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COUNCIL OF MINISTERS RESOLUTION 135

of 15 June 2022.

on the adoption of a public policy entitled Strategy for the development of social services, public policy until 2030 (with an outlook until 2035)

Pursuant to Article 21f(4) of the Act of 6 December 2006 on the principles of development policy (Journal of Laws 2021. item 1057 and 2022 item 1079) the Council of Ministers adopts the following:

§ 1 A public policy called Strategy for the Development of Social Services, Public Policy to 2030 is adopted (with an outlook to 2035), hereinafter referred to as the "Strategy", attached to the resolution.

§ 2. The monitoring of the implementation of the Strategy is entrusted to the minister responsible for social security.

§ 3 The resolution shall enter into force on the day following that of its publication.

Prime Minister: *M. Morawiecki*

Unofficial Machine Translated Document

Annex to Resolution No. 135 of the Council
of Ministers of 15 June 2022 (M.P. pos. 767)

STRATEGY FOR THE DEVELOPMENT OF SOCIAL SERVICES

public policy until 2030

(with an outlook to 2035).

The document was prepared in the Ministry of Family and Social Policy, on the basis of findings and conclusions developed within the Team for Developing the Strategy of Deinstitutionalisation of Social Services in Poland appointed by the Minister of Family and Social Policy, and with the participation of experts in the field of particular areas of social services concerned by deinstitutionalisation (persons with disabilities, the elderly, families and children and youth in foster care, persons with mental health problems and persons in crisis of homelessness). Representatives of various levels of local government participated in the development of the document.

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INTRODUCTION

Social services are an increasingly important component of state social policy. This is linked to processes such as demographic change and population ageing, the transformation of labour markets, an increase in the number of people in need of support in daily life and people with disabilities, new demands for competences and qualifications, transformations within the family, new forms of social exclusion, new social risks, including pandemics and environmental threats, etc. Alongside income security policy, social services are an important component of social policy, as they lead to improvements in the psycho-physical state of individuals in an individual and collective sense or to changes in their life situation. Social services, which are made available and organised in a professional manner, make a real difference to the quality of life of individuals and families.

It should be emphasised that social services are generally dedicated to everyone, but in a special way to those people who, due to their individual characteristics and broadly understood conditions, may be exposed to any manifestation of social exclusion or discrimination. This applies in particular to:

a) children, including children with disabilities,
b) people with disabilities and those in need of support in their daily lives,
c) people in mental health crisis,
d) older people,
e) people in crisis of homelessness,
f) all other groups at risk of poverty and social exclusion.

A number of documents from international organisations, including the European Union, mention the development of social services as an important objective of implemented social policies, which should be prioritised by states through the creation of strategies and programmes for the development of social and welfare services. Social services are supposed to contribute to the implementation of at least ten principles of the Pillar of Social Rights, adopted on 17 November 2017 by the EU institutions[1] . Point 18 refers directly to long-term care[2] and states that

[1] The proclamation of the European Pillar of Social Rights on 17 November 2017.
[2] As defined within the EU (e.g. 'Challenges in long-term care in Europe. A study of national policies' European Commission 2018 and 'Adequate social protection for long-term care needs in an ageing society. Report jointly

"everyone has the right to affordable and good quality long-term care services, in particular home care and community-based services". Also, many documents dedicated to specific social groups mention social services as an extremely important element of the social policies implemented. Poland has committed itself to taking action in favour of persons with disabilities by ratifying in 2012. Convention on the Rights of Persons with Disabilities drawn up in New York on 13 December 2006. (Journal of Laws 2012, item 1169 and 2018, item 1217). According to Article 19 of the Convention, persons with disabilities are granted the right to access "a wide range of support services provided at home or in institutions providing accommodation and other support services provided in the community, including personal assistance necessary for living and inclusion in the community and to prevent isolation and social segregation". Other social groups are also mentioned in other documents of international organisations, including the UN, the European Union or the Council of Europe. Access to social services is beginning to be prioritised in the context of the development of new social policy instruments.

With this in mind, measures should be taken to develop social services in the community to meet the needs of people in need of support in their daily life, by developing and implementing a comprehensive system of social service delivery that will guarantee the possibility for a person in need of support to make an undetermined personal choice, the most optimal form of service delivery.

Social services, according to the latest research and EU guidelines in this area, should be organised in a way that provides the most supportive and optimal conditions for people in need of support in their daily life. Hence, it is assumed that social services in the future should be more deinstitutionalised, which means the development of community-based services at the place of residence.

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prepared by Social Protection Committee and the European Commission" 2014), LTC is services and assistance for people who, due to physical or mental frailty or disability, require assistance with activities of daily living for a prolonged period of time and/or require continuous nursing care. The LTC system is understood as a combination of social and care services and cash benefits funded in whole or in part by the social security system. Whenever the term "long-term care" is used in this document and no other definition is indicated (e.g. from national health care legislation), it is to be understood in accordance with the referred European definition.

The document "Strategy for the development of social services, public policy until 2030 (with an outlook until 2035)" constitutes public policy within the meaning of the Act of 6 December 2006 on the principles of development policy (Journal of Laws of 2021, item 1057 and of 2022, item 1079).

On the national level, the idea of deinstitutionalisation has been present in Polish social policy for years. The document in question is part of Specific Objective II of the Strategy for Responsible Development until 2020 (with an outlook until 2030) - Socially sensitive and territorially balanced development, direction of intervention - Improving access to services, including social and health services, where deinstitutionalisation was indicated as an adopted direction of changes in the system of social services. In the Human Capital Development Strategy, deinstitutionalisation is included explicitly, among others, in the measures concerning foster care services and social services.

The document correlates with the National Programme for Combating Poverty and Social Exclusion. Update 2021-2027, Public Policy with an Outlook to 2030 (NPPUiWS)[3] , Strategy for Persons with Disabilities[4] , and the National Programme for the Development of the Social Economy until 2023. Social Solidarity Economy[5] . Issues of social inclusion for people of all ages, including through diagnosis of aptitudes and skills and skills development, are also highlighted in the public policy status document "Integrated Skills Strategy 2030"[6] .

The development of this strategy on deinstitutionalisation of social services in Poland is one of the criteria for fulfilling the basic conditionality for cohesion policy in the social area for the period 2021-2027 (condition 4.4, concerning the national strategic policy framework for social inclusion and poverty reduction).

The strategy, together with the document produced by the Ministry of Health entitled 'Healthy Future. A strategic framework for health system development 2021-2027,

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[3] Resolution No. 105 of the Council of Ministers of 17 August 2021 on the adoption of a public policy entitled 'National Programme for Counteracting Poverty and Social Exclusion. Update 2021-2027, public policy with an outlook to 2030" (M.P. pos. 843).

[4] Resolution No. 27 o f the Council of Ministers of 16 February 2021 on the adoption of the document Strategy for Persons The National Disability Council 2021-2030 (M.P. pos. 218).

[5] Resolution No. 11 of the Council of Ministers of 31 January 2019 amending the resolution on the adoption of the programme entitled "National Programme for the Development of the Social Economy" (M.P. item 214).

[6] General part of ZSU 2030: Resolution No. 12/2019 of the Council of Ministers of 25 January 2019, specific part of ZSU 2030: Resolution No. 195/2020 of the Council of Ministers of 28 December 2020.

with an outlook to 2030"[7] provides a common framework for the deinstitutionalisation process. Despite the development of two separate documents, which is due to the separation of the systems in Poland, they are complementary and complementary to each other.

The document is programmatic in nature and at this stage has no financial implications and does not constitute a basis for applying for additional funding. It is an indication of the direction of priorities and actions, which are primarily financed from sources already available. The new measures indicated in the individual priorities will not cause financial consequences for the public finance sector, nor will the level of financing planned from the state budget resources change. The Strategy for the Development of Social Services should therefore be used as intended as a strategic document indicating objectives and directions for the development of social services, using the indicated possibilities and indicative sources of financing.

[7] Resolution No. 196/2021 of the Council of Ministers of 27 December 2021.

Chapter I. DIAGNOZE

1. Family - children, including children with disabilities

The family is the natural environment for human birth and development. For this reason, it is the basic social institution that shapes the social structure through its functions. The fulfilment of the family's functions involves meeting the needs of its members, who are also members of society.

The last complete survey of families in Poland was carried out as part of the '*National Population and Housing Census 2021*'(NSP 2021). However, the overall results of the Census 2021 have not yet been published.[8] Therefore, for the purposes of this chapter, the results of the survey of families in Poland conducted as part of the 'National Population and Housing Census 2011' have been used. The 2011 data show that there were approximately 10 972.5 thousand families in Poland. Invariably, the most common family type remained a married couple with children. In 2011, there were 5 456.8 thousand such families and they accounted for almost half (49.7%) of the total number of families in Poland. Approx. 316.5 thousand families in Poland are partnerships (cohabitation), formed mainly by persons living in cities. More than half of these couples (171.3 thousand) were families with children. Just over 2 696 thousand marriages without children were recorded. More than one in four families was formed by a single parent with children. The number of single-parent families was 2,503 thousand, with about two thirds of these families living in the city.

In order to illustrate the more up-to-date composition of the family in Poland, a 2019 CBOS survey can be used.[9] According to them, almost half of Poles (49%) currently follow the model of a two-generation, nuclear family - consisting of parents and children. The percentage of people living in a large, multi-generational family is 22%, and in a marriage without children is 11%. One in ten people currently live alone (10%). The group living in informal relationships accounts for 3% and 1% are single.

The inter-census period included international panel surveys

[8] According to the CSO's timetable, the preliminary results of the Census 2021 on families will be published on the CSO Information Portal by November 2022. The preliminary results published in May 2022 do not cover the topic of families.

[9] CBOS Foundation, *Preferred and pursued models of family life*, Research Communication No. 46/2019. April 2019.

"Generacja i Rodzina"[10] , which shows that it is increasingly difficult to speak of a standard Polish family, but rather of a diversity of its forms. The dominant form is still marriage with a child or two children. However, more and more people who are in a relationship remain childless and, on the other hand, many couples consciously decide to have multiple children. Increasingly, marriages are breaking up and divorced spouses are creating new families or choosing to raise children on their own (mainly mothers). An increasing number of people are also choosing not to marry, even though they have children.

Household material situation

In 2020, there was an improvement in the material situation of households in Poland. The level of average monthly disposable income per person, rounded to the nearest PLN 1, was in 2020. - PLN 1919 and was 2.0% higher in real terms than in 2019. The average monthly expenditure per person in households reached PLN 1210 in 2020 and was 6.5% lower in real terms than in 2019. Expenditure on consumer goods and services amounted to PLN 1165 and was 6.2% lower in real terms than in 2019[11] . It should also be added that the impact on the decrease in spending may have been due to the SARS-CoV-2 coronavirus pandemic, e.g. through more cautious spending decisions, a decrease in the costs associated with the purchase of certain services due to their limited availability and others. In 2020, there was a further increase in the percentage of households assessing their material situation as either good or rather good (51.6% of households overall against 48.6% in 2019) and a decrease in the percentage of households perceiving it as either rather bad or bad (5.8% against 7.0% in 2019). Non-farm self-employed households had the best perception of their material situation (73.4% of positive ratings, almost unchanged compared to 2019), and the worst

[10] I. Kotowska, M. Mynarska head the Polish edition of the Generations and Families study within the international Generations and Gender Programme (GGP). The programme currently involves 21 countries - mainly from Europe. As part of the programme, panel studies are conducted every 3 years on a random sample of 15,000 to 20,000 respondents aged 18-79 in each country, https://forsal.pl/gospodarka/demografia/artykuly/8102395,badanie-nie-sposob-mowic-dzis-o-jednej-standardowej-polish-family.html.

[11] CSO, *Sytuacja gospodarstw domowych w 2020 r. w świetle wyników badania budżetów gospodarstw domowych*. Signal information, 31.05.2021, p. 1, https://stat.gov.pl/obszary-tematyczne/warunki-zycia/dochody-wydatki-i-warunki- zycia-ludnosci/sytuacja-gospodarstw-domowych-w-2020-r-w-swietle-badania-budzetow-gospodarstw- domowe,3,20.html.

pensioner households (23.5% of positive ratings compared to 22.4% in 2019). The subjective assessment of the material situation of households largely depends on the place of residence of the household. Households located in the countryside rated their material situation worse than those living in cities, especially the largest ones with a population of 500,000 or more, although in both cases the ratings, compared to 2019, improved significantly.

A very important objective measure reflecting the scale of the occurrence of a very difficult material situation is extreme poverty. The basis for determining the extreme poverty line is the subsistence minimum estimated by the Institute of Labour and Social Affairs (IPiSS). The subsistence minimum category determines a very low level of needs satisfaction. Consumption below this level hinders survival and poses a threat to the psycho-physical development of the human being.

In 2020, the extent of extreme poverty was around 5 per cent among people in households. It was 1 percentage point higher compared to 2019.

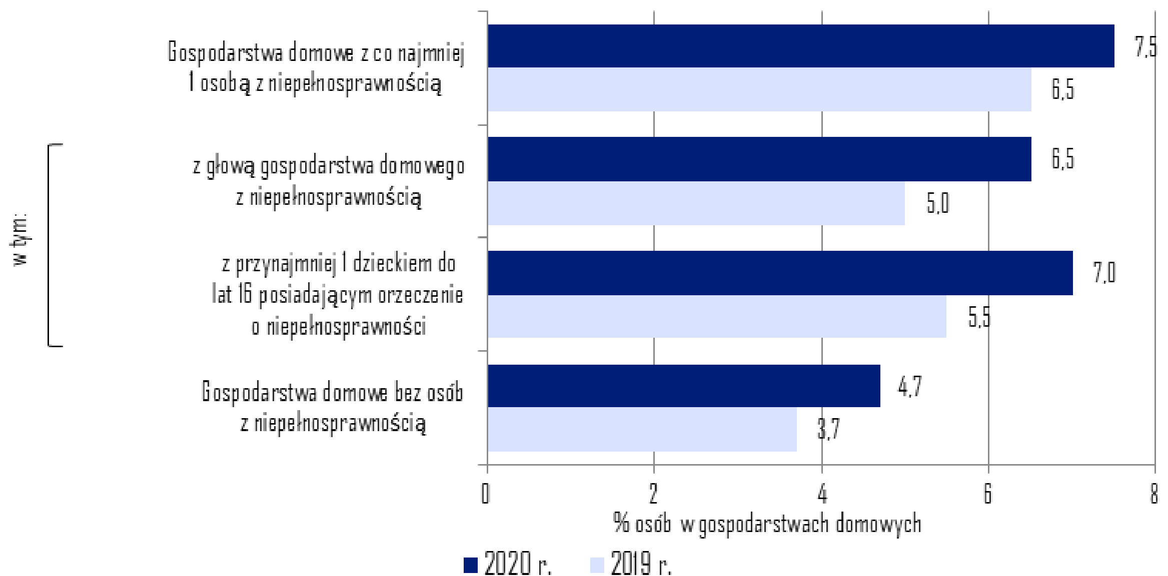
In 2020, households of farmers and households living mainly from so-called unearned sources were particularly exposed to extreme poverty (in both groups - almost 14% of people from these households). Among the latter, households living on social benefits other than pensions are noteworthy (around 15% of the poor). A higher than average level of extreme poverty also occurred in pensioner households (about 8%).

Households of those with a low level of education were also affected above average by extreme poverty. The poverty rate among households whose head (the head of the household (defined in the Household Budget Survey as the reference person) is a person over 16 years of age who earns the highest income among all household members on a consistent basis over a long period of time) had at most a lower secondary school education was more than twice as high as average and amounted to about 12% of persons in households. The percentage of the poor was also higher than average in the case of households of people with basic vocational education (about 8% of people). The group of households with a relatively high extreme poverty rate included households with persons with a disability certificate. The extreme poverty rate in households with at least one person declared disabled was 7.5%. A higher rate than the average for Poland

Extreme poverty in 2020 was also characterised by households with children under the age of 18. This was mainly the case for households with three or more children of this age (almost 9% of the poor), but also for households with two children (6.5% of the poor). The rate of extreme poverty among children and young people up to
18 was around 6% in 2020. If we consider the absolute changes in the incidence of extreme poverty between 2020 and 2019, expressed in percentage points, we find that the largest increases in the rate of this type of poverty were recorded for farmer households (by less than 4 percentage points) and households living on unearned sources (almost 3 percentage points). To a lesser extent - by about 2 percentage points - the percentage of poor people increased among pensioner households, as well as among households with at least three children under the age of 18. The extent of extreme poverty also increased by the same amount (i.e., by about 2 percentage points) among inhabitants of rural areas and the smallest towns and cities (less than 20 000 inhabitants), as well as among people from households in which the head had at most a lower secondary school education.
For the other population groups considered in the analysis, the values of poverty rates in 2020 were either at similar levels as in 2019 or the observed changes did not exceed 1.5 percentage points.[12]

[12] For more on the extent of economic poverty in 2019 and 2020, see the following CSO publications:
– Poverty in Poland in 2019 and 2020 (accessed: https://stat.gov.pl/obszary-tematyczne/warunki-zycia/ubostwo-pomoc-spoleczna/ubostwo-w-polsce-w-latach-2019-i-2020,1,10.html);
– Coverage poverty economic poverty w Poland w 2020 year (accessed: https://stat.gov.pl/obszary- thematic/living-conditions/poverty-support/poverty-economic-support-in-poland-in-2020,14,8.html

Figure 1: Extent of extreme poverty in 2019 and 2020, by presence of persons with an adjudication of disability in the household



Source: Range of economic poverty in Poland in 2020, CSO.

Family-friendly policies

In 2004. The Government Population Council indicated that "family benefits must supplement the family income to a level that allows the family to bring up the children properly. The level of benefits provided must provide a family with children with socially acceptable conditions of material existence. Families raising children must have access to all basic services of civilisation: health care, education, culture, leisure, they must create opportunities for the child to establish bonds and social contacts necessary for its development. The duty to assist families in creating appropriate conditions for the upbringing of children is the responsibility of public authorities"[13] . The issue was also seen in a broader perspective: "family assistance must not focus solely on the resources offered by social welfare institutions. Local family policy and family assistance must not focus on tackling the most visible and acute symptoms of poverty. Family assistance requires multidirectional programmatic and organisational activities building in local and working environments safe and friendly

[13] Government Population Council, *Sytuacja demograficzna Polski, Raport 2003,* Warszawa 2004, p. 18.

conditions and an atmosphere conducive to families raising children"[14] .

The development of a holistic and long-term family policy seems to be crucial for effective and efficient action in favour of the family in the context of the current demographic situation. It is also important that economic policies generating quality jobs are pursued alongside family policies. A. Sadowski believes that "universally available and well-paid work is the best family policy, and it can be implemented by reducing taxes on work and consumption in Poland"[15] . Thus, pro-family instruments will play a proper role when they complement the income earned from work allowing to support the family[16] .

Since 2015, the family has been at the centre of the government's social policy. Therefore, numerous state policy measures are being taken in favour of the child and the family. An example of such action is the government programme "Family 500+", which is the financial foundation of family support. The programme came into force on 1 April 2016 and has significantly improved the material situation of families, strengthened them and given them due priority. As a result of the launch of the government programme "Family 500+"there has been a significant increase in the share of state expenditure on family policy. Under this programme, families with dependent children are entitled to an upbringing benefit of PLN 500 paid monthly per child up to the age of 18, regardless of the family income. The second government programme supporting the family is the "Good Start" programme, under which support is provided as an investment in the education of Polish children in the form of PLN 300 in one-off support for all pupils starting the school year. Families receive the benefit regardless of income. This is support for 4.4 million pupils. The "Good Start" benefit is available once a year for a child studying at school until they reach the age of 20. A disabled child attending school is entitled to the benefit until they reach the age of 24. In turn, the 'Maluch+' Programme supports the development of childcare institutions for children up to the age of 3 - crèches, children's clubs and day carers. Its aim is to increase territorial and financial accessibility

[14] Ibid, p. 19.
[15] Ibid, pp. 2-3, [read: 18.10.2019].
[16] T. Zych, K. Dobrowolska, O. Szczypiński (ed. T. Zych), Report *Jakiej polityki rodzinnej potrzebuje Polska?* Institute for Legal Culture Ordo Iuris, Warsaw 2015, p. 9, http://demografia.ordoiuris.pl/Jakiej_polityki_rodzinnej_potrzebuje_Polska.pdf.

care places in crèches, children's clubs and day carers for all children, including children with disabilities and those requiring special care. The most recent measure introduced by the government, which took effect from 1 April 2022, is a subsidised reduction of the fee for a child's stay in a crèche, children's club or with a day carer - another instrument to support families. We know that access to care facilities for the youngest children is important for parents. Subsidies will be available to parents for a child attending a crèche, a children's club or under the care of a day-care provider and not using the family care capital.

Children deprived of parental care

One of the most sensitive aspects of pro-family policy in Poland is the problem of the adequacy of support for children deprived of parental care. The support system for this group of children is based on family foster care and institutional foster care. The most desirable and basic element of the support system for children deprived of the care of their biological parents are foster families.

However, special support tools should primarily target families in order to prevent the need to separate the child from his or her family.

According to MRiPS data, in 2020:

– 55,772 children were in family care of all types,
– there were - 16 291 children in institutional care of all types.

There were - 72,063 children in the entire custody system. It should be noted that the number of children indicated above also includes persons over 18 years of age who stay in the existing forms of foster care until they reach the age of 25, if they are studying (at the end of 2020 - 12,088 persons).

The aforementioned data shows that family care is by far the better developed area of support for children deprived of the care of biological families. However, the share of institutional foster care in the total number of children in the system is still quite high, at 23%. It is noticeable that the number of children in foster care overall is decreasing. For comparison, in 2016 there were 56,544 children in family care and 18,213 children in institutions. This means that in 2016, a total of 74,757 children were in the foster care system, including 12,253 children over the age of 18. It is evident

therefore a change in the number of children in care, as the number at the end of 2020 year decreased by 2694 people, or 3.60%.

The deinstitutionalisation of foster care also took place over the 5-year period, as the number of children in institutions fell by 10.55% (2016 - 18, 213, 2020 - 16, 291). Moreover, there was also a 17.6% decrease in the average number of foster carers (2016 - 17, 2020 - 14).

The right to live in a family is one of the most important and fundamental rights of a child, therefore the most desirable state is that children should not have to use the foster care system at all, and if they do, it should preferably be a family-type care. It should also be noted that in Poland, children are also accommodated in 24-hour long-stay institutions - functioning within various other systems, i.e.: social assistance, health care and education.

Children with disabilities in 24-hour institutions

Children deprived of parental care who are affected by illness or disability have their care and nurturing needs secured through various systems.

In the foster care system, children with disabilities primarily reside in

w:

– specialist foster families,
– specialised therapeutic facilities,
– regional care and therapy facilities,
– intervention pre-adoption centres.

Public statistics show that a total of 2017 children with disabilities were in institutional foster care in 2020, while 6446 children were in family care. Thus, of the 8463 children with disabilities and chronic illnesses in foster care, 23.83% of the children were in institutional care.

In addition, it should be noted that children with disabilities also reside in institutions of the social welfare system - i.e. in social welfare homes for children and young people with intellectual disabilities.

The number of social care homes for children and young people with intellectual disabilities in 2020 was 39, a decrease of 12 compared to 2016. The number of people up to the age of 18 residing in this type of home at the end of 2020 was 698. Practically

all children placed in residential care homes are referred for health and fostering reasons, including those diverted from family and institutional foster care.

According to statistical data, in 2020, the number of children over the age of 18 who left foster care was 6409, of whom 3939 adults left family forms of foster care. Full-term family care leavers established their own households in 79% of cases (3095 persons), which should be considered a very good result. Of the adults who left foster care in 2020, 159 returned to their natural families, while of the adults who left family foster homes, 19 returned to their natural families. A group of 10,240 alumni aged 18-24 remain in their current foster families and family children's homes.

In turn, 2474 adult persons left foster care institutions, of whom 771 persons (i.e. 31%) returned to their natural families, while 1278 persons (i.e. 52%) established their own households. This fact, in comparison with 79% of children who established their own households when leaving foster families, seems to indicate that children - alumni of institutional foster care - are less well prepared for their start in adulthood. As of 31 December 2020. 1848 children aged 18-24 still remain in foster care.

SUMMARY OF SUPPORT ELEMENTS

Support for community-based services

In the support system, the family receives service support in the form of:

– family assistantship,
– a personal assistant for a person with a disability,
– care services, including specialised services,
– respite services,
– day-care centres for children,
– assistance family support, support daytime for children with disabilities,
– rehabilitation and therapeutic support in an early intervention centre, facility

education and training,

– nutritional support for children under government programmes.

