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Published online: 01 Mar 2026.

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Discourse on deinstitutionalisation and disability rights in Czechia: professional stances and the persistence of institutional logics

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ABSTRACT

This study contributes to the international debate on why deinstitutionalisation may not be achieving its intended outcomes, drawing on the experiences of practitioners who have acted as change agents in the Czech context over recent decades. Through a discursive stance analysis framed within an interpretive, critical approach, the research offers detailed insights into their accounts of experience. The findings indicate a discourse that swings between paternalistic and rights-based perspectives, leading to divergent understandings of deinstitutionalisation and complicating both shared comprehension and the effectiveness of practical interventions. By highlighting the persistent influence of the need for paternalistic care in a post-socialist setting, the study underscores the call for professional change management and curated discourse that would consider individual and interpersonal factors alongside legal, financial and organisational measures, and foster more critically-informed interaction among actors, both across disciplines and in practice.

Points of Interest

- Over the past decades, many people with disabilities in Europe have moved from large care institutions into local communities. Still, in Czechia alone, tens of thousands continue to live in conditions that do not fully respect their human rights.
- This study shows that the needed change is more complex than simply closing large care institutions. It needs a coordinated approach involving groups and individuals with both supportive and resistant attitudes.
- Professionals do not always agree on what moving to a more independent life in the local community means. Also, those moving out of large institutions may feel uncertain or afraid of the change, often due to habits and ideas rooted in the old care system which was more protective and controlling.
- Policy and practice need to pay attention to how people talk about people with disabilities moving out of large care institutions, because communication and language are not neutral – they shape how people think and act.

Introduction

The United Nations Convention on the Rights of Persons with Disabilities (hereafter "Convention") obligates each signatory state to ensure that persons with disabilities can live independent lives fully included into society (United Nations 2006). In the Czech Republic (hereafter "Czechia"), the process of transforming care for persons with disabilities began in 1989 and was strengthened in 2006 with a new Act promoting community-based services instead of institutionalisation. Despite these efforts, progress has slowed, and the goals of the Convention have not yet been achieved (Ombudsman 2023; Paleček, Kocman, and Valianová 2024). According to the Czech Public Defender of Rights (hereafter "Ombudsman"), tens of thousands of persons with disabilities are still living in institutional care, often in unsuitable conditions (Ombudsman 2023:12), despite the continuing efforts to improve the situation (Ombudsman 2025a).

Similar concerns have been raised in other countries, where deinstitutionalisation has often been partial, stalled, and contested, while discourse plays a central role in obstructing or advancing deinstitutionalisation across welfare systems (Ferazzoli 2018, Hilton and Lambert 2025, Storer 2021). Mladenov and Petri (2020) highlighted how Central and Eastern European reforms often remain trapped in a discourse of "humanisation," which improves facilities without altering the underlying segregating logic. Zaviršek (2017) further highlights how post-socialist discourses continue to normalise institutional care as protective and legitimate, delaying the development of community-based alternatives. Šiška and Beadle-Brown (2022) add that European policy discourses frequently proclaim progress towards deinstitutionalisation while masking the continued reliance on institutional provision.

Furthermore, broader debates about the effectiveness and sustainability of deinstitutionalisation have emerged worldwide, focusing on human rights, the financial viability of services, the absence of meaningful community inclusion, and the persistence of paternalistic models of care (Harpur 2012; Mozo González and Lucena 2023; Slasberg and Beresford 2020; Yilmaz and Bilir 2022). Similar concerns are reported where deinstitutionalisation has been pursued without adequate community-based alternatives or without safeguarding self-determination (Yilmaz and Bilir 2022). Together, these studies underline that deinstitutionalisation is not a purely technical reform but a contested process shaped by historical legacies, stakeholder interests, and public attitudes. Power dynamics also remain embedded within community-based services, where full autonomy is often not achieved (Altermark 2017; Fullana, Palliser, and Díaz-Garolera 2019).

Aligning with the above scholarly findings, the Ombudsman reports that the principal obstacles in Czechia include systemic shortcomings in the planning and funding of social services, insufficient suitable housing and

qualified personnel, public prejudice and fear, and resistant attitudes among facility management and staff (Ombudsman 2025a:123). Although deinstitutionalisation as such appears among the 2025 priorities of the Ombudsman's advisory body responsible for monitoring the rights of people with disabilities under the Convention (Ombudsman, 2025a:12), the achieved or planned goals of public administration do not specifically address the persistent discursive barriers, namely the resistant attitudes, prejudice and fear identified as hindering progress. Highlighting this gap, this article focuses on discursive dynamics as a missing part of the transformation efforts.

Drawing on Ben-Moshe (2020) understanding of deinstitutionalisation as a political and discursive process, and taking inspiration from assemblage thinking (Goodley 2013; Hradcová and Synek 2023), this article considers disability and institutional care as a dynamic configuration of heterogeneous elements: discourses, institutions, material environments, professional identities, political forces and historical legacies. Adding the perspective of assemblage theory places discourse as a constitutive component of the experienced reality, highlighting that institutional logics may persist even after physical institutions are dismantled, as "institutionalisation without walls" (Priebe 2004). In the context of assemblage theory, deinstitutionalisation then represents a reconfiguration of key nodes within wider socio-material configurations (Nwokorie and Devlieger 2023).

