Latvia	General policy implemented by the Law on Social Services and Social Assistance and its 39 amendments	Since 2003
	Action Plan for the Implementation of Deinstitutionalisation for 2015–2020	2015–2020, establishing that further planning and implementation of the deinstitutionalisation process is to be carried out by local governments
	Regulations of Cabinet of Ministers No. 313: Action programme Growth and Employment 9.2.2. with the specific support goal ‘Increase the availability of high-quality social services as an alternative to institutional care at the place of residence and services closer to the family environment for persons with disabilities and children. 9.2.2.1. Implementation rules of the ‘Deinstitutionalisation’ measure	Since 2015
	Deinstitutionalisation plans of all planning regions	Since 2018
	EU-funded project supporting deinstitutionalisation, implemented in all planning regions	2015–2023
	Regulations of Cabinet of Ministers No. 857 regarding social guarantees for an orphan and a child left without parental care who is in out-of-family care as well as after the termination of out-of-family care	Since 2005
Lithuania	Action Plan for the Transition from Institutional Care to Family and Community Services for Disabled Persons and Children without Parental Care	2014–2023
	Catalogue of Social Services	Since 2006
	Community Children’s Care Homes	Since 2021 (pilot ran from 2014 to 2020)
Luxembourg	Plan d’action national sur les droits de l’enfant (National Action Plan on Children’s Rights)	2022–2026
Malta	National Children’s Policy	Since 2017
	Children’s Policy Framework	2024–2030
Netherlands	Hervormingsagenda Jeugd 2023–2028 (Youth Reform Agenda 2023–2028)	2023–2028
	Passende zorg voor jeugdigen die bescherming en veiligheid nodig hebben (Appropriate Care for Young People Who Need Protection and Safety)	Since 2022
Poland	Rządowy program wsparcia powiatu w organizacji i tworzeniu rodzinnych form pieczy zastępczej (Government Programme to Support the Counties in Organising and Creating Family Forms of Foster Care)	Since 2023
	Asystent rodziny (Family Assistant)	Since 2023
Portugal	Estratégia Nacional de Combate à Pobreza (National Anti-poverty Strategy)	2021–2030
Romania	Strategia naţională ‘Copii protejaţi, România sigură’ (National Strategy ‘Protected Children, Safe Romania’)	2023–2027
Slovakia	National Strategy on Deinstitutionalisation of Social Services and Substitute Child Care	2021–2030
	National Priorities for Development of Social Services 2021–2030	2021–2030
	Concept on the Implementation of Measures in Children’s Homes	2021–2025
Slovenia	Resolucija o nacionalnem programu socialnega varstva (Resolution on the National Social Assistance Programme 2022–2030)	2022–2030
Spain	Estrategia Estatal de Derechos de la Infancia y la Adolescencia (State Strategy for the Rights of Children and Adolescents)	2023–2030
	II PENIA – Plan Estratégico Nacional de Infancia y Adolescencia (National Strategic Plan for Childhood and Adolescence)	2013–2016
	In preparation: Estrategia estatal de desinstitucionalización (State Strategy for Deinstitutionalisation)	Not applicable
Sweden	Familjehemssatsning (Family-based Living Investment)	2023