Financial assistance support

Families in need of financial support can benefit from various forms. Among these forms we distinguish:

– family benefits, including family allowances with the corresponding allowances,
– attendance allowance aimed at a parent giving up employment and caring for a child with an appropriate certificate of disability or a significant degree of disability,
– maintenance fund benefits payable in the event of ineffective enforcement of maintenance,
– social assistance benefits.

In Poland, all families raising children can receive financial support in
under the universal (no income criterion) "Family 500+" programme and
"Good Start" addressed to parents, including parents who have adopted a child, and foster families, those running family children's homes, directors of care and educational institutions, directors of regional care and therapeutic centres where school-age children are brought up. Programme
"Family 500+" as a systemic support for families was introduced on 1 April 2016 on the basis of the Act of 11 February 2016 on state aid in upbringing of children (Journal of Laws of 2022, item 1577). Its aim is to improve the material situation of Polish families (primarily to reduce child poverty) and to create conditions facilitating the decision to expand the family (pro-natalist objective). The source of financing of the "Family 500+" Programme is the state budget. Under the government programme "Family 500+", families with dependent children are entitled to an upbringing benefit in the amount of PLN 500 for each child up to the age of 18. As of 1 July 2019, the upbringing benefit is universal and is due regardless of family income. In addition, in line with the changes introduced from 2022 onwards under the programme
"Family 500 +", parental benefit is available for children placed in foster care
substitute in lieu of the benefit allowance paid to date

upbringing allowance under the Act on Support for the Family and the Foster Care System. Therefore, persons who have been receiving an upbringing allowance so far, i.e. foster families, persons running a family orphanage, directors of foster care centres, directors of regional foster care centres and directors of intervention pre-adoption centres, may also apply for an upbringing allowance for children placed in foster care.

Childcare support for children deprived of parental care

Foster families

It is the most desirable and fundamental element of the support system for children deprived of the care of their biological parents. The forms of family foster care are:

1) foster family:
   a) related,
   b) reliable,
   c) professional, including professional acting as a family emergency service and professional specialist;
2) family orphanage.

Foster families and family children's homes can be supported by support families.

Family children's homes are run under the conditions of a family home for up to 8 children and persons who have reached the age of majority and remain in foster care while continuing their education. The rules of their operation are laid down by law, and the detailed scope of services is determined by an agreement with the entity commissioning the task.

Institutional foster care

Childcare is organised institutionally. The typology of institutions is differentiated by their profile. Institutional foster care is provided in the form of:

1. foster care facilities,
2. regional care and therapy facilities,
3. intervention pre-adoption centres.

The following types of foster care facilities are in operation:

– family care (from a functional point of view, it is part of the family care system replacement),
– intervention,
– socialisation,
– specialist-therapeutic.

Residential care homes (DPS)

The DPS houses children and young people with intellectual and motor disabilities. These are children referred on the basis of a family court decision or at the request of a parent - with the consent of the family court. Some of them are referred to the social welfare home after a previous stay in a foster family or an educational institution.

RECOMMENDATIONS

In terms of prevention activities:

– promoting the family as the natural environment for raising children,
– support for families with a child with a disability from birth or the onset of disability disability throughout life,
– the promotion of family-friendly employment (FTE) measures, bringing together the interests of both working parents and their employers,
– to continue and develop various forms of support for families with children, including universal and simple material support to offset the costs of indirect taxes paid for raising children,
– promoting actions aimed at increasing parents' knowledge and competence in meeting their children's needs, in particular protecting their rights,
– Coordinate and harmonise multiprofessional cooperation with and for the family in order to strengthen internal and external resources to meet the child's developmental needs independently,
– supporting family sustainability through, inter alia, the organisation of local support groups, parent/carer schools, family counselling, family assistants,

– implementing solutions to increase the participation of the child at risk of or separated from his or her family in decisions that affect him or her.

In terms of the development of social services aimed at supporting families with children:

– conversion of current 24-hour facilities supporting children and parents with special needs in order for them to provide community-based forms of re-socialisation, therapy and parenting support activities,
– the development of providers of family therapy and psychotherapy in a permanent, easily accessible and affordable way,
– the development of various forms of day-care centres with offers for children and families (accessible to all families and children),
– educational, cultural, sporting and recreational offerings for families and those raising children, with a particular focus on children,
– support by household trainers,
– development of correctional and educational programmes for violent people,
– support by support families (including specialised families of a therapeutic),
– participatory methods of working with families, aimed at stimulating wider family and/or community/neighbourhood resources,
– the development of various forms of care for children up to the age of three (care organised in the form of a crèche or children's club, as well as by a day-care worker and a nanny),
– Increasing the number of nursery school places, the number of day-care centres run in the form of care and specialised services,
– supporting families with special needs: large families, single-parent families and families with people with disabilities through care services, assistant services, respite care, day care, etc.

In terms of supporting a child in crisis:

– development of a network of community psychological and psychotherapeutic support centres for children and young people,

- the development of free, round-the-clock child and adolescent helplines staffed by professionals, including psychologists, psychotherapists,
- the development of small facilities, such as family children's homes, in return for reducing places in large centres,
- promoting foster and adoptive parenthood,
- implementing solutions focused on accelerating the achievement of stability of the child's life after separation from the family,
- supporting families with multiple problems,
- supporting families adopting children,
- creation of a system of foster families and family-type children's homes and family-type institutions to replace the existing institutional foster care institutions,
- further deinstitutionalisation of foster care facilities,
- creating local foster parent community support groups,
- reducing the number of places in children's residential homes in favour of others non-institutional forms of support for children with disabilities,
- supporting the process of empowerment of foster care alumni, with particular emphasis on people with disabilities,
- an audit of the situation of children placed in foster care within the framework of the implementation of the European Funds for Social Development Programme, by means of a teleinformatic system comprising a central register of vacancies in foster care and a central register of foster care institutions, thanks to which it will be possible to analyse the situation of children placed in foster care and to develop an action plan for stabilising the situation of children and for their eventual emancipation.

2. older people

The boundary at which old age begins in a person is sometimes defined differently. According to the definition contained in the Act on Older Persons of 11 September 2015 (Journal of Laws, item 1705), an older person is a person who has reached the age of 60 (Article 4, point 1 of the aforementioned Act). Demographic analyses on population ageing often use the concept of post-working age, i.e. the age which entitles to retirement. Currently in Poland, it is most often 60 years for women and 65 years for men.

The strategic directions of the senior citizen policy currently being implemented in Poland are set out in the government document entitled: 'Social Policy towards Older Persons 2030. Safety - Participation - Solidarity', which was adopted by the Council of Ministers on 26 October 2018.

Population ageing

The process of demographic ageing of the population has been observed in Poland for a long time. It manifests itself in an increase in the proportion of older people among the total population. This process is caused, inter alia, by a low birth rate, increasing life expectancy and a negative migration balance. Between 2009 and 2019, the number of people in the 60+ age category for women and 65+ for men increased by 2 096 328 (from 6 311 615 to 8,407,943), i.e. by 33.2%, and the share increased by 5.4% (from 16.5% to 21.9%). The population projection to 2050 envisages a continuation of the existing trend. According to the assumptions of the demographic forecast developed by the Central Statistical Office, covering the period up to 2050, in the adopted perspective there will be a significant reduction in the number of children and adults, while the number and share of elderly people will increase. In relation to 2013, the decrease in the number of children aged 0-14 is estimated at 1.65 million; consequently, the number of children in 2050 (4.96 million) will account for 71.4% of their number in the base year of the forecast (68.4% in urban areas and 75.2% in rural areas). In contrast, the number of adults (15-64 years) will decrease by 8.3 million in the 2050 outlook; in terms of numbers, the stock of this population group at the end of the forecast period will account for 61.5% of the 2013 stock in cities and 81.2% in rural areas. The reduction in the shares of children and adults means an increase in the proportion of older people (65+). By the end of the forecast horizon, an increase of 19 percentage points is expected in urban areas, slightly less in rural areas - by 16.8 percentage points. As a result, the share of older people will exceed 30% in rural areas, while in urban areas it will approach 35%. Nationally, the size of this population will increase by 5.4 million in 2050 (...). The course of changes in the size of the 65+ subpopulation coincides with the occurrence of birth highs and lows in the second half of the last century. After 2020, the dynamics of the process will slow down until 2035, after which - until 2050. - There will again be a significant increase in the size of this population group as a consequence of many of the 1970-1985 cohorts entering old age. In the last year of the

of the projected period, the number of people aged 65 and over will represent in cities 179.3% of the 2013 stock and 224.9% - in rural areas.[17]

It is also possible to notice the process of the so-called double demographic ageing, consisting in the increase, among the elderly, of the share of elderly people (80 years and over or 85 years and over)[18] . Another phenomenon common in the modern world is the feminisation of old age, i.e. the increasing prevalence of women over men as they move up through the age groups, which is linked to the higher life expectancy of the former. In 2019, among those aged 60-64, women accounted for 53.0%. As age increased, this share increased. For those in the 65-69 age bracket, it was 55.2%, 70-74 years 57.8%, 75-79 years 61.7%, 80-84 years 66.1%, while for the population aged 85 and over it was as high as 71.9%[19] .

Promoting active ageing

A prerequisite for successful ageing is good health, a low risk of disability and the maintenance of an active life, expressed in a high level of physical, mental and social fitness. Keeping older people active is also facilitated by their participation in various initiatives aimed at them by local government units, NGOs and other entities.

Universities of the Third Age (hereafter: 'UTAs') play an important role in keeping seniors active in life. These are institutions that enable older people to be included in the lifelong learning system, offering non-formal education that is not crowned with certificates of knowledge and skills, but is rich in form and content[20] . UTAs usually bring together people with tertiary education and living in cities. Thus, they are not representative of the entire senior population, including those living outside large population centres. According to a recent study by the Central Statistical Office, 640 U T A s were active in Poland in the 2017/18 academic year. UTW classes were attended by 113 193

[17] CSO *Demographic situation of the elderly and consequences of population ageing in Poland in the light of projections 2014-2050.*
[18] P. Błędowski, *Sytuacja osób starszych w województwie śląskim (Situation* of *older people in the Silesian Voivodeship),* Expert opinion commissioned by the Regional Centre for Social Policy in Katowice, Warsaw, November 2013.
[19] Central Statistical Office, *Bank...*, op. cit.
[20] Z. Hasińska, E. Tracz, *The role of third age universities in active ageing*, [in:] *Social Science* 1(7)2013, University of Economics in Wrocław, Wrocław 2013.

seniors.[21]

A large group of older people are also active as volunteers, e.g. in non-governmental organisations, parishes, housewives' associations or senior citizens' clubs. Many older people support their families by caring for grandchildren or their elderly parents. In addition, older people usually know their local environment well and help each other out through neighbourhood self-help.

Another example of measures to support seniors is the 'Senior+' long-term programme, implemented since 2015 by the Ministry of Family and Social Policy and addressed to local government units (formerly the 'Senior-WIGOR' Programme). The objective of the Programme is to increase active participation in the social life of seniors by developing the infrastructure of support centres in the local environment and increasing the number of places in "Senior+" facilities, while co-financing the activities of local government units in the development of a network of "Senior+" Day Care Centres and "Senior+" Clubs in their areas. The new edition of the "Senior+" multiannual programme for 2021-2025 was adopted by Resolution No. 191 of the Council of Ministers of 21 December 2020 on the establishment of the multiannual programme
"Senior+" for 2021-2025 (M.P. 2021, item 10).

As part of the implementation of the 2015-2020 'Senior+' multiannual programme to date, local government units have established a total of 970 'Senior+' support centres in the country by the end of 2020, including 308 'Senior+' Day Care Centres and 662 Clubs "Senior+", which offer more than 23,000 day support places for older people.

In the 2021 edition, funding has been granted for the creation of 113 new facilities, i.e. more than 2,500 places for seniors, and 560 existing Senior+ clubs and homes will receive funding (approximately 14,000 places).

Among the measures aimed at supporting the social activity of senior citizens is the 'Active+' programme implemented by the Ministry of Family and Social Policy, under which non-governmental organisations and other eligible entities can apply for funding for projects aimed at senior citizens. The multiannual programme for

[21] Central Statistical Office / Subject areas / Education / Education / Higher education and its finances in 2020; Universities of the Third Age in the academic year 2017/2018

The "Active+" Programme for Older Persons for 2021-2025 was adopted by Resolution No. 167 of the Council of Ministers of 16 November 2020 on the establishment of the "Active+" Multiannual Programme for Older Persons for 2021-2025 (M.P. item 1125). In this year's edition of the competition, more than 290 entities received support for an amount exceeding PLN 37.5 million. Under Priority I of the Programme, non-governmental organisations can implement initiatives aimed at supporting independence, which include the following activities:

– services for meeting daily living needs, maintaining hygiene, maintaining and developing contacts with the community and family,
– training in self-care and daily living skills and functioning in society,
– supporting the development and establishment of home services networks,
– training for informal carers aged 60+.

Table No. 1. Number of participants - seniors 60+ receiving support in ongoing government programmes between 2016 and 2020

Programme/year	2016	2017	2018	2019	2020
Multiannual programme "Senior+" for the years 2015-2020 (Senior+ Programme)	2772	5010	11 508	19 082	25 073
Government Programme for Social Activities for Older People 2014-2020 (ASOS Programme)	128 560	179 338	106 088	156 152	146 397

Source: MRiPS report.

The material situation of older people

The main source of income for persons aged over 60 (F) and 65 (M) is pensions and disability benefits. Their average amounts at the end of 2020 were: in the case of old-age pensions from the non-agricultural social insurance system - PLN 2544.90, disability pensions from the non-agricultural social insurance system - PLN 2042.02, and benefits for individual farmers - PLN 1376.40. The ratio of the average monthly pension from the non-agricultural system to the average monthly remuneration less social security contributions was in 2019. 56.4% (in 2009. -

60,8%). For individual farmers, the ratio was 30.4% in 2019. (in 2009 - 35%), and the average disability pension from the non-agricultural social security system - 36.9% of the average gross wage (in 2009 - 36.7%). Although poverty risk indicators for people aged 65+ are currently lower than the average for the population as a whole, recent studies indicate that the problem of poverty among seniors is becoming increasingly visible. It appears in both household budget surveys and opinion polls. However, in the case of the statutory poverty incidence rate, there has been a decrease from 7.0% in 2016 to 6.5% in 2019. On the other hand, according to the 2021 survey conducted by the Centre for Public Opinion Research, it appears that financial situation is significantly related to age, among other factors. Older respondents were worse off, with 22% of respondents aged 65 or over declaring that they live very poorly or modestly, compared to 14% for the entire population surveyed. The above process is likely to intensify as people enter retirement age who have experienced long-term unemployment, work in the shadow economy or minimum wage remuneration in their working lives. It should also be borne in mind that people aged 60+/65+ are much more likely than other age categories to face increased health and care expenses. A strong correlation can be observed between reaching advanced age and the likelihood of disability and long-term, often bedridden illness. Thus, the increasing number of seniors translates into an increased need for daily support and care[22] . Those a g e d 80 and over are recognised as needing ongoing support in the vast majority of cases[23] .

Between 2009 and 2019, the number of people aged 80+ increased by 434,515 (from 1,257,221 to 1 691 736), i.e. by 34.6%, while their share of the total population increased from 3.3% to 4.4%. The projection to 2050 shows a continuation of the above trend. At the end of this period, the number of people aged 80+ is expected to be 3,537,498, 109.1% more than in 2019, and their share of the total population to be 10.4%, which will represent an increase of 6.0 percentage points over the

[22] P. Szukalski, *Population ageing in the Silesian Voivodeship - an inevitable increase in demand for public support?*, *in+: Regionalny Ośrodek Polityki Społecznej Województwa Śląskiego, *Seniorzy w województwie śląskim*, Katowice 2012.
[23] id.

2019 r.

The process of ageing of the population results in an increase in the value of the dependency ratio[24] . In the years 2009-2019, this coefficient increased from 55.0 to 66.7. Taking into account the ongoing socio-demographic changes, it is forecasted that this negative trend will continue to deepen, thus decreasing the caring potential of families in Poland. The projection developed until 2050 indicates that at the end of this period the dependency ratio will reach 104.7 in Poland.

According to the canons of today's gerontology, the basic aim of measures for the elderly is to maintain their autonomy for as long as possible and to ensure a high quality of life by enabling them to function independently in the environment in which they have lived through earlier stages of their lives and to which they have become accustomed[25] . For this group of people, therefore, the following are of particular importance: care services, personal assistant services for the disabled, neighbourhood services, voluntary work, telecare and community infrastructure, e.g. in the form of day care homes, senior citizens' clubs, self-help clubs and supported housing.

According to the data, at the end of 2020, there were 1,478 elderly people awaiting placement in DPS (at the end of 2010 there were 1,901)[26] . In 2020, the number of DPS residents decreased (influenced, among other things, by the ongoing epidemic in 2020 caused by the spread of the SARS-CoV-2 coronavirus).

Seniors and others in need of support can also use the services of 24-hour facilities operating within the health c a r e system - nursing and care facilities.

In the context of providing support to older people in need of ongoing care, the support of their informal carers, who in many cases are also over 60 years of age, should not be overlooked. In addition, the health of those providing daily long-term care deteriorates over time, making it less effective. Long-term care can negatively affect the psycho-physical health of carers - the

[24] Population of non-working age (pre-working and post-working) per 100 people of working age.
[25] P. Szukalski, *Ageing...,* op. cit.
[26] Source: Report MPiPS-05 for 2010 and MRPiPS-05 for 2020.

causing them to require care and support more quickly and thus no longer be able to care for their loved ones themselves. respite care can help to counteract these negative situations. The aim of respite care is to relieve the burden on family members or carers of people who require intensive support by helping them with everyday tasks or by providing a temporary substitute for them. This gives carers time to rest and recuperate, as well as to run essential errands. A respite care service can also be used to periodically provide for the needs of a person with a disability when the carer, for various reasons, is unable to perform his or her duties for a certain period of time, e.g. due to a stay in hospital or a sanatorium[27] .

Elements of the support system

Care services

Residential care services are a basic social service aimed at people from all areas of deinstitutionalisation support. Families, older people, people with disabilities, people in mental health crisis, people in homelessness crisis are all potential recipients of these services. The table below shows a comparative overview of services.

Table No. 2 Number of benefits and municipalities - care services at the end of 2016 and 2020

SPECIFICATION		**2016**		**2020**	
		number benefits/ municipalities	**% of municipalities to their general numbers**	**number benefits/ municipalities**	**% of municipalities to their total numbers**
NUMBER OF BENEFITS - SERVICES TOTAL CARE	1	33 813 200		34 551 443	
of which (from line 1) NUMBER BENEFITS - SPECIALISED SERVICES CARE	2	1 208 823		1 365 914	
NUMBER OF GMINAS IN WHICH THEY WERE care services provided	3	2048	82,65%	2213	89,34%

[27] Ministry of the Family and Social Policy, *Programme "Wytchnieniowa Opieka wytchnieniowa" - edition 2021*, Warsaw, December 2020, https://www.gov.pl/web/rodzina/komunikat-o-ogloszeniu-programu-opieka-wytchnieniowa---edycja-2021.

of which (from line 3) NUMBER of municipalities in which there were specialised services provided care services	4	252	10,17%	309	12,47%
NUMBER of municipalities where no services were provided care	5	430	17,35%	264	10,66%
NUMBER of municipalities where no specialised services were provided care services	6	2226	89,83%	2168	87,53%
TOTAL NUMBER OF MUNICIPALITIES	7	2478		2477	

Source: own compilation of the MRiPS on the basis of annual reports MRPiPS-03 (in 2016 symbol: MPiPS-03).

From 2016 to 2020, we have seen an increase in the implementation of this task by municipalities: from 2016 to 2020, there was an increase of approximately 2% in the number of care services, while for the number of specialised care services, this increase was approximately 13%. There is also a systematic increase in the number of municipalities providing care services. In 2016, it was about 83% of the total number of municipalities, while in 2020 it will already be more than 89% of all municipalities. Unfortunately, there are still almost 11% of municipalities not implementing care services.

Sheltered housing

The care services described above are correlated with the provision of a service in the form of a stay in a sheltered housing. Sheltered housing can be run by any social welfare unit or public benefit organisation and aimed at support with different support profiles - from support for people with mental disorders to older people. The table below shows the status of this type of service in 2016 and in 2020.

Table 3. number of sheltered housing units comparatively 2016/2020 run by local government units (jst) or on their instructions

DATA ON SHELTERED HOUSING AT THE END OF 2016 AND 2020						
SPECIFICATION	**2016**			**2020**		
	number of units[1)]	number of places[2)]	number of people beneficiaries[3)]	number of units[1)]	number of places[2)]	number of people beneficiaries[3)]

RESIDENTS PROTECTED	1	703	2922	2774	1348	4098	3664

of which (from line 1): SHELTERED HOUSING TRENING[4)]	2				585	2120	1859
of which (from line 1): SHELTERED HOUSING SUPPORTED[4)]	3				763	1978	1805
of which {from line 1}: for persons leaving certain types of foster care and educational establishments, shelters, establishments correctional and other	4	318	1191	998	371	1333	1032
for persons with disorders mental	5	100	432	447	219	663	592

1) Number of units on the last day of the reporting period (31 December).
2) Number of seats according to statute.
3) Actual number of beneficiaries during the *reporting period.*
4) In 2016, there was not yet a distinction between sheltered training housing and supported housing.

Source: Report mrpips-03 (2016 symbol: MPiPS-03).

Between 2016 and 2020, the total number of sheltered housing units increased by almost 92% (from 703 to 1,348). The division into sheltered training and supported housing emerged after 2016, so it is not possible to compare the number of these housing units for 2016 and 2020. In contrast, several percent of the total number of sheltered housing units are sheltered housing units for people with mental disorders. The number of these flats in question has increased significantly over the years (from 100 in 2016 to 219 in 2020, an increase of 119%). Despite the significant development of this form of service, the number of sheltered housing units in 2020 is lower (1348) than the number of municipalities (2477), which means that statistically, sheltered housing units are not yet operational in every municipality.

The development of social services and the implementation of the deinstitutionalisation process necessitates legal changes and the standardisation of nomenclature in order to enable a wider range of services to be provided in the community and to increase their accessibility.

Legislative changes to housing are planned in the near future
protected, i.e. introducing the nomenclature - assisted housing with a basket of services.

Support centres

The service offer of community social services is supplemented by support centres of various types. Data on all s u p p o r t centres, specifying their typology, is presented in the table below.

Table 4. Number and type of support centres - comparative 2016/2020

DATA ON SUPPORT CENTRES AT THE END OF 2016 AND 2020					
SPECIFICATION		**2016**		**2020**	
		number of units[1)]	number of places[2)]	number of units[1)]	number of places[2)]
SUPPORT CENTRES	1	**1941**	**86 360**	**2362**	**84 811**
of which: (from line 1) SUPPORT CENTRES FOR PEOPLE WITH MENTAL DISORDERS	2	822	29 671	881	32 650
of which: (from line 2) Community self-help homes	3	779	28 579	844	31 975
Self-help clubs for people with mental disorders	4	32	566	37	675
DAY CARE HOMES	5	308	16 198	495	20 447
HOMES FOR MOTHERS WITH MINOR CHILDREN AND PREGNANT WOMEN	6	26	693	31	816
NIGHT SHELTERS, HOSTELS, HOMES FOR THE HOMELESS[3)]	7	297	12 551	X	X
SHELTERS FOR PEOPLE FREE	8	X	X	168	7 616
SHELTERS FOR THE HOMELESS WITH SERVICES CARE	9	X	X	33	942
self-help clubs (other than listed in line 4)	10	82	3082	456	11 574
OTHER SUPPORT CENTRES	11	270	8941	313	11 020

1) Number of units on the *last day of the reporting period (31 December).*

2) Number of seats according to statute.

3) In this row, not all unit types are support centres, however, up to and including 2016 they were not listed separately in the reporting.

Source: Report mrpips-03 (in 2016 symbol: MPiPS-03), except for data
Regarding ŚDS for the year 2016: Report mpips-05.
Between 2016 and 2020, the total number of support centres increased by approximately 22% (from 1941 in 2016 to 2362 in 2020). Over these few years, the number of each type of support centre increased, but the greatest growth was seen among self-help clubs, of which there were 82 in 2016 and already 456 in 2020, and among day care homes, of which there were 308 in 2016 and 495 in 2020. 495.

Family assistance homes

A family care home is a form of care and living services provided on a 24-hour basis by an individual or a public benefit organisation for no fewer than three and no more than eight persons living together who require support in this form due to age or disability. The standard of service provision by a family care home is set out in the Regulation of the Minister of Labour and Social Policy of 31 May 2012 on family care homes (Journal of Laws, item 719).