Complementing the above in the context of practice, dialogical approach in social work involves reflexive engagement in the co-construction of meaning (Parton and O'Byrne 2000). Recent critical disability studies also highlight how discursive and informational practices structure access and participation (May 2025). Such dialogical and reflexive approaches call for interrogating taken-for-granted narratives and assumptions, positioning deinstitutionalisation as fundamentally communicative as well as structural. This study aims to complement those approaches and inspire thinking about potentially underestimated or overlooked aspects of deinstitutionalisation, adding an important piece to the broader picture constructed by assemblage and dialogic approaches in social work scholarship and practice.

The context of deinstitutionalisation in Czechia

In Czechia, the state has been responsible for social care for people with disabilities since the end of the nineteenth century, following the advancement of the social welfare system (Pěč 2019). Many large-scale care facilities were established after World War II in nationalised monasteries and castles in remote border regions. Following political change in the 1990s, efforts emerged to re-include people with disabilities in mainstream society.

Since 2006, when the Social Services Act first embedded the principle of prioritising community-based social services, the Czech Ministry of Labour and Social Affairs has coordinated a series of national deinstitutionalisation programmes aimed at closing or transforming large residential institutions and developing community-based alternatives. Supported by EU structural funds, the most significant national projects funded transformation planning, staff training and methodological guidance during 2010–2021. Although the (Social Services Act, 2006) formally introduced the principle of preventing institutionalisation and subsequent national projects provided substantial support for transformation, these measures did not establish a binding national obligation. As a result, progress has depended heavily on personal leadership and regional priorities.

In the absence of a unified national strategy, consistent methodological guidance and a stable support structure, implementation has proceeded unevenly across 14 regions (Ombudsman 2025b). In 2023, the Council of Europe Commissioner for Human Rights (CECHR, 2023) highlighted the lack of a clear deinstitutionalisation agenda in Czechia and called for stopping the construction and refurbishment of institutional facilities. As a consequence, a national deinstitutionalisation plan has been drafted (Ombudsman 2025a). That said, the large-scale facilities operated directly by the Ministry of Labour and Social Affairs have yet to undergo deinstitutionalisation (Ombudsman 2025a).

Method

Stalling deinstitutionalisation prompted interdisciplinary collaboration in the project "Co-production of Social Work Knowledge Supporting the Rights of Social Work with People with Disabilities in the Process of Deinstitutionalization." The project, approved by the Ethics Committee of the University of Ostrava in two stages on 28 March 2022 and 31 March 2023, seeks to identify what enables or obstructs the right of people with disabilities to live independently and participate in the community, and to develop a model of social work and propose legislative measures that would protect these rights. Its inclusion of varied stakeholder groups, such as people with disabilities, social workers and representatives of local administrative units, brought contrasting interpretative positions that required separate analysis to preserve analytic clarity. This study examines the stances expressed in interviews with seasoned professionals active in the deinstitutionalisation movement.

Data collection

The study is based on semi-structured interviews with fourteen participants, gathered through participant-centred, purposeful sampling (Auerbach and Silverstein 2003), aiming to capture perspectives from key figures who have played leading or activist roles in the Czech deinstitutionalisation process

since 2006. Participants were recruited through snowball sampling due to their connections within related movements or initiatives. They were chosen not for their representativeness but to explore context-specific issues (Bonache 2021).

These individuals had been meeting regularly and had formed an informal community of practice that has helped steer and sustain momentum within the self-organised deinstitutionalisation movement. This group now provides access to forms of institutional memory, tacit knowledge and informal decision-making processes that are not documented elsewhere. This study offers in-depth, pioneering insight into the perspective of a stakeholder group with a shared vision and interests closely aligned with the aims of the Convention.

The sample comprised fourteen participants (eight women and six men) with diverse institutional positions within the Czech deinstitutionalisation process. These included a member of a European organisation for the rights of people with intellectual disabilities active in Unity for Deinstitutionalisation; three representatives of the National Centre for the Transformation; and two actors with regional transformation experience. Further participants were a leader of community-based social services, a manager of a residential home and transformation consultant, and a reformer of psychiatric care. Two participants were members of Unity for Deinstitutionalisation and one contributed additional transformation experience. The sample was complemented by two researchers, both engaged in research and advocacy for deinstitutionalisation.

All participants received an information about the research and gave consent prior to participation. Each interview lasted between 60 and 120 min. Interviews were conducted face-to-face at locations chosen by the participants or *via* secure online platforms, recorded with their informed consent, and transcribed verbatim. A semi-structured format allowed the interviewer to ask the same main questions while also probing emergent themes and clarifying meanings, ensuring depth and consistency across interviews. The question grid led participants to reflect on the following: their experience with deinstitutionalisation, their own role within it, and the successes, factors and conditions that may have enabled progress. They were further asked about perceived barriers and risks, changes or improvements needed to ensure the continuation of the process, and the roles of key institutions, organisations and individuals. Next, they were asked to reflect on their collaboration with social workers, what had been beneficial in such collaboration, what could change and what social workers should know about deinstitutionalisation. Finally, participants were invited to share any additional insights or lessons learned.

The interviewer maintained a reflexive stance throughout the research process, acknowledging her positionality as a researcher familiar with the Czech deinstitutionalisation context and actively considering how this background

could shape the formulation of questions, the interaction with participants and the interpretation of data. The interviews started taking place between June and September 2022 and were continued between April and May 2024. The second phase was rolled out to include participants who were unavailable during the initial period after the release of financial resources to carry out the remaining part of data collection.

Analysis

Our analysis rest upon a social constructivist paradigm of the social construction of reality (Berger and Luckmann 2001 [1966]), in which words are a "powerful tool to change ideas" (Palacios Rizzo et al., 2020). The overarching theoretical framework was provided by the social model of disability (Oliver 2013), which emphasises that disability arises from societal barriers rather than individual "deficits." Since the social model of disability has been criticised for its lack of attention to power relations (Vehmas and Watson 2014), the authors decided to employ a *critical* analysis of the data in the form of stance analysis.

