EUROPEAN COMMITTEE OF SOCIAL RIGHTS
COMITE EUROPEEN DES DROITS SOCIAUX





Case Document No.3

International Association Autism-Europe v. Czech Republic
Complaint No. 245/2025

SUBMISSIONS BY THE GOVERNMENT ON THE MERITS

Registered at the Secretariat on 31 October 2025



CZECH REPUBLIC

OBSERVATIONS OF THE GOVERNMENT ON THE MERITS OF THE COLLECTIVE COMPLAINT

AUTISM-EUROPE v. the CZECH REPUBLIC
(no. 245/2025)

PRAGUE

31 OCTOBER 2025

1. In its letter of 15 July 2025, the European Committee of Social Rights ("the Committee") informed the Government of the Czech Republic ("the Government") that, on 2 July 2025, the above-mentioned collective complaint lodged by the non-governmental organisation Autism-Europe ("the complainant organisation") against the Czech Republic, registered under no. 245/2025, had been declared admissible. Concurrently, the Committee invited the Government to submit their observations on the merits of the collective complaint.

I. SUMMARY OF THE COMPLAINANT ORGANISATION'S ALLEGATIONS

2. Before the Committee, the complainant organisation alleges a violation of Article 11§1 and §3, Article 14§1 and §2, and Article 16 of the European Social Charter ("the Charter"), read alone or in conjunction with the Preamble to the Charter. The subject matter of the complaint is the alleged failure of the State Party to ensure community-based social care services for persons with disabilities, in particular for people with autism, intellectual disabilities, and behaviour requiring a high level of care ("persons with disabilities"), which would be available, affordable, and individualised. According to the complainant organisation, this also gives rise to discrimination on the basis of disability.

3. The complainant organisation's principal allegations may be grouped under the following areas:

- the unavailability of residential care in smaller community-based facilities;
- the unavailability of outreach social services aimed at enabling independent living;
- insufficient levels of, and ineffective distribution of, financial resources;
- inadequate planning of the development of social services;
- violations of the rights of informal caregivers resulting from the above, in conjunction with a shortage of respite services;
- insufficient participation of users of social services, in particular persons with disabilities, in the process of planning the development of social services.

4. *First*, the complainant organisation submits that the system of social care in the Czech Republic depends on facilities such as homes for persons with disabilities and homes with a special regime, which are typically large-capacity and whose average capacity exceeded fifty beds in 2022. While the capacity of homes for persons with disabilities has decreased since 2010, the capacity of beds in homes with a special regime has, in contrast, increased sharply. As regards other residential services that may be characterised as community-based (for example, sheltered housing), the complainant organisation alleges unduly slow increases in capacity,

uneven accessibility depending on geographical location, and the inability to live an ordinary daily life in such facilities, as they often do not provide single-occupancy rooms.

5. *Second*, the complainant organisation submits that the number of users of outreach social services aimed at enabling independent living, i.e. personal assistance services and support of independent living, has increased in recent years, but at an insufficient pace and disproportionately to the rising capacity of non-community residential social-care facilities, which, according to the complainant organisation, continue to be prioritised over outreach services. For these types of services, the complainant organisation also points to uneven availability across regions. At the same time, it states that the per-capita volume of personal assistance services and support of independent living provided has remained virtually unchanged for a long period, despite the increasing number of beneficiaries.

6. *Third*, the complainant organisation submits that funding from various sources has a negative impact on the transformation of social services, because the conditions for drawing on these resources change over time, creating uncertainty for beneficiaries regarding future accessibility. The complainant organisation describes social services that have already been transformed as underfunded, as in its view the higher financial demands of transformed services have not been reflected in the volume of funds allocated, which may have a demotivating effect before the transformation of further facilities. It also links this instability to the one-year funding cycle for social services, which it argues does not allow for longer-term planning.

7. *Fourth*, the complainant organisation submits that, although the deinstitutionalisation of social care in the Czech Republic is frequently mentioned in various strategy and conceptual documents, no concrete steps or legally binding commitments to deinstitutionalisation exist in practice. According to the complainant organisation, the current Czech policies "plan only lowering number of beds in large residential services and increasing number of beds in smaller residential services". It further points to insufficient data collection regarding the need for various types of social services and notes that the deinstitutionalisation targets set differ between the State and the regions, as well as among individual regions, which may again lead to uneven service coverage for certain target groups.

8. *Fifth*, the complainant organisation submits that, as a result of the above, in conjunction with the shortage of respite services, the rights of informal caregivers are being violated, as they experience exhaustion, financial hardship, and social isolation.

9. *Sixth*, the complainant organisation submits that persons with disabilities and informal carers are not sufficiently involved in the process of adopting conceptual decisions and planning the development of social services, either at national or regional level.

II. OBLIGATIONS ARISING FROM THE PROVISIONS OF THE CHARTER INVOKED IN THE COMPLAINT

10. Article 11§1 and §3 of the Charter provides that:

> "With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed *inter alia*:
>
> 1. to remove as far as possible the causes of ill-health;
>
> 3. to prevent as far as possible epidemic, endemic and other diseases […]."

11. As the Committee has explained in its previous decisions, Article 11§1 of the Charter requires States Parties to provide appropriate and timely care on a non-discriminatory basis. Healthcare system that does not provide for the specific needs of persons with disabilities in terms of ensuring the accessibility of healthcare services will not conform with this provision (*EDF and Inclusion Europe v. France*, collective complaint no. 168/2018, decision on the merits of 19 October 2022, § 285).

12. The Government does not agree with the complainant organisation's claim that Article 11§1 and §3 of the Charter establishes a right for persons with disabilities to choose freely the type of social service they wish to use as a form of support. No such right can be derived from any decision of the Committee under Article 11 of the Charter, nor has the complainant organisation explained how such a right could be inferred.

13. Article 14§1 and §2 of the Charter provides that:

> "With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake:
>
> 1. to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;
>
> 2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services."

14. In its case law under Article 14 of the Charter, the Committee has emphasised that it cannot impose on States a particular method of community care for persons with disabilities; it is for States to decide which is the most appropriate and most closely matches their needs. This falls within its margin of appreciation in implementing the Charter provision relied on (*FIDH v. Belgium*, collective complaint no. 75/2011, decision on the merits of 18 March 2013, § 121).

15. The complainant organisation further argues that Article 14 of the Charter must be interpreted in the light of Article 15 of the Revised European Social Charter, which guarantees the right of persons with disabilities to independence, social integration, and participation in the life of the community. In this respect, the complainant organisation refers to the recent decision in *EDF and Inclusion Europe v. France* (cited above), in which the Committee found that France had violated

Article 15§3 of the Revised Charter because it had not adopted sufficient measures to ensure access of persons with disabilities to social services and their full social integration into the life of the community. The complainant organisation notes that, although the complainant organisations in that case also raised allegations under Article 14 of the Charter, the Committee chose to examine the allegations primarily under Article 15 of the Revised Charter. According to the complainant organisation, this implies that the Committee's conclusions under Article 15 of the Revised Charter are also relevant to the interpretation of Article 14 of the Charter.

16. The Government would point out that, however, that **unlike France, the Czech Republic has not yet ratified the Revised Charter**. The fact that, in a complaint directed against a State which has ratified the Revised Charter, the Committee decided to examine the allegations primarily under Article 15 of that instrument cannot, in the Government's view, be interpreted as requiring the Committee to proceed in the same manner in respect of a State which has not ratified the Revised Charter and for which it is therefore not binding. It is undisputed that **Article 15 of the Revised Charter establishes a *higher* standard of rights for persons with disabilities with regard to access to social services than Article 14 of the Charter**: this is acknowledged not only by the complainant organisation itself (see § 24 of the collective complaint in the present case), but also by the Committee in the above-mentioned case *EDF and Inclusion Europe v. France*, where it stated in § 102 of the decision that the authors of the Revised Charter had significantly expanded the scope of Article 15. Whereas in the original Charter that provision concerned only the right of persons with disabilities to vocational rehabilitation, its scope under the Revised Charter is substantially broader and requires States to adopt comprehensive measures to ensure social integration and personal autonomy of persons with disabilities.

17. The Government is therefore convinced that **a State which is bound by the original Charter but has not yet ratified the Revised Charter cannot be held responsible for obligations arising under the Revised Charter that go *beyond the scope* of the original Charter**. Such an approach would amount to an attempt to circumvent the will of the State by compelling it, through an excessively extensive interpretation of the obligations it has accepted, to comply with obligations to which it has not yet agreed to be bound by.

18. This interpretation also finds support in the Committee's case law: in *ERTF v. the Czech Republic* (collective complaint no. 104/2014, decision on the merits of 17 May 2016) the Committee dismissed an allegation of discrimination against Roma children in education, emphasising that the allegation fell outside the ambit of the right to health under Article 11 of the Charter; while it might have fallen under the right to education in Article 17 of the Revised Charter, the Czech Republic had not ratified the Revised Charter. The Committee therefore found no violation of Article 11 of the Charter on that ground (§§ 129–130 of the decision).

19. For these reasons, **the Government disagree with the complainant organisation's claim that Article 14 of the original Charter must be interpreted in the light of Article 15 of the Revised Charter**.

20. Article 16 of the Charter reads as follows:

> "With a view to ensuring the necessary conditions for the full development of the family, which is a fundamental unit of society, the Parties undertake to promote the economic, legal and social protection of family life by such means as social and family benefits, fiscal arrangements, provision of family housing, benefits for the newly married and other appropriate means."

21. In its case law under Article 16 of the Charter, the Committee has emphasised that the provision of appropriate care for highly dependent persons with disabilities by the community is no way incompatible with their families' involvement in the lives of the persons concerned, or even with the duty for their families to sustain a constant, good quality relationship with them. The Committee has also taken the view that this good quality relationship is fundamentally altered when families assume care and living support tasks for their relatives with severe disabilities which could have been properly performed, in close cooperation with the family, by social services appropriate to these persons' needs. Consequently, the Committee held that the shortage of social services adapted to the needs of persons with severe disabilities causes many families to live in precarious circumstances, and may amount, on the part of the defendant State, to a lack of protection of the family as a unit of society, and thus to a breach of Article 16 of the Charter (*FIDH v. Belgium*, cited above, § 183).

22. More generally, according to the Committee's case law for all the provisions cited above, the Charter does not impose an obligation of "results" on the States Parties but requires progressive realisation of the rights concerned. States must adopt the necessary legal, financial, and operational means of ensuring steady progress towards achieving the goals laid down by the Charter (see, for example, *FEANTSA v. France*, collective complaint no. 39/2006, decision on the merits of 5 December 2007, §§ 53–55). Where a right is exceptionally complex and particularly expensive to resolve, a State Party must take measures that allow it to achieve the objectives of the Charter: (i) within a reasonable time; (ii) with measurable progress; and (iii) to an extent consistent with the maximum use of available resources (e.g. *Autism-Europe v. France*, collective complaint no. 13/2002, decision on the merits of 4 November 2003, § 53).

23. States Parties must be particularly mindful of the impact that their choices will have for groups with heightened vulnerabilities, as well as for other persons affected including, especially, their families. The Committee has previously held that allegations of discrimination may be examined in the light of the Preamble to the Charter, in conjunction with the substantive rights it contains (*ERTF v. the Czech Republic*, cited above, § 112; *Autism-Europe v. France*, cited above, § 53).

24. In this respect, reference may also be made to recent case law of the European Court of Human Rights, which refers to the Convention on the Rights of Persons with Disabilities and underlines the importance of the full integration of persons with disabilities into society and their participation in the life of the

community, while also drawing attention to the principle of progressive realisation of the relevant rights and the discretion granted to public authorities in setting priorities and allocating funds (e.g. *Arnar Helgi Lárusson v. Iceland*, no. 23077/19, judgment of 21 May 2022, §§ 60–65).

III. DOMESTIC LAW

(i) Charter of Fundamental Rights and Freedoms

25. Article 31 provides that everyone has the right to the protection of health. Citizens are entitled, on the basis of public insurance, to free health care and to medical devices under conditions provided for by law.

(ii) Act no. 108/2006 on social services

(a) General provisions on the provision of social services

26. Section 2(2) provides that the scope and form of assistance and support delivered via social services must respect human dignity. Assistance must be based on the individually determined needs of the person, have an active impact on the person, support the development of their independence, motivate them to engage in activities that do not lead to long-term persistence or worsening of an adverse social situation, and strengthen their social inclusion. Social services must be provided in the interests of the person and with appropriate quality, in a manner that consistently ensures respect for human rights and fundamental freedoms. Preference should be given to those forms of social services that support a person's ability to remain in their natural social environment.

27. Under section 3(k), "caregiver" means: 1. a person named in an application for a care allowance who provides assistance prior to the award of that allowance; 2. a close person (typically a relative) providing assistance to someone who has been awarded a care allowance; 3. a person receiving a long-term attendance allowance under sickness insurance due to caring for a person requiring long-term care in a home environment; 4. a person whose long-term attendance allowance has ceased to be paid but who continues to care for a person requiring care in a home environment; or 5. a person providing care to an individual who falls within the target group of the relevant service.

