Slovakia
Monitoring Report

DIS-CONNECTED: DISABILITY-BASED CONNECTED FACILITIES AND PROGRAMMES FOR PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN

101049690- DIS-CONNECTED

Disability-based connected facilities and programmes for prevention of violence against women and children (101049690 – CERV-2021-DAPHNE)

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Monitoring Report

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Forum for Human Rights

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General information on the monitoring visit[1]

Name of the institution/community-based service/hospital unit:

1. Provider 1 (2 separate monitorings in 2 different services), Trnava Region
2. Provider 2, Banská Bystrica Region
3. Provider 3, Banská Bystrica Region
4. Provider 4, Banská Bystrica Region

Date of the monitoring visit:

1. 13 August 2024
2. 15 July 2024
3. 16 July 2024
4. 12 August 2024

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[1] The questions indicate the topics we would like to cover in the monitoring reports and in the international synthesis report. As almost all partners planned to monitor different settings, feel free to jump sections that are not applicable to your situation, and expand on the ones where you have important findings to share. You can also use the other issues section to highlight topics that we omitted from the template. Please try to answer briefly and to the point.

Selection of the institution

The institutions were chosen due to their varying profiles and regional locations to ensure a comprehensive assessment of social care services.

- **Provider 1**: A semi-rural institution providing a mix of residential and day-care services for individuals with intellectual disabilities, selected for its community-based support model (Source: Provider 1 Monitoring Report).
- **Provider 2**: Located in a remote area, this facility supports individuals with severe disabilities and has a reputation for long-term care provisions (Source: Provider 2 Monitoring Report).
- **Provider 3**: A women-only facility in the village focusing on rehabilitation and skill-building. Specific details on trauma-related programs were not explicitly mentioned in the report, requiring verification.
- **Provider 4**: Based in the town, it serves as a hub for transitional programs aimed at integrating individuals with disabilities into community life. Its vocational training programs make it a notable example of progress in deinstitutionalization (Source: Provider 4 Monitoring Report).

Methods used

- **Interviews:** Conducted with directors, staff, residents, and service users to gain insights into daily operations, policies, and individual experiences.
- **Observations:** Focused on the physical environment, resident-staff interactions, and adherence to institutional policies.
- **Documentation Review:** Analyzed institutional policies, incident reports, training records, and care plans.
- **Focus Groups:** Engaged residents and staff in discussions to evaluate awareness and implementation of CRPD principles.

Location of the institution

1. **Provider 1:** Semi-rural, accessible by public transport.
2. **Provider 2:** Remote village with limited transport options, impacting family visits.
3. **Provider 3:** Rural village setting with moderate accessibility.

4. **Provider 4:** Urban location with strong transport links and access to community facilities.

Profile of the institution and service(s) provided

The monitored facilities are public social service institutions funded primarily from the State budget. They provide residential and community-based services to adults and children with diverse support needs, including mental health disorders, intellectual disabilities, autism spectrum disorders, and challenging behaviors. The institutions are under the supervision of regional and local government authorities and aim to ensure a safe environment while promoting the well-being and social integration of their clients.

The services offered vary between facilities and include both long-term residential care and supported housing. Some institutions focus specifically on women at risk, while others serve both male and female residents.

Provider 1 focuses on community-based social services delivered in family-style homes with a maximum of six residents per unit. The institution provides specialized residential services and supported housing across several locations, serving both men and women in a smaller, home-like environment.

Provider 2 offers care primarily for women, though several male residents were also present at the time of the visit. Its services target individuals with intellectual disabilities, multiple disabilities, and autism spectrum disorders. The facility is divided into five units, accommodating 84 clients in the main building and an additional 15 clients in a nearby branch.

Provider 3 provides residential care exclusively for women with mental health disorders, behavioral issues, or intellectual disabilities. The facility is organized into four units with a total capacity of 85 residents, offering different levels of support based on individual needs.

Provider 4 operates seven family houses in the town and nearby village offering residential care for adults with intellectual disabilities, mental health disorders, and autism spectrum disorders, as well as individuals requiring intensive support due to challenging behaviours. The facility also provides therapeutic and activation activities aimed at enhancing social skills and personal development.