While the concept of stance is commonly used in studies of interpersonal interaction without necessarily addressing societal power relations (Du Bois 2007; Kärkkäinen 2003), its grounding in critical theory is well established, particularly in sociology and political studies (Jaffe 2009; Ushchyna 2018). Critical stance analysis can provide innovative and in-depth insights into interview data, while capturing competing interests in a nuanced way. Given that a critical analysis of discursive stances has been only recently introduced as a tool to social work scholarship in a study based on data from focus groups (Lovrits and Kalenda Vávrová 2025), the present study also promotes a methodological novelty in social work, while aligning with the dialogical and reflective approaches in social work (May 2025; Parton and O'Byrne 2000).

As a concept, stance represents descriptive, affective, or normative positioning that individuals take toward a topic, while taking into account recurring patterns of real or imagined positions of others (Jaffe 2009). Stance encompasses three constitutive features: the stance *subjects* and their *positioning*—whether aligned or misaligned—toward the *object* of stance (Du Bois 2007). In this study, the central stance object was deinstitutionalisation. Positioning was further examined by separating alignments from misalignments, allowing for identification of perceived discursive problems (misalignments) and their possible solutions (alignments).

Furthermore, from a critical perspective, discourse is never "neutral"; it both reflects and constructs reality, reinforcing or challenging power relations (Blommaert 2007; Cameron 2004). The interpretation of findings was therefore guided by a focus on the implicitly and explicitly expressed conflicts of interest. Unlike thematic analysis, critical stance analysis offers a more

nuanced view of conflicting interests, showing how professionals' narratives may perpetuate or transform institutional practices.

The main research question of this study asked: *"How are stances towards deinstitutionalisation constructed from the perspective of various actors and with what implications?"* In a qualitative analysis, the authors have examined stance patterns to understand what the stewards of Czech deinstitutionalisation believe is needed for more progress in deinstitutionalisation. Their perspectives and roles as leaders supporting deinstitutionalisation were approached critically, in order to ensure that we do not take for granted or generalise any unjustifiable claims.

The analysis was conducted in iterative rounds, starting with a preliminary content analysis of inductively coded themes in participants' discourse. This revealed that their views on structural aspects align with the Ombudsman's reports on the state of Czech deinstitutionalisation (CECHR, 2023; Ombudsman 2025b) – the perceived lack of material and personal resources (housing, community-based services, qualified staff, and funding), the absence of methodological guidance and conceptualisation of deinstitutionalisation at the national level, and the influence of conflicting interests on the current state of affairs. The analysis then proceeded with the main analysis of discursive stances (Blommaert 2007; Jaffe 2009) to gain a more in-depth understanding of the discursive barriers.

Findings

Results are further presented in four sections, reflecting the constitutive aspects of stance. First section outlines the stance subjects, providing insights into the stakeholders' interests from the participants' perspective. Second section then examines deinstitutionalisation as the central object. Next section explores stance misalignments from a critical perspective, focusing on the competing interests underlying the misalignments of stances. Final section discusses strategies suggested by participants for aligning stances and converting non-supporters into supporters of deinstitutionalisation. It is important to note that the accounts of resistance or supportive stances may reflect participants' interpretations of broader professional narratives rather than neutrally describing the state of affairs.

Stance subjects

The main stance subjects in the analysis were the participants themselves. They mentioned other subjects, namely: politicians, public administration at the national, regional and municipality level, professional associations, social service providers, legal guardians (conservators), families, people with disabilities, the public and journalists/media. Most of the subjects featured as supporters, indifferent, and opponents of deinstitutionalisation, depending on individual situational and personal constellations. There were only two types of social

actors that were only mentioned as supporters. The first are NGOs (the third sector) that traditionally address the need for community-based services in Czechia. The second, rather unexpected supporter of deinstitutionalisation, were the health insurance agencies. We will return to that later in the text.

Furthermore, no social group was seen as solely opponents in the data. Although the Association of Providers of Social Work was rather consistently portrayed as an opponent that upholds the interests of large-scale institutions, one participant explicitly expressed a hope for change, referring to a newly constituted section for deinstitutionalisation grounded within this association.

That said, participants also expressed concern about the structural impact of those who are neither supporters, nor opponents – i.e. the undecided, not-informed and disinterested actors. Those subjects were seen in an implicit opposition, since the public indifference does not create pressure on administration and politicians, which closes a vicious circle of ignorance and lack of support for deinstitutionalisation. While we have initially considered the opponents and the indifferent separately, we have concluded that they actually featured in a common positioning with the opponents – as *non-supporters*.

That said, the further discussed dichotomy supporters/non-supporters should not be considered as essentialist. Participants see the potential of shifting between the two discursive "camps" as an opportunity for proceeding with deinstitutionalisation:

> Emily: … *those people who were really- who were like saying that it [deinstitutionalisation] was definitely not going to work because they had like this- these reasons here for it, then actually when they saw that it was working, they became the biggest supporters. So, I learned not to give up on people who are actually in, like, opposition because they can actually be the best allies in the future.*

Indeed, even some of the interviewees were directors of a large-scale institution and opponents of deinstitutionalisation in their distant professional past. Thus, the dichotomy of supporters/non-supporters should be understood as a discursively expressed positioning, which can shift following an individual's experience or a change in social conditions. All non-supporters could be turned supporters.

