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A critical exploration of institutional logics of de-institutionalisation in the field of disability policy and practice: Towards a socio-spatial professional orientation

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1 Introduction

Since the 70's, disability policy and practice reforms across Europe have actively promoted 'de-institutionalisation' through the development of community-based care, as the key alternative to the provision of care in large-scale residential care institutions (Johnson & Traustadóttir, 2005; McConkey & Collins, 2010; Milligan & Wiles, 2010; Tøssebro et al., 2012). Due to societal criticisms emerging since the '60's, the living conditions in residential care institutions have been framed as violating the rights of disabled people due to the segregation and lack of inclusive social relations, stigmatisation, the custodial and repressive institutional professional culture, and poor living conditions (Mansell, 2006; Tøssebro et al., 2012; Roets et al., 2020). Whereas several countries such as North America, the Nordic countries, Britain, and Australia have consequently dismantled and closed all residential care institutions (Mansell, 2006; Tøssebro et al., 2012), in other countries such as Belgium, the Netherlands, Germany, Ireland, Spain, Greece, Czech Republic, Hungary, Slovakia,… a slow response to calls for de-institutionalisation is at stake (Van Loon, 2005; Mansell, 2006; De Rooij et al., 2012; Venema, 2016; Levrouw et al., 2018; Swerts et al., 2019). The segregation of disabled citizens in this persistently wide range of residential care institutions (see for recent research insights in the Dutch speaking part of Belgium (Flanders) Roets & Van Hove, 2003; De Waele et al., 2005; Benoot et al., 2022) is however considered a violation of diverse international Human Rights Conventions and Charters, such as the UN Convention on the Rights of Persons with Disabilities, the UN Convention on the Rights of the Child, and the European Fundamental Rights Charter (Harpur, 2012; EEGTICC, 2019). In the UN Convention on the Rights of Persons with Disabilities (2009; see Harpur, 2012), de-institutionalisation has been embodied in article 19, with an emphasis on the replacement of residential institutions by community-based services (EEGTICC, 2019). De-insitutionalisation thus currently continues to function as a key concept in the development of disability policy and practice, also in Flanders, the Dutch speaking part of Belgium (Department of Welfare, Public Health and Family, 2010, 2013).

However, interpretations of ‘de-institutionalisation’ in disability policy and practice have been institutionalized yet changed over time and place/context, and its current connotation in the international realm should be considered as essentially ambiguous and contested (Gibson, 2001). *Whereas the focus of the special issue of Social Work & Society* is situated as *of education and social care in the fields of social services and social work*, we are particularly interested in a critical exploration of the transformations of, and implications for, evolving professional paradigms and knowledge systems in disability policy and practice. Relying on neo-institutional theoretical ideas, we focus on the broader set of historical, social, cultural, and political belief systems that evolved in the particular institutional field of disability policy and practice, and investigate how they have transformed and influenced institutional norms, logics, expectations, and organisational cultures and professional paradigms in this field when dealing with disabled ‘service users’ (DiMaggio & Powell, 1983; Thornton, Ocasio & Lounsbury, 2012; Villadsen, 2013).

In what follows, we first discuss changing professional paradigms and knowledge systems in disability policy and practice, that result in contemporary institutional conceptions and conditions of ‘de-institutionalisation’. Second, we address that the current ‘community turn’ in strategies (see Gibson, 2001; Mansell, 2006; Milligan & Wiles, 2010; Tøssebro et al., 2012; Roets et al., 2020) has gradually produced a problematic dichotomy in disability policy and practice between ‘segregated living in residential, institutional contexts’ being framed as something to avoid, and ‘inclusive living in the community’ as a desirable goal. Based on this historical sketch, the question can be asked to what extent the ‘community turn’ can be reconciled with the complex challenges involved in the provision of care and support for the most vulnerable people with disabilities, when they are constructed and treated as ‘incompetent citizens’ due to normative ableist assumptions in societies. For this reason, we suggest that a socio-spatial professional orientation might enable us to de-institutionalise this dominant dichotomy.

