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The development of social services and deinstitutionalization in Poland as an example of good practices for Ibero-American countries

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ABSTRACT

The article explores the process of deinstitutionalization (DI) as a central challenge of contemporary social policy in Europe, with a special focus on Poland as an example of good practices for Ibero-American countries. DI means shifting from institutional, centralized care toward community- and family-based services, enabling people in need—such as the elderly, people with disabilities, and those in crisis of homelessness —to remain in their natural environments. The Polish case shows that implementing DI requires coordinated strategies, investment in human capital, digitalization, and multi-sectoral cooperation. Large-scale studies conducted by Janusz Korczak University in Warsaw, done in 2023–2024, involved over 8,000 participants and identified key areas: foster care, support for people with disabilities, mental health, homelessness, and elderly care.

Keywords: deinstitutionalization, social policy, community-based care, Poland, Latin America, social services, decentralization, innovation, multi-sectoral cooperation

1. Introduction

The process of deinstitutionalization (hereafter abbreviated as DI) constitutes one of the most important challenges for contemporary social policy in Poland and Europe. It entails a gradual move away from a model of care concentrated in large institutions toward the provision of services in citizens' natural living environments—close to family, neighbors, and the local community. This is not merely an organizational process but also a cultural and axiological one, as it redefines the role of the state and the community in supporting people in need. Its effective implementation requires a coherent strategy, multi-sector cooperation, and investment in human capital as well as technological innovation. When reviewing definitions of DI, it is worth citing two "institutional" formulations promoted by major multilateral structures such as UNICEF (UNICEF, 2010) and the European Union:

"Deinstitutionalization should be understood not so much as an endeavor to close round-the-clock care institutions, but as a process of developing care services at the level of the family and the local community, intended to enable a person in need of assistance to remain as long as possible in their living environment". (UNICEF, 2010).

This definition (in precisely this wording) is cited in the official document of the Ministry of Family and Social Policy (MRiPS)—*National Guidelines for Developing Local Plans for the Deinstitutionalization of Social Services*—as the definition used in EU policies and fund programming (European Commission, 2014; European Expert Group (2012/2013); MRiPS, 2024).

Deinstitutionalization is a process affecting a substantial share of Polish citizens, particularly those requiring support—persons with limited independence, those living alone, older adults, and people experiencing mental health crises or homelessness. It is a strategy for organizing public services, especially support services, not only in Europe and within EU structures. Elements of DI may also be observed—though perhaps defined differently—worldwide, particularly in advanced social policy systems. At the same time, DI-related mechanisms can also be found in the United States, which historically has not developed an extensive welfare or assistance sphere such as in the Scandinavian solutions. A meaningful illustration of this evolving approach is the recent federal legislation (an executive order) signed by the President of the United States, Donald J. Trump in November of 2025, which extends targeted post-care support for young people aging out of foster care (White House, 2025). The signed executive order aimed at expanding opportunities for education, career development, housing and other resources for foster youth aging out of care 2025, strengthens transitional assistance mechanisms for care leavers by enabling continued access to housing support, education and vocational training, mentoring, and employment-oriented services beyond the age of formal system exit. Although framed within the American context of limited universal welfare provision, this legal intervention reflects a growing acknowledgment that successful deinstitutionalization does not end at the moment of institutional departure but requires sustained, structured support during the critical phase of early adulthood.

In Poland, implementing the DI paradigm will affect the functioning of several thousand institutions in the area of social support at the municipal level; more than 200,000 employees of those institutions and their environments; many thousands of local and regional government employees; and thousands of people active in non-governmental organizations.

Above all, however, deinstitutionalization will profoundly shape the living conditions of up to several million recipients of community-based and residential support in various forms, as well as their families and close relatives. It is therefore a process whose implementation will influence—or is already influencing—the social functioning of a significant portion of citizens, their quality of life, and their well-being.