As for the participants themselves, they have been active supporters of deinstitutionalisation for decades, with some involvement dating back to before the Czech social transformation in the 1990s. Drawing on internationally shared experiences, they began to promote methods that were unconventional, thus potentially risky in the previously paternalistic system. Although many of them recall that their actions sometimes brought about a looming legal trouble, they have managed to carve out new paths and set new structures, as it was the case of the now internationally recognized system of interdisciplinary Mental Health Centres (Pěč 2019). However, rather than viewing themselves as radical agents of transformative change within

the "radical social model" (Harpur 2012), they preferred strategic manoeuvring within the existing system:

> *Eva: … to take a step outside and work around it. With some degree of resistance to authority and with their own convictions.*

One of the participants explicitly distanced herself from the label "activist", framing activism as an incompetent support of deinstitutionalisation with selfish (financial and career) interests in mind. In contrast to such self-centred interests, participants shared a deep concern with human rights and the principles of what is in theory understood as "rights-based" (Yilmaz and Bilir 2022) and "inclusive" (in contrast to "segregationist") approach (Mozo González and Lucena 2023), accompanied by a strong pragmatic focus on practical impact, as illustrated below:

> *Harry: …[is is important to] instil conviction, because it [deinstitutionalisation] is truly a matter of human rights, but also about finding ways to fulfil these rights in their everyday work.*

In sum, the analysis of stance subjects portrays participants as supporters of deinstitutionalisation, committed to realising human rights in social work practice. They contrast themselves with all types of non-supporters—a shared self-understanding from which they reflect on deinstitutionalisation and that frames the findings in the following sections.

Stance object

Previous investigation (Ombudsman 2023) established that the Czech discourse on deinstitutionalisation revolves around the same term, but not the same concept. Since previous consideration did not deal with this problem in more analytical detail, this study fills the gap. This section will show the principal differences and how (in what way and to what effect) the divergence undermines the formal logic of arguments, thus prevents the debate from developing in a rational manner.

While the participants tended to approach deinstitutionalisation from various professional viewpoints, their idea of *full deinstitutionalization* always circles back to the requirements of the Art. 19 of the Convention, encompassing the following three constitutive aspects (cumulatively):

A. *closing large-scale institutions* and freeing people with disabilities from the unnatural environment of "total institutions" (Goffman 2017),
B. while providing a network of good quality and scope of *community-based services* that support the people with disabilities of social work according to their changing needs in a natural social environment,
C. which enhances *self-determination and social functioning* with respect to their dignity, will, and capacities to act.

Moreover, a qualified human resources, suitable housing, and financial support was considered important aspects of the deinstitutionalisation. However, rather than defining deinstitutionalisation, these factors would only influence its scope and pace. It is also important to note that the idea of "full" deinstitutionalisation does not imply completion but rather the presence of all three constitutive aspects in a process of continuing re-adjustment that reflects the changing needs of people with disabilities and resources available in the community.

In contrast, deinstitutionalisation in the reported non-supporters' stances typically missed one or more aspects that the supporters considered constitutive. The first type of "partial construction" of deinstitutionalisation omitted aspect A, talking about "humanisation" *within* the large-scale institutions. Many participants criticised the Association of Providers of Social Services for promoting this type of "partial deinstitutionalisation". Participants were concerned that this type of partial understanding of deinstitutionalisation promotes the self-centred interests of large-scale institutional providers:

> Noah: When these projects were being prepared here, the intention of the ministry, which is an important player, among other reasons because it is actually the establishing authority of the psychiatric hospital, was to focus heavily on investing in these institutions, to follow the path of so-called humanisation, which is a road to hell, because when you invest in the institutions, you are only stifling the process.

As explicitly stated in the quotation above, participants considered this understanding of deinstitutionalisation as actually perpetuating the institutional care, and as a misuse of the funds dedicated to deinstitutionalisation. This indeed aligns with the published legal opinions (CECHR, 2023; Ombudsman 2023).

The other type of "partial deinstitutionalisation" identified in the analysis, was constructed *only* through the closure of large-scale institutions. We have indicated the examined aspects A, B and C in brackets in the excerpt below:

> Grace: And that's actually what many opponents of deinstitutionalisation say: "If you scatter them into individual apartments [A], they will lose contact with others and end up isolated", you know, but that's not what it's about. It's about connecting them to the community [B] or, like, giving them the option to choose [C] whether they want to live alone or not.

Furthermore, the above-refuted type of partial understanding that focuses only on the closing of large-scale institutions brings about a pattern of negative impacts. First, not ensuring the presence of alternative support services in the community (aspect B) can harm the people with disabilities, put too much pressure on the caregivers and communities, and render the new life outside of the large-scale institution too risky. Second, disregarding the need

for more self-determination and social functioning (aspect C) leaves people in small-scale home facilities within the old institutional regime. Regarding the latter, participants talk about the persisting "institution in the mind" and they plead for understanding that full deinstitutionalisation has to encompass persons' agency.

To sum up the analysis of stance object, it has reconstructed the misunderstanding (or deliberate misinterpretation) of what deinstitutionalisation means. While the hidden support for institutionalisation—by omitting aspect A—has been already refuted in the Ombudsman's report (2023), we contrast this with another limited understanding of deinstitutionalisation that overlooks aspects B and/or C. Viewing deinstitutionalisation as simply implementing aspect A—without providing alternative care and support for greater social functioning—results in negative effects from the missing aspects B and C being wrongly attributed to deinstitutionalisation itself. Since this partial view skews arguments in favour of institutional care, we put forward that it is essential to use the term in all its complexity to ensure compliance with the Convention.