2 Shifting professional paradigms and knowledge systems in disability policy and practice: institutional logics of cure, care, and support

In this section, we situate a historical-genealogical analysis (see Villadsen, 2007; Lorenz, 2008) of changing socio-political institutional welfare state logics in European societies, as a way of gaining a better insight into contemporary welfare rationalities influencing disability policy and practice.

2.1 Systematic segregation: cure

In most Western societies, disabled citizens represent a minority group of historically powerless people (Atkinson, Jackson & Walmsley, 1997; Roets, Dean & Bouverne-De Bie, 2019). At the end of the 19th century, the phenomenon of ‘disability’ has been seen as a threat and a burden to the social order, undermining the health and competitive national efficiency of European nation states (Taylor & Bogdan, 1989; May & Simpson 2003). Disabled citizens, especially people with ‘intellectual disabilities’ and people with ‘mental health problems’, have therefore been segregated into large-scale residential care institutions, located at the edge of society (Goffman, 1961; Foucault, 1961; Gibson, 2001; Masschelein & Verstraete, 2012). Whereas the idea of ‘pedagogical optimism’ was initially key to professional socialization and civilization strategies and replaced the former punitive regimes to regulate so-called potentially ‘disruptive members of society’ (and thus the ‘undeserving’ such as the poor, the disabled, and the old) in ‘workhouses’ (see Gibson, 2001), this development has paved a historical and professional pathway for education and social work actors in dealing with disabled citizens (Simpson, 2007). The underlying care paradigm was oriented towards cure, in which the focus is strongly on medical-therapeutic treatment. In the case of people with ‘intellectual disabilities’ and ‘mental health problems’, the attempts to cure, and thus civilize, so-called ‘asocial idiots’ was based on an unambiguous belief that civil life demanded their re-education “as a process of producing proper citizens” (Simpson 2007: 564). In architectural and spatial terms, the paradigm was translated into organizing care in large-scale residential facilities (so-called asylums), located on the periphery of cities or village centers. Because of the healing effect expected from natural or green environments, these facilities were situated on closed or isolated territories, which were literally cutting off care-dependent citizens from social life (Goffman, 1961). The modern asylum building, being conceived as a hospital model, was perceived as an important instrument for the healing process (Masschelein & Verstraete, 2012). Throughout Europe, disabled people have been gradually removed from their families and communities, and were subjected to the institutional routines and professional regimes of various forms of residential service settings (Atkinson et al. 2005; Johnson & Traustadóttir 2005).

As an early 20th century creation, Western societies furthermore started to categorise ‘disabilities’ and decontextualized predictive measures for people “unable to follow the developmental path to civilisation” (Simpson 2007: 571). Medical beliefs as to the nature of ‘intellectual disabilities’ and ‘mental health problems’ instigated a professionalization process to categorise individuals, defining “feeblemindedness as a hereditary, biological defect, thereby rooting the source of social failure and deviance squarely in the individual” (Carey, 2003: 412). Their supposed deviance and intellectual and mental inferiority increasingly instigated moral panic, that furthermore served their treatment in, often charity-based, institutions being exploited by professionals, and they were hidden from the public sphere (Smith, 1999). Although the legitimacy of interventions was based on a tyranny of ‘the normal’ (Skrtic, 1995), “these very powerful social control mechanisms were perceived as ‘treatments’ serving everyone’s best interests, including the best interests of the individual and society” (Carey, 2003: 413).