Drawing on our research experience, we have decided to propose this topic and post-research recommendations to Latin America and the Caribbean, a region with a particular tradition of social sensitivity and practical civic engagement. The South American region is characterized by linking social services with public health policy and measures to counteract exclusion. Although challenges such as unstable funding and high levels of social inequality remain relevant, these solutions show that deinstitutionalization can also be implemented effectively in developing countries.

2. The Research and Theoretical Experience

Our academic institution - Korczak University. Academy of Applied Sciences in Warsaw — initiated, organized, and conducted comprehensive research on DI in the period 2023–2024, bringing together leading researchers, practitioners, and social policy decision-makers across the most critical social service areas. This nearly one-and-a-half-year organizational and research effort resulted in conclusions and recommendations that we wish to propose as good practices or ready-to-adapt solutions. The study covered service providers and recipients

across six areas of social services: foster care; support for persons with limited independence; support and integration of persons with disabilities; support for persons with mental health problems; support for older adults; and support for people experiencing homelessness. Following the same order of areas, we propose recommendations and possible DI-related good-practice solutions. In the study, we analyzed various aspects of creating and delivering social services by institutions; the preparedness and expectations of service recipients; the potential for cross-sector cooperation; and the potential for using e-services and technology to create new services and transform institutions. Different qualitative and quantitative research methods were applied in the „Nationwide diagnosis of deinstitutionalization: Report on qualitative and quantitative research" (*Ogólnopolska diagnoza.., 2024)*": desk reserach done by all sub-tematic teams, extensive quantitative research with CAWI and PAPI in each of the six survey areas (users and providers), qualitative study of service providers and service users (FGI, individual interviews), 256 case studies in 16 regions, case studies based on individual and group interviews with managers of institutions, social workers, service recipients, their families and carers, experts panels and workshops. It was one of the biggest and the most complex social academic research has made lately in Polish academia. Therefore it should be highlighted that this research consisted of the CAWI surveys, 2,650 respondents from institutions and 3,518 recipients of residential and community-based services participated. Case studies covered 256 entities in all regions, and a survey of municipal governments covered 531 units. In total, more than 8,300 people participated in the research. The findings from the "Nationwide Diagnosis…" were presented, inter alia, in the *Social Services Development Strategy – Public Policy to 2035* and in the conclusions from the survey of decision-makers in municipalities. The overarching objective of our research was to diagnose the preparedness of social assistance and social integration institutions to implement deinstitutionalization in Poland. We decided to share our results, conclusions, propositions of applying DI aaproach towards public serivces to the most spreaded public, sometimes beyond European perspective to confront with more remote views. For instance, we decided to present our research to Iberoamerican audience during the annual Congress of FLACSO 2025 in Buenos Aires (Grewinski, Kawa, 2025).

2.1 Shared Goals and Foundations for Implementing DI Worldwide. Elements of Deinstitutionalization in Latin America and the Caribbean

At the level of political strategy, deinstitutionalization—also in Latin countries—should become a paradigm of change in social policy: a mechanism of continuous design of the social services system and modification of institutional practices to meet emerging client needs. This paradigm requires both the creation of new community-based services and the modification of existing ones, as well as the development of cooperation among institutions and across sectors (state and local-government institutions, social assistance units, non-governmental organizations, social economy enterprises, and the private sector). It also assumes greater involvement of the informal sector—families, caregivers, neighbors—in service provision. This generates specific management challenges and needs. When examining the Latin American and Caribbean region, pioneering and advanced DI solutions in social policy can also be observed.

The tradition of deinstitutionalization-related solutions in Latin America and the Caribbean has roots in the democratic transformations of the late twentieth century and in a strong emphasis on human rights and social inclusion. It is worth briefly mentioning below examples that confirm that DI is neither alien nor distant in the Americas.