Misalignments

In the next step, we inspected the stances featuring misalignments to reconstruct the underlying interests and assumptions. This section focuses on how the participants sought to understand the motivation of non-supporters' opposition to full deinstitutionalisation. We specifically followed the reported misalignments in *evaluative* positioning—why (partial) deinstitutionalisation may be perceived as better or worse than large-scale institutional care—and in *normative* positioning—i.e. why one approach is considered right or wrong, and thus preferred over the other.

From the broadest perspective, it is the heritage of paternalistic care that winds as a golden thread through misalignments between supporters and non-supporters. The value placed on the third constitutive aspect of deinstitutionalisation (C) – self-determination – may be relatively low in the post-communist country, when compared to the discourse in Western European countries (Sépulchre 2018; Slasberg and Beresford 2020). One participant refers to this international contrast, implying the lack of basic trust between the supporters and non-supporters:

> Noah: … here it's a bit like everyone sees it [deinstitutionalisation] as some kind of Western model that we're pushing here.

Referring to the "Western" model, using the pejorative "Western", situates the discussion in an international context while invoking the legacy of paternalistic care within a state-led organisation of the communist political regime.

In international scholarly debates, the disagreement about the value of professional intervention versus active participation and self-determination is reflected in the discussion on the theoretical shift from the "medical model" (Harpur 2012) to the social model of disability (Oliver 2013), recently refined into a suggested "socio-ecological model" (Ungar 2012) or "diversity and dignity model" (Mozo González and Lucena 2023). Whereas participants frequently advocated for abandoning the medical model, they did not explicitly label or concisely define the desired alternative model. Thus, the study only presents the participants' perception of the "outdated" perspective that underpins the reflected resistance to full deinstitutionalisation.

First, participants point out what they consider a *false sense of security* in relation to the institutional care. According to the participants, non-supporters in the key structural positions—such as judges in custodial cases, municipal police, politicians, and the media—still tend to consider institutional care as the safer, more secure option, despite the requirements of the Convention and tragedies like major fires and the problems caused by crowding people with diverse backgrounds. At the same time, the community-based, decentralised services may tend to be pictured by non-supporters as too risky, expensive, and difficult to manage:

> James: … they feel that in the residential facility, the person is really completely safe, and if they get sick because they've overeaten, swiftly the care like comes, you know. There's this tendency to emphasize that- the medical care, and it's kind of overseen that this isn't the only thing in life. For example, a person might have less materially or caregiving supported but could be more at ease, psychologically, in a natural environment.

Furthermore, the argument for the safety and security of institutional care can mask a desire to protect the personal *comfort* of stakeholders, including families who may not want to "bother" with a member needing extra support. Many directors, social workers, and support staff at these large institutions may also find it convenient to maintain the status quo, as it secures their stable income, routines, and social influence. This dynamic extends to local politics, where the institution is often the largest employer in remote areas with high unemployment. The staff, dependent on employment in the institution, represent a significant voting pool, creating social and political pressure to keep the facility open. Although the employees could seek job training, alternative work opportunities in the areas are scarce, leaving them with little motivation to abandon their established roles within the institution:

> Thomas: When they talk about service users, I feel that they're actually talking about themselves. They're afraid they won't make it, or they don't want to leave the institution because they live in that village, maybe they don't have a driver's licence, and now they'd have to travel between service locations in the community, five service users here, five there – and not everyone's that proactive.

The fear of the loss of comfort is seen as a common reason for resisting deinstitutionalisation. Even the service user may prefer to stay institutionalised to avoid personal effort (and potential failure). Staying institutionalised, they have a place to sleep and receive food without needing to worry about finances or shopping. Especially for those who have never experienced a life outside of the institution, the idea of leaving can feel overwhelming, which participants also acknowledge:

> Olivia: I think the fear of the unknown is huge for them because there, they have security and safety.

The *fear of the unknown* seems to affect the professionals responsible for providing support, as deinstitutionalisation broadens the scope of their responsibilities. Since the hierarchical superior traditionally handled decisions beyond routine care, supporting deinstitutionalisation may seem too risky for social workers or legal guardians. They may feel vulnerable if something goes wrong with a service user outside the institution:

> John: … and suddenly, the staff started to fear supporting any kind of self-sufficiency among those people, because they were put under pressure, even from [law enforcement] authorities, and it was looked like they might go to jail, you know.

The verbatim above refers to the stress experienced by social workers during the investigation of a service user's death outside the institution. While investigations into the quality of professional conduct are standard practice, social workers may not be prepared for this. Thus, they may prefer working with institutionalised service users, where the institution primarily bears responsibility for any issues that arise.

Additionally, participants repeatedly noted a *low professional self-confidence* of social workers, particularly in comparison to healthcare staff. This sometimes leads to social workers being "silenced" in discussions and the inferior discursive positioning. The underlying insecurity of social workers can create practical challenges in practice:

> Thomas: … one department against another; the healthcare staff against the social workers, you know, and so. We didn't really cooperate, but there was this strange rivalry.

Participants also suggest that the professional rivalry may be changing over time and across contexts, as other people-centred professions gradually move away from the "medical model" of care. Experiencing the benefits of multidisciplinary collaboration and case management reveals the advantages of modern (deinstitutionalised) social work, helping to balance the positioning of social workers within multidisciplinary teams.

Additionally, as the social workers' professional authority and confidence rises, the need to clarify the potential limits of the confidence are highlighted. As illustrated in the excerpt below, participants believe that in some cases, it

is right to push service users towards greater activity or even to act on their behalf, even without the explicit consent:

> Noah: … sometimes you support the person even if they, like, if they don't fully express consent because, simply from their perspective and perception of reality, they're not capable of doing so.