In the course of the 20th century, the individual as well as collective identity of people with ‘intellectual disabilities’ and ‘mental health problems’ was furthermore defined for them as a professional social construct, being increasingly rooted in the eugenics movement which has led to the development of policies and practices to exert invasive control over their lives (Barton, 2000; McClimens 2003). The policy of institutional segregation extended to the sexes to prevent the breeding of moral defectives, and was reinforced by extreme measures such as sterilisation to control people’s fertility, sexuality and possibly parenthood as rampant and dangerous (Brantlinger 1995; May & Simpson 2003). As one of the most extreme strategies in recent European history, the Nazi persecution of disabled people began with forced sterilisation and embraced eugenics and forced euthanasia of the so-called ‘incurably sick’ as a component of radical public health policies to exclude hereditarily ‘unfit’ and ‘feeble-minded’ people from national communities (Robcis, 2021). In that time juncture, a specific policy of extermination of the cognitive disabled was actively promoted by the Nazi regime, yet in other countries “soft extermination” was silently endorsed, that would let disabled people die of cold, starvation, or a lack of care within the confines of the residential institutions and psychiatric hospitals themselves as could be observed during the French Vichy regime (Robcis, 2021). This desire to eliminate mental illnesses and disabilities from the population reflects the dominant scientific and medical thinking in Europe during the first half of the 20th century, influenced by eugenics while highlighting the costs of care for disabled people as a financial burden to society (Radford, 1994). The eugenics argument of economic savings to regenerate the nation justified the systematic killing of disabled people who were assessed to determine whether they were able to work; those who were assessed as being unemployable and useless were killed in secrecy since 1939 in Germany and other European countries.

2.2 Integration: a paradigm shift to care

Shortly after the second World War, the United Nations (UN) was established to prevent future conflicts, to foster international cooperation, and to secure the quest for a substantial realization of human rights and social justice. As a significant milestone, the United Nations Declaration of Human Rights (UNDHR) appeared in 1948 and formally incorporated not only civil and political rights, but social, economic and cultural rights as well. According to Article 25, the UNDHR also embodied the right of disabled people to care and support, stating that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Roets, Dean & Bouverne-De Bie, 2019).

In the decades following the conception of the welfare state, however, the poor living conditions and the violation of rights of disabled people in residential care was sharply criticised from the '60's onwards. In 1961, both Erving Goffman's 'Asylum: Essays on the Social Situations of Mental Patients and Other Inmates' and Michel Foucault's shortened version of the 'History of madness' were published. Goffman (1961) introduced the concept of 'total institutions' or 'asylums', with reference to the common characteristics of military schools, prisons, industrial factories, boarding schools or religious cloisters, which enables us to grasp the nature of professional practices in disability care in those days. According to Goffman (1961: p. xiii), total institutions represent "places of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life". The time and space of the inmates were seemingly completely controlled by the staff, settled by institutional regimes, which led to treating disabled people as objects of treatment and thus the 'mortification of the profanation of the self' (Masschelein & Verstraete, 2012: 6). Whereas Goffman's critique on the dehumanizing effect of 'total institutions' mainly tackled the limited space of the asylum, Foucault's historical critique on the dichotomy between 'madness' and 'reason' symbolized a critique on society at large; "the birth of the asylum (…) was a metaphor of a changing power-knowledge complex which sought to shape and incorporate the individual's liberty in a new way of wielding power" (Masschelein & Verstraete, 2012: 7). Rather than formulating the critique only about the functioning and implications of total institutions or asylums, Foucault (1961) argued that our societies had to be considered as a kind of unlimited asylums, being produced by professional power-knowledge systems constructed around the coding of 'disability' as a form of abnormality, and functioning as a powerful medical-therapeutic apparatus that paved a professional pathway to socialization and civilization strategies. Professional regimes thus exercised a so-called 'subtle' sort of paternalistic and disciplinary social control over these classified individuals, representing 'the common good' (Roets, Dean & Bouverne-De Bie, 2019).