Source: *Network of Eurofound Correspondents*

Table A8: National deinstitutionalisation strategies – adults with disabilities

Member State	Strategy	Years covered
Austria	No strategy identified	Not applicable
Belgium	No strategy identified	Not applicable
Bulgaria	Закон за личната помощ (Personal Assistance Act)	Since 2018, amended in 2022
	Закон за социалните услуги (Social Services Act)	Since 2020, amended in 2023
	National Long-term Care Strategy and Action Plan	2022–2027
Croatia	National Strategy for the Equalisation of Opportunities for Persons with Disabilities	2017–2020
Cyprus	Πρώτη Εθνική Στρατηγική για την Αναπηρία 2018–2028 (συμπερ. Κατοικίες Υποστηριζόμενης Διαβίωσης) (First National Disability Strategy 2018–2028 (including Assisted Living Residences))	Since 2020
Czechia	Národní plán podpory rovných příležitostí pro osoby se zdravotním postižením na období 2021–2025 (National Plan for the Promotion of Equal Opportunities for Persons with Disabilities)	2021–2025
	Národní strategie rozvoje sociálních služeb na období (National Strategy on Social Services Development)	2016–2025
Denmark	No strategy identified	Not applicable
Estonia	Heaolu arengukava 2023–2030 (Welfare Development Plan)	2023–2030
Finland	In 2012, the Ministry of Social Affairs and Health published a ‘decision on principle’, according to which no person with a disability would live in institutionalised circumstances by 2020, but would be granted the right to independent, individual living	Since 2012
France	Prestation de compensation du handicap (PCH) (Disability Compensation Benefit)	Since 2005
Germany	SGB IX (Social Code Book IX)	Since 2001, reformed subsequently
Greece	Προσωπικός Βοηθός για Ἄτομα με αναπηρία (Personal Assistant for People with Disabilities) Άρθρα 32–39 Νόμος 4837/2021 (ΦΕΚ Α 178/01.10.2021), «Πρόληψη και αντιμετώπιση περιστατικών κακοποίησης και παραμέλησης ανηλίκων, Πρόγραμμα «Κυψέλη» για την αναβάθμιση της ποιότητας των παρεχόμενων υπηρεσιών σε βρεφικούς, βρεφονηπιακούς και παιδικούς σταθμούς, διατάξεις για την προώθηση της αναδοχής και της υιοθεσίας, «Προσωπικός Βοηθός για τα Άτομα με Αναπηρία» και άλλες διατάξεις» (Articles 32–39 of Law 4837/2021 (Official Government Gazette A 178/01.10.2021), ‘Prevention and treatment of incidents of abuse and neglect of minors, Hive Programme to upgrade the quality of services provided in infant, nursery and day-care centres, provisions to promote foster care and adoption, personal assistant for persons with disabilities and other provisions’)	Since 2022
Hungary	Országos Fogyatékosságügyi Program (National Disability Programme)	2015–2025
	Intézkedési Terv (Implementation Plan), Government Decree 1187/2020	2019–2024
	A fogyatékossággal élő személyek számára ápolást-gondozást nyújtó szociális intézményi férőhelyek kiváltásáról szóló 2019-2036. évekre vonatkozó hosszú távú koncepció (The replacement of places in social institutions providing care for persons with disabilities. Long-term concept for years 2019–2036)	2019–2036
	Government Decree 1257/2011 (VII.21.): a 30-year strategy for the deinstitutionalisation of people with disabilities	2011–2041
Ireland	Time to Move On from Congregated Settings: A Strategy for Community Inclusion	2012–2017
Italy	Fondo per la non autosufficienza (Fund for Non-self-sufficiency)	Since 2007
	‘Dopo di noi’ (‘After Us’)	Since 2016
	Notice No. 1/2022 PNRR: Next generation EU – Proposte di intervento per l’inclusione sociale di soggetti fragili e vulnerabili (Intervention proposals for the social inclusion of fragile and vulnerable persons)	Since 2022
	Assegno di inclusione (Inclusion Allowance)	Since 2024
Latvia	General policy implemented by the Law on Social Services and Social Assistance and its 39 amendments	Since 2003

Member State	Strategy	Years covered
Lithuania	Plan No. A1-83 (actions for the initial process of deinstitutionalisation, such as improving legislation on the provision of community-based social services for adults with disabilities (2014–2023) and developing and implementing projects on new forms of social services for people with disabilities and their families (2017–2023))	2014–2027
	Disability Reform	Since 2024
Luxembourg	Plan national de mise en oeuvre de la convention relative aux droits des personnes handicapées (National Implementation Plan for the Convention on the Rights of Persons with Disabilities)	2019–2024
Malta	2021–2030 National Strategy on the Rights of Disabled Persons	2021–2030
Netherlands	Toekomstagenda Gehandicaptenzorg: Zorg en ondersteuning voor mensen met een beperking (Agenda for Future Care for the Disabled: Care and Support for Disabled People)	Since 2021
Poland	Strategia na rzecz Osób z Niepełnosprawnościami (Strategy for Persons with Disabilities)	2021–2030
Portugal	Estratégia Nacional para a Inclusão das Pessoas com Deficiência (National Strategy for the Inclusion of Persons with a Disability)	2021–2025
Romania	Strategia națională de dezinstituţionalizare (National Deinstitutionalisation Strategy)	2022–2030
Slovakia	National Programme on Improving the Living Conditions of Persons with Disabilities	2021–2030
Slovenia	Zakon o socialnem vključevanju invalidov (Social Inclusion of Disabled Persons Act)	Since 2019
	Resolucija o nacionalnem programu socialnega varstva (Resolution on the National Social Assistance Programme 2022–2030)	2022–2030
Spain	Estrategia Española sobre Discapacidad (Spanish Disability Strategy)	2022–2030
	In preparation: Estrategia estatal de desinstitucionalización (State Strategy for Deinstitutionalisation)	Not applicable
Sweden	Lagen om stöd och service till vissa funktionshindrade (LSS) (Act Concerning Support and Services for Persons with Certain Functional Impairments)	Since 1994