The typical residents in these institutions are individuals requiring long-term care and support due to their specific mental or physical conditions. The services are financed through the State budget, with no direct fees from residents or their families. Staff in all facilities consist of social workers, therapists, and healthcare professionals, supported by administrative personnel and specialists with personal experience in the social care field.

Physical environment

The social care facilities evaluated in these reports share some common characteristics, despite their varying sizes and locations. All of them are situated in residential-style buildings or institutional settings, with the aim of providing adequate care and housing for their clients. The general environment across these facilities is focused on meeting the basic needs of clients, including accessibility, cleanliness, and functionality. However, there are notable differences in how these features are implemented. Commonly, the facilities provide clients with private or shared rooms, bathrooms, and common areas, though the degree of comfort, privacy, and accessibility varies. Cleanliness is generally well-maintained in all settings, and the rooms, although often personalized, are designed with basic functionality in mind. The buildings, however, vary in their ability to accommodate clients with mobility issues or other specific needs, and the overall atmosphere ranges from more institutional to homelike environments.

Provider 1 represents a significant improvement, offering a more residential, homelike environment in newly built, single-story houses. Each house accommodates six clients, with easy access for those with mobility impairments. The rooms are accessible, well-lit,

and spacious, and the bathrooms and common areas are equipped with necessary adaptations like rail systems and mobile lifts. The atmosphere feels more personal and homelike, with each client having more autonomy over their living space. However, there are still some challenges, such as inadequate materials in bathrooms and the absence of air conditioning, which affects comfort during warmer months. The facility's design fosters a greater sense of community and independence, which sets it apart from the more institutional environments found in other facilities.

Provider 2 operates in an institutional environment with long corridors and shared spaces that make it difficult for clients to feel at home. The building does not meet accessibility standards in all areas, and certain parts, like staff offices or dining rooms, are inaccessible. The rooms are shared, leading to a lack of privacy, and some clients are unable to access their personal belongings due to locked storage. The facility is clean, but issues with mold and poor ventilation persist. Bathrooms are shared, and basic hygiene items are sometimes missing. The overall design still maintains an institutional feel, despite efforts to allow clients to personalize their spaces.

Similar to Provider 2, **Provider 3** operates in a large institutional building, resembling a mansion, which is not conducive to a homelike atmosphere. The rooms are large and shared (4-6 beds), which may affect privacy and autonomy. The building's long hallways, shared dining rooms, and institutional features like neon lighting create a sterile environment. While the facility is maintained and clean, it lacks accessibility for clients with mobility challenges, and the rooms are not equipped with the necessary adaptations to meet the needs of all clients, such as adequate window ventilation or barrier-free access. The bathrooms are shared and sometimes lack basic hygiene supplies, and accessibility for bedridden clients is limited.

Provider 4 shares several positive aspects with Provider 1, offering a homelike environment in a family-style setting. Located in a residential area near the city center, the

building's design is more familiar and inviting. The rooms are spacious, well-lit, and accessible, allowing clients to personalize their spaces. Each house provides common areas for relaxation, cooking, and socializing, promoting a sense of community. The bathrooms are barrier-free, though minor issues like missing handrails and improperly positioned mirrors were noted. The facility also offers outdoor spaces for clients to engage in activities, further enhancing the homelike atmosphere. The environment is clean and well-maintained, and safety measures such as ramps and stair lifts ensure accessibility for all clients.

While the facilities evaluated differ significantly in their structure and design, common themes emerge across all of them. Cleanliness and basic functionality are prioritized, and each facility provides spaces for privacy and socializing, though the level of comfort and autonomy varies. The more institutional facilities, like Provider 3 and Provider 2, face challenges with accessibility and privacy, often relying on shared rooms and spaces that limit personal freedom. These environments, while clean and functional, lack the warmth and personalization found in more community-based settings. On the other hand, facilities like Provider 1 and Provider 4 stand out for their more homelike, accessible environments, which are better suited to clients' individual needs.