Partly due to the advocacy of parents and the self-advocacy movement of people with disabilities themselves (Williams & Shoultz, 1982; Roets & Goodley, 2008), a process was actively promoted in favour of inclusive and community-based care and support (Stevens 2004; Taylor, 2005; Mansell, 2006; Bylov, 2006; Johnson & Traustadóttir, 2005; McConkey & Collins, 2010; Van Gennep & Ruigrok, 2002). Driven by the impulse of de-institutionalisation, the care paradigm gradually shifted from cure to care, based on a paradigm of integration into society (Van Gennep & Ruigrok, 2002). This shift in thinking was shaped by a principle of normalization, which means that people with disabilities should be given the opportunity to acquire a place in normal life, and to function in a living and housing environment that is as normal as possible (Van Gennep, 2000; Vanderplasschen et al., 2006). This view of de-institutionalisation refers to the goal to organize care and support in the community, ranging from small-scale group homes to independent homes (Van Loon, 2005; Van Loon & Van Hove, 2001; Mansell, 2006). The institutional logic and paradigm of care and integration focused on intellectual social attitudes and skills, avoiding a stigmatizing identity of otherness, and integrating people with disabilities into ordinary life as much as possible (Van Gennep, 2000; Vanderplasschen et al., 2006). The leaders in this field in continental Europe were probably the Nordic welfare states, and particularly Sweden and Norway (Tøssebro, Gustavsson & Dyrendahl, 1996).

2.3 Towards inclusion: a support paradigm

However, this institutional logic and paradigm of care was not immune for criticism, and was further reoriented towards a paradigm of inclusion. From the 1980s onwards, the institutional logic of ‘care’ shifted to a logic of ‘support’, formulated as a challenge to society to develop respect for diversity in social interactions (Hughes, 2002; Winance, 2007). Relying on the criticism that the normalization principle placed too much emphasis on conforming people with disabilities to what was considered the social norm in society, a shift to a rhetoric of citizenship took place (Van Gennep, 1997, 2000; Vanderplasschen et al., 2006). The discourse on citizenship and disability rights was also suggested and incorporated by disability rights activists in the UK and other international contexts, advocating for a social interpretation of disability in the emerging field of disability studies. In 1976, what has been called a ‘social model of disability’ has been formulated in the UK, in which disability is inscribed in a historical-materialist tradition and understood as a form of social oppression (UPIAS, 1976; Oliver, 1992). In the British context, the rise of disability studies was strongly aligned with the social model of disability and subsequently purported by academics to pave a road for social change (see Barton, 1996). Disability studies challenged medical and pathological takes on disability, framed as ‘impairment’, since “the significance of disability theory and practice lies in its radical challenge to the medical or individual model of disability. The latter is based on the assumption that the individual is ‘disabled’ by their impairment” (Barnes & Mercer, 1997: 1-2). In the social model, impairment and disability were claimed to be conceptually distinct categories between which there was no causal relation (Oliver, 1992), and the aim was to change oppressive and discriminatory mechanisms in society. Also for people with intellectual disabilities, this rights-based social model of disability was stressed as an important frame of reference by disability rights activists and social work and social care professionals, promoting inclusion and community-based services (Moore, 2000). At that moment, also the self-advocacy movement gained new momentum in response to a structural lack of recognition of the full citizenship of people with the label of intellectual disabilities, defined by its members and their allies as a collective human rights movement (Roets & Goodley, 2008). These ideas resulted in the ambition to create inclusive living, housing, and working conditions through an expansion and differentiation of quality, outpatient, accessible care and support in the community, including social housing and supported or independent living (Mansell, 2006; Johnson & Traustadóttir, 2005).

In spite of its vital political implications, critics have argued that the social model “does not, on its own, provide a strong theoretical basis for articulating the extent and nature of the justice or rights claims of disabled persons nor their actualization in policy and practice” (Stainton, 2002: 752). In ongoing debates over the last decades, however, it was also argued that ‘the impaired subject’ remains an under-theorised backdrop and a taboo in disability studies (Corker, 2001). As such, the contemporary state of the field of disability studies is recently reframed as critical disability studies, in which a theoretical deepening enables us to uncover underlying and largely taken-for-granted assumptions that undergird the exclusion of disabled people and permeate many social settings (Corker & Shakespeare, 2002). We will return to these discussions in the last part of our contribution.

