Article

Deinstitutionalisation and 'Home Turn' Policies: Promoting or Hampering Social Inclusion?

Christopher Hall [1], Suvi Raitakari [2,]* and Kirsi Juhila [2]

[1] Department of Social Work and Social Care, University of Sussex, UK; E-Mail: ch550@sussex.ac.uk
[2] Faculty of Social Sciences, Tampere University, Finland; E-Mails: suvi.raitakari@tuni.fi (S.R.), kirsi.juhila@tuni.fi (K.J.)

* Corresponding author

Abstract
By the end of the twentieth century, caring for vulnerable adults in the community had become a pervasive policy trend in the Western world. In this article, this policy is described in two phases: deinstitutionalisation and the 'home turn' that are reflected from the perspective of social inclusion. Deinstitutionalisation has meant large institutions and asylums being replaced by group homes and communal-supported housing units in the community. In the second and current phase, the 'home turn' emphasises well-developed community care, home-based services, everyone's right to have their own home, and having a valued place in the community. In this semi-systematic narrative review, the widely shared incentives, premises, and criticisms of deinstitutionalisation and the 'home turn' are mapped from the research literature. The special focus is on the possibilities of and hindrances to social inclusion in both policy phases. The research results are mixed and conflicting concerning social inclusion, but there exists a wide consensus that small housing units and supported housing with devoted workers enhance social inclusion better than big institutions. However, the prevalent view is that deinstitutionalisation has not fulfilled its promise of social inclusion, and although the 'home turn' is a step in the right direction, there are still problems in strengthening service users' involvement and creating inclusive and accepting communities.

1. Introduction

By the end of the twentieth century, caring for vulnerable adults in the community had become a pervasive policy aim in the Western world (Chow & Priebe, 2013; Hudson, 2019; Mansell, 2005; Novella, 2010; Pedersen & Kolstad, 2009; Priebe et al., 2009; Wiker et al., 2019). This 'community care' policy preceded an influential criticism, starting from the 1950s, towards total institutions that were deemed to be inhuman (e.g., Goffman, 1969). In its first phase, the policy of 'care in the community' meant that large institutions and asylums, such

as psychiatric hospitals and homelessness shelters, were largely replaced by group homes and supported housing units in neighbourhoods (Fakhoury & Priebe, 2007). In the second and current phase, the emphasis is on permanent flats and housing in ordinary residential areas with home- and community-based support services (e.g., Šiška et al., 2018; Walker & Thunus, 2021). For our purposes, we call this second policy phase the 'home turn.' Today, these two policy phases—deinstitutionalisation and the 'home turn'—are overlapping, yet the 'home turn' is strengthening and is increasingly seen as a primary policy choice. These policy phases have had major

consequences for vulnerable adults' housing conditions and support arrangements, social relationships and societal roles, even though social inclusion has not been the only driver of the policy. As Bostock et al. (2004, p. 41) argue, deinstitutionalisation has been represented as a major step towards the social inclusion of people residing in institutional care. We state that social inclusion is a demanding yet essential precondition for the wellbeing of vulnerable adults. Hence social and health care policies are necessary to evaluate especially from that point of view (see Šiška et al., 2018).

The 'care in the community' policy has decreased the number of beds in psychiatric hospitals and increased the number of supported housing, community care, and home-based services (e.g., Emerson & Hatton, 2005; Pedersen & Kolstad, 2009). This has resulted in dispersed service systems and various conceptualisations, resulting in different responses to supported living and social inclusion in the community. Lambri et al. (2012, p. 2) summarise the variety of accommodation, housing solutions and support models as follows:

> Briefly, models of supported accommodation include communal group homes and hostels with onsite support workers; therapeutic communities; independent living supported housing schemes for people with mental health problems through self-contained accommodation located in one building or site, with onsite support workers during office hours; independent tenancies in general needs housing with outreach workers or floating support visits regularly.