Such stances may lead to potential legal/ethical questions. In cases where service users are mistreated or harmed, confidentiality may supersede the need to share information for their protection. However, compensating for the missing consent may go against the imperative of self-determination, which is a constitutive part of deinstitutionalisation. Thus, we are flagging this aspect as a risk to be clarified for a unified and safe practice.

Moreover, there is another misalignment in the understanding of activisation within the supporters' camp. Some of the participants regret that modern social work focuses too much on the *individual* competencies, disregarding the need to adjust *social* conditions that would allow for more social functioning. One of the participants calls this "therapeutisation" of social work:

> Bob: It seems to me that the field has been fighting for so long to prove it's not medicine, that it has essentially turned into psychotherapy.

Eventually, the preference for paternalistic care shows up in the misalignment in reasoning about structural costs. Whereas participants focus on the quality of deinstitutionalisation, they regret that it is not the case with the politicians and public administration. Participants believe that the focus should be on measuring the quality of service based on the level of human rights protection, respect for dignity and self-actualisation. In contrast, public administration seems to emphasise the centralised control of the level of costs, staffing, and energy consumption. One of the participants suggests that this problem is linked to the indirect funding of social services in Czechia. However, the shift from a value-based to a cost-based approach appears to be part of a broader austerity trend, since people with disabilities receiving direct payments have been struggling in the UK recently, too (Slasberg and Beresford 2020).

In sum, the focus on misalignments revealed the perceived persistence of the paternalistic model of care as a key factor behind resistance to deinstitutionalisation among non-supporters. Participants highlighted the perceived insecurities and changing professional responsibility, while noting that service users often stay in a material comfort akin to hotel-like services, and a regimented schedule without opportunities for self-determination, even when already living outside large institutions. Too much emphasis seems to be placed on professional oversight, without support for learning from mistakes and self-actualisation. Moreover, even supporters differ in their view on the concept of professional responsibility for service users' activation, with some participants expressing concern over the

lack of attention to the structural conditions necessary for their social functioning. From an administrative perspective, institutional care may tend to be pictured as cheaper than deinstitutionalised support, which undermines the value placed on persons' self-determination and self-actualisation in social care.

Alignments

The final section of findings presents how participants perceived the potential for greater alignment of stances, and thus more support for deinstitutionalisation. Despite their rather sceptical views on state-led and regional administration efforts regarding deinstitutionalisation, they remain hopeful about changing individual minds and overcoming the persistent link to discomfort and insecurity. While emphasising practical action and pragmatic impact, participants believed that deinstitutionalisation is not only a structural transformation but also a personal change that happens in the person's mindset:

> Anna: The, like, human experience, that is absolutely crucial for the change, you know, because without it- because deinstitutionalisation is basically a change of stances, you know.

The Czech language does not linguistically distinguish "a change of attitudes/ stances." However, in the context that we have presented, the change goes beyond just attitudes. It involves a shift in understanding the stance object (the definition of deinstitutionalisation) and evaluative and normative views on what is good/bad, right/wrong. We highlight this aspect to support clearer cross-language understanding of the analytical depth brought by the analysis of stances.

Furthermore, participants believe that deinstitutionalisation currently relies on the personal engagement of too few enthusiasts devoted to the cause. Considering how to gain more supporters, they stress the importance of showcasing good practice examples grounded in personally relevant, practical experiences and focusing on the positive outcomes it brings. They emphasise that peer-to-peer knowledge transfer is the most effective approach, while also addressing the emotions of non-supporters, particularly their fears and insecurities that create misalignments.

Additionally, participants emphasise that people with disabilities who leave institutions face an unfamiliar world outside, which can be frightening for them. However, overcoming this fear can happen by refocusing on something personally important, like an opportunity to go fishing with a friend or visiting parents' graves. Therefore, aligning stances towards deinstitutionalisation in social workers providing direct services is perceived as crucial for the managers:

> Luke: You can, like, take whatever steps you want, but if there's just someone there who simply says, like, "Hey, you're not really moving out, are you? You're going to leave me

here? When I'll miss you?" … In that moment, it's like a huge step backwards. … [It is important to show] that what we want to do is good, safe- and good not only for the service users but also for them.

Participants believe that the desired alignment of social workers' stances towards full deinstitutionalisation may start with mere compliance; they don't have to give themselves fully to deinstitutionalisation. However, the workers should be open-minded and not go to work "like to a factory" (i.e. implying a mechanical approach to fulfilling their duties). While participants disavow the disengaged work ethic, described in previous research as "assembly-line mentality" (Pagano 2017) or "clocking in and out" (Lovrits and Kalenda Vávrová 2025), this passive approach seems to be rather common even in people-centred professions. Thus, participants conclude that achieving alignment on deinstitutionalisation will require more time than one might initially expect and call for patient but steady effort.