Source: *Network of Eurofound Correspondents*

Table A9: National deinstitutionalisation strategies – adults with mental health problems

Member State	Strategy	Years covered
Austria	No strategy identified	Not applicable
Belgium	Reform 107: hervorming van de geestelijke gezondheidszorg (Reform 107: Reform of Mental Health Care)	Since 2010
Bulgaria	National Long-term Care Strategy and Action Plan	2022–2030
	Националната стратегия за психично здраве на гражданите на Република България (National Strategy for Mental Health of the Citizens of the Republic of Bulgaria)	2021–2030
Croatia	National Strategy for the Equalisation of Opportunities for Persons with Disabilities	2017–2020
Cyprus	In planning: Εθνική Στρατηγική για την Ψυχική Υγεία (National Strategy for Mental Health)	Not applicable
Czechia	Národní akční plán pro duševní zdraví (National Action Plan for Mental Health)	2020–2030
	Strategie reformy psychiatrické péče (Strategy for Psychiatric Care Reform)	2014–2023
Denmark	Aftale om en 10-årsplan for psykiatrien og mental sundhed (Agreement on a 10-year plan for psychiatry and mental health)	Since 2022
Estonia	Heaolu arengukava 2023–2030 (Welfare Development Plan)	2023–2030
Finland	No strategy identified	Not applicable
France	Prestation de compensation du handicap (PCH) (Disability Compensation Benefit)	2005
Germany	Adults with mental health problems can claim benefits under their obligatory health insurance. Statutory health insurance is regulated by Social Code Book V	Since 1989
Greece	Κοινή Υπουργική Απόφαση Δ12/ΓΠοικ.13107/283/2019 - ΦΕΚ 1160/Β/08.04.2019 (Κωδικοποιημένη), «Προϋποθέσεις ίδρυσης και λειτουργίας Στεγών Υποστηριζόμενης Διαβίωσης Ατόμων με Αναπηρίες» (Joint Ministerial Decision 13107/283/08.04.2019 (Official Government Gazette B 1160/08.04.2019), ‘Conditions for the establishment and operation of supported living homes for persons with disabilities’)	Since 2019