Residents, service-users

The facilities visited provide residential care services for adults with diverse support needs, primarily individuals with intellectual disabilities, multiple disabilities, autism spectrum disorders, and mental health conditions. The institutions typically serve both men and women, though some—such as Provider 3—exclusively women. Residents range from young adults to seniors, with the majority being middle-aged or older. Entry into these services is generally based on referrals from social services or healthcare providers, and eligibility is determined by the individual's need for care.

Facility capacity and living arrangements vary but the common phenomenon is highly institutional nature in non-transformed facilities and extreme differences: Provider 1 provides care in smaller family-style homes with a maximum of six residents per unit. Provider 2 accommodates as many as 84 clients in its main building and an additional 15 in a nearby branch. Provider 3 offers residential care for up to 85 women in four units with different levels of support in former chateau building, while Provider 4 operates seven family houses in the town and nearby village providing specialized care for adults with intellectual disabilities and those requiring intensive support due to challenging behaviours.

Staff

The evaluation of staff across all four facilities reveals several shared challenges related to staffing levels, qualifications, training, and the support provided to staff members. While all facilities meet the minimum staffing requirements set by law, the organization of work and current staffing levels do not allow for sufficient individualized care for the residents. Staff members are primarily focused on fulfilling basic needs such as assistance with eating and hygiene, leaving little room for fostering independence or preparing residents for community-based living. A recurring issue across all facilities was the difficulty monitoring teams had in finding staff during their visits, which sometimes left residents relying on mutual help. This raised concerns about staff availability during certain shifts or periods, although it is unclear if this was a regular occurrence or influenced by the monitoring visit. For example, in Provider 1 staff work 12-hour shifts, with only one staff member covering both units in the same building during the night. According to employees, their workload has increased, and they experience greater isolation compared to working in a larger facility. In complex situations, they have to make decisions on their own, without immediate

consultation.

Additionally, while specific details on staff supervision and ongoing training were not extensively mentioned, it is evident that staff are often overstretched and may not have adequate support or opportunities for professional development, particularly in areas related to deinstitutionalization and community integration. There was no specific mention of staff knowledge regarding CRPD standards, but the challenges highlighted suggest that greater education and training on these issues are needed to provide more individualized care and better prepare clients for a transition to community-based services. Overall, while the basic staffing requirements are met, the ability to support residents in line with deinstitutionalization principles is limited, and addressing these issues could significantly improve the quality of care and outcomes for residents.

Staff across the facilities have the opportunity to participate in training programs, but their satisfaction with these opportunities varies. In some cases, staff members expressed contentment with the training they received, particularly those working with clients in more independent living environments, such as in "mansard" rooms. These staff members reported feeling well-prepared to provide individualized support to clients. However, staff working with more dependent residents, such as those in "bedridden" departments, expressed a need for further, more comprehensive training. This discrepancy highlights the importance of targeted education, especially for staff supporting residents with higher care needs.

Additionally, some staff members indicated that training beyond mandatory credits is not always offered, even though there is an expressed interest in further education. Furthermore, some employees reported not being included in supervision sessions, which are supposed to be provided regularly. The facility management indicated that supervision is indeed provided on a monthly basis and will continue in the future, but the short duration

of the monitoring visit makes it difficult to assess whether there are discrepancies between the management's claims and the staff's experiences.

Training on specific topics, such as abuse prevention and de-escalation techniques, has been provided to staff, with management planning to continue this focus. Regular supervision sessions are available, and several staff members have expressed satisfaction with them. However, there seems to be an overall need for more extensive training, particularly for staff working with residents in need of more intensive care and support.

Gender- and disability-based violence

Across the facilities, there were no reported cases of sexual violence, and there is a general focus on promoting intimacy and sexuality education. In some facilities, staff members have received training on intimacy and sexuality in social services, and they actively support clients in this area. This includes providing information on sexual health and facilitating the purchase of necessary items. Some clients are also encouraged to avoid abuse through education and open discussions. However, in some cases, the duration of the monitoring visits was too short to draw definitive conclusions.

In **Provider 3**, relationships with partners from other facilities or the community are allowed, and there are instances of lesbian relationships among clients. However, the support for intimacy and relationships is not consistent across all sections of the facility. Clients in different areas do not receive the same level of support, and the issue of privacy and autonomy regarding intimacy remains a concern. For example, clients must request permission from staff to use personal items, such as erotic devices, in private areas.