2.2 Brazilian care system and other examples of DI applied in Latin America.

In Brazil, community-based Psychosocial Care Centers (*Centros de Atenção Psicossocial*—CAPS) have expanded. Since the 1990s, CAPS have gradually replaced large psychiatric hospitals. They provide support close to people's places of residence, including psychiatric treatment, psychotherapy, community-based interventions, integration programs, and vocational activation. Currently, more than 2,500 CAPS facilities operate across most regions of the country, forming the backbone of Brazil's mental health policy. This program is supported by the National Mental Health Policy and exemplifies a model that combines medical treatment with social rehabilitation and anti-stigma measures (Amarante & Torre, 2017; Ministerio da Saúde do Brasil, 2011). Brazilian reforms aligned with deinstitutionalization proceed along three major directions: transforming the care system from closed and isolating to integrative and accessible; strengthening local-level support through stronger social bonds and more personalized assistance; and promoting autonomy and empowerment through integration with the local community and activation.

Mexico

In Mexico, the development of local family support centers and the "*Estancias Infantiles*" programs, which provide care and early education in family-proximate environments, can be indicated as DI-related good practices (El País, 2025). Childcare reform was initiated between 2007 and 2018 as a federal program aimed at supporting low-income families through access to local nurseries and preschools run by communities. Additionally, Mexico (El País, 2025) is developing a network of "*Centros de Atención Integral*" supporting older adults and persons with disabilities, offering day care, counseling, and integration activities. The first 12 centers are to be launched in Ciudad Juárez, a border city with intensive migration flows, and will serve children aged from 1.5 months to 4 years old. The centers are designed to provide not only safe spaces during parents' working hours but also comprehensive care—health monitoring, supervised nutrition, and education. The model includes diverse governance forms: direct management by IMSS; partnerships with companies (e.g., in industrial parks); and cooperation with the social organization DIF for families not registered with IMSS. This innovative program addresses the needs of working women and aims to rebuild and transform the care-support system (El País, 2025).

Chile

In Chile, DI elements appear in the implementation of supported housing and social integration programs for persons with disabilities, and in the development of a network of community-based services (Ministerio de Salud de Chile, 2017). A key component is the *National Mental Health Plan 2017–2025*, which assumes a gradual reduction of large psychiatric hospitals by replacing them with smaller mental health centers more closely connected to local communities. Programs such as "*Residencias Protegidas*" provide a support in housing to persons with mental illness, enabling greater autonomy and social integration (Ministerio de Salud de Chile, 2017). In Costa Rica and others Caribbean territories on a smaller scale, developments can also be observed in Costa Rica—long-term policy grounded in the decentralization of health and social services and a strong system of primary community care—and in Jamaica, Trinidad and Tobago (World Health Organization & Ministry of Health, Republic of Trinidad and Tobago, 2007; Pan American Health Organization, 2025), where initiatives have expanded community-based care in child protection and family support, emphasizing alternatives to institutional care. In Costa Rica, the aforementioned long-term policy based on decentralization of health and social services and a robust primary community care system has manifested in a key reform pillar (since the 1990s): EBAIS primary health care teams (*Equipos Básicos de Atención Integral de Salud*),

which provide integrated, community-based care close to residents' homes, combining prevention, mental health, and social support. In Costa Rica, by 2019, more than 1,050 EBAIS teams and 106 support teams (including psychiatrists and social workers) were operating, covering more than 94% of the population. In mental health, the country implements a community mental health profile—emphasizing the integration of psychiatric care into primary care, community-based crisis support, supported housing, and hospitalization in general hospital wards rather than in large psychiatric hospitals (Hickling, 1994; UNICEF LAC & CPFSA, 2022). The reform uses a digital health record and fieldwork by ATAP assistants, who conduct home visits and map family needs, supporting deinstitutionalization and limiting isolating care. In Jamaica as well, a pioneering shift in the Caribbean took place between the 1960s and 1990s—from hospital-based care to community psychiatry—inter alia through a network of outpatient clinics and psychiatric nurse teams, significantly reducing the number of patients in the country's only psychiatric hospital and expanding community treatment. In child protection, the state agency CPFSA is implementing the "Beyond Institutionalization" reform: 84% of alternative care is family-based (adoption/reintegration/foster family care), and 16% is institutional. LIFE programs are being developed, foster care is being strengthened, and "gatekeeping" mechanisms identify children in need before the system escalates, alongside reporting channels (211 line) and standardized facility quality.