Member State	Strategy	Years covered
Hungary	Act III of 1993 on Social Services Section 66/A. (1)–(3) (pertaining to residential care for people with disabilities, mental illness or addiction)	Since 1993
Ireland	Sharing the Vision: A Mental Health Policy for Everyone – Implementation Plan	2022–2024
Italy	Tutela della salute mentale 92–94 (Mental Health Protection ’92–94)	Since 1994
	Fondo per la non autosufficienza (Fund for Non-self-sufficiency)	Since 2007
	‘Dopo di noi’ (‘After Us’)	Since 2016
	Notice No. 1/2022 PNRR: Next generation EU – Proposte di intervento per l’inclusione sociale di soggetti fragili e vulnerabili (Intervention proposals for the social inclusion of fragile and vulnerable persons)	Since 2022
	Assegno di inclusione (Inclusion Allowance)	Since 2024
Latvia	General policy implemented by the Law on Social Services and Social Assistance and its 39 amendments	Since 2003
Lithuania	National Progress Plan	2021–2026
Luxembourg	Plan national santé mentale (National Mental Health Plan)	2018–2023
Malta	A Mental Health Strategy for Malta	2020–2030
Netherlands	Programma ‘Een thuis voor iedereen’ (‘A Home for Everyone’ programme)	Since 2022
Poland	If a person with mental health problems is granted disability status, they can benefit from the support provided under the Strategia na rzecz Osób z Niepełnosprawnościami 2021–2030 (Strategy for Persons with Disabilities 2021–2030) and Program ‘Za Życiem’ (‘For Life’ programme)	2021–2030
Portugal	Plano de Recuperação e Resiliência (Recovery and Resilience Programme)	2021–2026
Romania	Strategia naţională pentru sănătatea mintală a copilului şi adolescentului (National Strategy for Child and Adolescent Mental Health)	2016–2020
Slovakia	Koncepcia humanizácie ústavnej zdravotnej starostlivosti v odbore psychiatria (Concept on Humanisation of Residential Healthcare in Psychiatry)	Since 2022
	Koncepcia zdravotnej starostlivosti v odbore detská psychiatria (Concept on Healthcare in Child Psychiatry)	Since 2022
Slovenia	Zakon o osebni asistenci (Personal Assistance Act)	2019–2028
	Resolucija o nacionalnem programu duševnega zdravja (Resolution on the National Mental Health Programme 2022–2030)	2022–2030
Spain	Estrategia de Salud Mental del Sistema Nacional de Salud (Mental Health Strategy of the National Health System)	2022–2026
	In preparation: Estrategia estatal de desinstitucionalización (State Strategy for Deinstitutionalisation)	
Sweden	Lagen om stöd och service till vissa funktionshindrade (LSS) (Act Concerning Support and Services for Persons with Certain Functional Impairments)	Since 1994

Source: *Network of Eurofound Correspondents*

Table A10: National deinstitutionalisation strategies – older people (aged 65+)

Member State	Strategy	Years covered
Austria	The following is included in the government’s work programme as one of the ‘basic principles’ regarding long-term care: ‘As much as possible at home and on an outpatient basis – as much as necessary on an inpatient basis’	2020–2024
Belgium	No strategy identified	Not applicable
Bulgaria	Закон за социалните услуги (Social Services Act)	Since 2020, amended in 2023
	National Long-term Care Strategy and Action Plan	2022–2030
Croatia	Strategy for Combating Poverty and Social Exclusion and Construction and Equipping of Centres for the Elderly, as a part of the national recovery and resilience plan	2021–2026
Cyprus	No strategy identified	Not applicable