In **Provider 4**, there was no indication of abuse or inappropriate behaviour during the monitoring visits. Sexuality is addressed as a topic, and some clients live in couples, with one couple planning a wedding. Clients are informed about contraception, and one client voluntarily uses birth control, as they do not plan to have children. The facilities also address hygiene, rules for masturbation, and specific issues in clients' risk plans.

While there has been some training on sexuality and intimacy, staff members express a desire for further support in addressing these topics effectively. Clients are encouraged to discuss their sexual lives, especially among couples, and they are aware of boundaries. However, more support and resources would be appreciated in these areas.

Institutionalisation and its alternatives: least restrictive environment,support for community living

Efforts to offer a least restrictive environment and support for community living are observed to vary across facilities. While some clients have the opportunity to leave the premises independently, these opportunities are limited and depend on both their individual initiative and the availability of staff to provide the necessary support. For example, some clients can travel to nearby towns for personal needs or social visits. However, the support for activities outside the facility is often inconsistent and insufficient, which results in a stronger reliance on the institution for many individuals, especially those with limited mobility or in need of additional assistance.

While some facilities provide access to outdoor spaces such as gardens, terraces, and courtyards, there are limitations in the use of these areas due to the inadequate staff numbers. Clients who need assistance for leaving the building or participating in outdoor activities often find themselves isolated, with only rare opportunities to enjoy fresh air or to engage in community life. Some clients in bedridden units rarely leave the building and are mostly confined to spaces like a balcony, which restricts their ability to access more diverse activities outside the facility.

Group outings are sometimes organized for clients, but these activities are often seen as collective events with larger groups of people, leading to stigmatization and reinforcing a sense of being different from the general community. Additionally, not all clients are involved in the planning or decision-making process for these activities, and there is often little room for personal preferences to shape the experiences offered.

For clients in more autonomous settings, there are opportunities to participate in local community activities, but these are not always as freely available or as diverse as they could be. The facility's location within residential areas offers access to some services, but for some residents, there is still a significant gap between their ability to engage with the wider community and the institutional environment they live in. This gap is often exacerbated by a lack of opportunities for meaningful work, social interaction, or activities that would promote independent living outside the institutional context.

In conclusion, while some residents may enjoy more freedom and autonomy, there is a significant disparity between the levels of support offered across different facilities. Community integration is possible but often limited, and there is a clear need for individualized, consistent support to ensure that all clients have equal opportunities for social participation and independence, moving away from an overly institutionalized setting.

Participation in decision-making, respecting individual choice and autonomy

The reports highlight significant challenges regarding participation in decision-making, individual choice, and autonomy of residents. The institutional setting, with rigid daily routines and limited flexibility, restricts clients' ability to influence their schedules, activities, and living arrangements. The environment is structured around a set of standardized activities, such as ceramics workshops or music therapy, which may not always align with personal preferences. The lack of a rehabilitative environment and limited resources for clients with mobility issues further hinder autonomy.

While certain facilities allow residents to engage in hobbies or individual activities (e.g., gardening, crafting, animal care), others face limitations, especially those in communal living spaces. These clients may only access external services once a week, and their interaction with the broader community is constrained. Concerns also arise from the

practice of the facility acting as a legal guardian for residents, which can undermine their rights and protection. Despite efforts by management to address these concerns, the overlap between service provision and guardianship can compromise transparency and independence.

In general, these facilities struggle to provide an environment where residents have full autonomy over their choices and daily lives, with institutional practices taking precedence over individual preferences. While there are attempts to incorporate personalized care, the systemic limitations still present significant barriers.

Support in access to education, work and leisure activities

In some facilities, the environment encourages dependency on institutional services, offering limited activities that promote self-reliance and social inclusion. The paternalistic approach strengthens institutional culture, and everyday skills such as cooking, shopping, and managing personal finances are rarely supported or practiced. While a few residents engage in work-related tasks such as cleaning, gardening, and taking care of animals, these activities are mostly unpaid and lack structured training aimed at preparing residents for community-based services or open market employment. In one case, a partnership with the Employment Office is a positive development, although currently, only one resident is considered for work placement within the facility itself (laundry services).