To provide a comparative overview of selected social services that have been deinstitutionalized in certain dimensions in Latin America and the Caribbean, we present the following illustrative table (Pan American Health Organization, 2020; VanderZanden et al., 2021):

Country	Key solutions	Numerical data / indicators
Costa Rica	EBAIS teams and integration of mental health into primary care; ATAP home visits; supported housing	>1,050 EBAIS teams + 106 support teams (2019); system coverage > 94% of the population
Jamaica	Community psychiatry since the 1960s–1990s; foster care and reintegration instead of institutions	58% decline in psychiatric hospital patients (1960–1990); 84% family-based alternative care vs 16% institutional
Trinidad and Tobago	Mental health policy reform 2019; WHO QualityRights Training 2025; development of community-based services	Still high share of beds in psychiatric hospital (WHO-AIMS 2007); decentralization and staff training processes initiated

Comparative table: Deinstitutionalization in Costa Rica, Jamaica, and Trinidad and Tobago.

2.3 Deinstitutionalization in Poland

As a systemic paradigm, deinstitutionalization has recently gained broader recognition in Polish social policy; however, signals of this process were observable more than a decade ago in selected sectoral policies—e.g., foster care, and even earlier in policies addressing homelessness. Nevertheless, it did not become a mainstream policy instrument. Poland, as a mid-sized EU country, is rapidly integrating its care and assistance standards with EU deinstitutionalization assumptions (Chorąży & Kubicki, 2018; MRiPS, 2022; Uczelnia Korczaka, 2024; Social Protection Committee, 2021). Although full synergy remains distant, even before EU accession in 2004 Poland successfully implemented pilot DI programs financed by the European Social Fund and the Phare fund for accession countries. The inevitable direction toward deinstitutionalizing public services — especially support services — is indicated by numerous international documents that Poland has ratified or is obligated to implement (Chorąży & Kubicki, 2018; MRiPS, 2022). Deinstitutionalization is a key element of the EU agenda and the 2021–2027 financial perspective. The EU allocates significant European Social Fund resources to the development of social services and DI.

Deinstitutionalization of services is also a strategy of the Polish government: in 2022, the Sejm of the Republic of Poland adopted the Ministry of Family and Social Policy's *Social Services Development Strategy: Public Policy to 2035*. This document sets the vector for ministerial and local-government actions for the next years. It also obliges regional authorities to prepare social service development programs within the DI stream, while municipal and county authorities are required to create local plans for social service development. Attempts to change social policy were also undertaken earlier, for example through the 2013 initiative to reform the social assistance system, where proposals included the establishment of local (municipal and county) social service centers and social work agencies, as well as within systemic projects of the Human Capital Operational Programme, which introduced the possibility for Social Assistance Centers (OPS) and County Family Support Centers (PCPR) to deliver active integration services and to disseminate social work practice within the system. Unfortunately, attempts to integrate these solutions into mainstream social policy were unsuccessful. In subsequent years, traditional instruments of income support were strengthened through direct social cash transfers (the 500+ program and subsequent "plus" social programs dedicated to families with children), which, instead of delivering necessary services, primarily transfer money. Over the last three decades of transformation, a "3 × DE-" model was implemented, in which decentralization, demonopolization, and—much more weakly—deinstitutionalization processes intersected. In this sense, DI is not entirely new: its elements appeared in earlier strategies, especially the environmental/community dimension—"opening" institutions to their surrounding environments, "reaching out" to local communities, developing care services, and similar measures. These processes accelerated considerably over the last decade, alongside the development of senior policy and the introduction by local governments of new social services for the 65+ population. Decentralization and demonopolization also yielded some results in terms of incorporating the NGO sector, the social economy, and the informal sector as natural providers of community-based services. At the same time, concerns about change persist, stemming more from insufficient knowledge about DI implementation in the studied institutions, employees' fear and uncertainty within social assistance units, inadequate financial and staffing resources, competence gaps—especially regarding the implementation of e-services—and insufficient development of inter-institutional and cross-sector cooperation. Among DI shortcomings and challenges in Poland, one of the greatest is the slow development of network-based cooperation: institutions' reluctance to engage in sustained collaboration, limited habit of delivering services through cross-sector partnerships, a low and insufficient number of NGOs available for cooperation in many regions, and the continued underestimation of private-sector potential. Consequently, building a durable architecture of cross-sector cooperation remains one of the central challenges of DI in Poland.