Member State	Strategy	Years covered
Czechia	Strategický rámec pro přípravu na stárnutí společnosti (Strategic Framework in Preparation for Societal Ageing) Implemented by: Akční plán k naplnění Strategického rámce pro přípravy na stárnutí společnosti (Action Plan for the Implementation of the Strategic Framework in Preparation for Societal Ageing)	2023–2025
	Národní strategie rozvoje sociálních služeb na období (National Strategy on Social Services Development)	2016–2025
Denmark	Det Gode Ældreliv (Good Life for the Elderly)	Since 2020
Estonia	Heaolu arengukava 2023–2030 (Welfare Development Plan 2023–2030)	2023–2030
Finland	In Finland, the priority is for the regions to provide their inhabitants with services that help them live at home for as long as possible. Institutionalised housing or living, *laitosasuminen*, is reserved only for people who cannot be provided with the care they need at home	Not applicable
France	Allocation Personalisée pour l’Autonomie (APA) (Personalised Allowance for Autonomy)	Since 2014
Germany	Care insurance is obligatory in Germany. It is regulated by Social Code Book XI	Since 1995
Greece	«Βοήθεια στο σπίτι» (‘Help at Home’)	Since 1997
Hungary	Idősügyi Nemzeti Stratégia (National Strategy for Senior Affairs)	2009–2034
	Tartós ápolás-gondozásra vonatkozó stratégia (Strategy for Long-term Nursing and Care)	2021–2027
	Tartós ápolás-gondozásra vonatkozó stratégia 2030 (Strategy for Long-term Nursing and Care 2030)	2021–2030
Ireland	Enhanced Community Care	Since 2022
Italy	Piano Nazionale per le non autosufficienze (National Plan for the Non-self-sufficient)	2022–2024
	Notice No. 1/2022 PNRR: Next generation EU – Proposte di intervento per l’inclusione sociale di soggetti fragili e vulnerabili (Intervention proposals for the social inclusion of fragile and vulnerable persons)	Since 2022
Latvia	General policy implemented by the Law on Social Services and Social Assistance and its 39 amendments	Since 2003
Lithuania	2021–2030 nacionalinį pažangos planą (National Progress Plan 2021–2030)	Since 2021
	Naujos kartos Lietuva (Next Generation Lithuania)	Since 2021, amended in 2023
	Ilgalaikės priežiūros paslaugų teikimo tvarkos (Procedure for the Provision of Long-term Care Services)	Since 2023
	Integralios pagalbos plėtros 2022–2029 metų veiksmų plano (Action Plan for the Development of Integral Assistance 2022–2029)	2022–2029
Luxembourg	Stratégie active ageing (Active Ageing Strategy)	2018–2023
	Plan démence (Dementia Plan)	2024–2028
	Plan national «fin de vie et soins palliatifs» (National End of Life and Palliative Care Plan)	2023–2026
Malta	National Strategic Policy for Active Ageing	2021–2027
Netherlands	Programma Wonen, Ondersteuning en Zorg voor Ouderen (Housing, Support and Care for the Elderly Programme)	Since 2022
	Programma Kwaliteit Verpleeghuiszorg: Thuis in het Verpleeghuis (Nursing Home Care Quality Programme: At Home in the Nursing Home)	2018–2023
Poland	Program Korpus Wsparcia Seniorów na rok (Annual Senior Support Programme)	Since 2024
Portugal	Plano de Ação do Envelhecimento Ativo e Saudável (Action Plan on Active and Healthy Ageing)	2023–2026
Romania	Strategia națională privind îngrijirea de lungă durată și îmbătrânire active (National Strategy on Long-term Care and Active Ageing)	2023–2030
Slovakia	Long-term Care Strategy	2021–2030

Member State	Strategy	Years covered
Slovenia	Zakon o dolgotrajni oskrbi (Long-term Care Act)	Since 2023
Spain	Estrategia Nacional de Personas Mayores para un Envejecimiento Activo y para su Buen Trato (National Strategy for Active Ageing and Good Treatment of Older People)	2018–2021
	In preparation: Estrategia estatal de desinstitucionalización (State Strategy for Deinstitutionalisation)	
Sweden	Socialtjänstlagen (2001:435) (Social Services Act) § 6 states that social services should enable individuals to keep living at home and stay in contact with others, through home services and activities	Since 2002

Source: *Network of Eurofound Correspondents*

Table A11: National deinstitutionalisation strategies – people experiencing homelessness

Member State	Strategy	Years covered
Austria	No strategy identified. The federal states have undertaken significant activities in the area of deinstitutionalisation (e.g. the principle of 'outpatient before inpatient' applies)	Not applicable
Belgium	Belgisch samenwerkingsakkoord over dak- en thuisloosheid 12 mei 2014 (Belgian cooperation agreement on homelessness of 12 May 2014)	Since 2014
Bulgaria	Закон за социалните услуги (Social Services Act)	Since 2020, amended in 2023
Croatia	Strategy for Combating Poverty and Social Exclusion	2018–2020
Cyprus	No strategy identified	Not applicable
Czechia	Strategie sociální inkluze (Social Inclusion Strategy)	2021–2030
Denmark	Nationale retningslinjer for indsatsen mod hjemløshed (National Guidelines for Action against Homelessness)	Since 2020 (due to be updated in 2024)
Estonia	No strategy identified	Not applicable
Finland	Coordination Group for the Government's Homelessness Prevention Operational Programme (2016–2019)	2016–2019
France	Droit au logement opposable (DALO) (Enforceable Right to Housing)	Since 2007
Germany	Homeless people can apply for social welfare benefits (including financial support for rent) In 2022, the federal government produced the first national report on homelessness. As announced in 2023, it is also working on a national action plan to overcome homelessness by 2030	Not applicable
Greece	Κοινή Υπουργική Απόφαση, Αριθμ. Δ13/οικ. 42815 (ΦΕΚ 2788/30.06.2021) «Καθορισμός των όρων και των προϋποθέσεων υλοποίησης του προγράμματος με τίτλο 'Στέγαση και Εργασία για τους αστέγους'» (Joint Ministerial Decision No. D13/ac. 42815 (Official Government Gazette 2788/30.06.2021), 'Determination of the terms and conditions for the implementation of the programme entitled "Housing and Work for the Homeless"')	Since 2021
Hungary	No strategy identified	Not applicable
Ireland	Housing First National Implementation Plan 2022–2026	2022–2026
Italy	No strategy identified	Not applicable
Latvia	General policy implemented by the Law on Social Services and Social Assistance and its 39 amendments	Since 2003
Lithuania	No strategy identified. 2021–2030 nacionalinį pažangos planą (National Progress Plan 2021–2030) envisages tackling the problems of housing provision and homelessness	2021–2030
	Socialinių paslaugų katalogo (Catalogue of Social Services (recast)) includes the service of temporary shelter for the homeless	Since 2022
Luxembourg	Stratégie nationale contre le sans-abrisme et l'exclusion liée au logement (National Strategy against Homelessness and Housing Exclusion)	2013–2020
Malta	National Strategic Policy for Poverty Reduction and for Social Inclusion	2014–2024
Netherlands	Nationaal Actieplan Dakloosheid: Eerst een Thuis (National Action Plan on Homelessness: First a Home)	Since 2022