The development of this form of social service between 2016 and 2020 is illustrated in the table below.

Table No. 5. Number of family care homes and places in family care homes comparatively from 2016 to 2020

2016		**2017**		**2018**		**2019**		**2020**	
number of units[1)]	number of places[2)]	number of units[1)]	number of places[2)]	number of units[1)]	number of places[2)]	number of units[1)]	number of places[2)]	number of units[1)]	number of places[2)]
26	150	33	208	29	193	33	228	47	354

1) Number of units on the last day of the reporting period (31 December).
2) Number of seats according to statute.

Source: Report mrpips-03 (2016 symbol: MPiPS-03).

Between 2016 and 2020, the total number of family care homes (by almost 81%: from 26 in 2016 to 47 in 2020) and places in this type of institution (by 136%: from 150 in 2016 to 354 in 2020) increased. The largest increase is observed in 2020 relative to 2019. - the number of family care homes increased by 14: from 33 to 47 (an increase of more than 42%) and the number of places by 126: from 228 to 354 (an increase of more than 55%).

Residential care homes (DPS)

A residence in a social welfare home is entitled to a person in need of 24-hour care

due to age, illness or disability, unable to function independently in daily life and who cannot be provided with the necessary assistance in the form of care services in a residential environment. DPS offers comprehensive and interdisciplinary services. It provides living, caring, supportive and educational services at the level of the applicable standard, in the scope and forms resulting from the individual needs of its residents. The DPS can also provide care services and specialised care services for persons not residing there.

The organisation, scope and level of services provided by the DPS takes particular account of the freedom, intimacy, dignity and sense of security of the home's residents and the degree of their physical and mental capacity.

The detailed standard for the provision of services by a social welfare home is described in the Regulation of the Minister of Labour and Social Policy of 23 August 2012 on social welfare homes (Journal of Laws of 2018, item 734). The legislator has also provided for the possibility of the social welfare home to provide care services and specialised care services for persons not residing there, which means that these services may also be provided in the environment of the residence of a person in need of support.

A measure to be strengthened and emphasised is the development and expansion of intermediate forms of support providing care in social welfare homes in line with the idea of deinstitutionalisation, for example The development of voluntary work in the centres, the introduction of a form of supporting or befriending families for DPS residents, the possibility of providing care services and specialised care services by the home for those who do not reside there, respite care or the separation and creation of branches (single units, in existing DPS (within their structure) in order to provide services individualised to needs, aimed at strengthening the autonomy, subjectivity and dignity of the resident, as well as creating small micro-communities instead of houses with a large number of residents.

The total number of social care homes in operation, over a 5-year period,
is illustrated in the table below.

Table 6. number of social care homes between 2016 and 2020

House types	**2016**	**2017**	**2018**	**2019**	**2020**	**Comparison 2020:2016**	
						difference	difference %

Total number of municipalities and supra-municipal social welfare homes	816	822	825	823	826	10	1,2%

Source: mrpips-05 report (2016 symbol: MPiPS-05).

During the period under review, the number of social care homes increased by 10 units, of which more than 73% are run by local authorities. Despite the increase in the number of social care homes in 2020 relative to 2016, the total number of residents decreased. Details of this are shown in the table below.

Table 7. number of residents in nursing homes 2016-2020

SPECIFICATION	2016	2017	2018	2019	2020	Comparison 2020:2016	
						differen ce	difference %
Total number of total residents in DPS (as at 31 December), including for:	78 954	79 476	79 828	79 766	75 133	-3821	-4,8%
1) the elderly	7104	7105	6691	6686	5719	-1385	-19,5%
2) chronically somatically ill persons	13 996	13 952	14 047	13 734	12 157	-1 839	-13,1%
3) chronically mentally ill persons	20 605	20 809	20 755	20 494	19 765	-840	-4,1%
4. adults with intellectual disabilities	10 727	10 220	9931	10 438	9860	-867	-8,1%
5) children and young people with intellectual disabilities	3610	3078	3321	2561	2 649	-961	-26,6%
6) persons with physical disabilities	666	1037	819	669	704	38	5,7%
7) alcohol-dependent persons	60	57	60	60	147	87	145,0%
8) the elderly and chronically ill somatically ill	9677	9854	9533	9594	8687	-990	-10,2%
9) Chronically somatically ill persons and persons with physical disabilities	1411	1488	1554	1403	1505	94	6,7%
10. elderly and disabled persons physically	1569	1699	1638	1686	1453	-116	-7,4%
(11) adults with intellectual disabilities and children and young people with intellectual disabilities	5185	5741	5271	5579	5574	389	7,5%
12) other, in accordance with Article 56a(2) and (3) of the Act of 12 March 2004 on social assistance (Journal of Laws 2021, item 2268 and 2270 and 2022, item 1, 66 and 1079)	4344	4436	6208	6862	6913	2569	59,1%

Source*:* mrpips-05 report (2016 symbol: MPiPS-05).

During the period under review, the number of residents in social welfare homes decreased by 3821 people, a decrease of 4.8%. The largest number of residents is in homes for the chronically mentally ill.

In the context of discussing deinstitutionalisation processes, it is impossible not to point to data on the empowerment of social welfare home residents. The following

the table shows the number of home residents who have been granted independence over the last five years.

Table No. 8. Number of persons granted independence in social welfare homes in the years 2016-2020

SPECIFICATION	2016	2017	2018	2019	2020	Comparison 2020:2016	
						difference	difference %
Total number of persons granted independence in social welfare homes, of which:	324	311	333	324	338	14	4,3%
in supra-community houses	302	295	305	305	305	3	1,0%
in communal houses	22	16	28	19	33	11	50%

Source: mrpips-05 report *(2016 symbol: MPiPS-05).*

Between 2016 and 2020, the number of people emancipated from residential care homes increased by 4.3%.

It is also worth quoting the results of a survey conducted in 2020 by one of the Regional Social Policy Centres under the title 'Residents of social welfare homes promising to become independent'. The survey was conducted using the full method, covering 104 DPS operating in the region.

The study shows that in the region in 2020, 132 people ended their stay in social welfare homes by leaving the unit. The reasons for leaving the institution varied. Among them, one can mention:

-willingness of the resident to become independent (16 cases - 33%),

-no consent for further isolation (coronavirus) (14 cases - 29%),

-difficulties in adapting to the institution (13 cases - 27%),

-high cost of residence fees (12 cases - 25%).

The largest number, a total of 26 responses, was indicated in the 'other' category:

-change of DPS - 9 cases,

-return to family - 8 cases,

- transfer to a care and treatment facility - 3 cases,
- transfer to hospice - 2 cases,
- single situations: alcohol dependence; lack of ability to adapt to life in a DPS - conflictual nature; transfer of the person to the custody of a legal guardian on the basis of a court order and temporary stays in a DPS due to the winter period[28] .

SUMMARY OF THE SUPPORT SCHEME

In terms of community-based social services

An older person in need of support in daily living and their carers can expect service support in the form of:

– care services, including specialised services, provided at home,
– care services provided at a day support centre,
– care services provided in supported housing and family care homes.[29]

Relief services for carers under government programmes or EU-funded projects are also increasingly being offered.

In terms of cash benefits

Older people and their carers can also be provided with financial support, which includes cash benefits:

– from social assistance (allowances to meet the necessities of life),
– from the family benefits system,
– from the social security system (ZUS).

In terms of services provided in institutions

Persons who need 24-hour care and whose needs cannot be secured in a residential environment, due to their age and disability, are also entitled to

[28] Residents of DPS promising to become independent in the Śląskie Voivodeship. Report from research. Regionalny Ośrodek Polityki Społecznej Województwa Śląskiego 2020, https://rops-katowice.pl/strategie-programy-badania-raporty-i-analizy/.
[29] Currently, according to the Act of 12 March 2004 on social assistance, there are sheltered training and supported housing. After the planned amendment to the provisions of the Act, sheltered and supported housing will be replaced by assisted housing.

the possibility of implementing a stay and services in a social welfare home (DPS). The stay in a DPS is around the clock and residents are referred to the facility for permanent residence. DPSs are usually run by local governments or commissioned by local governments - therefore they are part of the public system. DPS run without a commission by local authorities are few in Poland (about 8%). A person in need of round-the-clock care can benefit from a stay in an institution providing round-the-clock care for persons with disabilities, chronic illnesses or the elderly. The activities of these facilities are aimed at people who require round-the-clock care due to age, illness or disability, who are not interested in services in the public service system and therefore choose to purchase services under a civil law contract. The operator of the facility undertakes to provide services on a basis agreed with the client and for a period of time agreed with the client.

RECOMMENDATIONS

In terms of prevention activities:

– supporting active senior citizenship by, inter alia, facilitating access to services provided by cultural, recreational and educational institutions, supporting the development of bodies for senior citizens and promoting the idea of volunteering among people in this age category,
– implementation of programmes aimed at seniors to alleviate the economic deficits of this group of people,
– promoting a balanced image of seniors as a group of people who are both recipients and givers of support (caring for grandchildren or elderly parents, neighbourhood self-help),
– promoting the extension of services from institutions in various areas not directly aimed at older people in order to keep them active,
– carrying out continuous monitoring at regional level of the demographic situation and activities carried out for older people,
– carrying out continuous monitoring of the economic situation of senior citizens.

Systematic solutions preventive carried out at at level local z involvement of multiple institutions and organisations can reduce the demand for

institutional forms of care.

In terms of developing community-based social services for people elders:

- supporting families with caring responsibilities for senior citizens,
- development and adaptation of the support system for the elderly to the needs of an ageing society, including through the development of good quality and affordable care services provided in a residential or community setting by professionally trained care staff,
- development of self-help clubs (including senior citizens' clubs), day care centres, care farms and family care homes,
- development of assisted housing,
- the development of alternative forms of support, such as neighbourhood services or telecare,
- development of voluntary activities in local communities and cooperation with NGOs in this regard,
- support for carers of people with intensive support needs who are ill, including through the development of respite care, including community-based facilities and 24-hour short-term care,
- informational, educational and psychological support for informal carers of people in need of support in their daily functioning,
- maintaining the resources of 24-hour care institutions at a level that is necessary and adequate for the number of people whose health and family situation make it impossible to provide care in a residential environment. Placing a person in a 24-hour institution should be the last, least desirable, link of support,
- adapting the system of social services to the ever-increasing needs of an ageing population.

3. People with disabilities

At least two definitions of persons with disabilities are used in Poland. The first one stems from legal regulations and concerns the legal basis for qualifying as a group of persons with disabilities. The second, much broader, is used in statistics

CSO. The statistical definition includes not only people with legally recognised disabilities, but also those who, although they do not have a disability certificate, declare the existence of limitations in performing selected activities. This is known as biological disability. The two independent questions on legal and biological disability used in statistical research make it possible to present data on the collective of people with disabilities in a breakdown into three basic groups, i.e. people with legal and biological disability, legal disability only and biological disability only.

Systemic measures for persons with disabilities are regulated in Poland by the Act of 27 August 1997 on Vocational and Social Rehabilitation and Employment of Persons with Disabilities (Journal of Laws of 2021, item 573 and 1981 and of 2022, item 558). The Act applies to persons with disabilities according to the accepted legal definition, i.e. those whose disability has been confirmed by an appropriate certificate. Tasks under the Act are performed by government administration bodies, bodies of local self-government units and the State Fund for the Rehabilitation of Persons with Disabilities (PFRON). The Strategy for Persons with Disabilities 2021-2030 provides for changes in the functioning of certain statutory instruments concerning persons with legal disabilities.

According to data from the Social Insurance Institution, as of December 2019, there were 2.4 million people in Poland[30] , receiving pension benefits and/or insured by contributory payers, who had a disability certificate (issued by the Disability Assessment Boards) or a certificate of inability to work (issued by the Social Insurance Institution)[31] .

The study population of people with a certificate was predominantly male, accounting for 53.7%. Taking into account age in the set of people with a disability or i n c a p a c i t y ,

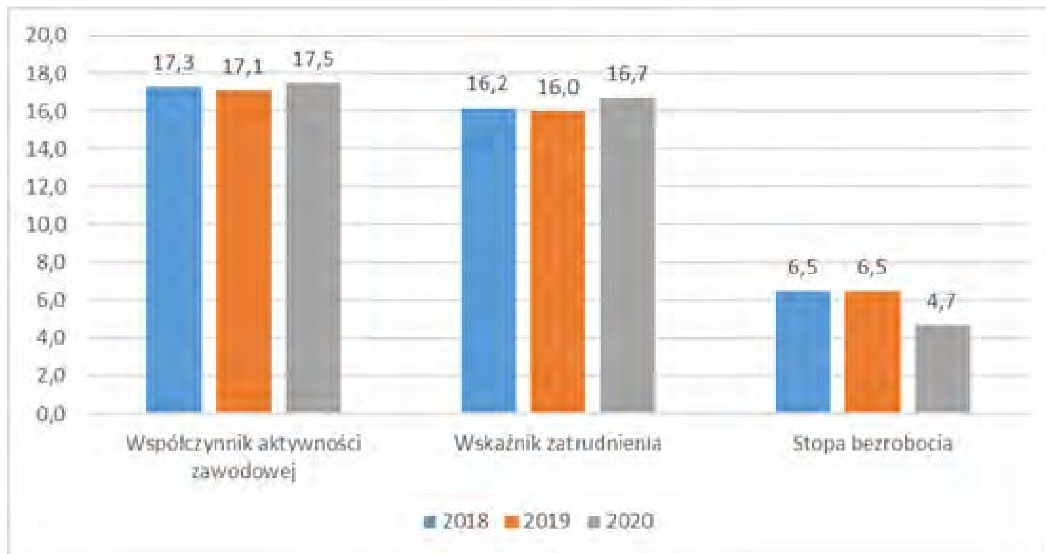
[30] Compiled on the basis of merged datasets from the information systems of the Social Insurance Institution and after removing repeated and blank observations. Central Statistical Office, *Persons with disabilities in 2019*, Signature information, 3.12.2019.

[31] Pursuant to Article 5 of the Act of 27 August 1997 on Vocational and Social Rehabilitation and Employment of Persons with D i s a b i l i t i e s , certain certificates issued by ZUS practitioners on inability to work, inability to lead an independent life and the advisability of retraining are treated on a par with a certificate on the relevant degree of disability. Central Statistical Office, *Persons with disabilities in 2019*, Signatory information, 3.12.2019.

The most common were men aged 64 (56.4 thousand). The largest number of women with a disability or inability to work certificate was a g e d 59 (33.7 thousand). Most men and women with a disability or inability to work certificate lived in the Śląskie Voivodeship (146.5 thousand and 120.7 thousand respectively). Half of the surveyed population lived in the Dolnośląskie, Małopolskie, Mazowieckie, Podkarpackie, Śląskie and Wielkopolskie Voivodeships. In counteracting social exclusion of people with disabilities, professional work, undertaken both on the open and sheltered labour market, plays a special role. It provides an opportunity to become independent in life and gain economic independence. Over the 2018-2020 period, the population of people with disabilities aged 16 and over, based on the Labour Force Survey/BAEL, decreased slightly (2018 - 3,040 thousand people, 2020 - 3,024 thousand people), but the number of employed people increased (2018 - 491 thousand, 2020 - 504 thousand people) and the number of economically inactive people decreased (2018 - 2,514 thousand, 2020 - 2,495 thousand). The improvement in the economic situation can also be seen in the analysis of economic indicators. The labour force participation rate increased by 0.2 percentage points. - from 17.3% in 2018 to 17.5% in 2020, the employment rate increased by 0.5 pp. - from 16.2% in 2018 to 16.7% in 2020, while the unemployment rate decreased by as much as 1.8 pp. - from 6.5% in 2018 to 4.7% in 2020. [32]

Figure 2: Economic indicators of disabled people aged 16 and over in years 2018-2020 (annual average figures):

[32] Due to the main goal of the survey, which is to provide data on the situation on the labour market, the LFS cannot be treated as a source of data on the size of the disabled population. Moreover, the LFS is a representative survey (the results are subject to sampling error) and covers only people living in private households (for this reason, the results do not take into account people staying in collective accommodation facilities, e.g. in care homes, etc.).

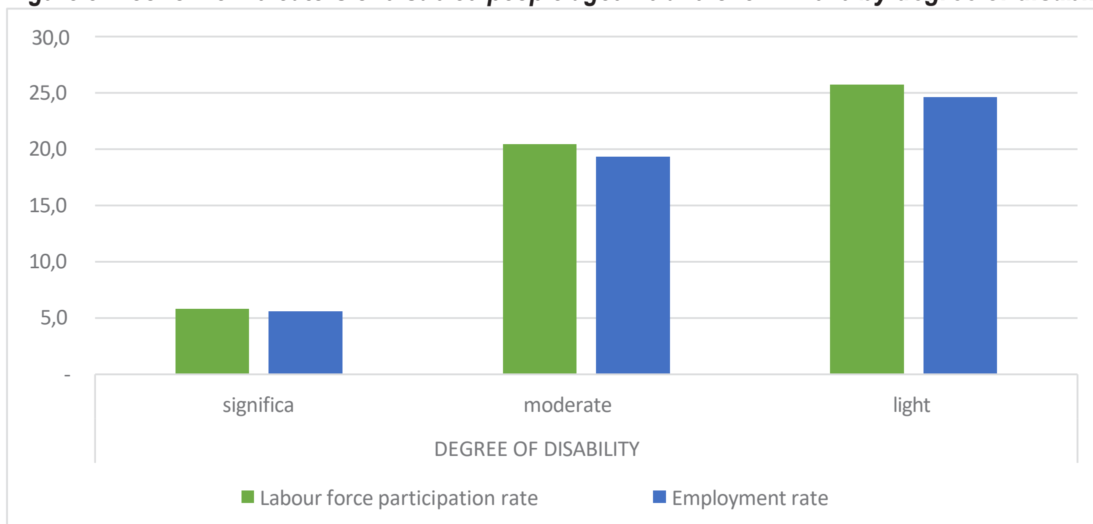


Source: own elaboration by BON at the Ministry of Labour and Social Policy on the basis of LFS data.

The situation for people with mild disabilities is relatively best in 2020, with a labour force participation rate of 25.7% and an employment rate of 24.6%.

The most disadvantaged are those with severe disabilities, with a labour force participation rate of 5.8% and an employment rate of 5.6%.

Figure 3: Economic indicators of disabled people aged 16 and over in 2020 by degree of disability:



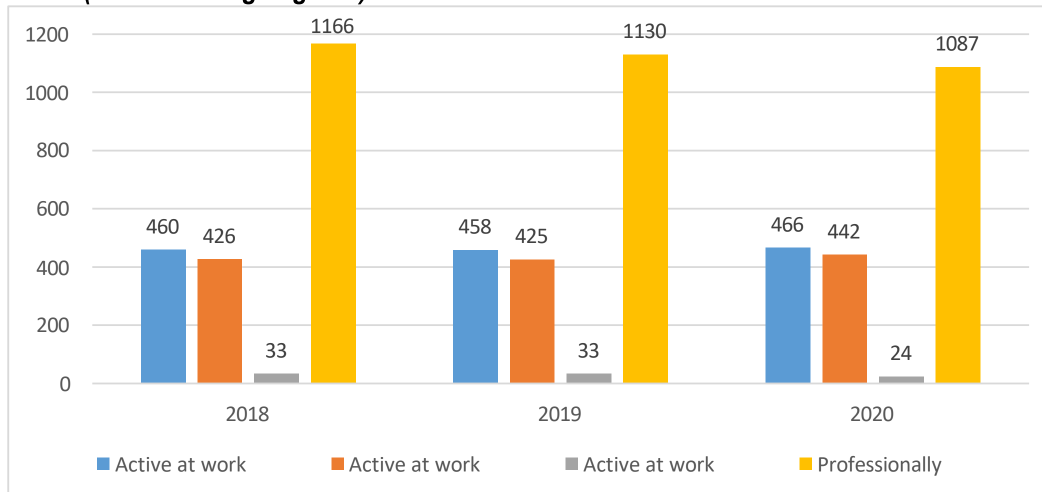
Source: own elaboration by BON at the Ministry of Labour and Social Policy on the basis of LFS data.

The population of people with disabilities of working age was in 2020.

1 553 000 people, of whom 466 000 were economically active (including 442 000 working),

and 1 087 000 people were economically inactive.

Figure 4: Economic activity of disabled people of working age in years 2018-2020 (annual average figures):



Source: own elaboration by BON at the Ministry of Labour and Social Policy on the basis of LFS data.

Compared to 2018, the population of people with disabilities of working age in 2020 decreases by 72 000 (-1 625 000 in 2018, 1 588 000 in 2019). In contrast, there is a gradual increase in the number of people in work (426 thousand in 2018, 425 thousand in 2019, 442 thousand in 2020) and a slight decrease in the number of unemployed: 2018 r. - 33 thousand, 2019. 33k, 2020. – 24 tys. Pozytywną zmianą jest zmniejszenie liczebności grupy osób biernych zawodowo z 1 166 tys. w 2018 r. do 1 087 tys. w 2020 r. In 2020, there is - compared to 2018. - a marked increase in the labour force participation rate of people with a legal disability of working age, i.e. by 1.7 percentage points (from 28.3% in 2018 to 30.0% in 2020), and an increase in the employment rate, i.e. by 2.3 percentage points (from 26.2% in 2018 to 28.5% in 2020). The unemployment rate fell from 7.2% in 2018 to 5.2% in 2020. Pursuant to Article 49(6) of the Act of 20 April 2004 on employment promotion and labour market institutions (Journal of Laws of 2022, item 690, 830 and 1079), unemployed persons with disabilities belong to the category of persons who are in a special situation on the labour market. For many years, there have been numerous social campaigns in Poland promoting employment and equality at work for people with disabilities. In spite of this, many economically active people with disabilities cannot find suitable work. It is therefore not surprising that the labour force participation of people with disabilities differs significantly from that of the general population in

Poland[33] . In 2020, the labour force participation rate for people with disabilities in Poland aged 16 and over was 17.5%, while the employment rate (indicating what proportion of the population aged 16 and over is in work) was 16.7%. On the other hand, for the total population, these rates were at the level of 56.1% (persons aged 15 and over) and 74.9% (persons of working age)[34] . Analysing data from the System for Subsidies and Reimbursements (hereinafter: 'SODiR') of the State Fund for Rehabilitation of Persons with Disabilities, the share of employees working in sheltered workplaces registered in SODiR in relation to the total number of employees with disabilities has a decreasing trend, while employment of persons with disabilities on the open labour market has increased. In addition, it is evident that the epidemiological situation in the country, as well as governmental restrictions and regulations aimed at minimising the transmission of the SARS-CoV-2 virus, has had an impact on the labour market situation. In particular, in the open labour market, a clear decrease in the employment of workers with disabilities registered in the SODiR can be seen from November 2019 to April 2020. From May 2020 onwards, with the stabilisation of the situation in the country and in the labour market, employment in the open market started to slowly increase. On average, in 2018, the share of workers employed in sheltered workshops (hereafter: 'SHPs') was 43.9%, in 2019 it fell to 41.1% and in 2020 it ranked at 39.9%.

At the end of December 2020, 797 sheltered workshops were in operation (December 2019. - 867, in December 2018. - 922), which employed 128,988 p e o p l e , including 100,079 people Disabled people (compared to 138,483 in 2018, of which 107

903 were persons with disabilities, and in 2018 the employment level was 145 876 persons, including 113 766 persons with disabilities). The share of disabled people employed in sheltered workshops remained almost unchanged: in 2018 it was 78.0%, in 2019. - 77.9%, and in 2020. - 77.6%.[35] . The shrinkage of the sheltered labour market is certainly not a positive development, as, despite some drawbacks, this market is often the only employment opportunity for certain groups of workers. The most obvious alternative to sheltered workshops - i.e.

[33] D. Kobus-Ostrowska, *Economic activity of disabled people and their development opportunities*, [in:] P. Ucieklak-Jeż. (ed.), *Social aspects of market economy*, S. Podobińskiego Publishing House of the Jan Długosz University, Częstochowa 2011, p. 241.

[34] CSO, LDB.

[35] http://niepelnosprawni.gov.pl/p,84,dane-dotyczace-zakladow-pracy-chronionej.