3 Residential care institutions’ versus ‘community’: Asylum with/out Walls

The original meaning of was related to an institutional dismantling and closure of residential care settings for the sake of “the movement of individuals from an institutional setting to a community setting” (Gibson, 2001: 96). Yet over time, strategies are pursued while a structural transformation of the system of public service delivery and welfare state arrangements itself is at stake (Gibson, 2001; Kessl, 2009; Garrett, 2018). Recent welfare reforms across Europe have implemented market-based and managerial approaches to restructure welfare provision (see Mansell, 2006; Pavolini & Ranci, 2008; Dowse, 2009). Dominated by a concern to ‘liberate’ disabled people from state intervention, the key mantra of ‘choice’ and, in several welfare states, the implementation of a system of direct payments has cast disabled citizens as competent citizen-consumers, who must choose their service provider and purchase, buy, and manage services in the market place (Mladenov, 2012; Mladenov et al., 2015; Dowse, 2009). Furthermore, an increasingly significant level of provision is expected to be provided by the ‘informal sector’, meaning from families and communities (Kisby, 2010; Dean, 2015; Runswick-Cole & Goodley, 2015; Grootegoed, Broër & Duyvendack, 2013). In that sense, Milligan and Wiles (2010: 745) refer to a renewed ‘community turn’, which emerged “from the neo-liberal shifts which occurred in many advanced capitalist countries from the latter half of the twentieth century”. Contemporary welfare states are no longer conceived as the main providers of welfare resources and services (Lorenz, 2016; Roets et al., 2020), which is reflected in the shift away from institutional, formal and professional services towards informal care in the private sphere of our societies.

This complex welfare state transformation is also at stake in Flanders. The Ministers of Social Welfare, Public Health and Family Affairs Jo Vandeurzen (2010-2019), Wouter Beke and Hilde Crevits (2020-ongoing) have implemented a welfare reform called ‘vermaatschappelijking van de zorg’ (*or ‘re-socialization of care’*, see Roets et al., 2020). This welfare reform in Flanders explicitly reaffirms the importance of rebalancing professional, formal care for disabled citizens with care offered by informal care with/in the community (Dermaut et al., 2020). The welfare reform also introduced a system of direct payments to disabled people (‘persoonsvolgende financiering’), demanding the relocation of public resources from professional care providers to disabled consumers who buy and manage their own care and support (Benoot et al., 2022). As such, a market is created with competing providers of disability services, turning disabled service users into consumers who have cash for care and more choice where to live (see Benoot, 2022 for Flanders; see Dowse, 2009, Mladenov et al., 2015 for other countries). As such, policy makers in Flanders also believe that the implementation of the system of direct payments will serve as an incentive for , “reducing investment in collective infrastructures and giving greater consideration to personal choices” (Benoot et al.,2022: 2).

Despite all the efforts done by a wide diversity of societal actors (such as policy makers, care providers and professionals, disabled citizens and their families, (self-)advocacy organisations,…), during the current implementation of welfare reforms for the sake of there nonetheless continue to be complexities. We recently addressed that a problematic dichotomy has increasingly been produced by disability policy and practice during the last decades, based on the predominant idea that disabled citizens living in residential institutions is something 'bad' to avoid and disabled citizens living in the community is 'good' and desirable (Remmery et al., 2022). This dichotomy might be characterised as newly emerging Asylums with/out Walls.

3.1 Asylum without Walls

Our historical-genealogical analysis shows that the dominant conception of de-institutionalisation has produced inclusion policies and practices for disabled citizens. Research evidence however shows that *physical* inclusion in the community does not necessarily entail *social* inclusion of disabled citizens (Chowdhury & Benson, 2011; Bredewold et al., 2016; McConkey et al., 2016). Community-based care thus rather refers to the development of new spaces of care-giving outside traditional, residential institutional environments, being replaced by emerging care arrangements "that may resemble the old institutions, but which are virtually apart from the old building", resulting in re-manifestations of institutional cultures through new spaces and times which potentially end the interior/exterior distinction of the institution (Milligan & Wiles, 2010: 746). This phenomenon is named in international literature as 'institutionalisation at home' (Beadle-Brown et al., 2007; CECHR, 2012; Vervliet et al., 2019), 'trans-institutionalisation' (Högström, 2018; Knibbe & Horstman, 2019), 'community institutions' or 'institution-like practices within community care' (Tøssebro et al., 2012), 'asylum without walls' within the community (Dear & Wolch, 1987 in Hall, 2005), or 'exstitutions' (Milligan & Wiles, 2010). These developments refer to the often un-intentional reproduction of institutional, professional cultures with controlling or oppressive logics and perceptions of care and support regardless of the living environment, the lack of social resources (such as facilities), or the lack of tolerance for otherness in social interactions in society (Murphy & Bantry-White, 2021; Hall, 2005; Högström, 2018; Knibbe & Horstman, 2019).