A further significant challenge is the underestimation of social communication — both in relations with service recipients and with stakeholders. The process requires the development of a convincing, positive narrative for recipients and providers of services, information campaigns, and a sense of urgency for change within institutions. This constitutes the foundation of change management, indispensable for a social transformation on the scale of community service development envisioned here. Currently, many recipients lack sufficient knowledge about the available social service offer, depriving them of the ability to use it. These are the long-term challenges and deficits in Poland that constrain the momentum of more extensive deinstitutionalization of public services. DI can even be perceived as another major reform of Polish social policy—potentially the third "great change" after decentralization and partial demonopolization..

3. Recommendations and Good Practices of using DI within social services

We derive our recommendations mainly from results of the mentioned research the „Nationwide diagnosis of deinstitutionalization: Report on qualitative and quantitative research" (*Ogólnopolska diagnoza.., 2024)*" and Conclusions from Poland's DI Strategy for Public Services.

The recommendations presented here apply to all levels of the process of developing social services—from the central level (vision and strategy), through the regional level, to the county and municipal levels. They are also relevant from the perspective of individual social policy institutions. Implementing social change should begin with a clear vision, preceded by diagnosis, and with a well-communicated strategy. It requires an efficient coordination mechanism and multi-level governance, a clear division of roles and tasks among all stakeholders (including the health sector), and sufficiently strong decision-making authority on DI within executive power structures.

One of the most important initial recommendations is to secure adequate national and local-government resources for implementing the DI strategy, including the introduction of finance-mix solutions and mechanisms linking social benefits with services. Financial benefits should be more strongly linked to the possibility of allocating them to community-based support services. It is necessary to create effective mechanisms for involving NGOs, informal support, social economy enterprises, private entities, and other stakeholders in service delivery and in implementing multi-sector policy, as well as to develop cross-sector cooperation mechanisms for network-based service delivery.

We decided to enumerate these the most importnant and useful recommendations of applying DI solutions and tools mostly for the Ibero-American area but also for others. We devided them along the stakeholders who would be interested in:

1. Develop and implement solutions that more broadly involve families and the immediate environment of service recipients, in accordance with the "pyramid of social services" concept—analogous to A. Maslow's pyramid—whose base consists of support provided by the closest environment of persons requiring assistance.

2. The best long-term investments are investments in the competences of local social policy staff, particularly change-management competences and the soft skills necessary to coordinate cross-sector cooperation. It includes enhancing the prestige of social professions, increasing remuneration, and creating new professions and occupational roles. It is important to improve the status of helping professions and ensure adequate pay to prevent staff outflow and attract new personnel. Introduce mandatory MBA programs focused on DI process management for local leaders implementing DI.

3. Develop the habit of evaluating the results of community-based service development at the central, regional, and local levels. Create a platform for exchanging good practices and databases of case studies, as well as social innovation forum, to increase innovativeness and disseminate best solutions among DI stakeholders.

4. Complete decentralization efforts by transferring parts of tasks to NGOs and the private sector in line with the cross-sector principle. This process has had varying intensity; in some periods, the private sector was valued more as a partner than NGOs.

5. Proceed from decentralization to demonopolization of services: create services close to citizens' residences and transform large 24-hour institutions toward smaller facilities more open to local environments.

6. Personalize services in the context of social ties: adopt an individual approach to each recipient's needs and respect their choices and preferences. In practice, personalization may entail individual budgets or vouchers; however, it may also risk extreme individualization and lead to recipients' social isolation (as currently observed in some countries).