Conversely, some facilities provide better opportunities for independence. For example, residents are supported in learning daily living skills, and individual support is given when needed. Barrier-free spaces and accessibility measures, such as elevators and assistive devices, promote independent movement and a more respectful approach to individual needs. However, certain areas still require improvements, such as installing additional grab bars or tactile guiding elements for visually impaired residents.

Regarding leisure activities, some facilities offer a variety of group excursions and local community events. While these activities are valuable, they are often conducted in large

groups, which may reinforce stigma and limit individual engagement. Additionally, the potential for more diverse and individualized activities remains largely untapped.

Opportunities for physical exercise and outdoor activities vary significantly. Some residents are free to leave the premises independently and travel to nearby villages to visit family. Others, especially those with limited mobility, face challenges in accessing the outdoors due to staff shortages or locked areas. Outdoor spaces are often limited to balconies, and bedridden residents rarely have access to fresh air.

While some facilities offer occasional vocational workshops or creative activities, there is a lack of structured skill development programs that would help residents transition to more independent living or open market work. Hipotherapy and other therapeutic activities mentioned in the past are no longer available, and opportunities for external activities remain limited to infrequent trips.

Overall, while certain facilities demonstrate good practices in promoting autonomy and independence, others still need to shift from an institutional model towards a more community-oriented and person-centered approach that fosters residents' skills and self-reliance.

Maintenance of contact with family members and the community

Throughout the monitored facilities, clients' access to communication tools and their contact with family members and the community varies. In some facilities, clients have access to mobile phones, tablets, and computers with internet connections, often depending on their financial means. Wi-Fi is provided in several facilities, allowing clients to use social media and video calls. However, not all clients have the financial means to own personal devices, and some rely on shared phones, which are limited due to privacy concerns.

A few facilities offer ICT literacy education, but it is not consistently provided to all clients. In some cases, communication is facilitated through letters and postcards, especially for clients whose families are not actively engaged. Some facilities support clients who can afford phones, while others provide access to staff phones when necessary.

Family visits are generally allowed without restrictions, and some clients receive regular visits or trips with family members. For clients whose families show little interest, facilities may attempt to send postcards or packages, though this practice is considered inappropriate and misleading.

Clients in some facilities have the opportunity to participate in community activities, such as cultural and sports events, though this depends on their mobility and the availability of staff. In facilities with predominantly immobile clients, community contact is more limited, with support for outings when possible. Overall, there is a need for improved access to technology and ICT literacy to enable greater independence and better connections with family and the community.

Complaints mechanisms

The process for submitting complaints in the facilities is generally structured, with designated complaint boxes available throughout the buildings, as well as clear guidelines displayed for residents. However, the complaint processes are not always easily understandable for all residents, particularly those who cannot read or write, which makes submitting written complaints difficult. In some facilities, staff are the primary recipients of complaints, with clients either speaking directly to trusted personnel or relying on oral complaints. This often means that complaints are addressed informally and without a standardized procedure, leaving some clients dependent on staff discretion. This is particularly problematic for residents who do not communicate verbally, as no established procedures exist for handling complaints from these individuals.

While some facilities provide a mechanism for complaints in "easy-to-read" formats to ensure accessibility, it remains unclear whether these systems are effectively used. Many clients rely on staff members to voice their concerns, and the majority of complaints seem to be handled verbally, often directly between the staff member who received the complaint and the resident. Despite this, clients have access to a support system that includes a designated confidant, although this option has only been used by a very small number of individuals.

Additionally, some facilities have a lack of transparency in how complaints are handled, with no formal records or processes in place to track or evaluate the issues raised. Concerns have been raised that verbal complaints may not always be treated impartially, as they might be addressed by the very staff member against whom the complaint was made. This prevents anonymous complaints and raises questions about whether complaints are used to improve service quality effectively. It is recommended that facilities enhance the accessibility and transparency of the complaint process, providing more information to residents about how they can express concerns, and introducing alternative means for those with communication barriers.

Other issues

The environment is often highly institutional, with large shared rooms, long corridors, and common dining areas that foster anonymity and passivity, reducing personal autonomy and individualized care. A transition to a community-based model is needed to create more home-like, private spaces.