28. Section 7(1) provides that a care allowance is granted to persons dependent on the assistance of another individual. Through this allowance, the State contributes to the provision of social services or other forms of assistance in meeting a person's basic living needs. Section 7(2) provides that the allowance may be granted to a person who, due to a long-term adverse health condition, requires assistance from another individual in managing their basic living needs, where such assistance is delivered, *inter alia*, by a relative or by a social-care assistant.

29. Sections 8(1) and (2) set out the four-level categorisation (I–IV) of persons with disabilities for the purpose of determining eligibility for a care

allowance, depending on the degree to which they require assistance in managing their basic living needs.

30. Section 33 provides that social services are delivered as residential services, outpatient services, or outreach services. Residential services involve accommodation in a social-care facility; outpatient services are those to which a person travels, is brought, or is transported to a social-care facility, and do not include accommodation; outreach services are delivered to a person in their natural social environment.

31. Section 33a(1) provides that outreach, outpatient, and residential services delivered in a manner that enables a person to live independently, in conditions comparable to those of people of the same age, and that prevent segregation, are designated as community-based services.

32. Section 33a(2) provides that the location of outpatient services delivered as community-based services must not lead to the creation of areas with a higher concentration of persons for whom the service is intended. Residential services delivered as community-based services may be provided only in a flat, a multi-family building, or a single-family building situated within the ordinary built-up area of a municipality. The location of residential community-based services must not create areas with a higher concentration of their intended users or an environment that differs from ordinary community life in the municipality.

33. Section 37(3) provides that professional social counselling is provided with a focus on the needs of specific social groups, *inter alia* in counselling centres for persons with disabilities and in a person's natural social environment. Under Section 37(4), this service includes: (a) facilitating contact with a social environment; (b) social-therapeutic activities; (c) assistance in exercising rights, pursuing legitimate interests, and handling personal matters; (d) activities providing support to caregivers and activities that involve training caregivers in the skills required to care for persons dependent on their assistance.

34. Section 37(5) provides that basic social counselling relating to the listed social services (i.e. personal assistance services, home-care services, respite services, and day centres) may also be provided to caregivers to the extent of activities that support caregivers and activities involving the training of caregivers in the skills required to care for persons dependent on their assistance.

35. Section 38 provides that social-care services assist individuals in achieving physical and psychological self-sufficiency, with the aim of supporting life in their natural social environment and enabling them to participate to the fullest extent possible in ordinary social life, or, where their condition excludes this, to ensure they enjoy dignified living conditions and treatment. Everyone has the right to social-care services in the least restrictive environment.

36. Section 40 defines home-care services as outreach or outpatient services provided to persons with reduced self-sufficiency due to age, chronic illness, or disability, and to families with children whose situation requires assistance from

another individual. The service is delivered both in the person's home and in home-care service facilities.

37. Section 44(1) defines respite services as outreach, outpatient, or residential services provided to persons with reduced self-sufficiency due to age, chronic illness, or disability who are otherwise cared for in their natural social environment; the purpose of the service is to enable the caregiver to have the rest they need. Residential respite care may be provided by the same provider for a maximum total of 180 days per calendar year.

38. Section 70a(1) provides that a mental-health centre delivers day and outreach services to persons with mental illness or behavioural disorders and to persons at demonstrable risk of developing such illness or disorder who are in an adverse social situation, as well as to their relatives. Section 70a(2) provides that these services may be delivered only if, at the same time, health services under the Health Services Act are arranged in the mental-health centre (see § 56 below). Under section 70a(3), these services include: (a) training in the skills required for self-care, independence, and activities leading to social inclusion; (b) facilitating contact with a social environment; (c) educational, training, and activation activities; (d) assistance in exercising rights, pursuing legitimate interests, and handling personal matters; (e) social-therapeutic activities.

39. Section 83 establishes the institution of a social-care assistant, who is required to provide assistance personally and to enter into a written agreement on the provision of assistance with the person to whom assistance is delivered.

(b) Responsibilities in the provision of social services

40. Where a person is not receiving a social service and finds themselves in a situation in which the failure to provide immediate assistance would endanger their life or health, the municipal authority is responsible for arranging the provision of a social service or another form of assistance under section 92.

41. Section 93 provides that the regional authority coordinates the provision of social services within its administrative district, and carries out and coordinates social-work activities aimed at addressing adverse social situations and the social inclusion of individuals.

42. Sections 94–95 provide that regions and municipalities are responsible for identifying any needs for the provision of social services to individuals or groups of individuals in their territory. Regions also draw up a medium-term plan for the development of social services in cooperation with municipalities in the region, with representatives of social-service providers, and with representatives of individuals who receive social services. They monitor and evaluate the implementation of development plans for social services, ensure the availability of social services in their territory in accordance with the medium-term plan for the development of social services, and define the network of social services in the region.

43. Representatives of social-service providers therefore not only cooperate by law in the preparation of the plan for the development of social services, but also have the right to monitor its implementation and to participate in its evaluation.

44. Section 96 provides that the Ministry of Labour and Social Affairs ("the MLSA") prepares a national strategy for the development of social services, monitors and evaluates its implementation, and, in cooperation with the regions, determines the parameters of the availability of social services.

(c) Funding of social services

45. Section 101a provides that regions receive an earmarked subsidy from the State budget to finance the ordinary expenditure associated with the provision of basic types and forms of social services for the relevant budget year. The application must include the region's medium-term plan for the development of social services, which contains an economic analysis of the needs identified in the plan and the manner in which they are to be financed. The MLSA determines the subsidy for each region as a percentage of the total annual volume of financial resources allocated in the State budget to support social services for that budget year; the percentage for each region is set out in an annex to the Social Services Act. These shares range from 3.40% (Karlovy Vary Region) to 11.99% (Moravian-Silesian Region). Their level is not determined automatically by the size of the region, but also reflects its specific characteristics in this field (for example, the Moravian-Silesian Region, which has the largest share, is only the fourth largest region by population).

46. The regional assembly decides, in accordance with the conditions it has laid down, whether to award funds from the subsidy to social-service providers and what amount to grant.

47. Section 104(1)–(3) provides that the MLSA may award earmarked subsidies from the State budget to registered social-service providers to fund ordinary expenditure associated with the provision of social services. A subsidy may be granted:

- to support social services of a nationwide or supra-regional character;
- for activities of a developmental nature, in particular the training of social-service workers, support for the quality of social services, and the preparation of medium-term regional plans and municipal plans in the area of social services;
- in response to emergency situations, such as natural disasters, fire, or ecological or industrial accidents.

(iii) Decree of the Ministry of Labour and Social Affairs no. 505/2006 implementing certain provisions of the Social Services Act

(a) Requirements for community-based services

48. Section 36a(1) of the Decree provides that the point at which a social service is delivered, where a residential service is provided as a community-based service, must be located at least 250 metres, measured in a straight line, from any other location at which a social service is delivered, where a residential service for the same category of persons is provided that is not delivered as a community-based service. "Same category of persons" means persons with disabilities, older persons, children, families with children, socially excluded persons, or persons at risk of social exclusion.

49. Section 36a(2) provides that the total number of individuals receiving residential services as community-based services at several locations for the provision of social services that lie less than 250 metres apart, measured in a straight line, may not exceed 18. The maximum number of individuals to whom a residential service may be provided as a community-based service at a single location is 18, in single or double rooms, and the capacity of each housing unit in a multi-unit residential building may not exceed six individuals. Residential services delivered as community-based services may not, in total, be provided to more than 18 individuals on a single plot of land.

(b) Medium-term plan for the development of social services in the region

50. Section 39a provides that the medium-term plan for the development of social services in the region must include a descriptive section, an analytical section, an evaluation of the implementation of the previous medium-term plan, a strategic section, and the method for securing the network of social services.

51. The analytical section forms the basis for the strategic section and encompasses, *inter alia*:

- an assessment of the needs and adverse social situations of individuals in the region in relation to social services and the meeting of those needs within the region, with a particular focus on unmet needs, insufficient service capacity, and the unavailability of particular types of social services in the given area;
- a qualified estimate of the number of individuals receiving social services, and of applicants refused access to particular types of social services;
- a summary of information drawn from methodological and strategy documents of the region and of the MLSA, and, where relevant, from other public authorities whose documents have a direct impact on the region and on the field of social services;

– a summary of the results of needs analyses in the field of social-service provision drawn from medium-term development plans, including the number of applicants refused for particular types of social services, and the availability of particular types of social services within the region;
– a summary of information compiled in connection with the performance of social work at municipal and regional level;
– other information that has an impact on the field of social services.

52. Section 39b provides that the draft medium-term plan is ordinarily discussed publicly with representatives of social-service providers, municipalities, and individuals to whom social services are delivered.

(iv) Criteria for community-based social services and criteria for transformation and deinstitutionalisation

53. In April 2022, the MLSA issued Criteria for Community-Based Social Services and Criteria for Transformation and Deinstitutionalisation ("the Criteria"), a document prepared to establish uniform and transparent conditions for projects aimed at transforming social services in the Czech Republic. The purpose of the Criteria is to set out clearly, and to distinguish, what does and does not constitute a community-based social service.

54. The Criteria set out definitions of basic terms related to deinstitutionalisation and lay down conditions for all forms of social services, i.e. outreach, outpatient, and residential community-based services. These include, for example, the location of a service within a locality, the maximum capacity of a service at a single location, household facilities and equipment, and conditions for transformation projects, such as the use of former premises of residential social-service facilities.

55. The annexes form an integral part of the Criteria. They specify in greater detail certain conditions laid down in the Criteria and also serve to streamline data collection for the monitoring of the process of deinstitutionalising social services in the Czech Republic.

(v) Act no. 372/2011 on health services

56. Sections 44b–44d of the Act regulate mental-health centres. Section 44b(1) provides that a mental-health centre delivers health services under section 44c to patients with a mental disorder or behavioural disorder, and to persons with a demonstrable risk of developing such a disorder, and delivers social services to them to the extent and under the conditions laid down in the Social Services Act.

57. Section 44b(2) provides that the services of a mental-health centre are delivered by health professionals and by workers performing expert activities in social services under the Social Services Act, acting in close cooperation with each other.

58. Section 44b(3) provides that a mental-health centre also delivers assistance and support to persons close to a patient with a mental disorder or behavioural disorder.

59. Section 44c(1) provides that a mental-health centre delivers health services in the form of outpatient care and care delivered in the patient's own social environment, and may also deliver them as day care or inpatient care. Long-term management is always an element of the health services delivered by a mental-health centre.

60. Section 44c(2) provides that a mental-health centre also delivers health services at the place where a patient with a mental disorder or behavioural disorder, or with such a suspected disorder, is currently located and where the patient, owing to their state of health, is unable to receive health services in a healthcare facility or in their own social environment, or does not have such an environment.

(vi) Case law of the Constitutional Court

61. The Constitutional Court, in its judgment no. I. ÚS 2637/17 of 23 January 2018, held that persons with disabilities who find themselves in an adverse social situation have a public subjective right to the availability of appropriate social-care services. This right stems from Section 38 of the Social Services Act, which, at statutory level, covers the exercise of several fundamental rights of persons with disabilities: the right to health (Article 31 of the Charter of Fundamental Rights and Freedoms), the right to an adequate standard of living (Article 11 of the International Covenant on Economic, Social and Cultural Rights), and the right to live independently and be included in the community (Article 19 of the Convention on the Rights of Persons with Disabilities).

62. According to the Constitutional Court, this right entails a corresponding obligation on the part of public authorities to ensure the availability of appropriate social services for persons with disabilities who are in an adverse social situation. Under Section 95(g) of the Social Services Act, regions are therefore required to ensure that individuals in an adverse social situation within their territory have access to the necessary social services, including social-care services. The point is not that the individuals concerned must have access to social care in a particular form precisely matching their ideal preferences (for example, from a specific social-service provider), but that services must exist and be available to them which are adequate to their condition and circumstances and which can help them to lead a dignified life that is as independent as possible, preserving the greatest attainable degree of personal autonomy, without social exclusion and with the fullest possible social inclusion.

63. Where a region fails to take reasonable and targeted steps to secure the availability of appropriate social services that an individual in need of social care could use, an action seeking protection against unlawful interference under the Code of Administrative Justice may be an appropriate procedural remedy for safeguarding that individual's rights.

64. The present case specifically concerned the obligation of the competent region to secure the provision of appropriate social services to an individual with autism and an intellectual disability.