Member State	Strategy	Years covered
Poland	Pokonać bezdomność. Program pomocy osobom bezdomnym Edycja 2023 (Assistance Programme for Homeless Individuals 2023)	Since 2023
Portugal	Estratégia Nacional para a Integração das Pessoas em Situação de Sem-Abrigo (National Strategy for the Integration of Homeless People)	2017–2023
Romania	Strategia națională privind incluziunea socială a persoanelor fără adăpost (National Strategy on Social Inclusion of Homeless People)	2022–2027
Slovakia	National Strategy on Preventing and Ending Homelessness	2022–2030
Slovenia	Resolucija o nacionalnem programu socialnega varstva (Resolution on the National Social Assistance Programme 2022–2030)	2022–2030
Spain	Estrategia Nacional para la lucha contra el sinhogarismo en España (National Strategy for the Fight against Homelessness in Spain) In preparation: Estrategia estatal de desinstitucionalización (State Strategy for Deinstitutionalisation)	2023–2030
Sweden	Bostad först (Housing First)	2022–2026

Source: *Network of Eurofound Correspondents*

Table A12: National deinstitutionalisation strategies – victims of domestic abuse

Member State	Strategy	Years covered
Austria	No strategy identified	Not applicable
Belgium	No strategy identified	Not applicable
Bulgaria	Закон за защита от домашно насилие (Law on Protection from Domestic Violence)	Since 2009; amended in 2023
Croatia	Strategy for Combating Poverty and Social Exclusion	2018–2020
Cyprus	Κοινωνική Υπηρεσία του ΣΠΑΒΟ (SPAVO Association for the Prevention and Handling of Violence in the Family)	Since 2021
Czechia	Akční plán prevence domácího a genderově podmíněného násilí na léta (Action Plan for the Prevention of Domestic and Gender-based Violence)	2023–2026
	Strategie rovnosti žen a mužů na léta (Gender Equality Strategy)	2021–2030
Denmark	Handlingsplan mod partnervold og partnerdrab (Action Plan against Domestic Violence and Partner Homicide)	2023–2026
Estonia	No strategy identified	Not applicable
Finland	Naisiin kohdistuvan väkivallan torjuntaohjelma 2020–2023 (Programme to Combat Violence against Women 2020–2023)	2020–2023
France	Aide universelle d'urgence pour les personnes victimes de violences conjugales (Universal Emergency Aid for Victims of Domestic Violence)	Since 2023
Germany	Victims of domestic abuse can apply for social welfare benefits (including financial support for rent) and other services	
Greece	The strategy for homeless people – that is, Κοινή Υπουργική Απόφαση, Αριθμ. Δ13/οικ. 42815 (ΦΕΚ 2788/30.06.2021) «Καθορισμός των όρων και των προϋποθέσεων υλοποίησης του προγράμματος με τίτλο 'Στέγαση και Εργασία για τους αστέγους'» (Joint Ministerial Decision No. D13/ac. 42815 (Official Government Gazette 2788/30.06.2021), 'Determination of the terms and conditions for the implementation of the programme entitled "Housing and Work for the Homeless"') – also applies to women accommodated in hostels for women victims of violence	Since 2021
Hungary	No strategy identified	Not applicable
Ireland	Third National Domestic, Sexual and Gender-based Violence Strategy	2022–2026
Italy	Reddito di Libertà (Freedom Income)	Since 2020
Latvia	General policy implemented by the Law on Social Services and Social Assistance and its 39 amendments	Since 2003
	Procedures for Providing Social Rehabilitation Services to Adult Persons Who Are Victims of Violence and Who Have Committed Violence	Since 2015
	Amendments to Regulation of Cabinet of Ministers No. 790, Procedures for Providing Social Rehabilitation Services to Adult Persons Who Are Victims of Violence and Who Have Committed Violence	Since 2023