The ways in which community care has been organised and defined vary according to local and national contexts and times. As can be drawn from the various conceptualisations above, housing and support services are connected to each other in many ways, and what is called 'supported housing' or 'supported accommodation' can take on different forms of service provision (e.g., Bostock et al., 2004; Emerson, 2004; McPherson et al., 2018; Šiška et al., 2018; Wiker et al., 2019, p. 211).

In this semi-systematic narrative literature review article, which is based on the research literature on deinstitutionalisation and the 'home turn' from the 1990s onward, we ask: (1) What kinds of supportive and critical evaluations are presented on the 'care in the community' policy at its two phases? (2) What do the evaluations tell about reaching the aim of social inclusion?

We narrowed our considerations to services targeted at working-age adults living in vulnerable life situations and suffering from, for example, mental and substance abuse problems and being at risk of homelessness (Kuluski et al., 2017). Much of the deinstitutionalisation and community care literature concerning working-age adults analyses changes in adult psychiatric services, yet there is also research on services for people with intellectual disabilities (e.g., Emerson, 2004; Tøssebro, 2016). We are not aiming at country-specific descriptions, but instead focused on uncovering general premises and policy shifts in the care, support, and housing services targeted at adults with multiple service needs.

The article is structured as follows: First, we clarify our theoretical viewpoint on the policy of 'care in the community' and describe how we conducted the semi-systematic narrative literature review. Then we introduce the incentives, premises, and reflections as well as critics of the deinstitutionalisation phase. Second, we depict how the 'home turn' has developed in response to the shortcomings of the first phase of deinstitutionalisation and by the ambitions of recovery, self-determination, client-centredness and the 'right to home.' Throughout the narrative, while describing these two phases, we pay special attention to the social inclusion aspect. In the conclusion, we consider the limits, preconditions, and possibilities of the 'care in the community' policy to produce inclusive communities with socially integrated members.

2. Narrative Literature Review: Reaching the Aim of Social Inclusion in Two Policy Phases

Social inclusion is seen as a crucial element of human wellbeing and meaningful life. Inclusion is often presented as a key element in successful housing and living in the community. Šiška et al. (2018) define the concept as active presence in the community, contributing to the community and participating in one's own life. Possibilities to contribute to society are often referred to as having 'a valued role' (Wolfensberger, 2000). Quilgars and Pleace (2020, p. 5) adopt a broad focus and define social integration as formerly homeless people's ability "to live, work, learn, and participate in their communities to the extent that they wish to, and with as many opportunities as other community members." In summary, social inclusion can be understood as active citizenship, connectedness, and involvement in the community (see Raitakari et al., 2016). We understand social integration and social inclusion as parallel terms, but for consistency, we mainly use the term social inclusion in this article.

The 'care in the community' policy aims to provide safe and meaningful living and participation in ordinary neighbourhoods equally for everyone despite disabilities and/or vulnerable life situations and special care needs (Tøssebro, 2016; Walker & Thunus, 2021). It thus includes a promise of social inclusion, why it is crucial to reflect on whether this promise is fulfilled and, if not, what prevents its fulfilment. Research evidence concerning the issue is inconsistent and limited, as seen in the following findings section based on the literature review. Variety of the research evidence reflects the contradictory nature of deinstitutionalisation and 'home turn' in different contexts.

In mapping the supportive arguments and critical evaluations of deinstitutionalisation and 'home turn' policies, especially from the point of view of social inclusion, we have applied the basic ideas of a

semi-systematic narrative literature review (Green et al., 2006; Snyder, 2019). This review type fits well when studying complex and diverse research fields, and when reviewing every single article that could be relevant to the topic is simply not possible. A narrative literature review provides a comprehensive overview and helps to place existing information into perspective (Green et al., 2006; Snyder, 2019). In a narrative literature review, as Efron and Ravid (2018, p. 21) state:

> The reviewer gathers a broad spectrum of the literature written about the topic and synthesizes it into a coherent interpretation that highlights the main issues, trends, complexities, and controversies that are at the center of it. The author may also identify a potential direction for future research, problems that need to be explored, or possible applications for practice.