7. Introduce realistic cost-sharing models. Although there is strong expectation that most services should be free of charge, some recipients wish to pay for services; a significant share of institutional staff also emphasize that, for various reasons, services should not be universally free. Our research indicates that community-based services may be more costly than residential care. Costs may therefore be shared between the beneficiary's family and the public (local) budget. Secure adequate central and local resources and continuity of financing for social service development projects; introduce finance-mix solutions based on co-payment by different payers (including potentially commercial sponsors as part of CSR). Link social benefits with services.

8. Strengthen prevention and risk mitigation. A DI approach includes the reinforcement of preventive actions that reduce the materialization of social and health risks. This requires closer cooperation between the health sector and social policy (as does integrated care). Prevention requires separate strategic reflection, including decisions on who should lead and how actions should be implemented.

9. Overcome low use of e-services and institutional resistance. "Dual digital exclusion," affecting both service recipients and providers, inhibits the development of e-services and the use of technology to facilitate communication and service delivery. Technology should become a core element of social service design. E-services should not be treated as somethnign "additional," but as an integral part of the support system—analogous to the growing role of e-government services. Expand telecare, tele-support, and telecounseling; introduce solutions facilitating online contact between providers and recipients; and deploy sensor-based and robotics-supported services. As part of digitalization, create a nationwide technological platform—a database of social service recipients—enabling decision-making institutions to access beneficiary data, needs, and utilized services to better coordinate support. Implement software and applications that enable efficient field service provision, verification of staff actions, and quality control of delivered services.

10. Develop and implement a system for accrediting and certifying service providers to authenticate service quality. Introduce solutions enabling recipients to choose providers based on their rights and co-decision possibilities. Conduct regular monitoring studies (e.g., a national social services diagnosis every few years) using a unified methodology.

11. Create mechanisms for deeper involvement of NGOs, the informal sector, private entities, and other stakeholders in programming and delivering services—for example, through multi-stakeholder commissions at central, regional, and local levels; implement cooperation and co-production mechanisms to deliver services through networked partnerships.

12. Design mechanisms stimulating the emergence of new entities with the potential and competences to cooperate with local government in creating and delivering social services—NGOs, parish and neighborhood mutual-aid organizations, social cooperatives, etc. Introduce regulations and solutions ensuring partners' financial stability, such as long-term contracts (3–5 years) for delivering social services by non-public providers to stabilize their development potential.

13. Apply service design across the full delivery chain: define the service, its standard, and target group; identify providers; train relevant personnel; develop communication methods to inform recipients (how they learn about the service, ordering process); deliver the service at the intended standard; settle accounts and analyze delivery costs (estimate cost, collect any co-payment, analyze recipient experience and satisfaction). Alongside standardization, flexibility is crucial. Research indicates that excessive regulatory rigidity currently hinders designing services for older adults, such as the "golden maitenance handyman" (repair/maintenance services supporting seniors in daily life) or support services enabling seniors to handle administrative matters independently.

Different recommendations are dedicated to decision makers, politiciansm central authorities such as:

1. Increase wages in the support sector and link indexation to the national average wage. Introduce a strategy to ensure staffing in the support sector. Organize the education system for social professions (including caregivers, assistants, and other helping professions). Review professional requirements and regulations; reduce requirements where they are excessive relative to the nature of the profession. Describe new occupations/professions emerging due to deinstitutionalization and AI development and prepare educational pathways. Develop commissioned study programs in social fields.

2. Conduct a nationwide analysis of the potential of social economy entities (PES), NGOs, and the informal sector for creating social services, to determine realistic possibilities for involving these sectors. Develop a "social services index" as a social policy indicator. Develop DI progress indicators for units, regions, and municipalities to monitor implementation.

3. Adopt unified terminology for deinstitutionalization and social services to be clear and understandable for all participants. Develop a catalog of services and definitions to track the course and dynamics of the process. Shape an information policy on social services and community-based services free of jargon, scientific and administrative language—communicated in terms of benefits for recipients.