Member State	Strategy	Years covered
Lithuania	No strategy identified	Not applicable
	The Domestic Violence Protection Order was incorporated into the Law on Protection against Domestic Violence	Since 2023
Luxembourg	Stratégie nationale contre le sans-abrisme et l’exclusion liée au logement (National Strategy against Homelessness and Housing Exclusion)	2013–2020
Malta	National Strategy on Gender-based Violence and Domestic Violence	2023–2028
Netherlands	Toekomstscenario kind- en gezinsbescherming (Future Scenario on Child and Family Protection)	2023–2026
	Veiligheid in de Vrouwenopvang (Safety in the Women’s Shelter)	Since 2020
	Handreiking deskundigheid huiselijk geweld en kindermishandeling (Expert Guidelines on Domestic Violence and Child Abuse)	Since 2021
Poland	Wspieranie Jednostek Samorządu Terytorialnego w Tworzeniu Systemu Przeciwdziałania Przemocy w Rodzinie (Supporting Local Self-government Units in Creating a System for Counteracting Family Violence)	2017–2022
	Rządowy Program Przeciwdziałania Przemocy Domowej na lata 2024–2030 (Government Domestic Violence Prevention Programme 2024–2030)	2024–2030
	Krajowy Program Przeciwdziałania Przemocy w Rodzinie na lata 2014–2020 (National Programme for Counteracting Family Violence 2014–2020)	2014–2020
Portugal	Plano de Ação para a Prevenção e o Combate à Violência contra as Mulheres e à Violência Doméstica (Action Plan on Preventing and Combating Violence against Women and Domestic Violence)	2023–2026
Romania	Strategia naţională privind promovarea egalităţii de şanse şi de tratament între femei şi bărbaţi şi prevenirea şi combaterea violenţei domestice (National Strategy on Promoting Equal Opportunities and Treatment between Women and Men and Preventing and Combating Domestic Violence)	2021–2027
Slovakia	National Strategy on Equality of Women and Men and Equal Opportunities in the Slovak Republic	2021–2027
	National Action Plan for Prevention and Elimination of Violence against Women	2022–2027
Slovenia	Resolucija o nacionalnem programu socialnega varstva (Resolution on the National Social Assistance Programme 2022–2030)	2022–2030
Spain	Estrategia Estatal para combatir las violencias machistas (State Strategy to Combat Gender Violence)	2022–2025
	In preparation: Estrategia estatal de desinstitucionalización (State Strategy for Deinstitutionalisation)	
Sweden	Nationell strategi för att förebygga och bekämpa mäns våld mot kvinnor (National Strategy to Prevent and Combat Men’s Violence against Women)	2017–2026