Moreover, the recent implementation of consumerist regimes suppose a high level of responsibility for disabled citizens themselves, their families and/or an informal network, based on the assumption that disabled people should claim rights, and manage and buy care and support services as competent citizen-consumers (Dowse, 2009). There is however increasing international research evidence that disabled citizens who live independently in the community have to rely mainly on themselves and/or on informal care of their families and communities, undermining the inclusion aimed for. The state and professional care steps in only as a last resort (Morel, 2007; Dermaut et al., 2020). Disabled citizens living independently in the community may thus suffer from a lack of qualitative and professional care and support in the home environment (Mansell, 2006; Beadle-Brown et al., 2007; McConkey & Collins, 2010; Chowdhury & Benson, 2011; Bredewold, Tonkens & Trappenburg, 2016; CECHR, 2012). This is partly dependent on the specific spatial context, and the spatial differentiation of available resources in their living environments (Spatscheck, 2019). For example, there are significant differences between living in a social housing estate in disadvantaged quarters in cities, in an expensive villa district, in a village with limited basic services, or in a remote residential or suburban area far away from everything and everyone. Moreover, the inclusion process proves to be least successful in the case of disabled people who have complex, multiple problems and high support needs (Mansell, 2006). In those circumstances, exclusion, stigmatization, and loneliness are recurring observations (Bredewold et al., 2016).

3.2 Asylum with Walls

On the flip side of the implementation of pronounced inclusion policies and practices, dominant interpretations and practices of strategies also tend to create a residual group of disabled citizens who cannot meet the requirements of inclusion policy and practice and continue to end up in residential care (Williams, 2001; Dermaut, 2020). Inclusion policies are often unintentionally rooted in expectations of independency, self-determination, and individual responsibility “as part of the quest for the model citizen” (Goodley, 2011: 72), who are supposed to behave as choice-making, self-directing entrepreneurs of themselves. As Goodley (2011: 72-73) argues aptly, a strange paradox emerges for disabled people: whereas they are cast as the dependent other, “when they do attempt to gain a foothold on the ladder of individualism then they are expected to demonstrate extra-special, hyper-individual forms of being to maintain their place. (…) [They] have to be more normal than normal people. (…) And if disabled people fail, then a host of professionals lie in wait to aid and (re)habilitate their journey toward self-containment”.

Current policy rationales therefore paradoxically reinforce normative ableist assumptions in our societies (Goodley et al., 2019) and mark disabled people, and especially people with ‘intellectual disabilities’ and ‘mental health problems’, often as different in kind (Williams, 2001) and as incompetent (Dowse, 2009).The most vulnerable citizens risk being excluded from the notion of inclusion when implementing inclusion policies, and still end up, permanently or not, in residential care (Roets, Dean & Bouverne-De Bie, 2019; Roets et al., 2020). Residential living and housing environments in Flanders, for example, are - due to historical beliefs, combined with the time it takes for them to be redeveloped - still often organized as so-called ‘Asylums with Walls’, in large-scale facilities and locations segregated and isolated from society due to institutional cultures and exclusive social interactions (Roets & Van Hove, 2003; Remmery et al., 2022). Also in terms of care logics and paradigms, despite all good intentions of professionals, the state only allows people to make use of publicly funded residential care facilities as a kind of ‘last resort’ (see Department of Welfare, Public Health, and Family Affairs, 2013), and thus disability care continues to bear the consequences of the principle of subsidiarity, historical categorization, and intersectoral fragmentation of highly specialized care.