Vocational Activity Establishments (VACs) - offer only a fraction of the places available within the sheltered labour market. At the end of December 2020, there were 127 occupational activity establishments (December 2019: 124, December 2018: 116), which employed 7588 people, including 5820 persons with disabilities (by comparison, in 2018, the employment level was 7197, of which 5492 were persons with disabilities, and in 2019, the employment level was 6663, including 5069 persons with disabilities). The proportion of people with disabilities employed in occupational workshops remained almost unchanged: in 2018 it was 76.1%, in 2019. - 76.3%, and in 2020. - 76,7%. In total, the employment in the Vocational Activity Establishments in the years 2018-2020 increased by 925 persons, including 751 persons with disabilities[36] As the research shows, the Vocational Activity Establishments only to a small extent realise the social and rehabilitation goals that have been set for them - the employment in favourable conditions of the most disadvantaged persons, in particular those with a significant degree of disability. The unfavourable situation in this respect is confirmed by almost the same percentage of disabled employees with severe disabilities employed in the open as in the sheltered labour market. ZPCH, by employing mainly people with lower degrees of disability, prevent them from entering the open labour market, while not striving to activate people with significant disabilities, for whom sheltered employment is the only chance for professional activity.

In PFRON's Register of Employed Disabled Persons in Poland

Over the two years (2018-2020), the total number of employers registered with the SODiR PFRON from 31,294 in December 2018 to 32,422 in December 2020, with:

– the number of open labour market employers increased from 30,388 in December 2018 to 31,638 in December 2020,
– the number of employers in the sheltered labour market decreased from 906 in December 2018 to 784 in December 2020.

Over the period 2018-2020, there is an apparent decrease in the number of self-employed disabled people registered in the register applying for reimbursement of social security contributions: for monthly average data in 2018.

[36] PFRON, *Survey of sheltered workshops*, December 2020, p. 42 https://www.pfron.org.pl/fileadmin/ZPCh_raport_koncowy_pelny.pdf?utm_campaign=pfron&utm_source=df&utm_medium=download.

The figure was 22,948 people and in 2020 it will be 17,737 people[37] .

Advanced illness means disability and seriously impedes the possibility of gainful employment. Exclusion from working life often becomes the cause of further serious economic problems and a difficult housing situation. Due to differences in the level of education and professional activity, as well as health problems, the disabled constitute a group at high risk of social exclusion, poverty and poverty[38] . According to PFRON research, among people with disabilities, households of people with intellectual disabilities have the greatest financial problems[39] . Opportunities for social and vocational rehabilitation for people with disabilities who are unable to work are provided by occupational therapy workshops (OPTs), where therapeutic and workshop activities are organised. On the other hand, occupational activity workshops are places where people with disabilities learn not only how to perform their assigned duties, but also how to cope with everyday life and how to cooperate with others. In 2019, there were 720 vocational workshops and 123 ZAZ.[40] The number of ZAZ increased by 7 units compared to 2018 (the same increase also occurred between 2017 and 2018). The majority of units in 2019 (64.2%) were run by non-profit organisations. For 34.1% of the ZAZs, the running body was local government units (municipalities or counties) and 1.6% of the establishments were run by social cooperatives. The structure of the running bodies of the ZAZs did not change significantly from 2018, however, for all newly established establishments the running body was non-profit organisations. At the end of 2019, a total of nearly 7,200 people were employed in all vocational activity establishments. Compared to 2018, the total employment in ZAZ increased by 8.5%. By law, the reintegration activity of ZAZs is aimed at people who have a significant degree of disability and people with a moderate degree of disability who have been diagnosed with autism, mental retardation or mental illness. At the end of 2019, the number of reintegrated people employed in ZAZ was 5,5 0 0 , including people with a severe degree of

[37] Office of the Government Plenipotentiary for Disabled Persons, http://www.niepelnosprawni.gov.pl/index.php?c=page&id=80&print=.
[38] *Surveying the needs of people with disabilities...*, op. cit..., p. 92.
[39] Above all, this is due to the fact that at least one parent is usually deprived of the possibility to w o r k d u e t o t h e need for permanent childcare. *Survey of the needs of persons with disabilities..., op. cit.* p. 95.[40] Central Statistical Office, *Centres for social integration, social integration clubs, occupational activity establishments, occupational therapy workshops in 2019*.

disabilities accounted for 59.0%. The number of employed persons with severe or moderate disabilities in the total number of employees was 75.8% and increased by 0.3 percentage points compared to the previous year. On average, one ZAZ employed for reintegration purposes in 2019. 45 employees with disabilities. At the end of 2019, 720 W T Z s were actively operating, i.e. 2 more than in the previous year. WTZs most often, compared to other types of units reintegration Socio-vocational, were run by non-profit organisations - nationally they were the organiser of 78.2% of WTZs. Another 17.9% of WTZs operated within local government units and institutions subordinate to them, and 3.9% were run by other entities. In 2019, 27.7 thousand people with certified disabilities benefited from classes in WTZs, 0.2 thousand more than in the previous year. On average, 38 people participated in classes in one WTZ (the same as in the previous year). Examples of solutions that allow vocational activation of people with disabilities are such social economy entities (including social enterprises) as social cooperatives, vocational activity establishments, whose mission is social and vocational reintegration of employees, and whose organisational culture allows for the creation of a supportive work environment, using the interaction of employees with similar experience of illness. In 2019, 1547 social cooperatives were listed in the KRS.

Other entities important in the context of social and professional reintegration of persons at risk of exclusion, including persons with disabilities, are Social Integration Centres and Clubs. Over the 2016-2019 period, the number of Social Integration Centres (CIS) shown in the statistics of the Ministry of Labour and Social Policy (MRiPS) increased by 23 units, an increase of 12.8%. Counting from 2012, the total of these entities has increased by more than 100%. On the other hand, the number of Social Integration Clubs (SICs) for the aforementioned three years increased by 26 units, or 9.6% compared to 2016. The nominal number of CIS and KIS, based on the reports completed and sent by these entities, in 2018 was 486 (193 CIS and 293 KIS). In 2019, the number of reporting entities increased by 12 units and amounted to a total of 498 entities (202 CIS and 296 KIS).[41] Despite the noticeable increase in the number of these reintegration entities, it should be noted that their distribution is uneven across the

[41] MRiPS 2020, Information on the functioning of Social Integration Centres and Clubs operating on the basis of the Act of 13 June 2003 on social employment - for the period 2018-2019, page 7.

individual provinces, so access to the services provided by these entities is not equal either. An important conclusion from regular surveys of reintegration entities is that the percentage of persons who have completed classes remains stable for both CIS and KIS. This is a positive phenomenon, testifying to the relatively accurate profiling of the offer according to the needs of participants[42] . At the same time, it should be added that CIS is more oriented towards pro-employment activities than KIS, and social integration is treated as an element of professional integration. On the other hand, according to the model assumption of the reintegration process, persons with significant deficits of social and professional competences should first participate in KIS classes, then be placed in CIS, and finally find employment on the open labour market, including in the social economy sector. As regards participation in social integration centres and clubs, it should be emphasised that the activities of these entities easily find their addressees. Social and vocational reintegration services within the CIS were used by 12.1 thousand people in 2018 and in 2019. 11.1 thousand people. On the other hand, 11.9 thousand people started classes under KIS in 2019, which was a result of 1 thousand people less than in 2018. Participants in both types of entities are dominated by the unemployed, including long-term unemployed. According to the 2019 data, people with disabilities constitute the third largest subgroup of CIS participants (1.4 thousand people, or 13% of CIS participants) and the second largest subgroup of KIS participants (2.1 thousand people, or 17.6% of KIS participants)[43] .

Material situation of people with disabilities

According to data from the Social Insurance Institution, in December 2019, the average main benefit (including pension, disability pension, survivor's pension or social pension) paid to persons recognised as incapable of working under Article 5 of the Vocational and Social Rehabilitation and Employment of Persons with Disabilities Act of 27 August 1997 was PLN 1628.38 in Poland. On average, men received PLN 1762.91 and women PLN 1473.90. The average amount of the benefit varied by voivodeship. The highest value (without breaking it down by gender) was observed in Śląskie Voivodeship (PLN 1790.07), while the lowest in the Voivodeship of

[42] Ibid, p. 89.

[43] Ibid, p. 25.

Podkarpackie (PLN 1494.00).

In 2020, there were 703.7 thousand people in Poland receiving inability-to-work pensions from the non-agricultural social insurance system. In 2020, the average monthly inability-to-work pension was at the level of PLN 2042. Despite the relatively better situation in this area, the pension collected allows only modest satisfaction of the subsistence needs of persons with disabilities.

In 2019, the average monthly disposable income per person in pensioner households in Poland was PLN 1498, 17.7% lower than the national average (20.0% lower in 2018).

In the hierarchy of needs of persons with disabilities, ensuring an adequate material and living situation comes first[44] , as in many families with persons with disabilities such needs are not fully met. In view of the above, it is important to maintain financial assistance to households of persons with disabilities in a vulnerable situation, as well as to carry out activities that increase the labour force participation of persons with disabilities, as it has a very strong impact on their overall quality of life. This demand also applies to caregivers of persons requiring continuous care.

Research shows that some people with disabilities tend to reduce their own needs to the most basic ones, and lack knowledge of how they could improve their quality of life. There is also sometimes a lack of comprehensive information - designed in a simple and visible way, adapted to the perceptual capacity of people with disabilities - about the possibilities and how to get support.

For the past five years, the number of cash social assistance benefits granted for the disability of a person living in a family or running an independent household has also been decreasing. The situation is illustrated in the table below.

Table No. **9**. Data on individuals and families granted social assistance benefits due to disability for the period 2016-2020.

[44] Central Statistical Office, *Situation of households in 2018 in the light of the results of the Budget Survey Households. Signature information,* 30.05.2019, p. 228.

SPECIFICATION	2016	2017	2018	2019	2020
NUMBER OF PERSONS TO WHOM TEMPORARY BENEFITS WERE GRANTED BY DECISION DUE TO DISABILITIES	53 042	53 296	50 745	45 730	40 611
NUMBER OF FAMILIES GRANTED SOCIAL ASSISTANCE DUE TO DISABILITIES	393 878	384 939	364 682	347 516	311 006

Source: MRPiPS-03 report (2016 symbol: MPiPS-03).

Among the various aspects of the living situation of people with disabilities, housing has a special place. Support in terms of housing and the adaptation of living space to disability-related needs is most crucial for people with disabilities. People with disabilities strive for independent living that allows them to gain independence. In many cases, the housing occupied by people with disabilities requires a series of adaptation measures involving the introduction of universal design as a universal principle.

The results of other studies show that the problems experienced on a daily basis by people with disabilities include: financial difficulties, insufficient access to health care and rehabilitation, lack of work, architectural, communication and organisational and staffing barriers, limited access to culture, sport and recreation and lack of leisure activities, social isolation, limited contacts, lack of acceptance and intolerance and insufficient availability of organised forms of support. Families of people with disabilities additionally experience difficulties in reconciling paid work with caring for a disabled family member and burnout, exhaustion and lack of strength[45] .

People with disabilities need support in three main areas in their daily life:

- housing and independent living (assistance by a personal assistant or nurse in daily activities, adaptation of the home to the individual needs of the person with a disability, access to training opportunities

[45] CBOS Foundation, *Disabled among us. Research communication*, No. 169/ 2017, December 2017, p. 3.

independent living in supported housing),

- access to technical aids - devices or technologies (e.g. orthopaedic or optical aids, hearing aids, ACC aids and computer aids, but also various everyday devices to help overcome disability-related limitations),
- transport and mobility - mainly the elimination of architectural and communication barriers in public spaces, but also the adaptation and purchase of appropriate means of transport[46] .

According to research by PFRON, people with disabilities do not assess the amount of support they receive very favourably. In their opinion, the assistance is too small, disproportionate to needs or not available at all. The support they receive is not individualised and the support system is perceived as highly bureaucratic, with dispersed responsibilities, information and requirements[47] .

Lack of identification of the needs of people with disabilities in a given area, and consequently lack of sufficient support, translates into limitations in meeting basic needs and into quality of life. The global quality of life index adopted in the above-mentioned studies, being an average value of partial indices, took the value of 38.5 points out of 100 possible, which means that the quality of life of people with disabilities in Poland is not good. The above indicator had a higher value for people with a moderate degree of disability than for people with a significant degree of disability, as well as among people without couplings compared to people who have been diagnosed with a coupled disability. In addition, the value of the quality of life indicator clearly decreased as the age of disabled people increased[48] . People with intellectual disabilities (24.5 points) and people with mental disorders (31.2 points) assess their situation most poorly.

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[46] *Surveying the needs of people with disabilities...*, op. cit..., pp. 47-48.

[47] *Surveying the needs of persons with disabilities...*, op. cit., p. 45. cf. B. Gąciarz, P. Kubicki, S. Rudnicki, *System Institutional support for persons with disabilities in Poland - a diagnosis of dysfunctions*, 2014, *in:+ B. Gąciarz, S. Rudnicki Seweryn (eds.), *Polscy niepełnosprawni - od kompleksowej diagnozy do nowego modelu polityki społecznej*, Wydawnictwa AGH, Kraków 2014.

[48] *Survey of the needs of disabled people...*, op. cit. p. 5. The survey covered legally disabled people with a severe or moderate disability certificate or a disability certificate (people up to 16 years of age) aged 14-60.

Families with people with intellectual disabilities are a group particularly vulnerable to bearing the consequences of the disability of their loved ones, many of whom require constant care, assistance for the rest of their lives and do not undertake age-appropriate social roles.

Supporting the factual carers of people with disabilities is a very important issue. For the past five years, there has been a noticeable increase in the number of recipients of the attendance benefit, which is available to the factual caregiver of a person with a disability if he or she resigns from employment due to the need to provide permanent and direct care for the person with a disability. The table below shows the change in the number of recipients of the attendance benefit between 2016 and 2020.

Table No. 10: Number of recipients of the attendance benefit between 2016 and 2020

NUMBER OF RECIPIENTS OF ATTENDANCE ALLOWANCE 2016-2020					
YEAR	**2016**	**2017**	**2018**	**2019**	**2020**
NUMBER OF RECIPIENTS (IN TYS.)	117,16	123,19	131,18	142,72	164,10

Source: own elaboration of the Ministry of Labour and Social Policy on the basis of material and financial reports on the performance of tasks in the field of family benefits for 2016-2020.

The amount of the attendance allowance in 2021 is specified by the announcement of the Minister of Family and Social Policy of 4 November 2020 on the amount of the attendance allowance in 2021 (M.P. pos. 1031). As of 1 January 2021, the amount of the nursing benefit is PLN 1971.00 per month.

In the case of people with intellectual disabilities, the timing of their exit from the education system and their smooth transition to day support centres such as SEN and LTIs is particularly important, as there is often a lack of support centres in the area with a therapeutic and occupational offer appropriate to their needs, to which, to a large extent, the lack of a principle of monitoring in advance the need for such facilities among graduates of special education contributes. Consequently, families who have invested many years of intensive work in the rehabilitation and education of their loved ones are forced after

the end of compulsory schooling, i.e. after the age of about 24, either to observe their rapid regression or to increase work and resources to stop it, at the point when they themselves start to need support due to the age they reach. In addition, it is crucial to safeguard the fate of those who require intensive support (particularly emphasised by carers of people with intellectual disabilities) in the event of the illness or death of their carers. This safeguarding should consist of training for independent living in forms of supported housing as early as possible, both for the person with a disability and for his or her whole family.

SUMMARY OF SUPPORT ELEMENTS

Support for community-based services:

– care services or specialised care services,
– day care facilities (support centres), including community self-help homes,
– family care homes,
– services provided in sheltered housing with a profile appropriate to the degree of disabilities and the independence of their users,
– occupational therapy workshops and social integration centres and clubs,
– employment in vocational activity establishments,
– personal assistant for a person with a disability.

Support for cash benefits

A person with disabilities is entitled to the following benefits:

– disability pension,
– training pension for a period of 6 months - in the case when the advisability of professional retraining was stated due to the inability to work in the current profession,
– social pension,
– survivor pension,
– attendance allowance,
– supplementary benefit for persons incapable of independent living,
– special carer's allowance (benefit for a carer of a person with a disability regardless of the age of onset of the disability),
– carer's allowance (benefit for a carer of a person with a disability

paid in connection with the implementation of the Constitutional Court judgment K27/13 of 5 December 2013 to economically inactive carers of adult disabled persons whose decisions on care benefits expired by law on 1 July 2013),

– attendance benefit (a benefit for the carer of a person whose disability arose no later than when they reached the age of 18 or when they were studying at a school or college, but no later than when they reached the age of 25),
– education and rehabilitation allowance supplement.

In addition, families and people with disabilities can receive financial support through the social assistance system in the form of:

– permanent, targeted and temporary benefits.

Support for 24-hour services in institutions

Persons who, due to a disability, need support in the form of 24-hour care and whose needs cannot be secured in a residential environment, are also eligible for residence and services in a social welfare home. The stay is round-the-clock and residents are referred to the facility for permanent residence.

Persons with disabilities can also benefit from health services provided by nursing or assisted living facilities, provided that they score below 40 points on the independence scale (Bartel), which will mean that they need to be cared for and cared for continuously, including the continuation of treatment. These facilities secure a 24-hour stay, but of a temporary nature, until their condition improves.

Community support in the form of support circles

Circles of support involve the creation of a circle of supporters around a person, according to their needs, combining formal (e.g. personal assistant, social worker, therapist, lawyer) and informal (family, friends, acquaintances, neighbours, volunteers, shop assistant in the local shop). This form of support is particularly often used with people with intellectual disabilities, who are most affected by exclusion and isolation or segregation from community life, but it also works successfully with older people.

In order for social inclusion to become a reality, it is necessary to animate and organise the local community, to bring out local potential, to integrate resources, to build cooperation networks and various forms of self-help. It is the creation of community social support, including the development of support circles, volunteering and neighbourhood support in everyday life in the local community, creating attitudes of sensitivity and social solidarity. It is the implementation of education, animation and social support programmes in local communities.

It is also necessary to work in and with the community to integrate people who are excluded or at risk of social exclusion into the local environment, enabling them to be active and live on an equal footing with other members of the community. The support is strictly focused on the needs of the person according to his or her individual preferences and assumes a fully inclusive character, so that the person can remain in the residence of his or her choice, with the necessary support services provided, also when his or her immediate family is no longer able to support him or her (due to, for example, illness, death, a state of epidemic or pandemic, or due to the choice of the elderly and disabled person himself or herself).

Circles of support put into practice the idea of deinstitutionalisation and community-based support and can be both preventive (long-term planning, ensuring a secure future outside institutions), interventionist (responding to emergencies) and supporting the transition from institutions to community-based support.

RECOMMENDATIONS

In terms of preventive measures

- dissemination of prevention health from in terms ofprevention of disabilities, promoting physical, intellectual and social activity,
  -building the empowerment of people with disabilities as full members of local communities,
  -creating conditions for better access to education for people with disabilities at all levels,
- conducting activities on conducting activities for counteracting stigmatisation of people with disabilities,

- reducing barriers, including architectural barriers, in local environments for people with disabilities,
- promoting the idea of 'independent' living,
- development of assisted housing with a basket of services adapted to the individual needs of the person,
- independent living training,
- Creating conditions for people with disabilities to function with dignity and independence in their environment - including the permanent removal of barriers, the implementation of the concept of accessibility,
- dissemination and implementation of the idea of circles of support,
- dissemination of alternative communication methods,
- countering exclusion, including digital exclusion,
- undertaking environmental activities in support of the implementation of the model supported decision-making.

On the development of social services for people with disabilities:

- development of care services,
- development of neighbourhood services,
- development of personal assistantship,
- providing services to support decision-making,
- respite support for family members or carers caring for a person with disabilities,
- providing day care for people with disabilities who need it,
- development of assisted housing,
- development of a network of care and housing centres,
- development of the social economy sector - creation of social economy entities, including social enterprises as providers of social services and potential employers for people with disabilities,
- the creation of a fast-track pathway to information and support offers for people with disabilities under the age of 16 and just after acquiring a disability, at a time when rehabilitation is most desirable and effective,

- developing the potential of people with disabilities, actively involving them in the life of the local community,
- Vocational activation of people with disabilities, creation of disability-friendly employment models,
- individualisation of the path of professional activation of people with disabilities taking into account their potential and limitations with the use of vocational activity centres, social cooperatives, cooperatives of the invalids and the blind, social enterprises and sheltered workshops.

4. People with mental disorders and in crisis psychiatric

According to the Act of 19 August 1994 on Mental Health Protection (Journal of Laws 2020, item 685 and 2022, item 974), the definition of a person with a mental disorder refers to a person:

a) mentally ill (displaying psychotic disorders),
b) mentally handicapped,
c) demonstrating other disturbances of mental function which, according to the state of medical knowledge, are classified as mental disorders, and the person requires health services or other forms of assistance and care necessary for living in a family or social environment.

In 2019, a total of 1505.73 thousand adult patients and 148.81 thousand minor patients were treated in psychiatric care and addiction treatment in Poland. The number of patients by disorder group is presented in Tables 11 and 12.

Table 11. number of adult patients in psychiatric and addiction care in 2019 by groups of principal diagnoses in reported benefits

Group of disorders	ICD-10 code	Number patients
Anxiety disorders	F40-F45, F48	528130
Mood disorders	F30-F34, F38-F39	305799
Addictions	F10-F19, F63, Z81	264479
Organic disorders	F00-F07, F09	253625
Schizophrenia	F20, F21, F25	163528
Intellectual disability	F70-F73, F78-F79	61380

Adult personality and behavioural disorders	F60-F62, F68, F69	40465
Mental disorder not otherwise specified	F99, Z03	39409
Psychoses other than schizophrenia	F22-F24, F28-F29	18611
Behavioural syndromes associated with disorders physiological and physical factors	F51-F55, F59	13594
Psychological development disorders	F80-F84, F88, F89	5344
Behavioural and emotional disorders beginning usually during childhood and adolescence	F90-F95, F98	5172
Eating disorders	F50	3351
Gender identity and preference disorders sexual	F64-F66	1192

Source: DAiS MZ compilation based on NFZ data.

Table No. 12. Number of minor patients in psychiatric care and addiction treatment in 2019 by groups of principal diagnoses in reported benefits

Group of disorders	ICD-10 code	Number patients
Comprehensive developmental disorders	F84	35 386
Other mental disorders in children and adolescents	F00, F02-F07, F09, F51-F55, F59-F66, F68-F69, F80-F83, F88-F89, F94, F98-F99, Z03	28 815
Neurotic disorders related to stress and somatic form	F40-F45, F48	28 266
Hyperkinetic disorders	F90	26 214
Behavioural and mixed disorders behavioural and emotional disorders	F91-F92	23 016
Emotional disturbances in adolescents	F93	17 186
Intellectual disability	F70-F73, F78-F79	9583
Mood disorders	F30-F34, F38-F39	8176
Mental and behavioural disorders caused by the use of psychoactive	F10-F13, F15-F19, Z81	3697
Eating disorders	F50	1891
Tiki	F95	1488
Schizophrenia and delusional disorders	F20-F25, F28, F29	1352

Source: DAiS MZ compilation based on NFZ data.

In 2018, people with a diagnosis of mental disorder (excluding addiction) who were treated

in outpatient psychiatric care units was 1,405,616 (3,659.4 per 100,000
population), including 321 134 for the first time (836 persons per 100 000 population).
269,980 adult patients were provided services in organisational units dedicated to the treatment of addiction. A total of 2,880,000 counselling sessions were provided to them, hospitalisations covered 2.94 million person-days. 35.31% were women, 13.7% patients aged 60 and over[49] .

The number of residents with a diagnosis of mental disorder residing in residential social care institutions in Poland in 2020 was 22,841. This number has remained at a similar level since 2010.[50] In 2020, there were 174 social welfare homes for the chronically mentally ill in Poland, with 20,716 places. The number of residents was 19 948[51] .

Thanks to changes in legislation, the gradual dismantling of the asylum model, which was based on isolating people with mental health disorders in large hospitals, began as early as 1994 and was replaced by a community-based model. This was accompanied by the top-down organisation of institutions specific to the community-based model of support. New institutions also emerged. Since this period, community self-help homes, among others, have been established. Their number is constantly increasing, which means that the availability of services is in fact constantly improving.
In terms of health service provision, the number of contracted places in day wards has increased, while the number of places in inpatient wards has decreased. One can therefore speak of a progressive institutional change in the area of mental health care, a measurable indicator of which is the increase in the number of day facilities.
Thanks to legislative changes, there have also been increased opportunities for social economy entities, including social enterprises and NGOs, which often provide services that are not available under the benefits offered by public entities. An example is the so-called supported employment, rated as the most effective form of assistance in obtaining and maintaining a job. However, a common

[49] Health Needs Maps, Psychiatric care and addiction treatment, https://basiw.mz.gov.pl/index.html#/visualization?id=3451.
[50] Central Statistical Office, Local Data Bank, https://bdl.stat.gov.pl/BDL/dane/podgrup/tablica.
[51] Central Statistical Application, MRPiPS-05 reports for the period I-XII 2019.

The denominator for these measures is the lack of systemic mechanisms for integrating a given form of support with others, in particular health care benefits with social benefits[52] .