The reviewing task was challenging, as there is literature starting from the 1950s concerning criticism towards large institutions and the processes of deinstitutionalisation in different contexts. However, as our interest is in a more recent time when 'care in the community' has been established as a pervasive policy trend in the Western world, we have concentrated on peer-reviewed research articles published between 1990–2021, which can be seen to continue the earlier, often rather critical research tradition on institutions, asylums, and community care (e.g., Barton, 1976/2013; Goffman, 1969; Kugel & Wolfensberger, 1969; Scull, 1977). Furthermore, to manage the large material, we used accurate search words (deinstitutionalisation, home, home AND mental health, home AND learning difficulties, home-based services) and limited databases (Andor and Google Scholar), although this may have left some relevant contributions out of the review. Our aim is not to present all research done in the field but to describe the most common supportive and critical evaluations concerning the aim of social inclusion in two policy phases (deinstitutionalisation and 'home turn'). In other words, we concentrated on the evaluations that are repeated in many studies and are thus widely shared in the academic community. The repetition is marked in the text by listing many references to back up our findings and conclusions.

3. Deinstitutionalisation Policy and Social Inclusion

Although deinstitutionalisation has been a pervasive policy trend during the last decades, it is an inconsistent process with great variation within and between Western countries (e.g., Chow & Priebe, 2013; Keet et al., 2019; Mansell, 2005, 2006). As Salisbury et al. (2016, p. 1) state, there is no consensus on how deinstitutionalisation should be defined or what its key components and ways of implementation are, which has made the evaluation and comparisons of its success difficult. Despite its fragmentary nature and the political and ideologi-

cal differences of deinstitutionalisation (e.g., Cummins, 2020), some incentives, premises, and criticisms, as well as viewpoints regarding social inclusion, are common and recognisable.

3.1. Incentives and Premises of Deinstitutionalisation

As stated above, the core incentive for deinstitutionalisation has already been the strong criticism of institutions and asylums since the 1950s. It revealed such shortcomings in residential care as overcrowding, understaffing, underfinancing, isolating, and not taking individual needs into account, causing negative effects for inmates and patients living in institutions (Barton, 1976/2013; Kugel & Wolfensberger, 1969). Further, in more recent studies, institutions, and asylums are blamed for moving adults with vulnerabilities and complex needs to isolated areas 'outside' society, in various asylums, homelessness shelters and psychiatric hospitals. Although institutions had been established with a good intention at the time, they were later seen as poor in quality, overcrowded, and offering inhuman facilities (Cummins, 2020; Emerson & Hatton, 2005; Fakhoury & Priebe, 2007; Novella, 2010; Walker & Thunus, 2021). The segregation of vulnerable adults was partly seen as resulting from a cultural stigma connected to mental illnesses that enabled families and communities to abandon their sick members (Shen & Snowden, 2014, p. 4). Deinstitutionalisation has been associated with wider societal changes, such as progress and developments in medicine, client-centredness and recovery movements, economic incentives and political ambitions (Chow & Priebe, 2013; Hudson, 2019; Salisbury et al., 2016; Tuokkola & Katsui, 2018). Novella (2010, p. 223) depicts deinstitutionalisation as an 'expanding chain reaction' with various triggers:

> In a sort of expanding chain reaction, within two decades, all major Western countries were affected by a similar process of upheaval in their mental health systems: crisis of the old model, discussion of alternatives—often on the background of a growing social and media interest, and political involvement with new legislation or national guidelines, including variable fund provision for new model services' development.