IV. RESPONSE TO THE COMPLAINANT ORGANISATION'S ALLEGATIONS

(A) INTRODUCTORY REMARKS

65. In the light of the obligations arising from the provisions of the Charter invoked in the complaint, and of the principle established in the Committee's case law that the Charter does not require States Parties to achieve specific results, but obliges them to ensure the progressive realisation of the relevant rights, i.e. to adopt the legal, financial, and operational means necessary to ensure steady progress towards achieving the goals laid down by the Charter (see § 22 above), the Government will set out the steps that the Czech Republic is taking to secure an ever broader range of community-based social services for persons with disabilities.

66. It should be pointed out at the outset that the Czech Republic ratified the United Nations Convention on the Rights of Persons with Disabilities in 2009, and its Optional Protocol in 2021, thereby recognising the competence of the UN Committee on the Rights of Persons with Disabilities to examine complaints submitted by individuals or groups of individuals alleging violations of rights under that Convention. Since 2018, the Ombudsperson has monitored the Czech Republic's compliance with its obligations under the Convention and acts as the independent monitoring mechanism under Article 33(2). The Ombudsperson supports the implementation of the rights of persons with disabilities and proposes measures for their protection.

(B) STATE'S EXISTING STRATEGY DOCUMENTS

67. The deinstitutionalisation of social services has long been a priority for the Czech Republic, supported by a clear vision, strategy, and legislative reforms. The Czech Republic is unequivocally committed to promoting independent living and the social inclusion of persons with disabilities. That commitment is reflected in the following key strategy documents.

68. The *first* is the National Strategy for the Development of Social Services for 2016–2025, approved by the Government in 2016. This strategy document sets out the objectives, priorities, and measures for social services in the Czech Republic. It is a fundamental conceptual document that defines the overall direction of social services. It identifies ten principal areas requiring systemic solutions, including the deinstitutionalisation and transformation of social services, the funding of social services, and support for informal carers. For each of these areas, strategic and specific objectives are established and developed through measures, activities, tasks, and indicators of implementation.

69. The *second* is the National Plan for the Promotion of Equal Opportunities for Persons with Disabilities for 2021–2025, approved by the Government in 2020. This is the central national document governing equal opportunities for persons with disabilities and defining State policy in this area. Its aim is to continue promoting and supporting the integration of persons with disabilities and, through concrete measures, to give effect to the individual articles of the Convention on the Rights of Persons with Disabilities. The National Plan was prepared by the Government Board for Persons with Disabilities, the advisory and initiating body of the Government on disability matters, which established a working group composed of representatives of the relevant departments and bodies, including organisations of persons with disabilities. The National Plan is divided into five parts, the third and most extensive of which lists 17 strategic areas of support for persons with disabilities. Its objectives explicitly include promoting the deinstitutionalisation and transformation of residential facilities for persons with disabilities, adopting measures to support independent living, protecting caregivers, and ensuring the participation of persons with disabilities in political and public life.

70. The *third* key strategy document is the Action Plan for the Transition of Social Services to Community-based Care, for Greater Individualisation of Care, and for the Support of the Deinstitutionalisation of Social Services for 2023–2025, approved by the Government in 2023. The Action Plan serves as a tool for continuing to promote and support the social inclusion and independent life of persons disadvantaged by age or health, in particular older persons and persons with disabilities. It does so by laying down specific measures in the deinstitutionalisation of social services with the aim of ensuring that care is provided primarily in an individual's natural environment, and of reducing the number of beds in non-community residential facilities.

71. *Fourthly*, and finally, there are the Systemic Measures to Support Persons with Intellectual Disabilities and Behaviour Requiring a High Level of Care for 2024–2030, approved by the Government in 2024. The aim of this document is to ensure that persons with intellectual disabilities and behaviour requiring a high level of care, and persons close to them, receive the widest possible range of comprehensive support, so that their needs and wishes are systematically taken into account, their dignity and quality of life safeguarded, and the risks of inappropriate treatment, abuse, and neglect prevented. The document seeks to strengthen systematic support for this group of persons with disabilities and thereby improve their access to the healthcare, social-service, and education systems, as well as to other areas. The Systemic Measures set out basic principles, foundational values, and long-term and short-term objectives. The long-term objectives are divided into five groups: the creation of a functioning system of comprehensive, accessible, and high-quality care for persons with behaviour requiring a high level of care; the reduction of stigma; better information for their families; enhanced human resources in work with persons with intellectual disabilities and behaviour requiring a high level of care; and the development of key competences of professional caregivers and specialists. Each area contains specific objectives to be achieved and

a set of measures, together with the departments responsible for their implementation. Representatives of central government authorities, the non-profit sector, and persons concerned participated in the preparation of the Systemic Measures, including the organisations NAUTIS, TUDYTAM, Mikasa, Naděje pro děti úplňku, and the Diaconia of the Evangelical Church of Czech Brethren.

(C) SUPPORT FOR INDEPENDENT LIVING

72. Although the collective complaint focuses on the conditions for providing care to persons with disabilities within the system of social services, it also refers to the fulfilment of obligations arising from Article 19 of the Convention on the Rights of Persons with Disabilities, which guarantees the right to independent living and inclusion in the life of the community. In the context of support and assistance for persons with disabilities, it is therefore necessary to consider other benefit-based and non-benefit-based interventions enabling persons with disabilities to remain in their home environment and to lead an independent life. In this respect, particular reference may be made to the mobility allowance, the allowance for special aids, and the disability card and the benefits derived from it.

(i) Mobility allowance

73. The mobility allowance is granted to persons over one year of age who are entitled to a disability card at the level of particularly severe disability, and who, throughout the calendar month, repeatedly travel or are transported for a fee, provided they are not receiving residential social services under the Social Services Act in a home for persons with disabilities, a home for the elderly, a home with a special regime, or in an inpatient healthcare facility.[1] The monthly amount of the mobility allowance is CZK 900, or CZK 2,900 for a person who uses, throughout the calendar month, a medical device for long-term home oxygen therapy or a medical device for home artificial lung ventilation, and has demonstrated this fact by producing confirmation issued by the relevant health-insurance provider. Both the number of recipients of the mobility allowance and the related expenditure have been rising slightly, as shown in the following table.

Year	Annual expenditure (CZK billions)	Average number of recipients per month
2019	2.652	261,358
2020	2.628	261,755
2021	2.5611	251,835
2022	2.668	255,563
2023	3.759	263,552

[1] Persons receiving the residential social services listed above may, for reasons worthy of special consideration, also be granted the mobility allowance.

2024	3.847	266,527

(ii) Allowance for special aids

74. Through the allowance for special aids, the State assists persons with disabilities in acquiring a broad range of products, items, and works, referred to for this purpose as "special aids". These might include, for example, a motor vehicle, a stairlift, a lifting platform, adaptations to a bathroom or toilet, a signalling device for a doorbell, or a mobile stair climber. Many such special aids enable persons to remain in their home environment. The trend in allowances granted for special aids fluctuates, owing to several factors.[2]

Year	Annual expenditure (CZK billions)	Number of allowances
2019	0.931	7,355
2020	0.899	6,300
2021	0.887	4,932
2022	0.904	6,260
2023	0.908	6,057
2024	0.943	6,217

(iii) Disability card

75. A disability card is issued to persons over one year of age with a physical, sensory, or mental disability constituting a long-term adverse health condition that substantially limits their mobility or orientation, including persons with autism-spectrum disorder.

76. The disability card, especially at the level of particularly severe disability, gives rise to mandated and discretionary benefits in various areas. For holders of a disability card at the level of particularly severe disability who require a guide, such benefits ordinarily apply to the accompanying person as well. Examples include fare discounts on regular train and bus services, free municipal public transport, free use of toll roads, exemption from certain administrative and local charges, and reduced admission fees (museums, cultural or historical monuments, etc.). Additional entitlements arise from the parking card issued to persons with disabilities, covering parking and other traffic-regulation rules.

[2] For example, the number of applications, the needs of applicants, and the fact that technological progress has replaced many such special aids with a smartphone, i.e. individuals apply only for that device rather than multiple other products.

(D) PROVISION OF CARE WITHIN THE SYSTEM OF SOCIAL SERVICES

(i) Introductory remarks

77. Most persons with disabilities in the Czech Republic live in their natural environment rather than in institutions. Data indicates that approximately 78% of recipients of a care allowance live at home. This trend is particularly evident among persons with higher levels of dependency: roughly 54% of recipients at dependency level IV and 72% at dependency level III live in their home environment. To support this trend, the Social Services Act was amended with effect as of July 2024 to provide that priority is to be given to forms of social-service provision that support an individual's continued stay in their natural social environment (see § 26 above).

78. Further, with effect as of March 2025, the Social Services Act introduced a definition of "community-based services" as those outreach, outpatient, and residential services provided in a manner enabling a person to lead an independent life comparable in nature to the ordinary life of persons of the same age, and preventing segregation (see § 31 above). This may be construed as a further clear step towards building capacity and strengthening the development of community-based social services.

79. Finally, although large-capacity residential facilities remain within the system, even these must comply with strict quality standards that guarantee dignified treatment and the protection of users' rights.

(ii) Social services providing care to persons with disabilities

(a) Types of social services providing care to persons with disabilities

80. In the Czech Republic, care for persons with disabilities is provided, in particular, through the following social services:

– **personal assistance** (*osobní asistence* – OA) – an outreach service provided to persons whose self-sufficiency is reduced owing to age, chronic illness, or disability and whose situation requires assistance from another person; the service is provided without time limitation, in the person's natural social environment, and in connection with the activities the person requires;

– **home-care service** (*pečovatelská služba* – PS) – an outreach or outpatient service provided to persons whose self-sufficiency is reduced owing to age, chronic illness, or disability, and to families with children whose situation requires assistance from another person; the service is provided at specified times in the person's home and in social-service facilities and covers defined tasks;

– **support of independent living** (*podpora samostatného bydlení* – PSB) – an outreach service provided to persons whose self-sufficiency is reduced owing to disability or chronic illness, including

mental illness, and whose situation requires assistance from another person;

– **respite services** (*odlehčovací služby* – OS) – outreach, outpatient, or residential services provided to persons whose self-sufficiency is reduced owing to age, chronic illness, or disability and who are otherwise cared for in their natural social environment; the purpose of the service is to give the caregiver the rest they need; residential respite care may be provided for a total of no more than 180 days in a calendar year, with only services provided by the same provider counting towards this limit;

– **day-service centres** (*centra denních služeb* – CDS) – outpatient services for persons whose self-sufficiency is reduced owing to age, chronic illness, or disability and whose situation requires assistance from another person;

– **day centres** (*denní stacionáře* – DSt) – outpatient services for persons whose self-sufficiency is reduced owing to age or disability and for persons with chronic mental illness, whose situation requires regular assistance from another person;

– **weekly centres** (*týdenní stacionáře* – TS) – residential services for persons whose self-sufficiency is reduced owing to age or disability and for persons with chronic mental illness, whose situation requires regular assistance from another person;

– **homes for persons with disabilities** (*domovy pro osoby se zdravotním postižením* – DOZP) – residential services for persons whose self-sufficiency is reduced owing to disability, whose situation requires regular assistance from another person;

– **homes for the elderly** (*domovy pro seniory* – DS) – residential services for persons whose self-sufficiency is reduced primarily owing to age and whose situation requires regular assistance from another person;

– **homes with a special regime** (*domovy se zvláštním režimem* – DZR) – residential services for persons whose self-sufficiency is reduced owing to chronic mental illness or substance addiction, and for persons with senile, Alzheimer's, or other types of dementia whose self-sufficiency is reduced owing to these conditions and whose situation requires regular assistance from another person;

– **sheltered housing** (*chráněné bydlení* – CHB) – a residential service provided to persons whose self-sufficiency is reduced owing to disability or chronic illness, including mental illness, and whose situation requires assistance from another person; sheltered housing takes the form of group or, where applicable, individual living arrangements;

– **social services provided in inpatient healthcare facilities** (*sociální služby poskytované ve zdravotnických zařízeních lůžkové péče* – SSZZ) – residential social services provided in such facilities to persons who no longer require inpatient medical care but who, owing to their health condition, cannot manage without assistance from another person and therefore cannot be discharged from the inpatient healthcare facility until help from a relative or another individual is secured, or until outreach or outpatient social services or residential social services in a social-service facility are arranged.

(b) Number of social services for persons with disabilities and number of clients of those services in 2019–2024

81. The trend in the number of social services for persons with disabilities (broken down by individual types of services) and in the number of clients of those services in the years 2019–2024 is shown in the table in Enclosure 1 to these observations.