The development of social services, especially care services, or those in the field of support for people requiring both social and health care assistance, is carried out on a complementary basis with the activities of the health sector. It is worth noting that the National Programme for the Protection of Mental Health for 2017-2022 is being implemented, with objectives related to, inter alia, the dissemination of the community mental health care model, the coordination of available forms of care and assistance, and the prevention of stigmatisation and discrimination of people experiencing mental disorders.

A pilot programme in mental health centres has also been implemented since 2018. The aim of the pilot is to test the community mental health care model based on the mental health centres referred to in Article 5a of the Mental Health Act of 1994 in terms of:

- organisational,
- Financial,
- qualitative,

-equality and accessibility to health services.

In accordance with the provisions of the Regulation of the Minister of Health of 27 April 2018 on the pilot programme in mental health centres (Journal of Laws of 2020, item 2086, as amended), the provision of services under the pilot programme is possible from 1 July 2018. The amendment of the pilot regulation of 21 December 2020 extended the duration of the pilot until 31 December 2022. Each entity qualified for the pilot programme forms one mental health centre. The task of the implementer of the pilot programme, i.e.: the therapeutic entity responsible for the operation of the mental health centre, is to provide comprehensive psychiatric care (emergency, outpatient, community, day and 24-hour care) to the adult population residing in its area of operation (between 50,000 and approximately 200,000 inhabitants). The total population to

[52] Ibid, pp. 97-98.

covered by the 39 centres is about 4 million people from all over Poland.

In view of the need for urgent changes in child and adolescent mental health care, the Ministry of Health is addressing the implementation of a reform aimed at creating a nationwide, comprehensive system to provide support to underage patients experiencing mental disorders and their families. The new model for the child and adolescent mental health system involves the creation of a network of centres within three reference levels. Each reference level will provide support to patients with different health needs. The aim of the reform is to deinstitutionalise the child and adolescent psychiatric care system and to increase the role of community-based services. A key change is the generalisation of help provided in newly established facilities located close to the child's place of residence - community psychological and psychotherapeutic care centres for children and adolescents, staffed by psychologists, psychotherapists and community therapists. Patients can use these centres without a medical referral. People who do not need a psychiatric diagnosis or pharmacotherapy can receive help at these centres. In fact, for many mental disorders occurring in childhood, effective help can be provided through interventions such as individual and group psychotherapy, family therapy or work with a peer group.

The first centres for community psychological and psychotherapeutic care (reference level I) started operating in April 2020. According to current data (February 2022) on competitions, services at Level I of child psychiatry are provided at more than 345 sites[53] . The provincial departments are currently conducting further competition proceedings. Contracts for Level II and Level III of reference will be initiated at the next stage.

ELEMENTS OF THE SUPPORT SYSTEM

Support for systems

People with a diagnosis of mental disorder living in the community can benefit from

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[53] List centres available on website: https://www.nfz.gov.pl/dla-pacjenta/informacje-o-swiadczenia/protection-psycho-health-children-and-youth/

of two types of support:

– the healthcare system,

– the social assistance system.

As part of the health support, people can benefit from psychiatric care

healthcare provided in an outpatient setting.

Community treatment teams enable patients to be treated both on site

patient's residence, as well as in the institution.

In terms of social support services, these people can benefit from:

– specialised care services for people with mental disorders,

– services provided in a community self-help home, including 24-hour services,

– self-help club services for people with mental disorders,

– services provided at crisis intervention centres.

Service support can also be provided in the form of services provided in sheltered housing with a profile appropriate to the health problems of its users.

Support for financial benefits

People with a diagnosis of mental disorder and their families can be supported financially. These are social assistance benefits (allowances to meet the immediate needs of life).

Relief services for carers under government programmes or EU community-funded projects are also proposed.

Support for institution-based services

Persons with a diagnosis of mental disorder, whose needs cannot be secured in a residential environment, are also entitled to stay and services in a social welfare home if their health condition so permits. The stay is round-the-clock and residents are referred to the facility, as a rule, for a fixed period. In the case of referrals issued by the courts to such facilities, the persons referred are subject to periodic mental health examinations to the extent that they justify their continued stay in a DPS.

People with mental disorders benefit from various forms of treatment under the

National Health Fund.

RECOMMENDATIONS

In terms of prevention

- Mental health promotion through the implementation of activities aimed at strengthening mental health, improving the quality of life of individuals, groups and populations (e.g. children, adolescents, employees, seniors, etc.),
- taking action to reduce risks and incidence rates for mental disorders,
- educating the public about mental health,
- preventing the stigmatisation of people experiencing mental disorders,
- prevention violence i harmful action abuse of substances psychoactive drugs,
- diagnosing the needs of people with mental disorders at a local level and monitoring the situation of these people and the action taken locally on their behalf.

With regard to the development of social services for persons with mental disorders and persons with in mental health crisis:

- support for families with caring responsibilities for people with mental disorders, e.g. through the development of respite care, the running of self-help and support groups, assistant services, the development of support centres, e.g. residential care centres,
- development of specialised care services,
- development of day care centres and monitoring of demand for stays in the SDS among future graduates of special education,
- development of support services under the Act of 27 August 1997 on professional and social rehabilitation and employment of disabled persons, the Act on social employment, the Act on social cooperatives,
- implementation of empowerment and pro-employment programmes, including residence in supported housing, housekeeping training, job training, etc.

5. People in crisis homelessness

Homelessness is one of the most extreme forms of social exclusion. According to the definition set out in the Social Welfare Act of 12 March 2004, a homeless person is defined as a person who does not reside in a dwelling within the meaning of the provisions on the protection of tenants' rights and the housing stock of a municipality and is not registered for permanent residence, within the meaning of the provisions on population registration, as well as a person who does not reside in a dwelling and is registered for permanent residence in a dwelling where it is not possible to live. Homelessness is also one of the specific grounds for support indicated in the Social Assistance Act of 12 March 2004.

A serious impediment to comprehensive assistance to people in crisis of homelessness from the point of view of the current definition is that it does not include people supported by housing programmes. People who have so far been directed, for example, to sheltered housing as part of the process of exiting the homelessness crisis partially fall out of the support system, so to speak, as they cease to meet one of the main prerequisites for being considered homeless, concerning not living in a dwelling. At the same time, it cannot be said that their housing needs are met, as the support provided in sheltered housing is a social assistance benefit and not an element of housing policy implementation. Hence the need to supplement the definition of a homeless person with a person benefiting, in the process of leaving homelessness, from a form of support provided in a flat, which prepares people staying there under the care of specialists to lead an independent life or supports these people in their everyday functioning.

Over recent years, there has been a steady decline in the number of people in crisis of homelessness. During the most recent National Survey of the Number of Homeless People, which took place from 13 to 14 February 2019, 30,330 homeless people were diagnosed, 83.6 per cent of them

were men (25,369 people), while 16.4 per cent were women (4,961 people). Compared to 2017, the number of homeless people decreased by more than 9%, as 3078 fewer people were diagnosed in the last edition of the survey. The decrease was observed in all groups - both among women (by almost 0.5 thousand people), men (by almost 2.5 thousand people) and children (209 people).

As two years earlier (2017), among the persons surveyed, 24 323 (80.2%) were staying in various types of institutions, mainly in shelters for the homeless - 11 917 persons (almost 50%) and night shelters - 2987 (over 12%). In these facilities, as in most other places providing shelter, the predominant group of beneficiaries were men. In turn, 6007 homeless people (19.8%) were diagnosed outside institutions - in public spaces and non-residential places.

Based on the data obtained during the survey, it can be concluded that the majority of homeless people have vocational education (12,293 people) and primary education (8448 people). As in 2017, the most frequently declared source of income by those surveyed was social assistance benefits (just under 38%). However, retirement/pension was indicated in second place (15.8%), rather than collecting as previously, which is now the third most frequently declared source of income for homeless people - 11.6%. Those who claim to have no income at all are still quite numerous (17.8%).

Homelessness is certainly influenced by factors such as a difficult housing situation, difficult access to the labour market, including long-term unemployment, poverty, deprivation of housing (eviction), lack of a place to live after leaving various types of institutions (e.g. after returning from prison, leaving a children's home, after returning from a psychiatric hospital) combined with a lack of or insufficient social integration. A particular problem in this respect is the legal barrier of the impossibility of providing social work to persons incarcerated in prisons and jails, resulting from Article 13 of the Act of 12 March 2004 on social assistance. A statutory change in this respect is therefore necessary in order to work with persons about to leave penitentiary institutions to find a housing solution for them.

Critical life situations that may influence the risk of homelessness also include family breakdown and pathologies of family life (often associated with domestic violence). Significantly, the lack of adequate housing tends to correlate with extreme poverty, unemployment, low work intensity, employment in the informal economy, loss of health and threat to life, mental health problems, inability to function in the family and society. Specialists

working with the homeless indicate that typologies and schemes of various kinds are unable to cover the variety of reasons why people lose their accommodation. In this context, it is emphasised that very often it is not possible to talk about one main cause of homelessness, but about the co-occurrence of many critical events in a person's life, which consequently lead to a state of exclusion. During the most recent survey of the number of homeless people (2019), family conflict was the most frequently cited source of the homelessness crisis by those surveyed - 32.2 per cent (during the previous survey, in 2017, it was the second most common cause), immediately followed by addiction - just under 28 per cent (in 2017, in third place). This was followed by eviction, dereliction - 26.3%, which was considered the main cause of homelessness during the previous survey, in 2017, and then relationship breakdown - 18.4%.

Based on the information obtained during the last edition of the survey, it can be noted that, as in 2017, the largest number of homeless people was diagnosed in the 41-60 age bracket (13,801 people, including 1,770 women and 12,031 men). Significantly, almost all age groups saw a decrease in numbers. The exceptions are the homeless over 60 years of age - in this group, a slight increase in the number of people can be observed, both among women and men, from 9,521 people diagnosed during the previous edition of the study to over 10,000 in the latest one. Importantly, during the last All-Poland study of the number of homeless people, a group of young homeless people was singled out, i.e. in the age range of 18-25 years. In this age group, 784 homeless people were diagnosed, including 268 women and 516 men.

The latest data shows that episodes of homelessness among the people surveyed are lengthening. The most numerous group is now made up of people who have been in a homelessness crisis for more than 5 to 10 years - 7961 people (26.2%). The next largest group are those who have been homeless for the shortest period of time, i.e. up to 2 years - 6677 people (22%) - the most numerous in the previous study. The third group invariably consists of people in homelessness crisis for more than 2 to 5 years.

Elements of the support system

Support in the form of services provided in institutions

The systemic solutions and available forms of assistance to the homeless are defined in the Act of 12 March 2004 on social assistance. Municipalities are statutorily obliged to provide shelter, meals and necessary clothing to the homeless. However, it depends on the decision of the local government whether it will implement its own task independently with the help of municipal organisational units or whether it will delegate it to other entities (e.g. non-governmental organisations), providing subsidies to finance or co-finance the implementation of the commissioned task.

Shelter is provided by granting a temporary place in a night shelter, a shelter for the homeless, a shelter for the homeless with care services and a heating facility. The number of the forms of support in question is presented in the table below.

Table No. 13. Number of facilities providing temporary shelter to homeless people between 2016 and 2020

Facilities	**Night shelters**		**Shelters for homeless people**		**Shelters for homeless people with services care**		**Heating facilities**	
	Number of units	**numb er of places**	**Number of units**	**numb er of places**	**Number of units**	**numb er of places**	**Number of units**	**numb er of places**
2020 r.								
conducted by municipality/count y	46	1374	34	1348	3	98	38	642
carried out by another entity under contract with the entities self-government	74	2287	254	10 338	64	1989	54	1022
Total	120	3661	288	11 686	67	2087	92	1664
2018 r.								
conducted by municipality/count y	44	1234	45	1590	4	103	33	573
carried out by another entity under contract with the entities self-government	58	1796	172	8379	18	567	38	890

Total	102	3030	217	9969	22	670	71	1463
2016 r.								
conducted by municipality/county	46	1322	45	1874			25	499
carried out by another entity under contract with the entities self-government	54	1600	167	8377			26	648
Total	100	2922	212	10 251			51	1147

Source: own compilation based on annual reports MRPiPS-03 and supplementary report DPS.III.73.AB/2017.

The forms of assistance and the conditions under which it is provided are regulated in such a way that support is tailored to the needs of the beneficiary. Warming facilities provide emergency shelter, night shelters offer mainly spending the night in conditions guaranteeing the protection of life and health, while shelters are, so to speak, a higher form of work with a homeless person.

According to the statutory definition, a homeless shelter provides homeless people who have signed a social contract with 24-hour temporary shelter and services aimed at strengthening social activity, exiting homelessness and achieving independent living.

A similar function is fulfilled by shelters for homeless people with care services, which are intended for people who are incapable of self-care, but who do not require 24-hour care, but only partial, temporary assistance with daily living needs and hygienic care.

In addition to facilities whose main profile of activity is providing temporary shelter, emergency support points play an extremely important role in the support system for people in crisis of homelessness. Among them we can distinguish: eating places, baths, laundries, food distribution points, clothing distribution points, day care centres for the homeless, consultation and information points, medical assistance points.

Given that long-term stay in multi-person institutions exacerbates social exclusion, e.g. in terms of not having to make decisions for one's own life, comprehensive measures should be introduced in the area of transition from service provision

for the homeless in institutions to community-based services by developing housing and providing services to support the return of the homeless to society and the labour market. At the same time, as housing solutions for the homeless are developed, there should be a gradual reduction in the supply of institutional forms of assistance to the homeless - in particular by converting existing facilities into housing solutions or multifunctional intervention facilities for temporary assistance until a housing solution is provided, as well as by limiting the possibility of opening new facilities of an institutional nature.

Support in the form of community-based services

Among social assistance benefits, a very important function is played by social work, which is aimed at helping individuals and families to strengthen or regain their ability to function in society by performing appropriate social roles and creating appropriate conditions conducive to this goal. In this context, there is a need to integrate preventive and intervention measures by, among other things, creating a standard for such measures to be applied during eviction proceedings or during periods of threatened eviction, which would allow, in many cases, to effectively prevent the crisis of homelessness.

One of the specific forms of social work with people who are already experiencing homelessness in their environment is streetworking. The number of streetworkers in individual municipalities who worked with people in crisis of homelessness in 2020 was 146, of which the highest number was employed in the Mazowieckie Voivodeship (51 people) and the Wielkopolskie Voivodeship (20 people). This is 20 people less than two years earlier, when municipalities reported a total of 166 streetworkers. Despite an overall decrease in the number of streetworkers in Poland compared to 2018, a total of 5419 people were supported in this form in 2020. This is an increase of more than 0.5 thousand people. The largest number of people, 1,536, were assisted in the Mazowieckie Voivodeship, followed by the Śląskie Voivodeship with 828 people experiencing homelessness.

Streetworking is crucial in supporting people in crisis of homelessness. Activities carried out in the environment in which homeless people are staying or clustering, i.e. in non-residential places and public spaces, are extremely important not only from the point of view of protecting the life and health of these people, but also because of the first contact in the

social reintegration process in the housing solutions envisaged in the strategy. Hence the need to include the development of this type of support in the document. An important element of support provided in the community is support in sheltered housing, which is a form of social assistance that prepares persons residing there under the care of specialists to lead an independent life or supports these persons in their daily functioning. The number of people in crisis of homelessness who were granted a benefit in the form of support in a sheltered flat in 2020 was 675 people, including 211 women and 464 men. This is a significant increase of more than 40% from the previous reporting period.

It is worth pointing out at this point the important role played in the process of supporting the homeless by providing and developing various forms of non-institutional assistance other than sheltered housing. These are the so-called supported housing, readaptive housing, etc., which houses people in the process of leaving homelessness, preparing under the supervision of specialists to lead an independent life or assisted in daily functioning. The number of people in crisis of homelessness supported in 2020 in non-institutional forms other than sheltered housing is 736, including 205 women and 531 men. The support is mostly dedicated to people leaving institutions providing temporary shelter, as part of independent living training, but is also increasingly used to provide services based on the 'housing first' model for people experiencing chronic homelessness.

"Housing first" is a specialised service/form of assistance aimed at people who have been receiving traditional homelessness assistance for years and are nevertheless still homeless: those suffering from mental disorders or addictions, i.e. with a so-called dual diagnosis, and those experiencing long-term homelessness manifested by years of living in places that cannot be considered as housing.

The increase in popularity of support provided in this form in recent years is due to the awareness of the much greater effectiveness of non-institutional solutions in the process of exiting homelessness compared to institutional solutions. Hence the need to promote and develop various housing solutions, bearing in mind the possibility of adapting them to local conditions and possibilities, as well as to popularise knowledge of the "housing first" model.

The individualised support provided in housing is also of particular importance in the case of young homeless people - whether they are brought up in dysfunctional families or have a history of staying in institutional foster care or in various types of youth institutions - for whom being in an institutional setting perpetuates deficits in social and emotional competences that enable them to function independently in society.

Activation tools for people in crisis of homelessness

The Social Assistance Act of 12 March 2004 stipulates that a homeless person may be included in an individual programme to exit homelessness, which consists in supporting the homeless person in solving his/her life problems, especially family and housing problems, and in helping him/her to obtain employment. The programme should take into account the situation of the homeless person and provide specific support to the person actively participating in the exit from homelessness and, according to the needs of the homeless person, may take into account any means of assistance available to the social assistance centre implementing the programme.

In addition, a social contract may be concluded with the person in order to define the way of cooperation in solving the problems of persons in a difficult life situation, including homeless persons. Its implementation is aimed at reinforcing activity and independence in life, work or against social exclusion.

The dominant group in terms of numbers are the homeless people covered by the social contract, as 14,593 people used this tool throughout 2020. In turn, 3,696 people were implementing an individual programme to exit homelessness in 2020.

Summary of support elements

Support in the form of services provided in institutions

- hostels for the homeless,
- hostels for homeless people with care services,
- dormitories,
- heating facilities,
- emergency assistance points, i.e. canteens, baths, laundries, food distribution points, clothing distribution points, day centres for the homeless, consultation and information points, medical assistance points.

Support in the form of community-based services

-social work and streetworking,
-protected housing,
-other forms of non-institutional support than sheltered housing, i.e. so-called supported housing, readaptive housing, etc.

Activation tools for people in crisis of homelessness

-individual programme to exit homelessness,
-social contract.

Recommendations

In terms of preventive measures

-early provision of supportive housing services:

- aimed at people at risk of eviction: including support in the area of social and professional integration or reintegration, support in getting out of debt, monitoring and providing assistance at this stage,
- addressed to persons threatened with homelessness leaving institutions or facilities (e.g. penitentiary institutions, forms of foster care, youth education centres): involving the creation of a functioning system of housing for these people, in particular supported housing,

- the creation of a standard for prevention and intervention activities, including the development of a procedure for social welfare centres to obtain knowledge of eviction proceedings or threats of eviction and rent debts in order to provide the necessary support and take preventive action,
- integrating measures to prevent loss of housing, rent debt, eviction and homelessness, specialist support, financial counselling, specialised debt support, debt relief programmes, monitoring the effects of measures,
- conducting social campaigns on breaking down stereotypes about homelessness,
- conducting analysis and monitoring of the phenomenon of homelessness and ways of solving this problem.

Regarding the development of social services for people in crisis of homelessness

aiming to move from institutional support to support in the form of housing:

- the development of assisted housing, including in particular support for and pilots of programmes based on the 'housing first' model,
- The development of municipal programmes that take into account supported housing in terms of housing and the support services provided there, as well as a pathway away (reducing supply) from institutional solutions as housing services develop,
- the introduction of comprehensive systems linking the services provided in supported housing with other services available in the municipality,
- stepping up efforts to involve public (municipalities) and private (housing cooperatives, TBS/SIM) bodies in the creation of a stock of assisted housing for social policy purposes,
- a successive change in the nature and type of institutional support.

In terms of supporting people experiencing homelessness:

- amending the statutory definition of a homeless person by including people who, in the process of exiting homelessness, benefit from forms of support provided in flats, preparing those living there under the care of specialists to lead an independent life or supporting them in their daily functioning,
- developing streetworking and other outreach services,
- strengthening the participation of people experiencing homelessness in creating social policy solutions and shaping the aid addressed to them by establishing formal or informal bodies of a consultative and advisory character, which would include, apart from representatives of local government, representatives of non-public service providers, institutions from outside the social assistance sector and people experiencing homelessness (currently or formerly),
- developing, strengthening and improving social assistance instruments aimed at the social integration of people in crisis of homelessness,
- integration of available services ("one-stop shop" method) for obtaining

support for people excluded from housing.

Chapter II. LONG-TERM CARE SERVICES

In Poland, as in most EU countries, long-term care (LTC Long-tem care) services are provided both in the health care and social security systems. These services should be complementary and constitute a coherent system from the point of view of the recipient, i.e. the person requiring support and his/her family and local environment.[54]

The Ministry of Health, in parallel to the activities carried out by the Ministry of Family and Social Policy in this area, is working on the preparation of the Strategy for deinstitutionalisation of health services. Bearing in mind the organisational, legal and financial separation of the health care and social welfare systems, the Ministry of Health - in agreement with the Ministry of Funds and Regional Policy and the Ministry of Family and Social Policy - adopted a model of work on creating a strategic framework for deinstitutionalisation based on the preparation of a separate document relating to the area of health care. The Ministry of Labour and Social Policy also decided to develop a thematically analogous document covering activities in the area of social services development. The adoption of such a model of work is supported, inter alia, by the necessity of mutual complementarity of actions for deinstitutionalisation in the area of health services with other reforms in health care. The documents developed are complementary.

The document 'Healthy Future. Strategic framework for the development of the health system for 2021-2027, with an outlook to 2030' is a follow-up to the 'Policy Paper for Health Care 2014-2020'. It is required by the European Commission as a condition for the disbursement of European funds.

Healthy Futures is accompanied by two other documents - on the care of older people and people with mental disorders. The main objective - with regard to elderly care - is to improve the quality of life and health of seniors and their carers.

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[54]As defined within the EU (e.g. 'Challenges in long-term care in Europe. A study of national policies' European Commission 2018 and 'Adequate social protection for long-term care needs in an ageing society. Report jointly prepared by Social Protection Committee and the European Commission" 2014), long-term care is services and support for people who, due to physical or mental frailty or disability, require assistance with activities of daily living for a prolonged period of time and/or require continuous nursing care. The LTC system is understood as a combination of social and care services and cash benefits financed wholly or partly by the social security system.

This is to be achieved by developing staff resources, day care, home care and innovative forms of care. Support for informal carers and the coordination of community care is envisaged.

In the field of psychiatric care, investments in human resources and improvements in the quality of education in psychiatry and other specialities dealing with mental health care are assumed. It is also planned, among other things, to change the organisation of the provision of mental health care and to invest in infrastructure.

"Healthy Future" also refers to other key documents prepared by the Ministry of Health, in particular the National Health Programme and the National Cancer Strategy.

Given the above approach to planned change, it is important to remember that the directions planned in the Social Services Development Strategy include activities in the area of social services.

1. Social assistance in the context of service delivery social services

Social assistance is an institution of the state social policy aimed at enabling persons and families to overcome difficult life situations which they are unable to overcome using their own entitlements, resources and possibilities. The basic legal act regulating the functioning of the social welfare system is the Act of 12 March 2004 on social welfare and executive acts to the Act.

Social assistance is organised by governmental and self-governmental administrative bodies, cooperating in this respect, on a partnership basis, with social and non-governmental organisations, the Catholic Church, other churches, religious associations and natural and legal persons.

In terms of the entities performing the tasks of social welfare, two main sources of funding for the social welfare system can be distinguished: the state budget and the budgets of local self-government entities to the extent to which the law imposes obligations on entities to perform obligatory tasks in the field of social welfare.

1.1 Help Centres Social services

There are approximately 2,500 social assistance centres (SACs) and municipal social assistance centres in Poland, which employ approximately 19,685 social workers who carry out the majority of social assistance tasks. In recent years, there has been a clear shortage of people willing to practise this profession. For this reason, measures are being taken to introduce changes regarding the possibility of practising the profession of social worker (legal changes).

Actions are successively planned and implemented to improve the professional situation of social workers and family assistants. The directions of actions for these professional groups are included in the National Programme for Counteracting Poverty and Social Exclusion. Update 2021-2027, public policy with an outlook to 2030.

The tasks of the welfare centre include:

- organising and providing care services, including specialised services, at the place of residence and running and providing places in sheltered flats, (mandatory own task of the municipality),
- Preparation of documentation and referral of persons in need of care to social welfare homes and community-based support centres (the municipality's own task),
- running specialised care services for people with mental disorders, running and developing the infrastructure of support centres for people with mental disorders,
- implementation of assignments under government social welfare programmes aimed at protecting the living standards of individuals, families and social groups and the development of specialist support (assignments delegated by government administration).