Moreover, the facilities are not fully accessible, especially for clients with mobility issues. While elevators are available in some areas, many rooms and bathrooms remain inaccessible, and some rooms are so cramped that clients cannot move freely or fully open doors. These spaces should be restructured to meet accessibility standards and ensure clients' comfort.

The overcrowded rooms also impact privacy and comfort. Many clients lack personal items in their rooms, and those confined to bed do not receive adequate attention to their visual field or overall comfort.

Environmental conditions are poor, with issues such as mold and insufficient ventilation in some facilities, posing health risks, especially for those with respiratory conditions.

Security measures, such as locked windows, while necessary in some cases, disproportionately affect clients who do not pose a risk. These blanket restrictions should be replaced with individualized risk assessments to allow clients greater freedom while ensuring safety.

Another issue is limited access to bathrooms, with reports of some facilities being locked at night, restricting clients' privacy and autonomy. This practice needs to be addressed to guarantee all clients have proper access to essential facilities.

Meal provision in the facilities reflects an institutional approach, with fixed menus and meal schedules that limit personal choice and flexibility. Long gaps between dinner and breakfast can cause discomfort, especially for residents with specific dietary needs. Some practices, such as serving blended meals in undignified ways or limiting access to drinks, further reduce the sense of autonomy and dignity.

Summary of the main issues

One major concern is the persistence of institutional characteristics in some facilities, which reinforce dependency and limit clients' autonomy. These structures do not align with the principles of normality or dignity, and fail to meet the standards outlined in the Convention on the Rights of Persons with Disabilities. The facilities still operate with rigid practices that leave clients vulnerable, particularly in terms of privacy and personal space. Clients often lack adequate privacy in their rooms, with insufficient measures like curtains or personal storage, which can increase vulnerability to exploitation.

Another significant issue is the shortage of staff. The insufficient personnel is a critical problem that compromises both the quality of care and the safety of clients, especially in emergency situations. Alongside this, the care provided often lacks sufficient individualization, meaning that clients' specific needs and preferences are not always respected. This creates a one-size-fits-all approach that does not fully empower clients to make choices about their own lives.

While progress has been made in transitioning to community-based services, physical spaces and organizational practices still reflect an institutional approach, limiting full integration into the community. This contributes to social isolation and increases the risk of abuse. Furthermore, the facilities lack effective measures for preventing, recognizing, and addressing gender- and disability-based violence. Clients, particularly women and individuals with disabilities, remain vulnerable without clear reporting and response procedures or adequate staff training to address such issues sensitively and effectively.

Conclusions and recommendations

The examined facilities have made some progress in transitioning from an institutional model to a community-based service approach, but significant challenges remain. Many facilities still display institutional characteristics that reinforce dependency rather than fostering autonomy for clients. The services provided often do not align with the principles of normality or fully comply with the rights outlined in the Convention on the Rights of Persons with Disabilities.

While it is encouraging that most facilities acknowledge their limitations and are actively working with professionals to address them, the transformation process is still in its early stages in many cases. The shift toward community-based services is necessary, but these facilities continue to face logistical and structural barriers, including a critical shortage of staff, which impacts the quality of care and safety of clients.

Some positive practices have been implemented, such as staff training in emergency response and risk management, and efforts to improve client safety. However, the core issues of institutionalization, lack of privacy, and insufficient individualization of care remain.

Facilities must prioritize removing institutional elements, improving communication, and creating more personalized living environments. There is also a need to enhance the physical spaces to better accommodate rehabilitation, therapy, and daily activities for clients.

Key recommendations include improving client privacy, empowering clients to have more control over their personal space, and ensuring that the facilities' environments reflect the needs and preferences of the individuals they serve. Staff training in emergency situations should also be expanded, with regular drills for both staff and clients. Addressing the staff shortage is crucial, as it directly affects the quality of service and the ability to properly support clients during emergencies.

In conclusion, while some progress has been made, much more work is required to fully transform these facilities into community-oriented services that meet the dignity and rights of clients. Ongoing efforts, systemic changes, and collaboration with experts are essential to overcome the remaining challenges and provide the quality care that clients deserve.