82. This data shows that the proportion of **residential** social services within the overall number of services providing social care to persons with disabilities continues to exhibit a marked imbalance compared with the proportion of community-based services. It must, however, be noted that the positive trend of shifting from residential social services to outpatient, outreach, or residential community-based services was adversely affected or slowed after 2018 by several factors:

– the global COVID-19 pandemic caused a significant reduction in the provision of social services for many months;

– the energy crisis in 2022 contributed significantly to the sharp rise in inflation, leading to considerable increases not only in the price of energy, construction work, and building materials, but above all in the purchase prices of immovable property (both building plots and buildings suitable for the provision of social services);

– in the long term, the process of the deinstitutionalisation and transformation of social services is also limited by the general shortage of housing or premises suitable for living;

– it is also necessary to take into account that new capacity can be developed only to the extent that it remains feasible to secure a sufficient number of specialised staff; according to a survey carried out by the Association of Social-Service Providers (*Asociace poskytovatelů sociálních služeb*) in January 2025, 59% of respondents reported a shortage of qualified staff in 2025; in the social-service sector, 2,543 specialised employees are already missing in the positions of direct-care worker, social worker, and nurse;

– significant limits to the provision of community-based services also arise from prejudice and lack of understanding among residents of

municipalities, expressed in petitions opposing the provision of such services at proposed locations, which makes it extremely difficult to identify sites, plots, houses, or flats where community-based services could be provided.

83. As regards the scale of non-community residential social services, as at 1 July 2025 there were 220 facilities of the DOZP type (homes for persons with disabilities) in the Czech Republic, with 11,207 beds. This means that the average number of beds in a single DOZP facility is 50.94.

84. Ongoing analyses further show that, **at present, there are more places (9,442) in smaller facilities (up to 50 beds) than in large-capacity facilities (over 50 beds), which have 5,854 beds:**

Region	**Number of beds in CHB and DOZP facilities with a capacity of up to 50 beds in one building or in separate buildings within the same complex**	**Number of beds in DOZP facilities with a capacity of more than 50 beds in one building or in separate buildings within the same complex**
City of Prague	331	266
South Bohemia	371	386
South Moravia	627	815
Karlovy Vary	284	214
Hradec Králové	602	222
Liberec	429	58
Moravia-Silesia	1,446	392
Olomouc	443	639
Pardubice	509	275
Plzeň	610	714
Central Bohemia	1,069	986
Ústí nad Labem	1,488	426
Vysočina	502	295
Zlín	731	166
Total	9,442	5,854

85. This table is based on the fact that services with an overall capacity exceeding 50 beds may still be community-based. This is possible because such services are decentralised and, instead of a single large institution, consist of a group of small-capacity houses or flats located in different neighbourhoods and integrated into ordinary residential areas. This approach combines the pragmatic management of a large organisation (offering, for example, centralised administration and management) with individually focused support in an ordinary environment for each client. The criteria for community-based services therefore relate to the size and location of the individual buildings (for example, a maximum of six clients in

a household), not to the total capacity of the registered service. This model is considered an effective pathway towards independent living while maintaining organisational stability. The data shows that the trend towards decentralisation into smaller-capacity units is actively promoted and that most of the overall bed capacity is already located in facilities with a smaller number of beds (for a more detailed account at regional level, see §§ 168–173 below).

(c) Outreach services

86. The trend in the number of social services in the fields of personal assistance, home-care services, and support of independent living, as well as in the number of clients of those services, broken down by region, in the years 2019–2024 is shown in the tables in Enclosure 2 to these observations.

87. The table on personal assistance shows that the number of clients of such services rose from 9,516 in 2019 to 11,050 in 2024. Non-investment funding for personal assistance increased by 64% over the period under review, and by as much as 100% for home-care services. By contrast, funding for homes for persons with disabilities rose by only 32%. A clear trend of strengthening support for outreach services over residential services is therefore apparent.

88. The table on home-care services shows a decline in the number of clients over time (101,000 in 2019 versus just under 88,000 in 2024). Internal MLSA data nevertheless indicates that the number of unfulfilled applications has remained relatively stable and that staffing levels have risen significantly. These seemingly contradictory trends can be interpreted as showing that the complexity of tasks (and thus the level of care) required by clients in outreach social services is increasing – more staff are serving fewer clients.

89. In the case of outreach services, particularly personal assistance, home-care services, and respite services, a trend can be observed towards increasing support for the provision of care to persons with disabilities in their home environment. There are several reasons for this:

– in home-care services, the emphasis is shifting from “simple” tasks, such as meal delivery, to tasks requiring intensive care, which places significant demands on the capacity of these services and on adequate staffing;

– the scope of core activities that these social services are required to provide is gradually expanding to enable them to deliver care to persons in their natural environment (for example, assistance in ensuring safety and enabling a person to remain in their natural social environment in the case of personal assistance, home-care services, and respite services, or the optional basic activity of assistance with routine healthcare tasks, applicable from 1 July 2026 for personal assistance and home-care services).

(d) Outpatient services

90. The trend in the number of social services provided by day-service centres and day centres, as well as in the number of clients of those services, broken down by region, in the years 2019–2024 is shown in the tables in Enclosure 3 to these observations.

91. These tables show that day-service centres experienced a slight decrease both in their number and in the number of clients (77 facilities in 2019 versus 72 in 2024, from 2,609 to 2,103 clients), whereas day centres exhibit a modest increase (268 facilities in 2019 versus 277 in 2024, from 7,094 to 7,741 clients).

(e) Respite services

92. The trend in the number of respite services (broken down into residential, outpatient, and outreach forms), as well as in the number of clients of those services, broken down by region, in the years 2019–2024 is shown in the tables in Enclosure 4 to these observations.

93. Again, over the period in question, a notable increase can be observed in both the overall number of such services and the number of clients (313 respite services provided and 13,894 clients in 2019 versus 355 services and 16,380 clients in 2024).

(f) Sheltered housing

94. Among residential services of a community-based nature, the principal social service is sheltered housing. According to the MLSA Statistical Yearbook, the capacity of these services doubled between 2007 and 2018, rising from 2,087 to 4,104 places.

95. The table below illustrates the provision of sheltered housing ("CHB") as a social service ("SS") to persons with disabilities in the years 2019–2024.

Number of registered sheltered-housing services, total number of clients, and average number of clients per service, 2019–2024

SS CHB	2019	2020	2021	2022	2023	2024
Number of SS	218	223	227	223	224	226
Number of clients	4,554	4,580	4,635	4,689	4,802	5,013
Average number of clients per SS	21	21	20	21	21	22

Source: statistical data from the OKslužby – poskytovatel application

Both the number of sheltered-housing facilities and the number of clients accommodated in them have risen steadily in recent years.

96. There is no unified nationwide register or database of unfulfilled applications for social services in the Czech Republic. Relevant information can therefore be drawn only from reporting records, as shown in the following table.

Numbers of applicants refused access to sheltered housing owing to insufficient capacity, 2019–2024

SS CHB	2019	2020	2021	2022	2023	2024
Number of applications refused	1,384	1,342	1,342	1,614	1,502	1,418

Source: statistical data from the OKslužby – poskytovatel application

This data, however, is not fully reliable because:

– a single person may submit applications for the same social service to multiple providers, and the system does not identify applicants under a uniform number or by any other means;

– reporting by social-service providers exhibits a high error rate;

– the reporting system does not clearly indicate the statutory reason for refusing an application (for instance, the applicant does not fall within the service's target group, capacity is insufficient, or a health condition precludes admission).

Despite these limitations, information on unfulfilled applications remains an important source for determining the need for social services.

97. The collective complaint argues that the minimum acceptable standard for placement in sheltered housing should be a **single room**. In the Government's view, neither the impugned provisions of the Charter nor the Committee's case law impose an obligation on States Parties to provide single rooms within the scope of residential services for persons with disabilities. For the sake of completeness, the Government notes that, under the current binding standard, a community-based residential social service may be provided only in single or double rooms (see § 49 above). Moreover, both the number of single rooms in sheltered housing and the proportion of clients placed in them have increased in recent years, as demonstrated in the table below (2,434 rooms in 2019 compared with 2,982 in 2024; 53.45% of clients in 2019 compared with 59.49% in 2024).

Numbers of single rooms in sheltered housing, 2019–2024

SS CHB	2019	2020	2021	2022	2023	2024
Numbers of single rooms	2,434	2,559	2,744	2,796	2,942	2,982
Proportion of clients in single rooms	53.45%	55.87%	59.20%	61.76%	61.27%	59.49%

Source: statistical data from the OKslužby – poskytovatel application

Furthermore, as follows from the submissions received from the regions (requested by the Government for the purpose of preparing these observations; see § 166 below), in some instances clients expressly prefer double rooms (for example, partners, siblings, or close friends).

98. The collective complaint further asserts that sheltered housing accounts for just 11% of total residential-care capacity, while most residential care for persons with disabilities is non-community-based and provided in large-capacity facilities such as homes for persons with disabilities and homes with special regimes. In response, the Government points out that **most residents of homes with special regimes are, in fact, the elderly, rather than persons with disabilities, who constitute the complaint's intended target group** (see § 167 below for a regional breakdown of this aspect). For persons with disabilities, the primary residential services are homes for persons with disabilities and weekly centres. When viewed in that context, the proportion of sheltered housing within overall residential care for persons with disabilities is significantly higher than claimed in the complaint, as shown by the following tables – in 2024, sheltered housing accounted for 46.60% of facilities and 28.82% of clients.

Number of residential social services for persons with disabilities and share of sheltered housing (%) in the total number of residential social services for persons with disabilities, 2019–2024

Type of SS	2019	2020	2021	2022	2023	2024
DOZP	204	206	205	206	212	218
TS (only persons with disabilities)	44	42	42	43	44	41
CHB	218	223	227	223	224	226
Total	466	471	474	472	480	485
Proportion of CHB (%)	46.78%	47.35%	47.89%	47.25%	46.67%	46.60%

Source: statistical data from the OKslužby – poskytovatel application

Number of clients in residential social services and share of clients in sheltered housing in the total number of residential services (%), 2019–2024

Type of SS	2019	2020	2021		2022	2023	2024
DOZP	12,488	12,049	11,875		11,707	11,954	11,731
TS (only persons with disabilities)	761	732	731		712	724	653
CHB	4,554	4,580	4,635		4,689	4,802	5,013
Total	17,803	17,361	17,241		17,108	17,480	17,397
Proportion of CHB (%)	25.58%	26.38%	26.88%		27.41%	27.47%	28.82%

Source: statistical data from the OKslužby – poskytovatel application

(iii) Deinstitutionalisation and transformation of social services

99. The process of the deinstitutionalisation and transformation of social services in the Czech Republic is guided by long-term strategy documents and the action plans that implement them (see §§ 67–71 above).

100. In recent years, the Czech Republic has made significant progress in deinstitutionalisation. This progress stems from systematic and long-term efforts not only by the MLSA and other ministries, but also by many other key actors, including the regions and municipalities, social-service providers, and umbrella organisations representing users' interests. Despite these efforts, conditions for the complete abolition of all residential social-service facilities have not yet been created. Nonetheless, even in those institutional social-service facilities that have not yet entered the transformation process, measures are being taken to improve users' living conditions.

101. Beyond the measures already described, reference should also be made to the statutory reform of the age limit for placing a child in a residential facility providing collective care. In relation to children with disabilities within the social-services system, this reform takes the form of a prohibition on placing such children in residential social-service facilities, namely homes for persons with disabilities. The prohibition is being introduced in stages:

- with effect from January 2025: children with disabilities under four years of age, except for children at dependency levels III and IV, and except in cases of serious threat to the life or health of a child under four years of age;
- with effect from January 2027: children with disabilities under four years of age – no exceptions;
- with effect from January 2028: children with disabilities under seven years of age – no exceptions.

102. As regards the availability of community-based services, 11 regions are currently taking part in the present wave of the transformation project, as shown in the table below. Three regions (the Plzeň Region, the South Bohemian Region, and the City of Prague) have not joined the project, although this does not mean that they are not pursuing their own transformation initiatives.

New types of social services established in the present wave of the transformation project

	CHB	STD (social-therapy workshops)	DOZP	DZR	OS	DS	TS
Zlín Region	2	1	5	3			
Olomouc Region	5		6	1			

Liberec Region	3				1	1	1
South Moravian Region	14	1	9	4	Not yet known		
Ústí nad Labem Region	1						
Karlovy Vary Region		1					
Vysočina Region	10	2	15			2	
Central Bohemian Region			6				
Hradec Králové Region	3		5				
Pardubice Region	1		3	1			
Moravian-Silesian Region			4				

103. The current wave of transformation is based on very strict and comprehensive criteria, including the requirement that community-based residential services must not exceed a maximum capacity of eighteen persons per building (see § 49 above), and spatial requirements preventing the emergence of clusters that would differ from the surrounding municipal community (see § 32 above). These measures create essential legislative safeguards against the establishment of new segregated locations, which is crucial for the genuine inclusion of persons with disabilities in society.

104. As regards the completion of the process of the deinstitutionalisation and transformation of social services in the Czech Republic, the MLSA states, in the context of the forthcoming National Strategy for the Development of Social Services, its intention to work towards prohibiting the admission of new clients to non-community-based services by 2040 (see § 214 below).