1.2 County Assistance Centres Family

Poviat Family Assistance Centres (PCPR) perform the tasks of the poviat in various areas, e.g. in the field of family support and the foster care system, support for disabled persons under the Act of 27 August 1997 on vocational and social rehabilitation, employment of persons with disabilities and tasks in the field of social assistance. The county's own tasks include.

- providing specialist counselling,

- granting cash aid for becoming independent and for the continuation of education to persons leaving social welfare homes for children and young people with intellectual disabilities, homes for mothers with under-age children and pregnant women and shelters for minors, correctional centres, special education and upbringing centres, special upbringing centres, youth sociotherapy centres providing round-the-clock care or youth upbringing centres,
- assistance in the integration into the community of persons with difficulties in adapting to life, young people leaving social welfare homes for children and young people with intellectual disabilities, homes for mothers with under-age children and pregnant women and shelters for minors, correctional centres, special educational and upbringing centres, special educational centres, youth sociotherapy centres providing round-the-clock care or youth upbringing centres with deficiencies in adaptation,
- running and developing the infrastructure of supra-municipal social welfare homes and placing referred people in them,
- running sheltered housing for people from more than one municipality and district support centres, including homes for mothers with minor children and pregnant women, excluding community self-help homes and other support centres for people with mental disorders,
- running crisis intervention centres.

The government administration tasks carried out by the county include:

- running and developing the infrastructure of support centres for people with disorders mental health,
- the implementation of tasks resulting from government social welfare programmes aimed at protecting the living standards of individuals, families and social groups and the development of specialised support.

Table No. 14. number of people employed in selected aid units
social comparative 2016/2020

DATA ON EMPLOYMENT IN PCPR, OPS AND SUPPORT CENTRES AT THE END OF 2016 AND 2020				
SPECIFICATION	**2016**		**2020**	
	number of people	number posts	number persons	number posts
SUPPORT CENTRES	11 010	9 538,71	15 846	13 664,40
SOCIAL WORKERS TOTAL, of which:	20 830	20 666,80	20 218	20 031,73
SOCIAL WORKERS IN PCPR	1145	1 124,28	1034	1 010,18
SOCIAL WORKERS IN OPS	19 685	19 542,52	19 184	19 021,55
OPS STAFF PERFORMING SERVICES CARE	5582	5 302,48	6403	6 087,30
OPS STAFF EXECUTIVE SPECIALISED SERVICES CARE	744	697,03	811	769,29

Source: Report mrpips-03 (2016 symbol: MPiPS-03).

Employment in support centres has increased over the 2016-2020 period: from 11,010 persons employed in 2016 to 15,846 persons in 2020, an increase of approximately 44%. The number of social workers in OPS and PCPR, on the other hand, decreased slightly (about 3% over 5 years). The number of employees of social assistance centres providing care services and specialised care services has also increased, but when comparing the total number of full-time employees providing care services with the number of municipalities (2477), it turns out that on average there are 2.46 full-time employees per municipality. The above comparison shows that the majority of care services in the municipalities are provided by subcontractors rather than staff employed by municipal-level social welfare units.

1.3 Regional Policy Centres Social Policy

There are 16 Regional Centres of Social Policy (ROPS) in Poland. These are organisational units of social welfare, which perform, inter alia, tasks in the field of social welfare, family support and foster care, rehabilitation of persons with disabilities at the level of voivodeship self-government.

Basic tasks of ROPS:

1. Designing the voivodeship self-government's policy in the area of social policy by, inter alia, developing, implementing and coordinating a voivodeship strategy in the area of social policy which is an integral part of the voivodeship's development strategy and regional programmes, including in particular: supporting family and foster care, counteracting family violence, counteracting social exclusion, equalising opportunities for disabled persons, social assistance, participation in planning funds at the disposal of voivodeship self-governments (including EU funds), carrying out research and analyses.
2. Initiating, promoting and recommending innovative solutions in the field of social policy.
3. Supporting local self-governments in the organisation, coordination and implementation of tasks in the area of social policy, inter alia, through substantive, training and advisory support in the area of social policy, including, in particular, social assistance, support for the family and foster care, social and professional rehabilitation of persons with disabilities, counteracting domestic violence.
4. Support (financial and substantive) NGOs, inter alia by providing grants, creating spaces for the exchange of experience, including the organisation of thematic forums.
5. Supporting cooperation between institutions operating in the field of social policy, including in particular social assistance, support for the family and foster care, social and professional rehabilitation of persons with disabilities, counteracting domestic violence.

One of the new solutions proposed in the draft Partnership Agreement is to implementation by ROPS of projects coordinating the area of social inclusion in the new

financial perspective 2021-2027.These projects are tentatively scheduled for implementation in under the national programme European Funds for Social Development (FERS).

The aim of the proposed solutions is to ensure a better flow of information and coordination of projects between the national and regional levels and greater standardisation of implemented measures between regions, thus strengthening the less active ROPS and increasing the influence of the Ministry of Family and Social Policy as a gestor of social inclusion policy. This will strengthen the position of ROPS, enable a better flow of information between the national and regional levels and consequently make the support better aligned with both national policy and regional needs.

1.4 Departments of Politics Social Affairs

The organisational unit of the Provincial Office dealing with, inter alia, social welfare, family support, foster care matters.

Main tasks:

- conducting matters related to the supervision and control of tasks in the field of social welfare, family benefits, maintenance fund, prevention of family violence, support for the family and foster care, carried out by local government units, and supervision over the compliance of employment of employees of local government social welfare units with the required qualifications,
  -coordinating and implementing government social policy programmes,
  -implementation of the Act of 11 February 2016 on state aid in upbringing children,
- issuing permits for the operation of social welfare homes, care and educational facilities, regional care and therapeutic facilities and intervention pre-adoption centres and facilities providing round-the-clock care for the disabled, chronically ill or elderly, including those run as part of economic activities.

1.5 Service centres social

Social service centres (CUS) were established by the Act of 19 July 2019 on the implementation of social services by a social service centre (Journal of Laws, item 1818). They are

units, which will allow municipalities to adapt social services to the needs of their inhabitants and the financial possibilities of local governments. The aim of the CUS is to coordinate social services from different systems: social assistance, family policy, health promotion and protection, culture, public education, pro-family policy, support for disabled people.

The centres are the coordinating entities of local social service systems of general interest public in the field of:

1) family-friendly policies,
2) family support,
3) foster care system,
4) social assistance,
5) health promotion and protection,
6) supporting people with disabilities,
7) public education,
8) countering unemployment,
9) culture,
10) physical culture and tourism,
11) stimulating active citizenship,
12) housing,
13) environmental protection,
14) professional and social reintegration.

The catalogue of services that can be provided by CUS is broader than care services and is aimed at all residents in the local community, not just those on social assistance. Interested residents will be able to receive packages of services tailored to their individual needs.

The task of a CUS is to integrate and coordinate services provided by various local service providers (public and non-public) cooperating with the centre. The Act assumes the optionality of the creation of social service centres by interested municipal governments acting independently or under inter-municipal agreements and indicates in detail the tasks of the CUS and the principles of its organisation.

Currently, the creation of CUS is mainly taking place within the framework of the competition entitled Supporting the creation of

social service centres and the development of the services they provide, co-financed by the

European funds under Measure 2.8 of the Operational Programme Knowledge Education Development 2014-2020. 41 CUSs have so far been established as part of the competition funds. In addition, Centres are also being created with the municipalities' own funds.
After three years of operation of CUS, the law provides for the preparation of information on the implementation of the tasks under the law in the field of CUS. After carrying out the aforementioned task, amendments to the Act on the implementation of social services by the social service centre will be proposed.

1.6 Staff delivering social services in assistance social services

The basis for the provision of social services in a residential environment is the staff providing these services.
Staffing figures for Social Care Centres and Nursing Homes as at 31.12.2020 are as follows:

– OPS had a total of 56,544 employees at the end of 2020, of which 19,184 were social workers,
– DPS employed 55,832 people at the end of 2020, of which staff providing residential services were 17,888, staff providing care, education and support services were 37,944, of which 1,9277 were social workers and 19,473 were care staff.

The key to high quality of all support services is motivated and willing staff. The assumption of the document for the coming years is, inter alia, the development and strengthening of the staff of social assistance and integration institutions, in particular the staff providing social services, including above all through the training offer adapting the staff to the changes taking place, consistent with the directions of actions planned in the Strategy.
In addition, in the assumptions for the new financial perspective planned for 2021-2027, the Ministry emphasises activities that promote the social work profession and build professional prestige.

2. Other institutions and entities involved in the delivery of social services

2.1 Entities of the economy social

Due to their bottom-up nature and local rootedness, social economy actors are,

besides local governments, a key element of the system ensuring broad access to social services provided in a way that activates and engages the local community. This is confirmed by CSO research[55] .

The activity of social economy entities in the area of social services makes it possible not only to supplement the local government's offer, but also to support the process of diagnosing the real needs of recipients and adjusting actions conducted to them, as well as to activate the local community in matters directly concerning it. As a result, final recipients have access to services responding to their specific and individual needs, which at the same time are conducive to inclusion in the life of the local community and provided by entities rooted in it.

The catalogue of social economy entities includes above all: social cooperatives, non-governmental organisations and entities referred to in Article 3(3) of the Act of 24 April 2003 on public benefit activity and voluntary work (Journal of Laws of 2022, item 1327 and 1265), as well as work cooperatives and cooperatives of the disabled and blind and reintegration units (including CIS, KIS, ZAZ, WTZ).

An important challenge is to create conditions allowing even stronger inclusion of social economy entities into the market of social services. This will allow meeting the needs of local communities and their inhabitants with simultaneous strengthening of PES which perform reintegration functions towards persons threatened by social exclusion and contribute to creation of new jobs in the local community, and consequently limitation of poverty and social exclusion.[56]

2.2 Civil society organisations

The term 'civil society' refers to all forms of social activity undertaken by individuals or groups unconnected to and not governed by the state.

A civil society organisation is an organisational structure whose members are guided by the general interest using the democratic process. It plays a mediating role between public authorities and citizens.

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[55] *The role of the non-profit sector in the delivery of social services 2014-2016*, Warsaw, Krakow 2018.

[56] KPPUiWS, p.43.

Examples of such organisations include:

– social partners (trade unions and employers' federations),

– non-governmental organisations (e.g. environmental and consumer organisations),

– local organisations (e.g. youth or family associations).

According to the document entitled Cooperation Programme of the Minister of the Family and Social Policy with non-governmental organisations and entities mentioned in Article 3(3) of the Act on Public Benefit Activity and Volunteerism for 2021-2023 constituting an annex to Order No. 35 of the Minister of the Family and Social Policy of 21 December 2020. on the adoption of the programme of cooperation of the Minister of the Family and Social Policy with non-governmental organisations and entities mentioned in Article 3(3) of the Act on public benefit activity and voluntary work for 2021-2023 (Journal of Laws, item 38), 101,000 registered non-governmental organisations were active in 2018. Among them, the largest group were associations and similar social organisations - 69.1 thousand entities (68.4%), foundations - 14.5 thousand (14.4%) and trade unions - 12.5 thousand (12.4%). There were also 2.7 thousand economic and professional self-government organisations (2.6%) and 1.8 thousand social religious entities (1.8%). Among registered NGOs, 87.3 thousand entities belonged to the social economy sector, 9.3 thousand had the status of a public benefit organisation and 0.2 thousand were listed as social enterprises. In 2018, the largest proportion of associations and similar social organisations and foundations indicated sport, tourism, recreation, hobbies as their main field of activity (30.6%). Of these, 68.5% were sports associations. The most popular field of activity within this field was the provision of physical culture activities, the organisation of competitions and the operation of sports facilities (24.0%), to a lesser extent the organisation of tourism and recreational events and the operation of facilities for tourism (4.0%).

As part of the concurrent tasks carried out by the Ministry of Family and Policy

In the social field of social and humanitarian aid (7.3%), the main field of activity was helping people with disabilities (3.1%). Organisations that indicated the labour market and professional activation as their main area of activity accounted for 1.4%.

The contribution of non-governmental organisations to service delivery is illustrated in the report entitled The role of the *non-profit* sector in the delivery of social services in 2014-2016, produced in 2018 by the Central Statistical Office in Kraków.

Non-governmental organisations (NGOs) have for years played a significant role in the delivery of social services to people in need of support in their daily lives, both as implementers of activities and as advocates for planned and implemented changes in this area. Such a role is also enshrined in this document.

3. Programmes for deinstitutionalisation of services social services

All current activities in the field of social policy, especially in the sphere of the development of social services, are undertaken taking into account the idea of deinstitutionalisation. This approach is adopted both at a pan-European level, in numerous European Union initiatives with a social dimension, and has also been present for years in our national social policy, in the planned and implemented solutions for social security, the development of social services and support for people in need of help in their everyday functioning.

Measures included in the idea of deinstitutionalisation of social services currently being undertaken by the Ministry of Family and Social Policy include:

1) The "Care 75+" programme - Development of care services and specialised care services, including specialised services for people with mental disorders provided at home,
2) Development of community self-help homes and self-help clubs - network of centres support for people with mental disorders,
3) Development of sheltered housing, including supported and training housing,
4) Development of family care homes,
5) Development of a personal assistant service for people with disabilities,
6) Development of a respite care service,
7) Development of care and housing centres,
8) Senior+ Programme,
9) Programme entitled 'From dependency to independence',
10) Programme entitled 'Overcoming homelessness'.

1. THE "CARE 75+" PROGRAMME

From the point of view of the Ministry of Family and Social Policy, it is important that residential care services are provided in every municipality. Some

municipalities were not performing this task sufficiently, which is why, since January 2018, the 'Care 75+' programme has been implemented as a support to local governments and one of the answers to the challenges posed by the demographic processes taking place in Poland.

The strategic aim of the programme is to improve access to care services, including specialist care services, for both single people and those in families who are aged 75 and over.
The 'Care 75+' programme has been implemented since January 2018 and is aimed at urban, rural, urban-rural municipalities with up to 60,000 inhabitants.
Municipalities that join the programme receive financial support of up to 50% of the expected costs of implementing the task of providing care services, including specialised care services, for persons meeting the criteria set out in the programme.

Under the programme, a municipality can benefit from state funding for the provision of care services, including specialised care services, if:

1) the benefit in question is carried out independently, i.e. by employees of the social welfare centre, municipal office or other municipal organisational units (employed under an employment contract) or
2) outsources the implementation of the task in question to non-governmental organisations or
3) buys care services from private sector providers.

Due to the introduction of the 'Care 75+' programme, the number of municipalities providing care services has increased.
Z analysis of reports sent to by governors summarising implementation of the programme in question in 2020 shows that in the reporting year, the programme was implemented by 509 municipalities, services under the programme were provided to 7731 persons for the amount of over PLN 15 million. One of the effects of the introduction of the Care 75+ programme is an increase in the number of municipalities providing care services (from 2148 municipalities in 2018, through 2197 municipalities in 2019 to 2212 municipalities in 2020), i.e. an increase of 64 municipalities over these 3 years, with a total number of 2477 municipalities operating in Poland in 2019-2020 (in 2018, 2478 municipalities were operating in Poland). This means that more than 89% of municipalities in Poland are currently implementing this task. The implementation of the programme has also allowed for an increase in the number of people aged 75 and over using care services, including specialised services, as well as the

an increase in the number of hours of services for people who were already receiving this form of assistance. The assistance provided to older people has improved their lives, made them more active in their daily functioning and life needs, and enabled them to continue to function in their current environment.

2. DEVELOPMENT OF COMMUNITY SELF-HELP HOMES

These are periodic day or 24-hour facilities where people with mental disorders and intellectual disabilities can receive partial care and assistance with essential living needs and a meal.

The work of support centres, including support centres for people with mental disorders, is very important, acting as a supportive influence on the whole family, helping to carry out the caring functions of family members in need of support, while preventing them from being placed in 24-hour institutions. It also supports single people, preventing their multi-faceted exclusion from social life.

Community self-help homes are run by local government units as a delegated task - their creation and running is financed from the state budget.

From year to year, the number of community self-help homes is increasing. Today, there are already 844 such centres throughout Poland, providing approximately 32,000 places.

The financial outlay from the state budget for the development of the network of support centres for people with mental disorders has also increased significantly in recent years. In 2020, an amount of more than PLN 45 million has been allocated within the special purpose reserve of the state budget for the above and for an increase in the monthly subsidy for participants with autism spectrum and coupled disabilities.

It should be noted that the expenditure on support centres for people with mental disorders from the state budget is higher from year to year. The amount of funds spent on support centres for people with mental disorders was:

-in 2015 - PLN 404,866 thousand,

-in 2016 - PLN 457,396 thousand,

-in 2017 - PLN 483,948 thousand,

-in 2018 - PLN 583,170 thousand,

-in 2019 - PLN 713,232 thousand,

-in 2020 - PLN 721,395 thousand.

In 2021, an amount of PLN 713,982 thousand was planned for this purpose in the Budget Act. In addition, in 2021 funds from the specific reserve of the state budget in the amount of PLN 44,995,128 were released for the development of a network of support centres for people with mental disorders.

3. DEVELOPMENT OF SHELTERED HOUSING

A sheltered flat is a form of social assistance that prepares - under the care of specialists - people staying there for independent living or supports them in their daily functioning.

Sheltered housing offers support to adults who, due to a difficult life situation, age, disability or illness, need help in functioning in everyday life, but do not require services in the scope provided by a 24-hour care unit, in particular: persons with mental disorders, persons leaving foster care, youth rearing centre, juvenile detention centre, foreigners who have obtained refugee status, subsidiary protection or temporary residence permit in the Republic of Poland.

It is a municipality's own compulsory task or a district's task (conducted for people from more than one municipality).

They may be run by any social welfare organisational unit or
public benefit organisation.

As the law currently stands, sheltered housing can be run as either training or supported housing.

Sheltered housing is part of deinstitutionalised care.

It allows the person to function longer in his or her natural environment, thus removing the need for institutional care.

Contributes to maintaining a level of independence through supervised training and, through inclusive activities, helps to overcome feelings of loneliness and strengthen self-confidence.

It offers the chance to become independent and lead an independent life.

The implementation of the self-governments' own task is supported from the state budget funds under Measure 4.7 of the "Za życie" Comprehensive Support Programme for Families (Resolution No. 160 of the Council of Ministers of 20 December 2016 on the "Za życie" Comprehensive Support Programme for Families (M.P. item 1250 and of 2022 item 64)):

- For the years 2017-2021, funding from the state budget in the total amount of PLN 108 million has been provided for the construction or adaptation of premises for new sheltered housing (PLN 12 million in 2017 and PLN 24 million each from 2018).
- In 2017-2018, the grant was up to 50% of the cost of the task, increasing to 70% of the cost of the task in 2019 and up to 80% of the cost of the task from 2020 onwards.
- Number of sheltered housing units created under the 'For Life' Programme:
  - in 2017, 38 sheltered housing units were created with 147 places,
  - 48 sheltered housing units with 187 places were created in 2018,
  - 55 sheltered housing units with 180 places were created in 2019,
  - 18 sheltered housing units with 59 places were created in 2020.

The number of sheltered housing - training and supported housing - is increasing.

- As of the end of 2020,[57] there were 1355 sheltered housing units in operation with 4098 places, benefiting 3664 people.
- The number of sheltered housing units operating in 2020 was 249 units higher than the number of units that were operating in 2019 (1106 sheltered housing units), an increase of approximately 22.5%.

This document plans to introduce legislative changes to the naming and operation of sheltered housing. There will be a unification of nomenclature - assisted housing will function with a basket of social services specified for a person in need of support in everyday functioning. The unification of nomenclature will facilitate the creation of flats and implementation of services in this form of assistance.

4. DEVELOPMENT OF FAMILY WELFARE HOMES

Family care homes are an intermediate link in the social welfare system between residential care services and a 24-hour specialist support facility such as a social care home.

A family care home is a form of care and living services provided on a 24-hour basis by an individual or a non-profit organization for not less than

[57] Source: MRPiPS-03 report for 2020 - preliminary data, under revision.

three and no more than eight persons living together who require this form of support due to age or disability.

As intimate facilities for no more than eight people, they are part of the implementation of the idea of deinstitutionalisation of social welfare services, which is why, in the opinion of the Ministry of Family and Social Policy, the development of this type of facility is particularly desirable.

As this form of support is very unpopular (there are currently only 47 family support homes in Poland[58]), the Ministry has developed a programme to support the development of family support homes.

The aim of the Programme is to improve access to care services provided in family care homes and the development of this form of support.

The programme is a new initiative of the Ministry - it is planned to be implemented in 2022. Programme addressee:

Municipalities that have signed (or plan to sign) a contract with a PBO or an individual to run a family care home and refer or plan to refer persons to a family care home.

Municipalities that have a building in their stock that they plan to make available on a lease basis to a PBO or an individual for the purpose of starting up a family care home.

Resources provided for the programme:

Municipalities will receive funding from the state budget's special purpose reserve. Approximately PLN 16 million is envisaged for the programme from the state budget.

5. DEVELOPMENT OF PERSONAL ASSISTANT SERVICES FOR PEOPLE WITH DISABILITIES

The Solidarity Fund includes programmes:

- "Personal assistant for a disabled person",
- "Personal assistant for people with disabilities".

Both programmes are aimed at children up to the age of 16 with a disability certificate, including the following indications: need for permanent or long-term care or assistance from another person due to significantly reduced ability to lead an independent life.

[58] Data from MRPiPS-03 report for 2020.

existence and the need for the child's guardian to be permanently involved in the child's treatment, rehabilitation and education on a day-to-day basis, and to disabled persons with a severe or moderate degree of disability who require the services of an assistant in performing daily activities and functioning in society.

The programmes are intended to ensure, among other things, that people with disabilities are able to benefit from the assistance of an assistant in carrying out daily activities and functioning in society; to stimulate a disabled person to become active and enable the realisation of the right to independent living; to counteract discrimination on the basis of disability or to increase the support provided by Assistants for Students with Special Educational Needs (ASPE) in supporting disabled students, also in other dimensions of life and social functioning. The Personal Assistant for Persons with Disabilities programme is implemented through and with the participation of municipal and district governments.

The programme "Personal Assistant for a Person with Disabilities" is implemented by the NGOs that have received funding under the Programme.

Programme implementation:

- In 2019. 54 local authorities have applied for funding from the Personal Assistant for People with Disabilities Programme - 2019-2020 edition.
- In 2020, applications were submitted by 492 municipalities and districts. In this year's edition of the Programme (2021), applications were submitted by 751 local government units.
- An amount of PLN 80 million has been earmarked for the implementation of the Programme "Personal Assistant for a Person with Disabilities" - 2020-2021 edition was allocated PLN 80 million in 2020 and PLN 80 million in 2021.
- In 2021. 86 NGOs from all over Poland have been recommended for funding for the services of an assistant to a person with disabilities from the Solidarity Fund within the framework of the Programme "Personal Assistant to a Person with Disabilities" - 2020-2021 edition.
- A Programme announcement is planned for September/October 2022.
  "Personal Assistant for Persons with Disabilities" - 2022 edition and the Programme 'Personal assistant for a disabled person' - 2022 edition.

6. RESPITE CARE PROGRAMME

The Solidarity Fund is implementing the programmes "respite care" - edition 2021 and "respite care for family members or carers of persons with disabilities" - edition 2020-2021.

Who the programmes are aimed at and why you should support the provision of care services respite:

Both programmes are aimed at family members or carers with direct care responsibilities for children with a disability certificate or those with a severe disability certificate who require respite care services.

The programmes are aimed at family members or carers of persons with disabilities who require support in the form of an ad hoc, temporary break from direct care of children with a disability certificate, as well as persons with severe disabilities, and to improve their skills and knowledge in this area - respite care is intended to relieve the burden on family members or carers of persons with disabilities by supporting them in their daily duties or providing a temporary substitute.

- The 'respite care' programme - 2021 edition is implemented through and with the participation of municipal and district governments.
- The 'respite care for family members or carers of persons with disabilities' programme - 2020-2021 edition is implemented by NGOs that have received funding under the Programme.

The above Programmes are implemented in the form of the provision of respite care services in the form of day care, in the form of 24-hour residence and the provision of services by providing family members or carers with direct care for children with a disability certificate or persons with severe disabilities/ persons with an equivalent certificate with the opportunity to benefit from specialised counselling (psychological or therapeutic) and support in learning care/rehabilitation/dietetics.

Programme implementation:

- In 2019. 329 local authorities have applied for funding from the 'respite care' Programme - 2019 edition.