In a large international study, Shen and Snowden (2014, p. 4) outline the power and meaningfulness of deinstitutionalisation, as well as its incentives:

> Deinstitutionalization is one of the major milestones in the care of people with mental, neurological, and substance use (MNS) disorders in the second half of the twentieth century. It is construed as an administrative apparatus that is designed to prevent chronic disability, uphold human rights, and reduce the cost of care.

Deinstitutionalisation gained strength from optimism arising from a new treatment. Antipsychotic medications introduced from the 1950s onwards made it possible to reduce institutional placements because they were able to stabilise service users' conditions (Fakhoury & Priebe, 2007; Pedersen & Kolstad, 2009; Salisbury et al., 2016; Wiker et al., 2019). However, the need to reduce treatment costs and develop alternative and more cost-effective services has spurred deinstitutionalisation (Cummins, 2020; Priebe et al., 2009; Wiker et al., 2019). In some contexts, the development of public welfare services, such as disability pensions and publicly supported housing, has increased the possibilities for adults with complex needs to live independently in the community (Keet et al., 2019; Pedersen & Kolstad, 2009). This was linked to the recognition of the lack of civil rights and opportunities for normal life in institutional care settings (Emerson & Hatton, 2008; Keet et al., 2019; Wiker et al., 2019). Overall, the protection of human rights has been a key driver of the deinstitutionalisation and development of community care services (Keet et al., 2019, p. 4). Nowadays, it is a widely shared view that community settings are more humane, offer a better quality of life, and provide more opportunities for social inclusion than long-term living in institutional care (Emerson, 2004; Newton et al., 2000; Shen & Snowden, 2014).

3.2. Critics of Deinstitutionalisation Regarding Social Inclusion

Although deinstitutionalisation has undoubtedly had many positive impacts on service users' rights and welfare, it has also created some problems (Beadle-Brown & Forrester-Jones, 2003; Cummins, 2020; Lamb, 1993; Mansell, 2005, 2006; Salisbury et al., 2017). Significant numbers of individuals with mental health problems are homeless, in prisons, and experiencing a cycle of discharge and readmission (the 'revolving door'; see Lamb, 1993). Instances of abuse and neglect can also occur in community-based settings (Salisbury et al., 2017). There is a risk that adults with severe or acute mental health problems may be forced to stay in community settings, even in situations where they are in real need of institutional care. In addition, problems of deinstitutionalisation relate to undeveloped and poor-quality supported housing and community care services, as well as to stigmatisation and isolation (Mansell, 2006).

Community care services are argued to not correspond to actual demands and needs (Kovess-Masféty et al., 2006; Lambri et al., 2012; Wiker et al., 2019); they are too limited, short term, and rigid in response to the comprehensive needs of service users, shifting from managing psychotic symptoms to managing their own affairs and relationships in the community (Kovess-Masféty et al., 2006; Kuluski et al., 2017). Hence, the main criticism is that although institutional care has been significantly reduced, community care services are fragmented and under-resourced (Cummins, 2020; Shen & Snowden,

2014). Scarcity of resources is setting the intended objectives of the policy of 'care in the community' at risk. When community care services are insufficient, there is a risk that service users, families, friends, and neighbours are obliged to take too much responsibility for managing and supporting service users' everyday lives in the communities (Kuluski et al., 2017). It has been argued that service users are often left alone without support, with too high expectations of recovery and coping. Indeed, it is an overoptimistic expectation that merely living in the community would increase wellbeing, social life, safety nets, and inclusion (Beadle-Brown et al., 2007; Stancliffe & Lakin, 2006).

Furthermore, deinstitutionalisation has often resulted in the creation of residential homes where service users are offered a flat or room in an institution-like setting. These group homes are typically targeted at people suffering from similar problems, and geographically located in remote areas in a neighbourhood and, thus, may carry stigma and create prejudice. The neighbourhoods also often resist group homes being situated nearby, which is called a NIMBY (not in my backyard) phenomenon (e.g., Lyon-Callo, 2001). Because of the institution-like surroundings and possible prejudices, moving out of these group homes and taking part in social activities is challenging, or even impossible, creating risks of isolation and loneliness. The experiences of living in group homes regarding being stigmatised as the 'other' and an 'outsider' may not be that different from the experiences of those who have lived in 'total' institutions (e.g., Bild & Gerdner, 2006). Although service users usually have regular contact with workers and fellow service users in group homes, many residents have only limited contact with other friends and family members (Ashley et al., 2019; Priebe et al., 2009).