(iv) Funding of social services

105. The Czech Republic operates a multi-source system for funding social services. The costs of social services are covered by State-budget subsidies, user payments, care allowances, contributions from regions and municipalities, health-insurance payments, European funds, and other sources (including the resources of non-profit organisations providing social services, foundations, and donations).

106. Since 2015, the funding of social services at regional level has been the responsibility, within their independent competence, of the regions, which receive a subsidy from the MLSA. The MLSA determines the amount of the subsidy on the

basis of a percentage set separately for each region in the Social Services Act, taking into account the population and other criteria (see § 45 above).

107. The funding of social services at regional level in the Czech Republic therefore operates under a statutory mechanism, meaning that it is predictable and independent of political discretion on the part of central government authorities.

(a) National non-investment resources to ensure the provision of social services

108. Enclosure 5 to these observations contains tables setting out:

– State-budget resources provided to support social services for persons with disabilities in the years 2019–2024: non-investment subsidies;

– State-budget resources provided to support selected social services for persons with disabilities in the years 2019–2024: non-investment subsidies, including their percentage of the total volume of resources allocated to social-care services;

– non-investment State-budget resources provided to support selected social services for persons with disabilities in the years 2019–2024: per-client amounts;

– the amount of support in the form of State-budget subsidies granted to social services focusing on persons with disabilities under the MLSA subsidy programme for social services with supra-regional or nationwide scope ("Support Programme B") in the years 2019–2024.

109. These tables show that the volume of resources concerned has risen distinctly over time, both in absolute terms and per client. **The upward trend in funding likewise applies to community-based social services**:

– for example, **sheltered housing** received approximately CZK 0.7 billion in 2019, compared with over CZK 1.2 billion in 2024; per client, this is an increase from CZK 156,134 to CZK 245,241;

– **personal assistance** rose from approximately CZK 0.29 billion to CZK 0.48 billion in this timeframe; per client, this is an increase from CZK 31,280 to CZK 44,122;

– **support of independent living** rose from CZK 0.53 billion to CZK 0.68 billion in this period; per client, that translates into growth from CZK 51,027 to CZK 63,082.

110. The **number of social services with supra-regional or nationwide scope for persons with disabilities supported from the State budget** under the MLSA subsidy programme for social services with supra-regional or nationwide scope **has also increased** (62 services in 2019 compared with 81 in 2024), as has the **volume of these subsidies** (while the total volume of such subsidies amounted to approximately CZK 0.24 billion in 2019, it was approximately CZK 0.61 billion in 2024).

(b) Resources for the funding of deinstitutionalisation and the operation of community-based services

111. Under the current Action Plan for the Transition of Social Services to Community-based Care for 2023–2025 (see § 70 above), Strategic Objective D was set: to ensure accessible financial support in the implementation of the process for the deinstitutionalisation of social services.

112. As to the volume of resources allocated for the deinstitutionalisation and transformation of social services, the Czech Republic recognises the need for further increases. For example, the State budget for 2025 includes a significant rise in funding for social services, amounting to CZK 2 billion.

113. Just as the overall system of social-service provision is funded from multiple sources, so too is the transformation and deinstitutionalisation of social services. Resources come from European Union funds, the MLSA's investment-grant scheme, and financial contributions from regions, municipalities, and non-profit organisations.

114. Enclosure 6 to these observations contains an overview of financial resources drawn from **European Union funds** for investments in social-service infrastructure for the period 2019–2024. Virtually all such resources have been used to build the capacity of, or to develop, community-based social services, since all calls required adherence to the methodology concerning material and technical standards, including the criteria for community-based social services.

115. With regard to **national resources** for investments in social-service infrastructure for 2019–2024, the MLSA investment programme 013 310 – Development and Renewal of the Material and Technical Base of Social Services – spent a total of CZK 196,552,382 on projects targeting persons with disabilities in 2019–2024. The programme aimed to improve the availability, quality, and safety of social services through targeted investments in infrastructure. The total amount includes investments in services such as homes for persons with disabilities, sheltered housing, weekly centres, and early-intervention services. Supported projects involved structural modifications, barrier-free access, lift systems, technical equipment, and the installation of fire-alarm systems. Particular attention was devoted to expanding capacities for persons with autism-spectrum disorder ("ASD"), as well as for persons with physical disabilities and persons with multiple sclerosis. Under two national calls focusing on persons with ASD, nine services with a total capacity of 63 places were established, supported by CZK 82,948,000. These investment resources have contributed significantly to improving the quality of care, the availability of services, and the dignity of life of persons with disabilities throughout the Czech Republic.

(v) Social-service planning

(a) Planning in strategy documents

116. Although measures relating to the transformation of non-community-based services form an integral part of the process of deinstitutionalising residential

social services, as well as of the strategy documents adopted by the Government in this field, the Government cannot accept the allegation in the collective complaint that these strategy documents focus primarily on reducing beds in large residential facilities and increasing beds in smaller facilities. The documents contain a wide range of measures designed to support the development and strengthening of outpatient and outreach social services for persons with disabilities, thereby advancing the model of community-based care, as well as measures aimed at creating new capacities in residential community-based services.

117. Enclosure 7 to these observations provides a concise overview of the objectives and measures in the above-mentioned strategy documents that focus on the deinstitutionalisation and transformation of residential social services in the Czech Republic.

(b) System for social-service planning

118. The Social Services Act assigns the principal role in social-service planning to the regions, acting within their independent competence, since each region, as a self-governing unit, is responsible for identifying the need for the provision of social services to individuals or groups of individuals within its territory. On the basis of the needs thus identified, and in cooperation with municipalities within the region, with representatives of social-service providers, and with representatives of individuals receiving social services, the region prepares a medium-term plan for the development of social services (see §§ 50–52 above).

119. A regional medium-term plan for the development of social services is a strategy document that is usually adopted for a period of three years. It is rooted in the active identification of the needs of individuals within the region and the search for ways to meet those needs using available resources. It contains: the outcomes of underlying analyses and data; a description of the procedure for drawing up the plan, including an outline of cooperation with municipalities, social-service providers, and individuals receiving services; a description and analysis of available resources and the needs of the persons for whom social services are intended, including an economic assessment; a strategy for delivering and developing social services, setting out the desired future state and the measures by which this is to be achieved; the duties of the actors involved; the procedure for monitoring and evaluating implementation of the plan; the method by which changes in the provision of social services may be made; and the method for securing the network of social services within the region.

120. With the participation of representatives of municipalities, social-service providers, and individuals receiving social services, the region also monitors and evaluates the implementation of its plans for the development of social services, informs the MLSA of the level of implementation, ensures the availability of social services within its territory in accordance with the medium-term plan, and determines the network of social services within its territory.

121. It could therefore be stated that the combined set of the 14 regional medium-term plans for the development of social services represents the

identification of needs and the planning of the provision of social services across the entire Czech Republic.

122. Differences in planning practices between individual regions do exist, and the periods for which these medium-term plans are drawn up are not standardised. Since regions identify needs and plan the provision of social services within the scope of their independent competence, the MLSA has no direct influence on the shape of social-service networks in individual regions. However, to support the regions, the MLSA has prepared a number of methodological materials and recommendations relating to planning, which can improve or help to harmonise the planning process at both regional and municipal level.

123. At national level, the MLSA prepares the National Strategy for the Development of Social Services, monitors and evaluates its implementation, and, in cooperation with the regions, determines parameters for the availability of social services (see § 44 above).

124. Under certain circumstances and in accordance with budgetary rules, the MLSA may provide registered social-service providers with earmarked State-budget subsidies to cover current expenditure associated with the provision of social services (see § 47 above).

125. The MLSA determines the annual priorities and detailed focus of these subsidy schemes by issuing the MLSA Methodology for the Provision of State-budget Subsidies to Social-service Providers and for the Assessment of Applications for State-budget Subsidies in Supra-regional or Nationwide Social Services. A substantial proportion of supported projects concerns the provision of social services to persons with disabilities.

(c) Forthcoming developments in the field of planning

126. In order to improve coordination and unify the approach to identifying the need for social services within the individual regions and across the Czech Republic as a whole, significant changes in social-service planning will take effect in January 2026:

– the regional medium-term plan for the development of social services will be drawn up as a strategy document covering a five-year period;

– unlike the previous system, the MLSA will be a mandatory partner of the region in preparing the medium-term plan;

– the national strategy for the development of social services will also be prepared by the MLSA for a five-year period;

– the national strategy for the development of social services will be subject to Government approval;

– in preparing the strategy, the MLSA will draw on the regional medium-term plans for the development of social services;

– the MLSA will establish a nationwide or supra-regional network of social services; this network will consist of social services that, with

> sufficient capacity, appropriate quality, and adequate accessibility, assist in addressing adverse social situations throughout the Czech Republic and reflect the identified needs of the individuals living here; this network will also form part of the national strategy for the development of social services.

127. In connection with these changes, the MLSA is currently working on two methodological documents intended primarily for the regions: Methodology for Identifying the Needs of the Population and Methodology for Social-service Planning and Networking.

(d) Identification of users' needs

128. Within their independent competence, regions are responsible for identifying the need for the provision of social services in their territory. The Social Services Act provides that, in carrying out this task and in planning social services, regions are to cooperate with municipalities within their territory, with representatives of social-service providers, and with representatives of individuals receiving services (see § 42 above). The MLSA provides methodological support to regions in this field (see §§ 122 and 127 above).

129. The primary source used by the MLSA to determine the need for the provision of social services is the register of social-service providers, maintained as a public-administration information system. The register includes a system for reporting data on the social services provided. Reporting is carried out by individual social-service providers.

130. Another source of information used by the MLSA to assess the need for the provision of social services is the regions' medium-term plans for the development of social services, together with input from representatives of associations of social-service providers and from associations representing the various groups of persons to whom social services are provided, including associations representing persons with disabilities.

(e) Participation of persons with disabilities and informal carers in social-service planning

131. At national level, persons with disabilities are represented on the Government Board for Persons with Disabilities, a standing coordinating, initiative, and advisory body of the Government on matters relating to support for persons with disabilities. It deals in particular with issues that cannot be resolved by a single government department acting alone. Its aim is to help to create equal opportunities for persons with disabilities across all areas of social life.

132. The participation of persons with disabilities and informal carers in needs-assessment processes and in social-service planning within the regions' autonomous competence is described in the section on the preparation of the regions' medium-term plans for the development of social services (see §§ 118–120 above), as well as in the section summarising the statements of the individual regions in response to the present collective complaint (see §§ 186–189).

133. The MLSA, in order to ensure the participation of persons with disabilities and informal carers in both needs assessments and social-service planning, relies not only on consultations with representatives of associations and organisations defending the interests of various groups of persons, including persons with disabilities, but also on the establishment of various platforms and working groups, for example within the framework of system projects implemented under the Operational Programme Employment Plus.

134. In the adoption of legislative measures and governmental strategy documents in the field of social services, the MLSA proceeds in accordance with the Government's Legislative Rules and the General Principles for Regulatory Impact Assessments (RIAs). Cooperation with organisations representing persons with disabilities is secured in the legislative process, *inter alia* through their inclusion among the entities entitled to submit comments on draft legislation.

135. Under the current Action Plan for the Transition of Social Services to Community-based Care for 2023–2025 (see § 70 above), round tables were held with self-advocates, along with meetings of the Interdepartmental and Cross-sectoral Committee for Assessing the Implementation of the Process of the Deinstitutionalisation and Transformation of Social Services (persons with disabilities were represented through umbrella organisations defending their interests), as well as Discussion Forums. At regional level, cooperation took place with the Czech National Disability Council, as the umbrella body for organisations and associations representing the interests of persons with disabilities.

136. The MLSA has also established cooperation with major relevant non-governmental non-profit organisations, such as Asalto, o.p.s./Skok do života and Inclusion Czech Republic (*Společnost pro podporu lidí s mentálním postižením ČR*) and with other important actors. Persons with disabilities – self-advocates – are actively involved in the project Support for the Process of the Deinstitutionalisation and Transformation of Social Services in the Czech Republic. At present, 15 workshops with self-advocates are being held at facilities participating in the project. In these workshops, self-advocates share their experience of advocating for their rights, as well as their experience of transitioning from institutional to community-based services. Given the strong interest in these workshops, the MLSA is preparing specifications for a further public contract on a similar theme, which will involve persons with disabilities as trainers.

(vi) Provision of care for persons with high care needs

(a) Definition of "persons with high care needs"

137. Although the term "person with high care needs" is not defined in legislation, practice considers such persons to be individuals who are dependent on the care of another person and require such care to a substantial extent, i.e. care exceeding 12 hours a day. These are typically persons who, for the purposes of the care allowance, have been recognised as having level III or IV dependency (see § 29 above).