Source: *Network of Eurofound Correspondents*

Annex 3: Network of Eurofound Correspondents

Table A13: National correspondents who contributed to this report

Member State	Correspondent(s)	Organisation
Austria	Bernadette Allinger	Working Life Research Centre (FORBA)
Belgium	Liesbeth Op de Beeck and Dries Van Herreweghe	HIVA – Research Institute for Work and Society, KU Leuven
Bulgaria	Gabriela Yordanova and Ekaterina Markova	Institute of Philosophy and Sociology, Bulgarian Academy of Sciences
Croatia	Predrag Bejaković	Faculty of Economics, Business and Tourism, University of Split
	Irena Klemencic	Faculty of Law, University of Zagreb
Cyprus	Alexandros Perdikes	Cyprus Labour Institute of the Pancyprian Federation of Labour (INEK-PEO)
Czechia	Jana Váňová	Research Institute for Labour and Social Affairs
Denmark	Louise Fabricius	Fabricius Consulting
Estonia	Katre Pall	Praxis Centre for Policy Studies
Finland	Mikael Lundqvist	Oxford Research AB
France	Frédéric Turlan and Victoria Fonseca	IR Share
Germany	Sandra Vogel	German Economic Institute (IW)
Greece	Elena Kousta	Labour Institute of the General Confederation of Greek Workers (INE GSEE)
Hungary	Nóra Krokovay	Kopint-Tárki Institute
Ireland	Rosanna Angel	Industrial Relations News
Italy	Roberta Cupertino	Fondazione Giacomo Brodolini
Latvia	Raita Karnite	Economic Progress Centre, Ltd
Lithuania	Sandra Krutulienė and Inga Blažienė	Lithuanian Centre for Social Sciences
Luxembourg	Gaetan de Lanchy and Nathalie Lorentz	Luxembourg Institute of Socio-Economic Research
Malta	Christine Scerri	Centre for Labour Studies, University of Malta
Netherlands	Tom Kruis	Panteia
Poland	Anna Chowaniec	Ecorys Poland
Portugal	Heloísa Perista	Centre for Studies for Social Intervention (CESIS)
Romania	Nicoleta Voicu	Center for Public Innovation
Slovakia	Daniela Kešelová, Darina Kválová and Zuzana Turkovič	Institute for Labour and Family Research
Slovenia	Barbara Lužar	Faculty of Social Sciences, University of Ljubljana
Spain	Iñigo Isusi, Laura Gallo and Jessica Durán	IKEI Research & Consultancy
Sweden	Nils Brandsma and Sydney McLoughlin Laewen	Oxford Research Sweden

Getting in touch with the EU

In person

All over the European Union there are hundreds of Europe Direct information centres. You can find the address of the centre nearest you at: https://european-union.europa.eu/contact-eu_en

On the phone or by email

Europe Direct is a service that answers your questions about the European Union. You can contact this service:

- by freephone: 00 800 6 7 8 9 10 11 (certain operators may charge for these calls)
- at the following standard number: +32 22999696
- by email via: https://european-union.europa.eu/contact-eu_en

Finding information about the EU

Online

Information about the European Union in all the official languages of the EU is available on the Europa website at: https://europa.eu

EU publications

You can download or order free and priced EU publications at: https://op.europa.eu/publications
Multiple copies of free publications may be obtained by contacting Europe Direct or your local information centre (see https://european-union.europa.eu/contact-eu_en).

EU law and related documents

For access to legal information from the EU, including all EU law since 1952 in all the official language versions, go to EUR-Lex at: https://eur-lex.europa.eu

Open data from the EU

The EU Open Data Portal (https://data.europa.eu) provides access to datasets from the EU. Data can be downloaded and reused for free, both for commercial and non-commercial purposes.

EF/23/018

TJ-01-24-006-EN-N

Increasing emphasis on independent living and social inclusion is driving deinstitutionalisation – the shift away from a reliance on residential institutions towards family- and community-based settings for the provision of care and services. The aim is to ensure that people at risk of marginalisation have opportunities to participate fully in society and to exercise their personal rights and freedoms. An institutional culture that gives rise to social isolation and loss of autonomy can be present in any care setting, but it is commonplace in long-stay residential institutions such as children's homes and nursing homes. Although deinstitutionalisation strategies have been adopted across the EU, shortcomings are apparent.

This report presents evidence on changes in the extent of institutional living in the EU over time, as well as information on national deinstitutionalisation strategies and practices. It includes two person-centred case studies that illustrate the benefits of deinstitutionalisation and greater social inclusion and the challenges encountered in efforts towards these goals.

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.

Publications Office
of the European Union

ISBN 978-92-897-2439-5
doi:10.2806/4798019