- In 2020, applications were submitted by 359 municipalities and counties.
- Under this year's edition of the Programme (2021), applications were submitted by 699 local government units.
- For the implementation of the "respite care" Programmes - 2019, 2020 edition and the edition of the

  2021 has been allocated a total of PLN 112,471,033.15.
- The Programme 'respite care for family members or carers of persons with disabilities' - 2020-2021 edition has been allocated PLN 30 million in 2020 and PLN 50 million in 2021. In 2021. 49 non-governmental organisations from all over Poland received recommendations for funding respite care services from the Solidarity Fund under the Programme "Respite care for family members or carers of persons with disabilities" - edition 2020- 2021.
- The 2022 edition of the respite care programme - the 2022 edition - and the respite care programme for family members or carers of people with disabilities are ongoing.

7. CARE AND HOUSING CENTRES PROGRAMME

Residential care centres are for adults with severe or moderate disabilities (and a certificate treated as equal).

The joint stay of the participants at the Centre is intended to have a positive impact on the socialisation and interpersonal relations processes and to allow disabled people to undertake activities to the best of their potential and resources.

The Centre's infrastructure and the organisation and type of services provided are specifically designed to meet the needs of participants arising from the different spectrum of disabilities, to provide conditions for establishing and maintaining relationships with others, and to acquire and develop skills and competences that determine individual independence and the ability to undertake social roles.

The aim of the programme is, among other things, to strengthen the existing system of support by extending services for adults with severe and moderate disabilities, enabling independent, self-reliant and dignified functioning to the capacity and needs of people with disabilities.

The 'Care and Residential Centres' programme aims to create the conditions for local authority units at municipal/county level to establish and maintain day or 24-hour residential facilities for people with disabilities.

- Between August 2019 and May 2021, 39 applications from municipalities/counties have been approved for the Care and Residential Centres Programme.
- The amount of funding for approved applications was PLN 92 486 738.29.
- The budget of the Programme for the period 2021-2024 is PLN 75 million annually.

8. MULTIANNUAL PROGRAMME "SENIOR+"

Thanks to the measures taken by the Ministry, the support system for older people is developing effectively. Throughout Poland, "Senior+" day care centres and "Senior+" clubs are being set up to provide older people with, among other things, care and the opportunity to develop their passions.

The strategic objective of the programme is to increase active participation in the social life of seniors by developing the infrastructure of support centres in the local environment, by increasing the number of places in "Senior +" facilities, i.e. Day Care Centres "Senior +" and "Senior +" Clubs.

The programme is aimed at local authorities and consists of expanding the network of day care centres for the elderly and subsidising existing centres in their ongoing operations.

Under the programme, local authorities can apply through an open call for tenders for funding to set up or equip centres and ensure the operation of existing centres.

- For the implementation of the Senior+ programme, the ministry has allocated in 2021. PLN 60 million.
- A total of £310 million between 2016 and 2020.

9. PROGRAMME "FROM DEPENDENCE TO INDEPENDENCE"

The main objective of the programme is to enable people with mental disorders to overcome the difficult life situation they find themselves in, which they are unable to overcome by their own efforts, using their own entitlements, resources and abilities.

The programme is delivered in four modules that aim, among other things, to:

- enabling access for families of people with mental disorders to various services, e.g. periodic substitution in parental functions, initiating parents' self-help groups,
- implementation of projects to support the initiation and support of self-organisation, self-help for people with mental illness and intellectual disabilities,
- the development of skills that will contribute to the fullest possible independence in the daily functioning of people with mental disorders,
- initiating and implementing new forms of community support for people with mental disorders, especially by organisational units of social assistance services.

Funds allocated to the programme - PLN 3 million.

10. THE "OVERCOME HOMELESSNESS" PROGRAMME

The main objective of the programme is to inspire and support activities aimed at preventing and solving the problem of homelessness, to inspire the implementation of new methods of working with homeless people and programmes for their social and professional activation. The programme is delivered in four modules that aim, among other things, to:

- preventing homelessness by carrying out prevention activities,
  -conducting intervention and activation activities aimed at people
  those in crisis of homelessness,
- support entities w adapt run by them facilities
  providing services to the homeless to current standards,
  -inspiring the implementation of new solutions to help people
  homeless.

Funds allocated to the programme - PLN 5.5 million.

Chapter III. ESSENCE OF THE PROCESS DEINSTITUTIONALISATION

Defining deinstitutionalisation is not an easy matter. The European-wide guidelines on the transition from institutional to community-based care give a general definition. The guidelines state that "Wherever *possible, these guidelines avoid using the term deinstitutionalisation, as it is often understood simply as the closure of institutions. Where the term is used, it refers to the process of developing community-based services (including preventive services) to eliminate the need for institutional care.*" Thus, the guidelines do not directly indicate that the process of deinstitutionalisation is to include the closure of 24-hour care institutions, but it focuses strongly on the development of community-based services for people in need of community care, with the aim of achieving a situation where institutional care - 24-hour care - is not needed at all. The authors of the European guidelines also point out that no European country has achieved a situation without 24-hour care facilities.

Deinstitutionalisation is not, therefore, a process involving the absolute closure of institutions providing 24-hour care. It is a process of developing community-based social services and developing and implementing solutions that enable 'independent living' for older people, people with disabilities, people in mental crisis and others who need support in their daily lives, and children to live under family or family-like care.

However, the term 'independent living' does not mean having the ability to 'do things independently' or to be 'self-sufficient'. Independent living involves being able to make choices and decisions about where to live, about cohabitation and about how daily life is organised.

Thus, deinstitutionalisation measures should first focus on universal access to community-based services, as only unrestricted access to a broad spectrum of interdisciplinary community-based services can reduce the demand for inpatient long-term care. Universal access to community-based services can also be helped by changing the way

the activities of today's long-term institutions to provide support
in the local community.

Satisfying social needs in terms of the provision of services at the place of residence (in the local environment) will lead to a reduction in the need for institutional forms of services aimed at people in need of support in their daily functioning.

In summary, the deinstitutionalisation process will include the following lines of action:

– priority of community-based social services over services stationary,
– the development of personalised community-based social services, including services of a preventive nature, which will reduce the need for institutional care,
– using the resources and capacity of institutional long-term care to develop new community-based services,
– the development of various forms of housing.

The process of deinstitutionalisation of social services is a multi-area and long-term process and should be implemented with the basic assumption that it is intended to improve the well-being of individuals and families. However, it should be carried out very prudently, thoughtfully and responsibly, creating innovative quality of support systems for each of the mentioned social groups, based on the transformation of the existing service systems into the organisation of services in local communities and the development of new support tools. It is assumed in the Strategy to start this process from the date of entry into force of this Strategy and to complete it in time by 2030 (with an outlook to 2035).

The idea of deinstitutionalisation has been present in Polish social policy for years. It was expressed both in the adopted legal solutions and strategic documents. Also the currently binding and developed strategic documents take this aspect into account. At the same time, the development of the concept of deinstitutionalisation on a pan-European level and its operationalisation in the form of specific guidelines, now form the basis for setting directions on the national level and defining the key stages enabling the implementation of the concept in the area of services.

social relevant to policies to prevent poverty and social exclusion.

Deinstitutionalisation was indicated in the Responsible Development Strategy as an adopted direction of change in the social services system, and in the Human Capital Development Strategy it is included explicitly, among others, in actions concerning foster care services and social services.

The actions included in the Strategy build on the above-mentioned strategic framework and cover a time horizon consistent with these documents. At the same time, they are part of a strategic approach to deinstitutionalisation with a longer time horizon and in line with the Europe-wide guidelines for the transition from institutional to community-based care. In line with this approach, the Strategy considers those stages of the process that will be implemented by 2030 and are an essential part of its successful implementation. Actions beyond this time horizon will be modified and detailed accordingly, in line with the provisions of higher-level strategic documents (medium-term national development strategy, relevant development strategy).

The process of transition from institutional care to care provided at the level of local communities in the case of the diagnosed situation in our country requires long-term action - in a perspective of several decades - involving the following stages and blocks of action:

1) increasing the supply, availability and quality of services provided at home and in deinstitutionalised forms;
2) preparation and implementation of local and regional plans for the development of long-term care services;
3) progressive transformation, a then possible closure of establishments stationary.

Key milestones for the transition from institutional to community-based care to be undertaken by 2030 in the area of social services relevant to tackling poverty and social exclusion are:

1) A comprehensive review and assessment ("audit") of all 24-hour long-term care facilities operating as social welfare units, as well as shelters for the homeless and shelters with care services for persons

homeless and other shelters for the homeless and other establishments providing 24-hour social services, with a particular focus on analysing the structure of the residents of these establishments and their individual situations in terms of their prospects for becoming independent;

2) the continued development of the supply of residential care services;
3) development of assisted housing;
4) developing local and regional plans/strategies for long-term care services, in line with the concept of deinstitutionalisation;
5) stopping referrals to residential care homes for people under the age of 18. In terms of the development of the service system, ensuring that families and individuals in need of support have access to affordable community-based services is paramount. Promoting the development of community-based services is also highlighted in recent expert studies as essential in the strategic approach to the deinstitutionalisation process as part of the strategic framework for combating poverty and social exclusion[59] .

To achieve this, it is necessary to build a coherent system for programming, coordinating and monitoring the system of social services, the development of which should be based on public-social partnership and the participation of partners of the social economy sector in the co-creation, implementation and monitoring of activities.

By 2030, the target for the transition process from institutional to community-based services is:

1) increasing the availability of community care services at the municipal level,
2) increasing the number of assisted living facilities,
3) A reduction in the rate of the average number of people in a social welfare home and a shelter for the homeless and a shelter with care services for the homeless,
4) Increasing the proportion of services provided in the community and at home compared to institutional care (by reducing the ratio of institutional to community-based services).[60]

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[59] EAPN Poland, Poverty Watch 2020, p. 58.
[60] KPPUiWS, p. 48.

Chapter IV. VISION AND OBJECTIVES STRATEGIC

STRATEGY VISION

To prepare a system for the delivery of social services to people in need of support in their daily functioning, in particular due to old age, disability, mental health problems, homelessness, in such a way that they can function safely and independently in their place of residence for as long as they wish, and to ensure that children and young people deprived of parental care are cared for in a family or family-like setting.

The presented vision of the process of deinstitutionalisation of social services indicates the necessity to realise tasks that are crucial for the success of the process - the implementation of an effective system of providing social services in the local community, taking into account the needs of its inhabitants.

Key activities:

- Education of all stakeholders in the deinstitutionalisation process, regarding the necessity to take measures to increase the participation of the person in choosing the way of providing services. Education on wider dissemination of, among others, the catalogue of social services in the community, guidelines and recommendations for the implementation of individual forms and monitoring their quality,
- Development of national guidelines for deinstitutionalisation of social services and regional (provincial) and local (municipal and district) plans for deinstitutionalisation of social services,
- expansion of the system of environmental services allowing the choice of form and manner of the provision of social services by a person in need of support,
- continuing the deinstitutionalisation of foster care,
- changing the way social welfare homes function - DPS as environmental service centre,
- analysis of the legal situation and adaptation of existing legislation to the requirements

the deinstitutionalisation process,

-development of staff providing social services,

-development or modification of tools allowing ongoing monitoring of the process deinstitutionalisation,

-making legislative changes to sheltered housing - Unification of the nomenclature for 'supported housing with a basket of services',

-developing temporary accommodation with social services in line with the needs of the person in need of support in daily functioning,

-taking action to make people economically independent with disabilities through their vocational activation,

-guaranteeing the provision of social services in the local environment for everyone citizen,

- practical implementation of the idea of independent living for every person with disabilities,

-supporting the development of the capacity of social economy entities to deliver community-based social services.

The proposed actions are in line with *the* 'Europe-wide guidelines for the transition from institutional to community-based care', which define them as follows: "These commitments should go hand in hand with capacity building measures for family and community-based care or with support to ensure that facilities do not close before adequate services are in place. Strategies and action plans should also be accompanied by a budget indicating how new services will be funded."[61]

Achieving the above will require a series of systemic state reforms, the implementation of which must be staggered over time. Staggering the necessary processes over time to allow for real, sustainable and effective change is a guarantee that the deinstitutionalisation process will take place in a way that respects the rights of the different user groups of recipients, minimises the risk of harm and provides benefits to all participants in the process.

[61] "Europe-wide guidelines for the transition from institutional to community-based care", www.funduszeeuropejskie.gov.pl/media/17881/12.pdf, p. 71.

STRATEGIC OBJECTIVES

The realisation of the Strategy's vision requires the setting of detailed strategic objectives in individual areas of strategic intervention. The strategic objectives will be achieved through the implementation of the designated lines of action.

Strategic objective 1: Increase the participation of families and familial forms of foster care in the care and upbringing of children

Action lines for strategic objective 1

1. Developing preventive and direct community services to support children and families by:

1) Coordinate and harmonise multiprofessional cooperation with and for the family in order to strengthen internal and external resources to meet the child's developmental needs independently. Implement solutions to increase family participation;
2) implementing arrangements to increase the participation of the child at risk of or separated from his or her family in decisions that affect him or her, taking into account his or her level of maturity;
3) the introduction of preventive measures aimed at strengthening family ties, increasing parents' knowledge and competences with regard to meeting their children's needs, including the protection of their rights and psychological support;
4) support for adoptive families - support for parents and access to rapid, comprehensive diagnosis and therapy for children;
5) support for children with disabilities and children with developmental disorders and at risk of disabilities;
6) Strengthening and expanding the catalogue of support services for parents of children with special needs in order to prevent burnout due to burdens

arising from the provision of care;

7) support the process of achieving life stability for the child after separation from the family;
8) the development of activities targeted at young people who are socially maladjusted or at risk of such maladjustment through the development of community-based forms of re-socialisation, therapy and education;
9) increasing the number and strengthening the competence of family support system staff;
10) increasing the number of Expertise Judicial Panels in order to streamlining the work of the family courts and reducing the length of court proceedings;
11) creating so-called service baskets for families with children in the municipality;
12) support for families in the treatment of alcoholism and other addictions.

2. Development of family forms of foster care through:

1) developing the offer of support for children in family foster care and for foster parents;
2) measures to increase the range of services provided by specialist child and family support centres, which provide intensive, interventionist, highly specialised support, including 24-hour stays, but only of a short-term nature, carried out on a "turnaround" basis.

The proposed solutions will lead to an increase in the stock of family forms of foster care and will ensure that children receive the support best suited to their needs (in particular children with disabilities, fetal alcohol syndrome - FAS, mental health problems, experience of complex developmental trauma, chronic illnesses, social maladjustment or at risk of maladjustment). In addition, they take into account children's right to express their opinion and participate in decisions that affect them (regardless of their age and developmental level).

3. Changing the functionality of 24-hour long-stay facilities by:

1) gradual change in the function of 24-hour institutions for children in order to provide families and children with support in the local community and the implementation of institutional social services in a new formula (concerns: institutional foster care entities, youth sociotherapy centres, homes

social assistance);

2) adoption (w in order to planning development of services social services provided

in the local community) of the following assumptions:

-the aim should be to place the child in family foster care rather than institutional,

- institutional foster care should be a last resort,

- assumes is assumed operation of small, to 14 persons, establishments care Institutional facilities that will provide family-like care,

- every child should be placed with a family (biological, adoptive, foster). In the event of having to leave the family, he or she is immediately entrusted to a foster family or family home, which takes care of him or her and remains in ongoing contact,

- every child whose biological parents have been deprived of their parental rights has a legal guardian, who may be a person who has a permanent, direct relationship with that child as evidenced by existing or planned shared residence (in particular relatives, close unrelated persons, foster parents) or a relationship intended to be permanent, direct and evidenced by shared residence (family taking on the role of foster family). The child's views must be taken into account when choosing a legal guardian.

4. Improving the quality of empowerment of foster care and 24-hour residential institutions through:

1) developing individual empowerment plans for residents of 24-hour social welfare homes and for foster care alumni;
2) strengthening the role of the guardian of independence;
3) Creating baskets of social services for foster care and 24-hour institutions;
4) monitoring the fate of those who become independent;
5) development of assisted housing with an appropriate basket of services as a step preparatory prior to living in a self-contained property.

Assumed effects of the action lines:

1. Measures to support families from which children come will prevent placing children in foster care.
2. The situation of children in families in crisis will improve, resulting in their integration and social inclusion.
3. The implementation of the lines of action will make it possible to abandon the need for institutional foster care and ensure the supply of an adequate number of family forms of foster care.
4. Actions will lead to improved child protection and foster care systems.
5. There will be an expansion of family foster care, including targeting children with disabilities and illnesses.
6. Measures will be implemented to ensure that every child can grow up in a family or family-like environment.
7. There will be a change in the operation of the current 24-hour facilities for children from 24-hour long-term care to short-term respite and community-based services.

Timetable for implementation of action lines:

		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2035
Implementation deadline lines of action	**1**											
	2											
	3											
	4											
Indicative sources of funding	State budget Local authority budgets EU funds											
Implementers	Minister responsible for family affairs Ministry of Justice - Partner in the Process - its tasks will include support to legislative processes, including giving opinions on submitted draft laws Ministry of Education and Science - Partner in the process - especially regarding the situation of children located in 24-hour educational establishments Minister of Finance - with regard to the planning of funds for the implementation of the course of action Voivodship self-governments, within the framework of the tasks resulting from the acts currently in force legal Local government units (municipalities and counties), within the framework of the tasks resulting from the legal acts currently in force Civil society organisations - in accordance with the Act of 24 April 2003 on the public benefit activity and voluntary work											

The model outlined below represents a new way of operating support services families.

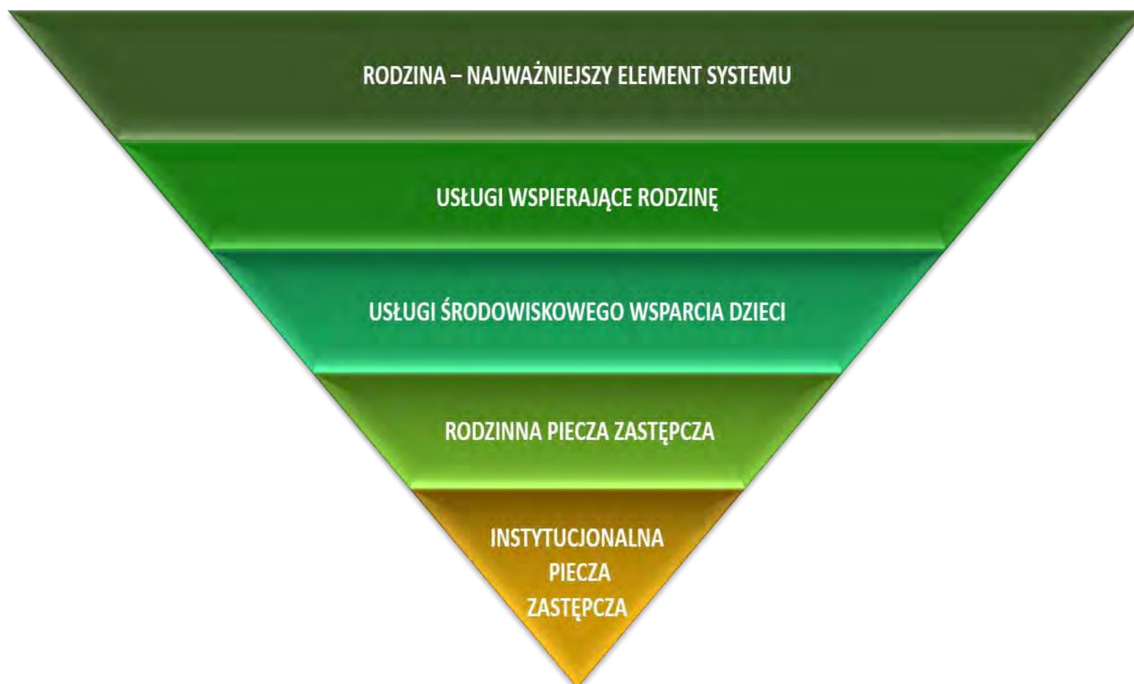

Figure 1 . Inverted pyramid - diagram of the organisation of family support services

Strategic objective 2. To build an effective and sustainable system providing social services to people in need of support in their daily functioning

Action lines for strategic objective 2

1. Implementing a system of coordination and standardisation of social services by:

1) promotion and dissemination among local self-government units of the function of social services coordinator in order to properly meet the needs of people in need of support in their everyday life;
2) legislative changes to the establishment of units
   local government social services coordinator;
3) promoting the creation of a Centre for Social Services (CUS) as a service coordination body;
4) creation of new CUS and networking of existing CUS;
5) development of standards and catalogues of social services for people in need
   support in daily life;
6) carrying out research and analysis in the area of quantity, quality and effectiveness of implemented
   social services;
7) contracting social services based on standards and qualitative research and analysis;
8) Diagnosing current needs and analysis in terms of the growth in the proportion of people requiring support in the municipality/county and assessing how this may increase/decrease the demand for social services provided in the community.

2. Support for family and those providing care to a person in need of support in day-to-day functioning by:

1) coordination, by the local authority, of support in the form of social services for families and persons acting as carers for persons in need

support in daily life;

2) training, psychological, transport, respite and technological support for families and informal carers;
3) activities in the area of popularisation and promotion of professional activity among people providing care for a person in need of support in everyday functioning, including amendment of the Labour Code regulations, introduction of various types of regulations facilitating professional activity of carers - flexible forms of work, remote work, telecare.

3. Development of community-based forms of support in the form of social services by:

1) development of community-based social services with a particular focus on standardised care services, day-care centres, care farms, family care homes;
2) moving towards the employment, by local and regional authorities, of persons providing community care services under an employment contract, which will contribute to greater influence by local and regional authorities on the quality of the services provided;
3) development of neighbourhood services implemented, e.g. through programme development, by
local authority and activities to promote volunteering;
4) development of supported housing with a basket of social services;
5) Use of local resources, by involving social economy entities, including social enterprises and non-governmental organisations, in the delivery of social services, as well as developing the potential of these entities to deliver social services. Creating partnerships, both social and partnerships with entrepreneurs;
6) transforming in-patient long-term care facilities (residential care homes) into comprehensive, in-patient and community-based services, including services providing in-patient short-term care (respite care).

4. Changing the way in which residential long-term care institutions (homes social assistance) by:

1) audit of long-term care institutions (social welfare homes)

in terms of the indications for r e s i d e n c e in this form of care of the persons in them, with the taking into account the possibility of their return to the local community;

2) to carry out a cyclical check of the possibility of the person using the services of the institution becoming independent and, if the possibility of returning to the community is identified, to take action in this respect;
3) Transforming nursing homes into community care centres, where inpatient care will only be offered when community-based support is not possible due to the state of health, degree of independence and level of care capacity of the family, or as a short-term stay. A placement rate will be defined;
4) changing the standards for the provision of in-patient long-term care services (social care homes) in terms of living conditions, including the provision of single rooms for service users (to the extent possible for individual DPS).

5. A sustainable funding system for long-term care in the social services area:

1) making detailed analyses of the financing of long-term care in the area of social services;
2) developing a model for the sustainable financing of social services to ensure that support is available to all those who need support in their daily lives;
3) Introduce a stable and sustainable funding solution for the costs of social services for people in need of support in their daily lives.

6. Support and development of staff providing social services by:

1) participation in training courses, including specialised training courses, to improve the qualifications and competences of professionals in the following professions: care assistant in a social care home, community care worker, carer for the elderly, assistant for the disabled;
2) reviewing care staff and regulating the profession of "care specialist". Giving specific professional competences, establishing degrees of specialisation will allow for an image change of those performing care functions in social care homes and in the community;
3) setting a minimum salary level for the profession of 'specialist in matters of

care".

Assumed effects of the action lines:

1. A comprehensive social service delivery system based on coordinated, individualised community services will be created.
2. Support measures will prevent older people from being placed in 24-hour care institutions.
3. Family carers and professional staff will be supported.
4. Staying in a 24-hour care institution will be the choice of the person using the support system. Placing a person in a 24-hour institution will be the least desirable, last line of support.