138. Given that persons with high care needs require intensive care (particularly nursing care), it is currently very difficult to deliver such care in their natural home environment. Efforts to provide care for these persons in their natural environment are hampered by the following factors:

– in the past, care for such persons was provided almost exclusively in residential social services; in view of the total number of users that have been placed in such services, and within a short time frame, it is both economically and practically very demanding to ensure the transition of these users to community-based social services;

– the provision of such care through outreach services requires a significant increase in the capacity of those services, but the social-services sector is facing a persistent shortage of staff.

(b) Support for persons with high care needs

139. In recent years, the MLSA has adopted a number of legislative and non-legislative measures to support the development of outpatient and outreach services for persons with high care needs, to ensure their availability in a natural environment, and to support the transition of such persons from residential non-community-based services to community-based services:

– the Social Services Act was amended, with effect from July 2024, to establish that priority is to be given to forms of social-service provision that support an individual remaining in their natural social environment, i.e. the principle of the preferential use of outpatient and outreach services over residential services (see § 26 above);

– with effect from July 2026, core activities provided as personal assistance and home-care services will be expanded to include a new optional basic activity, “assistance with routine healthcare tasks”;

– the focus of home-care services is shifting from the provision of simpler tasks to the provision of care to persons in their natural environment;

– an increase in the care allowance for persons who do not live in residential services;

– the strengthening of the position of, and support for, informal caregivers;

– the launch of a special subsidy scheme for personal assistance.

(c) Payment for the provision of social services

140. The MLSA has also taken account of the situation of persons with high care needs in terms of payment for the provision of social services. With effect from January 2023, the maximum payment for the provision of social services was increased pursuant to an amendment to Decree no. 505/2006 (see § 48 above). For clients who are dependent on the assistance of another person and require care in

excess of 80 hours per month, the maximum payment for the care provided was not increased.

(d) Special subsidy scheme for personal assistance

141. Part of the way the MLSA has sought to provide the required level of accessible care for persons with high care needs was the launch of a special subsidy scheme. In 2023 and 2024, it opened special subsidy proceedings for the award of State-budget subsidies for projects providing personal assistance to persons requiring help or care from another person to a substantial extent. This concerned the provision of care to persons dependent on the care of another person and receiving personal-assistance social services in their natural (primarily home) environment for 80 hours a month or more. Only providers of registered personal-assistance social services were eligible to apply.

142. In 2023, the total allocation of funds under these proceedings amounted to CZK 12,223,535, and a total of 29 projects were supported.

143. In 2024, the funds of CZK 16,087,035 were allocated, and a total of 38 projects were supported.

(e) Support for persons with behaviour requiring a high level of care

144. This issue is also addressed comprehensively in the Government-approved document Systemic Measures to Support Persons with Intellectual Disabilities and Behaviour Requiring a High Level of Care for 2024–2030 (see § 71 above).

145. The document contains a wide range of measures that directly and indirectly affect the system of care for persons with behaviour requiring a high level of care. It also includes support for the development of community-based social services, including respite services and outreach services (such as personal assistance and home-care services) aimed at this target group, as well as support for informal caregivers.

(f) Support for the transformation of social services for persons with high care needs

146. In its support of the deinstitutionalisation and transformation of social services, and in relation to persons with high care needs, in 2022 the MLSA issued and published the methodological document Recommended Procedure no. 5/2022 – Transformation of Social Services for Persons Requiring a High Level of Support. A person requiring a high level of support is understood to be an individual who is dependent on the care of another person and, in view of their long-term adverse health condition and level of dependency, needs support or assistance for 18–24 hours a day (in terms of basic social-service activities).

147. The Recommended Procedure is based on a body of experience and examples of good practice in the transformation of residential social services. It provides guidance and possible approaches for the entire transformation process,

from the provider's decision-making, planning, and preparation of staff and users, through to the implementation of the change itself and the support of users after leaving the original residential facility. In this connection, the Recommended Procedure highlights the specific circumstances of persons with disabilities as they leave institutional facilities, their needs, and their opportunities in everyday life. The processes described in the Recommended Procedure can also be used to prevent the institutionalisation of persons with disabilities who have not yet lived, and do not wish to live, in any social-service facility.

(vii) Social-care assistant

148. Another way of providing help or care in social services is through a social-care assistant, a role that makes it possible to provide help or care to persons with disabilities without requiring their placement in a residential service (see § 39 above).

149. The assistant does not provide the necessary help to another person as a business activity, and they do not need to register or meet any registration requirements. The care allowance may be used to pay the assistant.

150. The purpose of this arrangement is to enable a person receiving the care allowance to obtain care also from a natural person other than a relative living in the same household. A social-care assistant may therefore be, for example, a neighbour or another person willing to provide care. The concept of social-care assistant has broadened the range of care options outside residential social-service facilities, allowing a person to remain and continue living at home.

(E) SUPPORT FOR INFORMAL CAREGIVERS

(i) Introductory remarks

151. With effect as of July 2024, the Social Services Act introduced a definition of the term "caregiver" and enhanced the position of such persons (see § 27 above).

152. Support for informal care is an MLSA priority, as reflected, *inter alia*, in the National Strategy for the Development of Social Services for 2016–2025 (see § 68 above). This Strategy also encompasses support for caregivers and informal care. In this area, it sets out various specific objectives and measures, including the introduction of new financial support for caregivers, support for part-time and flexible forms of work for caregivers, the designation of the capacity of certain social services for unexpected situations arising in the families of persons receiving care, greater support for home-based care by healthcare services, and the establishment of a coordinated and systematic approach to supporting caregivers.

(ii) Support for caregivers through social services

153. Section 37(5) of the Social Services Act (see § 33 above) provides that basic social counselling in personal-assistance services, home-care services, respite

services, and day-care centres may also be provided to caregivers to the following extent:

– activities providing support to caregivers (helping them to navigate social benefits, social services, aids for persons with disabilities, the possibility of obtaining an electric bed through a health-insurance company, information on incontinence aids, etc.);

– activities involving the training of caregivers in the skills needed to provide care to persons dependent on their assistance (training in the correct handling of a user in a bed, recommendations on, and use of, aids for care in the home environment, etc.).

154. This statutory provision therefore expands, within the above-mentioned social services, the group of persons (beyond the legally defined target group of the service) to whom these services must provide basic social counselling, i.e. to caregivers. By including activities that consist of helping and supporting caregivers in basic social counselling, the Act also determines the financial coverage of such activities: these activities are provided to caregivers free of charge (see section 2(1) of the Social Services Act).

155. Caregivers are also provided with assistance and support within the scope of professional social counselling, likewise free of charge (see sections 37(3) and (4), and 72 of the Social Services Act).

156. An amendment to section 44(1) of the Social Services Act, governing the provision of residential respite services (see § 37 above), took effect as of January 2025. Under the amendment, this form of respite service may be provided for a total of up to 180 days in a calendar year (as opposed to the previous recommendation of a maximum of 90 calendar days per year); only a service provided by the same provider counts towards this limit, i.e. the number of days of residential respite social services provided in a given calendar year to a particular user is counted separately for each provider, if the user has more than one. The purpose of this new regulation is to enable persons otherwise cared for in their natural environment to make the greatest possible use of residential respite services, thereby ensuring that caregivers get the rest they need. There is no time limit on the provision of outpatient or outreach respite services by a single provider.

(iii) Other forms of support for caregivers

157. Caregivers may make use of other forms of support in various areas:

– support for the employment of caregivers – with effect as of January 2021, an amendment to the Labour Code introduced the concept of job sharing; this involves two or more employees with shorter working hours alternating in the same post. The aim is to improve employability, particularly for caregivers, and to encourage employers to offer more part-time positions;

– support for participation in social-insurance systems – if a person dependent on the assistance of another person has been granted a care

allowance above level I (including in the case of children under 10), the period of care provided by a caregiver is counted as a substitute insurance period for pension-insurance purposes; the caregiver's health-insurance contributions are also paid on their behalf;

– indirect support through the care allowance – there is currently no benefit that compensates for lost income for persons who choose to care for a relative rather than work; however, the care allowance may be used to pay for care provided by a relative (see §§ 158–165 below), which is not taxed as income in such cases;

– long-term attendance allowance (in force since June 2018) – the long-term attendance allowance under sickness insurance covers income replacement at 60% of earnings for caregivers providing care to a relative for up to 90 calendar days;

– with effect as of January 2027, a period of care for another person will no longer count, for pension-insurance purposes, as a period without income (an excluded period), but will instead be assigned a notional income derived from the national average wage applicable in the year in which the care is provided.

(F) CARE ALLOWANCE

158. Persons dependent on the assistance of another person are provided with the care allowance as a monetary benefit; by paying this allowance, the State helps to provide social services or other forms of help or care for these persons in managing their basic tasks and needs in life (see § 28 above).

159. The number of care-allowance recipients and the amount of funding spent on this non-insurance social benefit financed from the State budget continue to grow, as shown in the following table.

Year	**Annual expenditure (CZK billions)**	**Average number of recipients per month**
2019	29.768	363,474
2020	33.094	365,241
2021	32.726	355,619
2022	36.376	362,524
2023	37.176	369,724
2024	41.280	372,996

160. For 2025, total expenditure is estimated at CZK 46.062 billion. By way of comparison, and as evidence of the growth, annual expenditure on the care

allowance in 2010 amounted to CZK 19.599 billion, with an average of 311,490 persons receiving the benefit each month.

161. According to OKStat figures, approximately 78% of care-allowance recipients live in a home environment. As for recipients with level III and level IV dependency, approximately 54% at level IV and approximately 72% at level III live in a home environment.

162. In 2019, the care-allowance amounts for certain levels of dependency were increased, and differentiation based on the manner in which care was provided was introduced in favour of home-based care. From April 2019, the care allowance for level IV dependency both for children under 18 and for adults increased from CZK 13,200 to CZK 19,200 for persons in home-based care, i.e. persons not using residential social services. From July 2019, the allowance for level III dependency for children under 18 increased from CZK 9,900 to CZK 13,900, and for adults from CZK 8,800 to CZK 12,800, again for persons in home-based care, i.e. not using residential social services. Levels I and II remained unchanged.

163. From January 2022, the differentiation of care-allowance amounts for levels III and IV depending on the manner in which care was provided was abolished.

164. In 2024, the care-allowance amounts for certain levels of dependency were increased, and differentiation based on the manner in which care is provided was reintroduced for level IV. From July 2024, the care allowance for dependency levels II, III, and IV was increased; for level IV, differentiation of the amounts according to the manner in which care is provided was reintroduced in favour of home-based care. The amount for level I dependency did not change. For children, the care allowance for level II dependency was increased from CZK 6,600 to CZK 7,400; for level III from CZK 13,900 to CZK 16,100; and for level IV from CZK 19,200 to CZK 23,000 when using residential social services, and to CZK 27,000 when not using them. For adults, the care allowance for level II dependency was increased from CZK 4,400 to CZK 4,900; for level III from CZK 12,800 to CZK 14,800; and for level IV from CZK 19,200 to CZK 23,000 when using residential social services, and to CZK 27,000 when not using them. The changes introduced in 2024 are also illustrated in the following table.

Dependency level	**Original amount**	**New amount**	**Difference**
Children			
I	3,300	3,300	0
II	6,600	7,400	800
III	13,900	16,100	2,200
IV – residential services	19,200	23,000	3,800
IV – home environment	19,200	27,000	7,800
Adults			
I	880	880	0

II	4,400	4,900	500
III	12,800	14,800	2,000
IV – residential services	19,200	23,000	3,800
IV – home environment	19,200	27,000	7,800

165. The figures illustrating developments in recent years demonstrate the State's efforts to provide greater support to persons with higher care needs and to those living in a home environment.

(G) PROVISION OF SOCIAL SERVICES TO PERSONS WITH DISABILITIES IN THE INDIVIDUAL REGIONS

166. For the purpose of preparing their observations on the present collective complaint, the Government also requested statements from all 14 regions, i.e. the Czech Republic's territorial units required by law to ensure the availability of social-service provision within their territory. The Government set out below the information provided by the regions that is relevant to the present collective complaint.

(i) Use of homes with a special regime primarily for older persons

167. A large number of regions stated in their statements that, as regards **homes with a special regime**, where the collective complaint points to a rapid increase in capacity in recent years (see § 64 of the complaint), **the majority of residents are in fact older persons** (typically with specific needs associated with manifestations of dementia), **rather than persons with disabilities**, who are the focus of the complaint. The increase in the capacity of these facilities therefore primarily reflects current demographic trends in the Czech Republic, notably population ageing. Moreover, a significant proportion of these facilities are built using private funds, over which neither the regions nor the MLSA have any direct influence (see, for example, the statements provided by the Pardubice Region, the Hradec Králové Region, the City of Prague, the Central Bohemian Region, the Karlovy Vary Region, the South Bohemian Region, the Olomouc Region, and the Moravian-Silesian Region).