Moreover, participants share their experience that it is particularly effective to communicate *positive, deeply emotional and practical* experience with deinstitutionalisation rather than theorise or point out the threats and negatives of life in large-scale institutions. It helps to envision a better future, outweighing potential insecurities and new worries. Participants not only praised the effects of personal, deep human experiences but also the efforts to encourage stakeholders to step outside their social roles and *"put away the uniforms and start behaving like people."*

The need to see each other as fellow humans, rather than as objects of paternalistic care or as potential threats, was discussed in various contexts within the data. Firstly, in the context of initiating changes in large-scale institutions, deinstitutionalisation should begin by treating people with disability as partners. Secondly, the community also needs to come to view value of the deinstitutionalisation. An example of translating a role-based or principled stance into a personal relationship is illustrated in the following excerpt, which recalls the establishment of supported housing in a new community:

> *Lily: They [the future neighbours] didn't want it, we explained it to them, and they still were against. So, I thought—I said: "You know what, I'll send a company car for you tomorrow (…)" So they came, saw the [deinstitutionalised] service users. The nurse on duty made them coffee and gave them cake that they'd baked together with them. And suddenly, the neighbours were like: "Oh, alright then." And the problem was solved, you know.*

The manager in the excerpt above used the opportunity of the cultural habit of "coffee and cake", typical for many Czech and German (neighbourhood or work) communities. An informal meeting over sweet pastries helped facilitate small talk which further supports understanding of the communication

partners – managers, social workers and service users alike – as good people. Since trust has been identified as a crucial aspect of successful work with communities (Gojová et al. 2021), we believe this is a practical example of trust building worth sharing.

Furthermore, participants suggested that non-supporters should be approached as potential allies rather than adversaries. The art of persuasion and pragmatic communication can gain supporters even among opponents and in less obvious contexts. One particularly inspiring moment in the data was the realisation that health insurance agencies may become important supporters in the process of deinstitutionalisation. They have gathered significant data on the economic advantages of deinstitutionalised care, which is valuable information lacking at the national level of administration:

> Noah: the hospitals are still basically dependent on the occupancy rate, yeah, and the health insurance system doesn't really help. Although I have to say that actually the efforts of the insurance companies to find a solution are quite significant, and in the end it's sometimes them saying, but it seems to us that the reduction of beds is actually small and so they're actually our allies now more than like, the facility directors or, or the ministry, yeah.

The above experience presents a strong financial argument in favour of deinstitutionalised care. Health insurance agencies can become crucial supporters advocating for structural transformation, an opportunity that has so far been overshadowed by the predominant discourse on the costliness of deinstitutionalisation, as also previously discussed in research (Priebe 2004).

Participants' experiences demonstrate that deinstitutionalisation can be managed effectively without excessive complexity or cost. However, they highlight the necessity for greater expertise in change management and advocate for enhanced education in modern social work, including fundraising, grant writing, and involvement in policymaking. Social workers should also gain a deeper understanding of other professionals' roles to foster a holistic understanding and develop leadership skills.

Additionally, since politicians often align their support with community sentiments, participants stress the importance of social workers actively engaging in policymaking and facilitating multidisciplinary dialogue with other professionals, such as journalists and media experts. Ultimately, they see an urgent need for increased public relations efforts regarding deinstitutionalisation that respect the need for practical, "deeply human stories" (a term otherwise used by media professionals), positive experiences shared by people in similar positions, to which the public can emotionally relate. Professionals also need to share bad practice examples to prevent wasting resources on trial and error; however, addressing their insecurities and fears of losing comfort through personal, peer-to-peer support seems to be equally important.

Limitations of the study

Apart from participants' own stances, analysed stances are reported rather than directly expressed. The findings therefore reflect only the experiences and interpretations of a specific professional community. Nonetheless, the participants are experts on deinstitutionalisation in Czechia, and their long-term professional goal is to support the transformation in practice. Thus, they have pragmatic reasons to describe the situation as accurately as possible. For a more nuanced debate, though, future research must also involve other stakeholders, including administrators, care providers, and people with disabilities themselves.

Among the methodological limitations, it should be noted that data were collected in two phases (2022 and 2024), during which policy and practice contexts may have shifted. However, participants' reflections do not focus on mapping the current state of affairs or recent developments, but rather on patterns observed over more than a decade of experience with deinstitutionalisation.

Moreover, the character of findings is interpretive rather than descriptive. Actual outcomes of deinstitutionalisation were neither determined nor measured, but interpreted and framed by key actors, and then again interpreted and framed by the authors of this study. To address researchers' subjectivity during iterative coding, analysis, and interpretation, the issue was addressed through discussions among the authors, drew on their diverse disciplinary and institutional backgrounds. In the end, the interpretivist and constructivist character of the study does not permit broader generalisations. Still, it provides insights and inspiration, aiming for international relevance and the transferability of context-based knowledge (Smith 1984).

Discussion and conclusion

The authors put forward that discourse has been an underestimated part of the "assemblage" (Goodley 2013; Hradcová and Synek 2023) of ongoing reconfigurations of heterogeneous elements in processes of transformation. As deinstitutionalisation includes political and discursive processes in which meanings, power and institutional interests interact (Ben-Moshe 2020), discursive and informational practices shape access, legitimacy and participation within support systems (May 2025). Policy reforms and practical measures should therefore address communication and information routines as part of the transformation, drawing on knowledge provided by dialogical and reflective approaches to social work (Parton and O'Byrne 2000) and interdisciplinary collaboration (Dore 2016).

In the above context, this study contributes to current debates on deinstitutionalisation in two main ways. First, it explains how a diverse understanding of deinstitutionalisation distorts the rationality of debate, allowing for

legitimisation of the continuation of "new institutions" across national contexts (Mladenov and Petri 2020; Zaviršek 2017), leading to failure to conform to legal requirements (CECHR, 2023; Ombudsman 2025b). Second, it exposes the features of discursive dynamic of professional stances that are not merely reflections of policy but active forces shaping the practices and behaviours of stakeholders, as previously demonstrated in studies in England, Italy, Sweden, Australia and the United States (Ferazzoli 2018; Fish 2025; Hilton and Lambert 2025; Storer 2021; Svanelöv 2024).