4 De-institutionalising dominant institutional logics in disability policy and practice: towards a socio-spatial professional orientation

4.1 De-institutionalising logics: dismantling residential care?

In order to de-institutionalise the historically dominant and problematic notion of de-institutionalisation in disability policy and practice, we rely on neo-institutional theory as a field of research that allows us to focus on an (alternative) meaning of ‘the institution’ (Meyer, 2008; Thornton, Ocasio & Lounsbury, 2012; Villadsen, 2013; De Pra Carvalho et al., 2017). In that sense, reference is made to institutional theorists (DiMaggio & Powell, 1991), such as Weber’s ‘Verstehende’ sociology of social institutions (Sennett, 2006) and their blind spots (Scott, 1998), in addition to Schütz's phenomenological analysis of the lifeworlds or ‘Lebenswelt’. This stand of research focuses on how knowledge systems, and particular beliefs and institutional logics in thought and action, are created and institutionalized in the course of history, and on how professional, organisational and institutional logics and structures in our societies are easily legitimised (Meyer, 2008; De Pra Carvalho et al., 2017). This conception of institutionalisation provides an explanatory ground for how professional knowledge systems and paradigms gain a foothold in various countries and societies, but also for the reluctance of organisations, societal systems and structures, and associated actors, to question those evidences and innovate their ways of thinking and acting. In doing so, organisations and institutions can be framed as closed rather than open systems of meaning making (De Pra Carvalho et al., 2017), including both features of stability and transformation.

This body of thought offers vital perspectives to learn from, and radically rewrite, the historical-genealogical dimensions of in disability policy and practice in Western societies. It makes us aware of the persistence of the ways in which even contemporary redevelopment and innovation strategies in disability services and organisations continue to fold back on the dominant understanding of that has historically been incorporated in disability policy and practice, which refers to the necessity of dismantling residential care institutions and their architectural hospital model-alike carcasses, and the transfer of disabled people to 'the community'. This logic is still vital in contemporary disability policy and practice reforms in the international realm, for example in the recently developed guidelines by the European Expert Group on the Transition from Institutional to Community-Based Care (EEGTICC) in 2019, or in the United Nations' 'Guidelines on Deinstitutionalization' of the Committee on the Rights of Persons with Disabilities in 2022.

Our contribution shows that our societies continue to reproduce architectural and spatial approaches conceived as hospital models or isolated care environments even when we renovate or build new care settings. Also powerful marginalisation, othering, and exclusive dynamics in all different domains and societal interactions in societies continue to be at stake. As the seminal work of Goffman (1961) and Foucault (1961) already indicates, however, disabled people have not only been marginalised and excluded from mainstream societal dynamics and interactions in 'total institutions' or 'asylums', but disablist policies and practices have also led to their segregation and marginalisation irrespective of the living environments in which they live (see Goodley et al., 2019; Remmery et al., 2022). These findings however refer to aspects of stability in what has been institutionalised, yet lead us also to the necessity to embrace dynamics of transformation that are intrinsically part of contemporary 'institutions'. In that sense, the question is what should be transformed rather than dismantled and replaced?