(ii) Possibility of providing community-based services in homes for persons with disabilities

168. Several regions point out that it cannot generally be asserted – as the collective complaint does in the present case – that homes for persons with disabilities are always institutional or large-capacity in nature and therefore cannot provide community-based services (see § 65 of the complaint). **In practice, homes for persons with disabilities often provide residential community-based services, including in cases where their total capacity exceeds the 50-bed threshold referred to in the complaint** (see, for example, the statement by the Central Bohemian Region), **if the home is divided into smaller buildings and households** (see § 85 above).

169. In this context, the Hradec Králové Region observes that three homes for persons with disabilities within its remit currently operate with a capacity of over 50 beds within a single locality or site, but divided into several buildings and households, and that a further home with a total capacity of 104 beds is spread across seven buildings in four localities, with differing numbers of households. The latter facility, in particular, comes very close to a community-based service.

170. The Plzeň Region refers to the Stod Social Services Centre, which is likewise a home for persons with disabilities but has undergone a transformation aimed at converting the original form and method of providing residential social services for persons with disabilities into other types of services delivered within a natural community and promoting users' social inclusion. The transformation process is described in detail here. At present, this home has a capacity of 190 clients in 21 flats and 28 houses, with all clients placed in community households (a maximum of six persons per household).

171. Similarly, in the Liberec Region, the OSTARA facility operates within the framework of a service constituting a home for persons with disabilities. As part of the transformation, four buildings were constructed, within which eleven community-type households for a maximum of three persons each were created. The total capacity is 30 beds for a target group of persons with combined disabilities aged 19 and above.

172. In the same vein, the Karlovy Vary Region refers to the transformation of the home for persons with disabilities in Mariánská, where the original 217-bed capacity has been gradually reduced to 140 beds, and clients now live in eight households in a pavilion-type building and in two detached villas (each accommodating five clients).

173. Virtually all other regions also state that homes for persons with disabilities providing residential community-based services currently operate within their territory.

(iii) Use of passive planning tools

174. According to the collective complaint, the regions rely on passive planning tools when developing social-service capacity, such as open calls for providers to submit proposals to increase their capacity within the existing network of social services in the region, which has proved ineffective for the development of social services (see § 100 of the complaint).

175. Several regions disagree with this assertion. For example, the South Moravian Region states:

> "The South Moravian Region does not currently rely solely on passive planning tools. It is itself the initiator of the development of missing service capacity for persons with disabilities (see, for example, the recent round table on 'Social services for persons with autism-spectrum disorder', attended by the Governor of the South Moravian Region in cooperation with a parents' initiative bringing together caregivers of children with ASD). In particular, since 2024 it has been the driving

> force behind the process of transformation and deinstitutionalisation within the organisations it has established that provide services for the relevant target group. Under Resolution no. 2834/24/Z27, the Regional Assembly decided to include nine of the South Moravian Region's organisations partly funded from the public purse in the process of full transformation, meaning that the buildings in which institutional-type services are currently provided will be fully relinquished in due course and their clients moved to newly established community-based service facilities that meet the relevant criteria."

176. Other regions likewise note that, in their medium-term plans for the development of social services, they regularly update and specify which particular types and forms of social services are not currently provided within the region. This is determined on the basis of systematic needs-assessments in the territory carried out in cooperation with municipalities and social-service providers, as well as on the basis of input from users or applicants for services. The priorities and needs identified in the medium-term plan then guide the development of new social-service capacity through the publication of specific calls for social-service providers (for example, the Hradec Králové Region, the City of Prague, the Central Bohemian Region, the South Bohemian Region, and the Zlín Region).

(iv) Need for flexibility in social-service planning

177. Several regions point out the need for maximum flexibility when planning community-based social services for persons with disabilities, noting that users' current needs must be responded to on an ongoing basis and that the evolution of those needs over time cannot always be reliably predicted. They cite examples from their practice in which a new service that initially appeared necessary at a given time and place ultimately did not attract sufficient user interest.

178. The Olomouc Region observes in its statement:

> "The Olomouc Region established, on the basis of identified needs, a community facility for persons with ASD as part of the Klíč Centre for Social Services, an organisation partly funded from the public purse. This is a specialised facility dedicated to caring for persons with a combination of autism-spectrum disorder, intellectual disability, and challenging behaviour. Two households were created in this community facility, one for children (a capacity of six persons) and one for adult clients (five persons). The establishment of this new facility in the Nové Sady area of Olomouc had long been backed by experts, parents, and regional representatives. It began operating in January 2021. Although the facility was built partly in response to parents' requests, after it opened the organisation encountered refusals by parents to initiate service provision, as they did not yet wish to arrange assistance for their child through residential social care.
>
> This experience highlighted the need for the planning and development of residential community-based services to be as flexible as possible, allowing a prompt response to the current situation in which individual families found themselves. Only in this way can the capacity of newly

created services be used effectively and correspond to the actual needs of persons with disabilities and their caregivers."

179. The Moravian-Silesian Region adds:

"A factor that cannot be fully accounted for in planning social-service capacity is that persons with autism-spectrum disorder or with behaviour requiring a high level of care, both in childhood and at working age, tend to remain in the care of their families for as long as possible. These families often receive, for example, a level IV care allowance of CZK 27,000 per month, and in some cases the person's pension as well. In many instances, these persons are not registered in any social-service system, and therefore neither municipal social workers nor regional authorities have information about them. Families often begin to address the situation only once they are no longer able to manage the care, which tends to occur at a crisis point. In such cases, they frequently point to a shortage of available capacity, even though it is common knowledge that waiting times exist for residential services."

180. The Ústí nad Labem Region shares the following experience:

"One point worth highlighting in this regard is the agreement between the Ústí nad Labem Regional Authority and a provider to establish a day centre for persons with ASD in the Děčínsko area. As of 2022, this day centre operated for persons aged 12 and above with ASD. Unfortunately, due to insufficient utilisation, it was agreed in 2023 to expand the target group to cover both persons with ASD and persons with disabilities. The service reported that it had been promoted by the municipality, cooperating services and organisations, and APLA North Bohemia. Nevertheless, despite proper promotion, the capacity was never fully used solely by persons with ASD, rendering the service ineffective."

181. In relation to the 2017–2024 period, the South Moravian Region observes:

"Support of independent living was a service provided only to a limited extent during the period under review, primarily for a specific target group of persons with mental illness. Practice showed that, in terms of addressing the adverse social situation of these persons, it was not an appropriate type of social service; the relevant staffing was subsequently transferred to the social-rehabilitation service. For 2026, the South Moravian Region has newly planned and approved the development of support of independent living for persons with intellectual disabilities (including persons with ASD)."

182. The City of Prague notes the following:

"The target group for sheltered housing prefers other types of services, as a result of which demand for this service is low. This hypothesis is supported by providers' statistical data on sheltered housing, in particular the number of applicants refused for capacity-related reasons and the number of persons on the waiting list."

183. The Central Bohemian Region describes one of its recent cases, in which an action was brought against the region for failing to provide an adequate social service for a client with ASD. According to the expert assessments submitted with

the action, including the opinion of the National Institute for Autism (*Národní ústav pro autismus*), it was necessary to place the client in a community-based facility offering single-room accommodation. The judicial proceedings are ongoing. However, in the meantime, with the consent of the family, the client was placed in a double room in an institutional service, where the adaptation process was successful, the client is thriving, and both the client and the family are satisfied with the service provided. This example shows that, in some cases, even a person with ASD who, according to expert assessments, requires a particular type and form of social service may ultimately find another type and form of service suitable, even if those services had been considered insufficient in the assessments.

(v) Support for informal caregivers

184. Beyond the information already set out in the present observations on this issue, an example of good practice may be drawn from the information provided by the Olomouc Region:

> "In recent years, the Olomouc Region has devoted systematic attention to supporting informal caregivers, particularly those providing care to persons with disabilities. Under projects of the Olomouc Region financed through the Operational Programme Employment Plus and implemented between 2022 and 2025, the region supported targeted activities combining education, psychosocial support, and respite care.
>
> A key component of the support consisted of **multi-day stays** (of three days) delivered by providers of registered social services. Families with children with various types of disabilities took part, as did persons with intellectual or combined disabilities, users of early-intervention services, social-rehabilitation services, social-therapy workshops, sheltered housing, and respite services. The aims of these stays were to:
>
> - provide a **space for sharing experiences and mutual support** among caregivers and their relatives;
> - **strengthen caregivers' competences** and improve their skills in caring for a person with a disability;
> - provide **respite to caregivers**, giving them time for rest and recuperation;
> - ensure **psychological support and intensive education** for the target groups, including the involvement of typically developing siblings and other family members;
> - promote the **social inclusion of persons with disabilities** through training in self-care, social, and work skills.
>
> The stays were carefully planned with regard to the target groups – for example, families with children using early-intervention services received an educational programme focused on practising practical skills and family cooperation, while persons with intellectual or combined disabilities developed social and work skills through social-rehabilitation activities or social-therapy workshops. Implementation included professional support from instructors, psychologists, and

> therapists, and the stays followed a structured timetable designed to maximise the effectiveness of the support.
>
> In addition to these stays, the region systematically supported **meetings of parent and support groups**, expert-led workshops, and the development of **homesharing**, which facilitates shared care and respite in a home environment. These activities complement the region's overall strategy aimed at preventing social isolation, strengthening caregivers' competences, and ensuring the availability of support to all target groups across its territory. (…)
>
> The association Zet-My, z.s., under the project 'Support for Caregivers through Homesharing and Respite Services' (2024–2026), offers a weekend residential respite service with a capacity of three beds. It plans to connect up to 20 families with host carers. The project is co-financed from the Operational Programme Employment Plus and aims to create a functioning network of professional and supportive informal services in and around Olomouc."

185. Support for homesharing was also mentioned in the statements submitted by other regions, such as the Central Bohemian Region, the Liberec Region, and the Ústí nad Labem Region.

(vi) Participation of persons with disabilities and informal caregivers in social-service planning

186. The collective complaint further alleges insufficient involvement of persons with disabilities and informal carers in the planning of social-service development, including at regional level.

187. Here again, the statements by the various regions present a different picture. For example, the South Moravian Region observes:

> "An example of the participation of persons with disabilities and informal carers in social-service planning is the establishment of close cooperation with representatives of the *Alliance for Individualised Support* and their regional advocacy team, which took place this year as part of the process to transform the Habrovanský zámek organisation. The aim of the regional advocacy team is to take part in shaping regional policy and to contribute, both conceptually and systemically, to ensuring that social services for persons with disabilities and their caregivers in the South Moravian Region are consistent with their actual needs and rights. The advocacy team is specifically involved in commenting on the project for the construction of a community-based home for persons with disabilities in Slavkov u Brna, in terms of the spatial design of the community building and the project's objectives, preventing the transfer of institutional culture to the new setting, creating conditions that reflect ordinary life as far as possible, and preparing clients effectively for the transition to the new accommodation.
>
> At the level of the South Moravian Region, and in cooperation with the South Moravian Agency for Public Innovation (JINAG), a working group operates with the aim of devising the *Regional Plan for Equal Opportunities for Persons with Disabilities in the South Moravian Region*. This is a document defining objectives and measures to support

> these persons with the aim of creating equal conditions for them and improving their quality of life. The Czech National Disability Council National Council is the initiator and lead organisation in this area, and persons with disabilities are directly involved in preparing the plan."

188. The Vysočina Region notes:

> "In the process of the medium-term planning of social services in the region, a *Working Group of Providers of Services for Persons with Intellectual and Combined Disabilities and Persons with ASD* has long been in operation. The group was established primarily for the preparation of medium-term plans, but its role has since broadened considerably – it now serves as an expert platform contributing to the preparation and review of strategic materials, a forum where proposals for further improvements in social-service provision in the region are raised, and a space for sharing good practice and exchanging experience among providers. Members of this working group include representatives of social-service providers and representatives of persons caring for this target group. Additional capacity for persons with autism-spectrum disorder is created on the basis of input from this working group."

189. Virtually all other regions likewise state that, to secure the participation of persons with disabilities and informal caregivers in social-service planning, they use the following tools:

- involving these persons in regional advisory bodies, thematic working groups, or round tables engaged in preparing and reviewing strategy documents;
- in addition to the above, enabling comments on key strategy documents (such as the medium-term plan for the development of social services in the region, and the regional plan for equal opportunities for persons with disabilities) either through public consultation or at any time electronically;
- personal meetings and individual consultations;
- the possibility of submitting input and comments through questionnaire surveys or information-gathering procedures assessing the need for social services in the region;
- close cooperation between the region and the Czech National Disability Council.

(H) MEASURES OF THE MINISTRY OF HEALTH

190. Insofar as the present collective complaint also raises issues concerning the provision of health care, particularly in the field of psychiatry and mental-health support, the Government consider it relevant to set out the following.