Comparing the positioning of "supporters" and "non-supporters", the analysis showed that supporters view deinstitutionalisation as a cumulative combination of three elements: closing large institutions, ensuring safe and well-managed community support and strengthening the self-determination and social functioning of persons with disabilities. In contrast, non-supporters tend to omit one or more of these elements, which leads to discussion around the same term with differing meanings. Following Ben-Moshe (2020), this semantic divergence can be understood as part of the political contestation inherent to deinstitutionalisation processes, where the definition of what counts as "institutional" becomes a site of struggle. Addressing this potentially purposively created confusion may be particularly important in national contexts where smaller housing units alone have not resolved the problems deinstitutionalisation should address (Gould 2025; Šiška and Beadle-Brown 2022; Svanelöv 2020; Zaviršek 2017).

Seen through the assemblage perspective, confusion may also arise because deinstitutionalisation operates within shifting configurations of services, discourses, professional practices and community expectations rather than within a single coherent system (Goodley 2013). This highlights the need for policy-makers to establish clear definitions and communication strategies, as policy ambiguity creates space for practices that undermine reform goals. The Czech national strategy in preparation (Ombudsman 2025a) will hopefully provide such structure, offering not only technical guidance but also discursive tools for aligning meanings across sectors, such as shared definitions, communication templates and guidance for resolving inconsistencies.

Regarding the features of discursive dynamics, resistant stances often relate to fears of losing control or comfort, personal insecurities, and reluctance to assume responsibility for decisions. Indeed, in the paternalistic model prevalent in the post-socialist region (Zavrišek, 2017; Zaviršek & Fischbach 2023; Mladenov 2017), decisions may remain hierarchical, with doctors and managers holding authority while social workers see themselves as administrative staff rather than advocates for self-determination. While this aspect might be part of the debate seeking more rights-based and participatory approaches in social work, the authors suggest reconsidering the use of the term the "medical model" in such discussions. It evokes longstanding tensions between healthcare and social work, placing the two professions in

adversarial positions. The term "paternalistic model" may better reflect the context of post-socialist countries while highlighting the political dimensions of deinstitutionalisation that shape social impact at national and local levels.

Participants further emphasised the need for greater participation and broader efforts for social change, lobbying, and advocacy among professionals. They expressed concern that social workers often do not view structural interventions, such as participating in legal processes or addressing institutional mistreatment, as part of their professional role. Worried about the "therapeutisation" of social work, some participants noted that social work tends to compensate for structural shortcomings at the individual level. This discontent aligns with critical scholarship arguing that an excessive focus on individual responsibility sustains social injustice (Garrett 2015) and with Ben-Moshe (2020) claim that shifting structural power relations requires more than therapeutic engagement; it requires dismantling the discursive and material assemblages that sustain "institutional logic," as highlighted in studies from other European countries (Fish 2025; Mladenov and Petri 2020).

However, this call for more activism also raises questions of consent and confidentiality. The analysis confirmed that people with disabilities often appear in the discourse not as drivers of transformation but as objects of persuasion, an observation aligning with the Ombudsman's view that their voice is not heard enough (Ombudsman 2025b). More scholarly and practical attention to this aspect of discursive practice is thus needed. A transparent, preferably multidisciplinary debate on compensation for limitations experienced by people with disabilities would further strengthen accountability, support social workers' confidence, and help ensure their practice withstands legal scrutiny, which remains a key concern for practitioners. Embedding structured participation mechanisms in policy processes, such as user councils, accessible consultations, or periodic co-review of service standards, could further support people with disabilities in becoming active co-producers of reform rather than passive recipients. This change cannot be merely discursive, though. Seen through the assemblage lens (Goodley 2013), transformation requires also altering the complex configurations of actors, practices, and inter-professional hierarchies.

The analysis further highlights the need for stronger leadership and management skills among social workers, including securing resources and adapting community-based services to changing needs. Well-managed deinstitutionalisation would namely reduce anxieties of people with disabilities as well as of other stakeholders who might otherwise obstruct the process for personal reasons. Recognising individual motivations would help address fears and foster a mindset open to risk and responsibility, alongside professional readiness to make difficult decisions with accountability and pursue structural change.

Furthermore, policymakers and practitioners may need to consider how reforms are discursively framed, ensuring narratives emphasise dignity and diversity rather than paternalism or narrow managerialism (Fish 2025;

Hilton and Lambert 2025). Strategic use of media and relatable examples can shape public debate and promote nuanced discussion across professional groups, reinforcing interdisciplinary engagement (Dore 2016). The Czech public seems to be particularly responsive to film (Lovrits and Kalenda Vávrová 2025; Punová 2022), an aspect strategically used in support for closing institutional childcare through the film Amerikánka (Girl America). Shortly after the film's release, there was a debate on the public television broadcaster that explicitly framed the film as part of a conversation on child welfare policy (Česká Televize (Czech Television)) 2024). Using advocacy art to influence public discourse and build support could form part of a cross-national exchange on communication strategies supporting deinstitutionalisation (Šiška and Beadle-Brown 2022).

This eventually leads to the overarching theme highlighted by the findings: if policymakers and practitioners wish to move toward full deinstitutionalisation, professional and public discourse may require closer attention alongside the other actions already outlined by public administration (Ombudsman 2025a). In line with dialogical approaches to social work, fostering shared meaning-making and structured cross-professional dialogue may help build the consensus necessary for coherent policy implementation. Such dialogical processes can support the alignment of goals and create a shared understanding of the conditions and implications of full deinstitutionalisation while recognising the differing motivations of the actors involved.

Disclosure statement

Funding

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