4.2 Scenarios for re-institutionalisation: towards transforming care environments

One could argue that our historical-genealogical analysis of the process of triggers the key finding that the significance of how disabled people were 'othered' and systematically put 'out of place' in Western societies requires due attention (Masschelein & Verstraete, 2012; Kitchin & Wilton, 2003). These findings square with the recently emerging interdisciplinary perspective of critical disability studies (see Goodley et al., 2012, 2020; Vandekinderen & Roets, 2016), as an inspiring field of research that tackles individualist and biologically determinist/essentialist interpretations of disability (and impairment) often being the focus of medically oriented and other kind of professionals. In relation to the earlier mentioned critiques on the 'social model of disability', critical disability studies challenge translations of disability that reduce 'impairment' to essentialist assumptions, premised on pre-social ontology, pathology, and ideas of social death (Hughes, 1999). Since the phenomenon of intellectual disabilities is often framed as individual pathology, leading to the condition of people with intellectual disabilities not being accepted as fully human by the wider society, critical disability studies challenges the hard ontological existence of ‘abnormality’ (Goodley, Hughes & Davis 2012: 2). In contrast with essentialist social model understandings of ‘impairment’, it is stressed that impairment (e.g. of cognitive or intellectual disability) matters, and the impaired subject is recaptured as anti-essentialist, social, intrinsically interdependent, corporeal and in-process (Roets & Braidotti 2012; Feely, 2016).

This critical disability studies perspective suggests a useful framework for the field of social work, social care, and wider public service delivery. It allows us to tackle and transform forces and paradigms of segregation, normalization and even inclusion which have produced – through language, structure, discourse and practice – the very terms through which human beings are recognized as human or devalued as less than human, as a citizen or non-citizen (Braidotti, 2013). The key shift in the framing of de-institutionalisation is to be situated in transforming societal dynamics and interactions, including disability services and environments, rather than dismantling them and replacing disabled citizens to other places (such as ‘the community’). The challenge is to challenge the pathologizing gaze of society by creating particular historical, social, political and cultural conditions and circumstances through which “everyday norms, social policies, institutional arrangements, professional acts, family practices and personal values” might be changed (Goodley, Hughes & Davis 2012: 2).

An inspiring lens for the field of de-institutionalisation is thus to de-naturalise the meaning of ‘place’ (e.g. to think only about either residential care or care in the community) in terms of the creation of ‘space for care’ (Warming & Fahnøe, 2017; Kessl & Reutlinger, 2017; Spatscheck, 2019). The concept of ‘space’ refers not only to “just a passive container of life, but also as an active constituent of social relations” (Kitchin, 1998: 344). Indeed, space is socially produced in power relationships, dynamic and ambiguous, claimed and contested. Such a socio-spatial orientation enables us to gain a more in-depth understanding of “inclusionary and exclusionary processes” irrespective of the living environments of disabled people, as inclusion as well as exclusion can take place in every kind of environment (Warming and Fahnoe 2017, 3), and to re-institutionalise professional power-knowledge systems and paradigms in disability policy and practice.

This can be done, for example, by opening up and transforming, rather than merely dismantling, residential facilities through socio-spatial interventions, thereby transforming ‘monolithic care environments’ into differentiated ‘living environments’ that can respond to the diverse and ever-evolving desires, changing interdependencies, and aspirations of the most diverse people in society (Dermaut et al., 2020; Grunwald & Thiersch, 2009). In that vein, the work of protagonists of the French post-war institutional psychotherapy movement might be vital. Their basic argument entails that it was not the so-called ‘patients’ that had to be treated and cured, yet “the total institution that needed to be treated and cured”, a reconfiguration of the social which could be practiced anywhere (Robcis, 2021: 17). The idea was to profoundly rethink and transform the institution rather than closing it down, and “to constantly imagine and reimagine institutions that would produce (…) alternative, less hierarchical, and less oppressive social relations” (Robcis, 2021: 6). As an example, the work of the social pedagogue Fernand Deligny is relevant. Contrary to the dominant meaning of ‘Asylum’ as a place for isolation of those who are considered deviant from the norm, Deligny (1998) falls back on the etymological origin of ‘asylum’ (with lower case and with reference to the French word ‘asile’) as a refuge or sanctuary that offers protection, a place/space where asylum can be granted, where one can feel at home in the presence of very diverse people

(Masschelein & Verstraete, 2012). For the French educationalist, granting asylum therefore means repeatedly trying to respond to what occurs without predetermining a finality (tentative), and thus creating the circumstances (circonstances) and unlimited space to allow people to take the initiative, to appropriate a place in social interactions and living environments, to experience a sense of belonging and feel at home.

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