(i) Community services

191. At the Ministry of Health, too, the number of services delivered within the community (that is, services providing outpatient care and care within the patient's own social environment) is increasing. Examples include **mental-health centres**, which are established in law both under the Social Services Act (see § 38 above) and the Health Services Act (see §§ 56–60 above). Their number is rising, especially for people with severe mental illness. As at 31 December 2024, 36 such centres were operating, compared with 30 supported through Ministry of Health projects implemented between 2017 and 2022. Mental-health centres provide multidisciplinary outpatient care and, to a significant degree, care within the patient's own social environment. In June 2025, the Ministry of Health issued a revised standard for services provided in Mental-Health Centres for Children and Adolescents, clearly defining the structure, staffing, and principles of care, with the aim of contributing to high-quality and accessible community care for children and young people with mental-health difficulties in the Czech Republic.

192. Alongside mental-health centres, the development of **outpatient clinics providing enhanced care for persons with mental illness and for patients with addiction disorders** has also been supported. The number of the former increased markedly in 2024, rising from 5 to 19 clinics.

(ii) Care for persons with autism-spectrum disorder

193. Data from the National Register of Reimbursed Health Services show that the number of patients treated for autism-spectrum disorders (i.e. patients diagnosed under F84 Pervasive Developmental Disorders) has risen markedly. They are treated mainly in psychiatric or psychological healthcare facilities (primarily in outpatient areas of expertise such as psychiatry, child and adolescent psychiatry, and clinical psychology, and in some cases in inpatient psychiatric facilities). Their number has almost tripled over the past 10 years.

194. **In 2024, 4.3% of patients with autism-spectrum disorders were hospitalised in psychiatric inpatient care. Care is provided predominantly on an outpatient basis**: in 2024, 10,043 patients were treated by psychiatrists or child and adolescent psychiatrists, compared with 141 patients in acute inpatient psychiatric and child and adolescent psychiatric care, and 191 patients in follow-on inpatient psychiatric and child psychiatric care. These patients are also treated in other outpatient and inpatient facilities. In 2024, a total of 79 patients were hospitalised in acute paediatric wards. Higher numbers of hospitalisations for patients diagnosed with F84 occur in acute inpatient paediatric neurology and neurology, with a total of 139 patients in 2024.

195. At the same time, in the context of the ongoing reform of mental-health care and the transformation of facilities, psychiatric hospitals are encouraged to admit patients **only for the period necessary to provide essential inpatient care**. They are also encouraged to engage in multidisciplinary cooperation, i.e. not only with the patient's family, but also with other services (both health and social services) and with the regions (given their competence for configuring the social-

services network), so as to ensure adequate care is available that enables the patient to be discharged into the home environment.

(iii) Deinstitutionalisation of psychiatric care

196. The process of deinstitutionalising psychiatric care under the National Mental-Health Action Plan 2020–2030 is ongoing, as reflected both in the number of follow-on inpatient beds in psychiatric hospitals and in trends in psychiatric-hospital admissions. In January 2018, 2,846 patients had been hospitalised in psychiatric hospitals for more than 182 days; by January 2024, this figure had fallen to 1,921. The number of patients hospitalised for 90–181 days likewise decreased, from 900 to 765. There was also a reduction in the number of patients hospitalised for fewer than 90 days, from 4,326 to 3,820. It can therefore be concluded that the overall number of patients in follow-on inpatient psychiatric care fell from 8,072 in January 2018 to 6,506 in January 2024, and that the proportion of long-term hospitalised patients has declined relative to those hospitalised for fewer than 90 days.

(I) MEASURES OF THE MINISTRY OF EDUCATION

197. To complement the range of services provided by the State to the persons targeted by the present collective complaint, the Government also set out information on the education of children and pupils with autism-spectrum disorder, intellectual disability, developmental behavioural disorder, or combined disability.

198. In the Czech Republic, the preferred approach is to educate children and pupils with special educational needs in mainstream schools. This group may include children and pupils with autism-spectrum disorder, intellectual disability, developmental behavioural disorder, or combined disability. These persons may receive, free of charge, **support measures**, which are divided into five levels.[3]

199. If a school counselling facility considers that support measures alone are insufficient to meet the educational needs of a child or pupil, it will recommend education in a **class or school designated for children or pupils with a severe form of disability**. Education in such settings is provided by a remedial teacher

[3] At the first level, measures may include preparing a teaching support plan, adjustments to methods, the assessment or organisation of education, the provision of pedagogical intervention (the strengthening of instruction, compensation for insufficient home preparation, etc.), and enrichment of the curriculum for gifted pupils. If first-level support measures are insufficient, the school will advise the legal guardian of the child or pupil to seek counselling from a school counselling facility. Support measures at the second to fifth levels may be recommended by a school counselling facility (an educational psychology counselling centre or a remedial education centre), on the basis of psychological and/or remedial education diagnostics, the nature of the child's or pupil's difficulties affecting their education, information on their educational progress to date, and other relevant factors. These measures may take the form of an individual educational plan, assistive aids, subjects in remedial education care, adjustments to the conditions for admission to and completion of education, and, from the third level onwards, personnel support (a teaching assistant, an additional pedagogical worker, a school remedial teacher, a school psychologist, a Czech sign language interpreter, or a transcription assistant for deaf pupils).

with the support of a teaching assistant, in a class with reduced numbers of children or pupils (six to fourteen, which may be reduced to four to six), drawing, for example, on subjects in special-education care focused on speech-therapy intervention, therapeutic physical education, and other support tailored to their needs. Funding for these schools is similar to that for other schools, but the post of teaching assistant is funded on a systemic basis. In mainstream schools, a teaching assistant may be recommended as a support measure.

200. According to data provided by the Ministry of Education, Youth and Sports ("MEYS"), **as at 30 September 2024 more than 77% of pupils with disabilities were being educated in mainstream primary-school classes**. Available MEYS data indicate an overall increase in the proportion of children and pupils with autism-spectrum disorder, intellectual disability, developmental behavioural disorder, or combined disability being educated in mainstream schools, accompanied by the corresponding expenditure on support measures, and by an increasing number of support staff in schools, in particular teaching assistants, remedial teachers, and psychologists.

201. In line with the Strategy for the Education Policy of the Czech Republic up to 2030+, the MEYS is focusing on **strengthening inclusive school environments** through institutionalised support positions. With effect from January 2026, mainstream primary schools with 180 or more pupils will be entitled to systemic funding for psychologists, remedial teachers, or social pedagogues, and head teachers will be required to ensure the provision of services by a psychologist or remedial teacher. It is expected that support from these professionals will be extended to other types of schools in the future.

(J) FURTHER DEVELOPMENT IN THIS AREA – OUTLOOK

202. Following the submission of the present collective complaint to the Committee, the Czech Republic has adopted further strategic governmental documents that set out, at a conceptual level, the next steps and measures in supporting persons with intellectual disabilities and behaviour requiring a high level of care, as well as in the deinstitutionalisation of social services in the Czech Republic, together with other relevant measures.

(i) Action Plan for Implementing Systemic Measures to Support Persons with Intellectual Disabilities and Behaviour Requiring a High Level of Care for 2025–2027

203. On 20 August 2025, the Government approved the Action Plan for Implementing Systemic Measures to Support Persons with Intellectual Disabilities and Behaviour Requiring a High Level of Care for 2025–2027.

204. This action plan builds on and supplements existing State policy to promote and support the inclusion of particularly vulnerable groups. Its implementation will contribute to positive developments in social support and assistance, health care, education, and other key aspects of life for persons with intellectual disabilities and behaviour requiring a high level of care in the Czech

Republic. For the period concerned, the action plan sets out 5 objectives and 28 related measures, broken down into specific activities, including methods of implementation, timelines, responsible authorities, outputs, and sources of funding. Responsibility for the implementation of individual measures rests with the lead departments within whose competence the respective matters fall. Municipalities, regions, and other stakeholders participate in the implementation of certain measures.

(ii) Action Plan for the Deinstitutionalisation of Social Services in the Czech Republic for 2026–2028

205. On 30 September 2025, the Government approved the Action Plan for the Deinstitutionalisation of Social Services in the Czech Republic for 2026–2028.

206. This action plan builds on the above-mentioned Action Plan for the Transition of Social Services to Community-based Care, for Greater Individualisation of Care, and for the Support of the Deinstitutionalisation of Social Services for 2023–2025 (see § 70 above), and for the forthcoming three-year period sets out the strategic framework and concrete measures aimed at moving from an institutional model of social services to a system that supports independent and dignified living for persons with disabilities.

207. The Interdepartmental and Cross-sectoral Committee for Assessing the Implementation of the Process of Deinstitutionalisation, established at the MLSA in accordance with the principles of the Convention on the Rights of Persons with Disabilities, played a significant role in preparing this new action plan.

208. The development of this document also involved substantial participation by the Union for Deinstitutionalisation (*Jednota pro deinstitucionalizaci*), a platform of organisations and individuals advocating for a dignified life for persons with disabilities and their relatives, supported by local communities and community-based services.

209. The 2026–2028 action plan draws on lessons learned from implementing the 2023–2025 action plan and aims to achieve better outcomes through focused and actionable goals and measures.

210. The priority group for the 2026–2028 action plan comprises persons with disabilities – including persons with mental illness, children with disabilities, and persons requiring a high level of support (autism-spectrum disorder and behaviour requiring a high level of care) – who require specific and individualised care.

211. The action plan also introduces a monitoring system enabling the collection and analysis of accurate data on the progress made in transforming residential social services.

212. The action plan further includes measures to strengthen the participation of service users, persons with disabilities, and their relatives in the process of transforming and planning the development of social services. It provides, *inter alia*, that by 2028 the MLSA will issue methodological recommendations for all regions to establish systems for the participation of persons with disabilities and

their representation in working groups, regular consultation mechanisms, and the involvement of users with disabilities and their relatives in local and regional community-planning processes and other relevant decision-making procedures affecting their lives and the future shape of services, in a manner enabling them to participate fully in the transformation process and exercise their right to informed consent and choice.

213. The action plan also provides that the MLSA will organise at least 10 thematic round tables and discussion forums, with the potential participation of persons with disabilities, for managers and key staff at existing and transforming facilities, and for representatives of regions and municipalities. These platforms will support the intensive exchange of experience and the sharing of good practice in preventing the institutionalisation of persons with disabilities and in addressing specific challenges linked to actively offering community-based solutions.

(iii) National Strategy for the Development of Social Services for 2026–2030

214. The draft National Strategy for the Development of Social Services for 2026–2030 is currently undergoing interdepartmental consultation. Once comments have been addressed, the document will be submitted for governmental approval. The draft Strategy confirms deinstitutionalisation as a long-term priority of the Czech Republic in the field of social services.

(iv) Introduction of comprehensive care centres

215. With effect as of 1 January 2026, an amendment to the Health Services Act (specifically the new section 44f) will introduce, in the Czech Republic, the concept of centres for the comprehensive care of children with long-term health difficulties. The amendment defines such a centre as a healthcare facility in which minors with somatic life-threatening or life-limiting illnesses receive long-term inpatient and day-care treatment. This care is provided with an emphasis on supporting the patient's psychomotor and socio-emotional development, preventing psychological deprivation, and developing communication abilities, with a view to the patient's return to, or remaining in, their own social environment. To that end, a provider establishing a centre for the comprehensive care of children will also deliver health care to the patients referred to in the first sentence within the patient's own social environment.

(K) Conclusion

216. In the light of the above submissions, the Government consider that the Czech Republic is taking the steps necessary to ensure an ever broader range of community-based social services for persons with disabilities, in line with the requirements arising from the provisions of the Charter invoked. The legislative amendments, implementing measures, and detailed strategy documents presented above, aimed at further development in this area, are, in the Government's view, sufficient to conclude that the rights arising under Article 11§§1 and 3, Article

14§§1 and 2, and Article 16 of the Charter – whether taken alone or in conjunction with the Preamble to the Charter – are being progressively realised, taking particular account of the fact that the Czech Republic has not yet ratified the revised Charter (see §§ 16–19 above).

OVERALL CONCLUSION

217. In the light of the foregoing, the Government, in their observations on the complainant organisation's collective complaint, propose that the Committee hold that there has been no violation of the provisions of the Charter invoked, alone or in conjunction with the Preamble thereto.

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ENCLOSURES

1. Trend in the number of social services for persons with disabilities (broken down by individual types of services) and in the number of clients of those services in the years 2019–2024.
2. Trend in the number of social services in the fields of personal assistance, home-care services, and support of independent living, as well as in the number of clients of those services, broken down by region, in the years 2019–2024.
3. Trend in the number of social services provided by day-service centres and day centres, as well as in the number of clients of those services, broken down by region, in the years 2019–2024.
4. Trend in the number of respite services (broken down into residential, outpatient, and outreach forms), as well as in the number of clients of those services, broken down by region, in the years 2019–2024.
5. National non-investment resources to ensure the provision of social services in the years 2019–2024.
6. EU sources – investment in social-service infrastructure in the years 2019–2024.
7. Planning in strategy documents.

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