4. Conduct a nationwide social campaign informing citizens about the goals and assumptions of social service development. Design a narrative and explain changes in the social system to recipients of social and community-based services. Develop guidelines for nationwide, regional, and municipal communication activities emphasizing the urgency and importance of DI and explaining clearly why it is beneficial and socially desirable. Provide information activities for social assistance units to reduce fear and uncertainty.

To some extent differenrt recommendations of applying DI models will be for Regional Local Governments:

1. Create regional platforms for exchanging information and experience among local-government officials to improve knowledge of DI. Regional governments can play an important role in creating spaces for exchanging good practices both within and between regions. Sharing tools and practices can facilitate introducing standardized services and enhance the flow of ideas and innovations among institutions.

2. Assign deinstitutionalization strategic priority in municipalities. Social service development concerns many residents, carries strategic and political significance, and should therefore receive particular attention from local leaders. Community leaders should secure and support it politically, substantively, and through financial and staffing resources.

3. Develop social services in local communities, taking into account local specificity—including mobile services (services delivered to recipients) in regions where access is difficult due to low population density and lack of facilities; develop social transport enabling less mobile persons or those in transport-excluded localities to reach and use day services; develop telecare, safety bands, neighbor services, volunteering, and other forms of involving the informal support sector.

4. Invest in social infrastructure, such as training apartments for youth leaving family-based care/foster care, supported housing, and equipping local entities. Develop e-services and digital competences within facilities and among residents. Improve cooperation between social assistance units, organizations providing home/community care, and healthcare facilities.

Final recommendations are dedicated to NGOs, Social Economy Entities, and the Private Sector opened to social service market. Non-governmental organizations and private-sector entities should treat deinstitutionalization as an opportunity for institutional development through providing sought-after social services.

They should actively participate in creating local models of service development and expand their operations through cooperation with the public sector. Based on knowledge and experience, they should create innovative, cost-competitive services of high standard. Together with local government, they should develop models of co-creation and co-production of services. NGOs and the private sector should promote volunteering and more broadly engage volunteers in delivering social services, including non-financial incentive systems that motivate cooperation. Activate local community resources—youth, volunteers, neighbors, active seniors (not only institutions serving seniors)—in organizing leisure time and maintaining local community-based services.

4. Conclusions

Deinstitutionalization (DI) should be understood as a rights-based and system-wide transformation that shifts care and other public services from segregating institutions toward community- and family-embedded supports, strengthening autonomy, participation, and social inclusion (UNICEF, 2010; European Expert Group, 2012). Evidence from Poland's recent DI-oriented reforms and large-scale diagnostic research suggests that effective DI depends less on "closing facilities" and more on building a diversified local service ecosystem with clear standards, stable financing, and accountable governance across sectors. For Ibero-American countries as well as other areas of the world emphatically open to this social approach and DI model of organizing public services, DI is most feasible when implemented through multi-level coordination, local planning, and service design that integrates prevention, case management, and continuity of care (WHO, 2021). A central conclusion is that workforce capacity is a binding constraint: DI requires professionalization, better remuneration, and new roles (e.g., coordinators, community-based assistants, digital facilitators) to prevent service gaps and staff attrition. Equally critical is "gatekeeping" and needs-based allocation, ensuring that residential care is truly residual while community services are accessible, safe, and quality-assured (European Expert Group, 2012). Digitalization should be treated as core infrastructure—supporting telecare, monitoring, interoperability, and user-centered access—while mitigating dual digital exclusion among providers and recipients.

Personalization (including vouchers/individual budgets) can increase choice but must be balanced with safeguards against fragmentation and isolation; co-production with families and communities remains essential (Beresford, 2013). Financing should move toward mixed models that link cash benefits with service availability and enable co-payment where appropriate, without undermining equity and universality. Finally, DI requires narrative and change management: public communication, anti-stigma work (especially in mental health), and trust-building among stakeholders are indispensable for sustainable reform (WHO, 2021). In sum, Poland's pathway indicates that DI becomes durable when it is institutionalized as an adaptive policy cycle—diagnosis, piloting, evaluation, scaling—and when community-based services are treated as a strategic public investment rather than a residual add-on (UNICEF, 2010; WHO, 2021).

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