Timetable for the implementation of the action lines

		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2035
Implementation deadline lines of action	**1**											
	2											
	3											
	4											
	5											
	6											
Indicative sources of funding	State budget Local authority budgets PFRON EU funds											
Implementers	Minister responsible for social security Minister of Agriculture and Rural Development - partner in the process especially for the development of social, care services provided on farms (support and development of care farms) Minister of Finance - with regard to the planning of funds for the implementation of the direction of action of the Voivodeship Self-Governments, within the framework of the tasks resulting from the legal acts currently in force Local government units (municipalities and counties), within the framework of the tasks resulting from the legal acts currently in force Social economy entities - in accordance with the Act of 24 April 2003 on public benefit activity and voluntary work Civil society organisations - in accordance with the Act of 24 April 2003 on public benefit activities and voluntary work											

Strategic objective 3. Social inclusion of people with disabilities giving them the opportunity to live in the community regardless of their level of disability

Action lines for strategic objective 3

1. Implement a system of coordination and standardisation of social services for people with disabilities by:

1) coordination, by the local authority, of support in the form of social services for families and persons with a caring role for persons with disabilities;
2) legislative changes to the establishment of units
local government social services coordinator;
3) promoting the establishment of CUS as a service coordination body;
4) creation of new CUS and networking of existing CUS;
5) Development of standards and catalogues of social services for people with disabilities;
6) conducting research and analysis in the area of quantity, quality and effectiveness of implemented social services for people with disabilities;
7) contracting social services based on standards and qualitative research and analysis;
8) Diagnosis of current needs and analysis in terms of the incremental participation of people with disabilities in the municipality/county and assessment of how this may increase/decrease the demand for community-based social services.

2. Support for families implementing care for a person with a disability, including support in the form of service delivery by:

1) comprehensive action by local government units (municipality and county) to support families, including foster families who care for children with disabilities;

2) activities in the area of popularisation and promotion of professional activity among family carers of persons with disabilities, including amendment of the Labour Code, introduction of various types of regulations facilitating professional activity of carers - flexible forms of work, remote work, telecare);
3) training support, stress relief, specialist support, psychological support, transport support, respite and technology for family carers;
4) creating baskets of social services for people with disabilities;
5) the organisation of self-help activities;
6) dissemination and implementation of circles of support;
7) introduction of systematic for service persons assistance personal assistance service with disabilities;
8) developing the potential for the delivery of deinstitutionalised social and health services for people with disabilities by social economy entities, including social enterprises, and increasing the participation of these entities in the delivery of services commissioned by the local government.

3. Implementation of a systemic supported housing service by:

1) introducing legal changes with regard to the nomenclature and functions of assisted housing (unification of the existing nomenclature - sheltered, supported, training = assisted housing with a basket of services appropriate to the needs);
2) development of supported housing with a basket of services;
3) dissemination and development of residential care centres.

4. Implementing independent living for community-dwelling people with disabilities and residents of residential care homes by:

1) carrying out an audit of long-term care institutions - social care homes for people with disabilities with regard to the indications for the stay in this form of persons residing in them, taking into account the possibility of their return to the community;
2) to carry out a cyclical check of the possibility of the person using the services of the institution becoming independent and, if the possibility of returning to the community is identified, to take action in this respect;

3) creation and implementation of individual empowerment plans taking into account the social and professional activation of people leaving 24-hour institutions;
4) development of assisted housing with a basket of services;
5) developing places and forms of potential employment for people with disabilities;
6) Development, dissemination and implementation of a pathway for the socio-vocational reintegration of people with disabilities;
7) support for social economy entities, in particular social enterprises, in the professional and social reintegration of people with disabilities;
8) activities preventive w with a view to prevent targeting people with disabilities to 24-hour institutions;
9) implementation of support instruments adapted in their form and intensity to the person concerned;
10) introducing a model of supported decision-making;
11) development of environmental activities to support the implementation of supported decision-making;
12) conducting activities to create circles of support to ensure the full inclusion of people with disabilities in the community.

Assumed effects of the implementation of the action lines

1. It will be created comprehensive system support system people i families with disabilities.
2. Support activities will prevent the placement of people with disabilities in 24-hour care institutions.
3. It will be implemented the idea of housing independent living, supported by supported.
4. Support instruments adapted in their form and intensity to the individual.
5. Staying in a 24-hour care institution will be the choice of the person using the support system. Placing a person in a 24-hour institution should be the last, least desirable link of support.

Timetable for the implementation of the action lines

		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2035
Implementation deadline lines of action	**1**											
	2											
	3											

	4										
Indicative sources of funding	State budget Local authority budgets PFRON Solidarity Fund EU funds										
Implementers	Minister responsible for social security Minister of Justice - Partner in the process - his/her tasks will include supporting the legislative processes, including giving an opinion on the submitted draft laws Minister of Education and Science - Partner in the process - especially in the field of educational activities - planning support in education for people with disabilities within the higher education and science system Minister of Finance - with regard to the planning of funds for the implementation of the direction of the activities Voivodship self-governments, within the framework of the tasks resulting from the legal acts currently in force Local government units (municipalities and counties), within the framework of the tasks resulting from the legal acts currently in force Social economy entities - in accordance with the Act of 24 April 2003 on public benefit activity and voluntary work Civil society organisations - in accordance with the Act of 24 April 2003 on public benefit activities and voluntary work										

Strategic objective 4. Create an effective system of social services for people with mental disorders

Action lines for strategic objective 4

1. Implementation of a system of coordination and standardisation of social services for people with mental disorders by:

1) coordination, by the local authority, of support in the form of social services for families and persons with a caring role for persons with disabilities;
2) legislative changes to the establishment of units
local government social services coordinator;
3) promoting the establishment of CUS as a coordinating institution for social services;
4) creation of new CUS and networking of existing CUS;

5) Development of standards and catalogues of social services for people with mental disorders.

2. Development of integrated social services for people with mental disorders and in mental crisis by:

1) developing a standard of support for people with mental disorders;
2) increasing the level of delivery of specialist services for people with mental disorders;
3) securing the needs of people with mental disorders within the infrastructure of a local authority or under an agreement with another local authority;
4) developing and implementing cooperation mechanisms between institutions and entities, including NGOs performing tasks for people with mental disorders;
5) support at crisis intervention centres;
6) creating baskets of social services for people with mental disorders;
7) strengthening support pathways for people in mental health crisis within the existing the socio-occupational reintegration system;
8) development of supported housing with a basket of services adapted to the needs of the person with mental disorders;
9) development of care and housing centres;
10) development of social economy entities, in particular social enterprises performing tasks for professional and social reintegration of persons with mental disorders;
11) development of social services to support families with children with disorders mental health.

3. Changing the way in which a residential care institution for people with mental disorders operates by:

1) performance of an audit of long-term care institutions - social care homes for

of people with mental disorders and in terms of indications for the stay of people in this form, taking into account the possibility of their return to the community;

2) to carry out a cyclical check of the possibility of the person using the services of the institution becoming independent and, if the possibility of returning to the community is identified, to take action in this respect;
3) creation and implementation of individual empowerment plans taking into account the social and professional activation of people leaving 24-hour institutions;
4) Conversion of residential care institutions for people with mental disorders (community care homes) into community support centres, where residential care may only be the last possible element of support. An indicator for the number of places will be defined;
5) to change the standards for the provision of community-based residential care for people with mental disorders in terms of living conditions, including the provision of single rooms for service users where possible.

Assumed effects of the implementation of the action lines

1. A coherent system of support in the form of social services for people with mental disorders.
2. There will be development of services social services directed to persons with disorders mental health, which will reduce the need for 24-hour care services.
3. Specialist staff implementing community services for children and young people with mental disorders will be prepared.

Timetable for the implementation of the action lines

		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2035
Implementation deadline lines of action	**1**											
	2											
	3											
Indicative sources of funding	State budget Local authority budgets PFRON											

	Solidarity Fund EU funds
Implementers	Minister responsible for social security Minister of Finance - with regard to the planning of funds for the implementation of the course of action Voivodship self-governments, within the framework of the tasks resulting from the legal acts currently in force Local government units (municipalities and counties), within the framework of the tasks resulting from the legal acts currently in force Social economy entities - in accordance with the Act of 24 April 2003 on public benefit activity and voluntary work Civil society organisations - in accordance with the Act of 24 April 2003 on public benefit activities and voluntary work

Strategic objective 5 Creating an effective support system for people in crisis of homelessness and people threatened with homelessness

Action lines for strategic objective 5

1. **Implement a system of coordination and standardisation of social services to prevent homelessness by:**
   1) the development and implementation of prevention and intervention actions on housing to control debt;
   2) stepping up cross-sectoral cooperation for comprehensive helping people in crisis of homelessness;
   3) Introduce opportunities for social work with people in prison/independence training with people who are becoming independent;
   4) running public campaigns on breaking down stereotypes about homelessness, including targeting JST and social welfare units to raise awareness and knowledge of homelessness and housing exclusion;
   5) conducting analysis and monitoring of the phenomenon of homelessness and ways of addressing it.
2. **Development and implementation of solutions for transition from institutional support to support in the form of housing by:**

1) developing and supporting various forms of housing as dedicated tools addressing the homelessness crisis;
2) the development of supported housing, including statutory regulation, with a basket of services for people in crisis of homelessness;
3) changes to the planning and management of the municipality's housing stock taking into account the prospect of assisted housing, including the use of vacant properties;
4) Developing and implementing housing solutions for people at risk of homelessness and those emerging from homelessness in need of support to maintain housing, including with the involvement of Social Tenancy Agencies;
5) development of homelessness prevention programmes based on the 'housing first' model or others;
6) improving the competences and qualifications of staff providing support to people in crisis of homelessness, especially support provided in housing;
7) converting existing facilities for people in crisis of homelessness into combined supported housing or into intervention-type facilities.

3. Supporting people experiencing homelessness by:

1) changes to the definition of homelessness and the catalogue of persons entitled to Support;
2) integration of available services (" one-stop shop" method) for get support for people in crisis of homelessness;
3) strengthening and improving the system for intervention, health and life protection of persons homeless people, by providing support in the community using the streetworking method;
4) ensuring that people in crisis of homelessness participate in building and developing the support system and in becoming independent by setting up formal or informal groups/bodies of a consultative and advisory nature, which would include, in addition to representatives of local government, representatives of non-public service providers, institutions from outside the social assistance sector and people experiencing homelessness (currently or formerly).

Assumed effects of the implementation of the action lines

1. A comprehensive system of support for people at risk of homelessness and experiencing homelessness will be created.

2. Support measures will prevent people in crisis of homelessness from being placed in temporary shelters or minimise the length of stay in such institutions.

3. The idea of independent living will be implemented, supported by assisted housing.

4. Remaining in a shelter institution will be the choice of the beneficiary from the support system and, at the same time, the last, least desirable link of support.

Timetable for the implementation of the action lines

		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2035
Timing of directions activities	**1**											
	2											
	3											
Indicative sources of funding	State budget Local authority budgets EU funds											
Implementers	Minister responsible for social security Minister responsible for for economy, construction, planning i land use and housing Minister of Finance - with regard to the planning of funds for the implementation of the course of action Voivodship self-governments, within the framework of the tasks resulting from the legal acts currently in force Local government units (municipalities and counties), within the framework of the tasks arising from the from legislation currently in force Social economy entities - in accordance with the Act of 24 April 2003 on public benefit activity and voluntary work Civil society organisations - in accordance with the law of 24 April 2003 on public benefit activity and voluntary work											

Chapter V. RULES FOR THE IMPLEMENTATION OF PUBLIC POLICY

MONITORING and INDICATORS

The monitoring of the implementation of the Strategy's assumptions will be carried out in partnership and with the participation of all stakeholders, especially civil society organisations and social entities directly involved in the areas indicated in the document. A Team for the Implementation of the Strategy for the Development of Social Services, Public Policy until 2030 (with an Outlook until 2035) will be established in the Ministry of Family and Social Policy. It will be composed of representatives of the central administration. To work in the Team will be invited, on a voluntary basis, representatives of voivodeship and local self-governments, civil society organisations and social entities that operate in the areas covered by the Strategy, as well as representatives of the self-governmental side of the Joint Commission of Government and Local Self-Government. The team will develop a proposal for a strategy implementation plan (2-3 years), which will be submitted for decision to the minister co-ordinating the implementation of the Strategy. The team will also develop a detailed method of monitoring the progress of the implementation of the activities planned in the document and define the cyclicity of reports on their implementation. The point of reference in monitoring the implementation of activities will be the developed set of indicators depicting the expected results of the Strategy's implementation at the level of strategic objectives.

At the regional level, the coordination of activities will be carried out by the local government provinces through the activities of Regional Centres of Social Policy (ROPS), which will develop regional plans for the development of social services and deinstitutionalisation. The plans will be adopted for a period of up to 3 years and will constitute a structured concept of change in the areas covered by deinstitutionalisation at the regional level (including in particular: family and foster care support, elderly people, people with disabilities, people with mental disorders, people in crisis of homelessness).

The plans will provide guidance on the scope and conditions for the implementation of actions financed by regional programme funds (including those of an educational, animation and supportive nature for local authorities) and complementary to them actions financed by other funds, including primarily national, regional and local government funds.

The plans will eventually also include nationally funded activities,

regional and local, creating synergy and complementarity of actions. The role of ROPS as a coordinator of activities at the regional level is particularly important in the context of the activities planned in the FERS, the aim of which will be to coordinate support in the field of social inclusion through ROPS. The coordinating role of ROPS is important due to the necessity to ensure the compliance of activities financed from European funds with relevant strategic documents, including regional ones.

Table indicators

Lp.	Indicator	Unit of measurement	Value base	Expected value by 31.12.2025.	Expected value by 31.12.2030.	Expected value by 31.12.2035.	Source data
1	Number of newly created assisted housing units with a basket of services tailored to the individual the needs of the person	number	0	-	7000	12 000	MRiPS
2	Percentage of municipalities where a social services centre will be established	%	2%	-	up to 25%[62]	up to 25%	MRiPS
3	Percentage of municipalities where a place for coordination of social services will be established[63]	%	0	100%	100%	100%	MRiPS
4	Percentage of children for whom the child and family support plan developed on the basis of multidisciplinary teams (at least from district level) in the total number of all children separated from their families (in all forms of care replacement)	%	0	-	-	50%	MRiPS
5	Percentage of families for which a comprehensive analysis was applied	%	0	20%	50%	100%	MRiPS

[62] The creation of CUS is currently optional. The indicator sets a value of up to 25%.

[63] The role of service coordination at the municipal level can be played by the Social Services Centre.

	reintegration opportunities						
6	Percentage of children in care foster carers who grow up in family foster care	%	77%	-	-	85%	MRiPS
7	Percentage of establishments care and educational support 24-hour converted into daytime family support centres	%	0	-	-	25%	MRiPS
8	Percentage of interdisciplinary family support teams operating in the area of each district	%	n.d.	-	-	50%	MRiPS
9	Percentage of alumni who, up to 3 years after becoming independent, reside in housing for their own disposal	%	n.d.	-	-	30%	MRiPS
10	Percentage of inpatient care facilities converted into facilities providing comprehensive, inpatient and community-based services, including services providing inpatient short-term care. The transformation is to be about opening up the delivery of community services in parallel while keeping support to a minimum stationary	%	0	-	-	40% DPS-type units that will have the capacity and diagnosed need to provide comprehensive services in the environment	MRiPS
11	Percentage of DPSs where the following have been introduced research on the periodic assessment of the resident's possibilities for independence	%	0	100%	100%	100%	MRiPS
12	Changing standards of service provision	%	0	-	30% of places in	30% of DPS places	MRiPS

	in-patient long-term care (social welfare homes) with regard to living conditions, including the provision of rooms where possible for service users single-person				DPS		
13	Regulating the profession - care specialist and setting a minimum salaries for the profession	nd	bd	1	1	1	MRiPS
14	Number of residential care centres established (dissemination and development)	number	5 COM	100 COM	-	-	MRiPS
15	Number of businesses created Social	number	1606	2500	5000	8300 PS	MRiPS
16	Percentage of municipalities where specialised care services for people with mental disorders	%	50,9%	65%	70%	80%	MRiPS
17	Percentage of municipalities in which the following have been secured day care and support for persons with mental disorders	%	bd	30%	60%	80%	MRiPS
18	Percentage of municipalities implementing a standard for housing prevention and intervention to control indebtedness and prevent evictions	%	bd	-	15%	30%	MRiPS
19	Number of municipalities where streetworker services are provided integrated with the intervention services system	number	42	60	80	100	MRiPS

	shelter and other services such as outreach						
20	Percentage of institutions for people in crisis of homelessness converted to combined supported housing or to facilities of a intervention	%	0	-	25%	60%	MRiPS
21	Number of social tenancy agencies established, providing rental accommodation to, inter alia, people in crisis of homelessness or at risk of homelessness and others groups covered by the Strategy	number	0	20	45	70	MRiPS

Table No. 15. Indicators monitoring the implementation of the strategy objectives

The allocation of indicators to each specific objective is as follows:

Specific objective 1.1 - Indicators 4, 5 and 8
Specific objective 1.2 - Indicator 6
Specific objective 1.3 - Indicator 7
Specific objective 1.4 - Indicator 9

Specific objective 2.1 - Indicators 2 and 3
Specific objective 2.2 - Indicators 1, 2 and 10
Specific objective 2.3 - Indicators 10, 11 and 12
Specific objective 2.4 - Indicators 10, 11 and 12
Specific objective 2.6 - Indicator 13

Specific objective 3.1 - Indicator 3
Specific objective 3.2 - Indicators 1 , 14 and 15

Specific objective 4.1 - Indicators 2 and 3
Specific objective 4.2 - Indicators 1, 14, 16 and 17
Specific objective 4.3 - Indicators 10, 11 and 12

Specific objective 5.1 - Indicators 3, 18 and 19
Specific objective 5.2 - Indicators 20 and 21
Specific objective 5.3 - Indicators 3 and 19

FINANCING

This document sets out objectives for the state's social policy, the achievement of which is contingent on a number of factors, including financial factors.

It should be noted that the actions planned in the Strategy are of a very broad nature and organise activities at different levels of government and in different areas of state functioning. Therefore, an important element is the financial assembly, providing a synergy effect and guaranteeing that the projected objectives will be achieved. The directions of actions projected in the document are the starting point for further legislative work, the aim of which will be to gradually introduce changes to the law aimed at achieving the planned indicators and directions of action.

The financing of the measures envisaged in the Strategy is planned in particular from the funds of the state budget and the EU funds for the implementation of projects in the 2021-2027 perspective from the area of deinstitutionalisation of social services (including in particular the ESF+ and ERDF). An important contribution to the development of social services may also be made by funds from the budget of local self-government units. Measures resulting from the document, for which national financing is envisaged, will be implemented within the framework of expenditures planned in the Budget Act for a given year. As a result of the implementation of the directions of actions planned in the Strategy, the current funds allocated to the system of support for the development of community-based services will be used more effectively. Detailed cost analyses will be carried out when introducing legal changes necessary for the implementation of the planned directions of activities. At present, it is not possible to fully estimate whether the introduced changes will generate additional financial effects, or whether the resources already planned and allocated for community service activities will be used more efficiently. Therefore, when planning the introduction of changes, an Impact Assessment will be prepared each time, and in the case of additional costs for the implementation of new tasks or modification of already implemented tasks, the funds for these purposes will be secured, in particular, by funds from the state budget or dedicated programmes.

Legislative changes necessary to implement the lines of action planned in the
document will be introduced gradually. In order to implement the measures, there will also be
Dedicated programmes are being developed to provide financial support to institutions and

the entities implementing the indicated measures. The impact of the proposed regulations will be determined according to the 'Cost Benefit Analysis' method.

The activities planned in the Strategy can also be financed from combined sources of funding, both from the state budget and EU funds, as well as with the participation of local government units. Funds for some measures and directions will be mobilised under the Ministry's programmes or projects financed from the EU funds, from regional programmes, e.g. housing development or development of care services, and then, after the end of financing from the EU projects, in order to maintain the sustainability of the measures, it will be necessary to obtain government financing through dedicated programmes or introduction of relevant legal amendments to relevant acts. Among the sources of financing of the goals included in this Strategy, the state budget should be mentioned first. Financing of tasks from the state budget is based on legal regulations, which regulate the way of bearing the costs of implementing tasks of government administration. The development of social services will also be financed within the framework of funds for the implementation of social government programmes, among them:

1. 'Za życie' comprehensive support programme for families (Resolution No. 160 of the Council of Ministers of 20 December 2016 on the 'Za życie' comprehensive support programme for families);
2. Solidarity Fund (Act of 23 October 2018 on the Solidarity Fund (Journal of Laws 2020, item 1787)); MRiPS programmes financed under the Solidarity Fund: "Personal assistant for persons with disabilities",
   "respite care", "Residential care centres";
3. Surcharge Fund (Act of 8 December 2006 on financial support for the creation of housing for rent, protected housing, night shelters, shelters for the homeless, heating facilities and temporary accommodation (Journal of Laws 2022, item 377);
4. "Senior+" multi-annual programme for 2021-2025 (Resolution No. 191 of the Council of Ministers of 21 December 2020 on establishing the "Senior+" multi-annual programme for 2021-2025 (M.P. of 2021, item 10));
5. Ministry's 'Care 75+' Programme;
6. Multiannual Programme for the Elderly "AKTYWNI+" (Resolution No. 167 of the Council of Ministers of 16 November 2020 on establishing a multiannual programme for the elderly "Aktywni+" for 2021-2025 (M.P. item 1125));

7. The departmental programme "Overcoming Homelessness. Homelessness Assistance Programme';

   -and other departmental programmes.

In addition, in the performance of the state's tasks vis-à-vis its citizens, funds are available to targeted and institutions e.g:

1. State Fund for the Rehabilitation of the Disabled,
2. Social Insurance Institution.

Systemic changes in the delivery of social services will also be financed by European Union funds provided for in the new programming period 2021-2027. European Social Fund+ (ESF+) funds, under the European Funds for Social Development 2021-2027 (FERS) programme and regional programmes, will be allocated to the implementation of measures for the deinstitutionalisation of social services by stimulating and financing development activities, the creation of CUSs and the networking of existing CUSs.

The realisation of social services is an obligation of the state and local governments resulting from the legal acts in force. However, it is also necessary to participate in the costs of implementation of services for the persons to whom these services are provided. The implementation of the undertakings specified in the Strategy will take place while maintaining the macroeconomic stability of Poland, including in particular the public finance sector, taking into account the principle that the conducted budget policy has to take into account the limitations related to the binding fiscal rules, including the Stabilisation Expenditure Rule.

The diagram below illustrates the financial assembly of the process of deinstitutionalisation of social services.

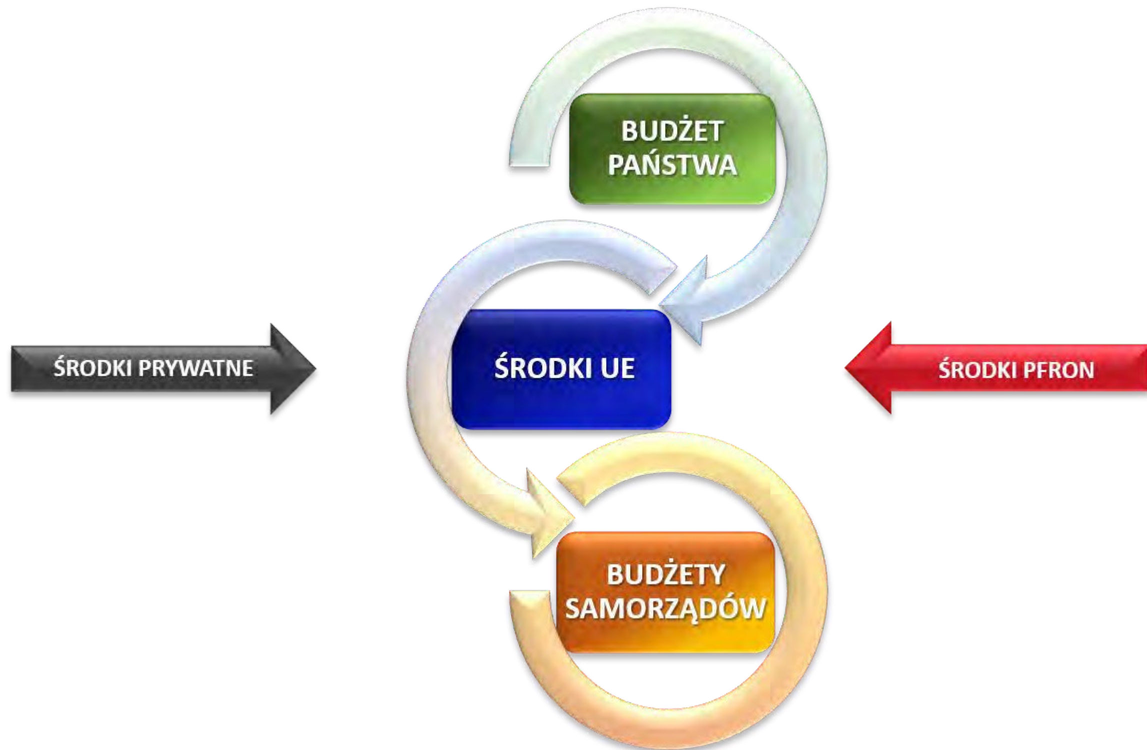

Illustration no. 2. Financial montage of deinstitutionalisation measures for social services

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