If service users with complex service needs are now supposed to live in the community instead of institutions, but their social contacts are limited to the residents and workers of group homes, deinstitutionalisation has not been able to fulfil the promise of the social inclusion and equality of all people (e.g., Beadle-Brown et al., 2007; Davidson et al., 1996). Fakhoury and Priebe (2007, p. 314) sum up the difficulties that mental health patients face in communities and the shortcomings of deinstitutionalisation policy:

> Original expectations that community care would lead to the full social integration of people with severe mental illnesses have not been achieved. The majority of patients with severe illness are still without work, have limited social contacts, and often live in sheltered environments. Services in the community sometimes provide a new 'ghetto' for the mentally ill, where patients meet each other but have little contact with the rest of the community. It has been argued that instead of 'community psychiatry,' reforms have established a 'psychiatric community.'

It has also been questioned whether major changes have actually occurred in frontline work among service users. In many cases, institutional care has only changed location, for instance, from mental hospitals to prisons, homelessness shelters, and custodial institutions (Priebe et al., 2005). Even if institutions are closed, institutional, and coercive practices are still in use in many settings (Cummins, 2020). This permanence is called 'transinstitutionalisation' or 'reinstitutionalisation,' meaning that restrictive and oppressive institutional care just emerges in new locations in the community, such as various supported housing units (Davidson et al., 1996; Fakhoury & Priebe, 2007; Priebe et al., 2005, 2008; Shen & Snowden, 2014, p. 5). There are also conflicting views on what is seen as a marker of deinstitutionalisation and what indicates reinstitutionalisation (Salisbury et al., 2016, p. 8).

Critical and doubtful arguments seldom question the main premise or aim of deinstitutionalisation per se. Thus, the policy itself is seen as clearly worth supporting, and the criticism is mainly targeted at its unsuccessful or unfinished implementation, highlighting the problems, shortcomings, and risks in the realisation of deinstitutionalisation (see Fakhoury & Priebe, 2007; Mansell, 2006). As Shen and Snowden (2014, p. 5) conclude: "The lack of synchronicity in closing or downsizing institution-based services with scaling-up community-based services has engendered a whole host of problems." The shift from institutional care and housing to community settings has only partly been achieved (e.g., Beadle-Brown et al., 2007). The societal transformation process is perceived as incomplete because of failures, gaps, and problems with the availability, performance, and suitability of community care and supported housing. This 'failure discourse' of deinstitutionalisation points towards the second phase of 'care in the community,' which comprises extending community care, especially home-based services, and everyone's right to have their own, permanent home. We call this policy the 'home turn.'

4. The 'Home Turn' and Social Inclusion

Since the turn of the millennium, various types of home-based support services, such as mental health and substance abuse floating support and home care, have increasingly been developed to support vulnerable adults and help them live independently in their own homes (Keet et al., 2019; Magnusson et al., 2003; Sawyer et al., 2009). In homelessness policy, there has been an ongoing gradual shift from a 'treatment first' model, where service users live in fixed-term, communal settings before getting their own home, to a 'housing first' model, where directly permanent housing for homeless people is offered (Bild & Gerdner, 2006; Padgett, 2007; Tsemberis, 2010; Y-Foundation, 2017). Strong support for the 'home turn' comes from research on the 'housing first' models, which emphasise respect for choice regarding both housing and services, harm reduction, empowerment, and inclusion (e.g., Hansen Löfstrand &

Juhila, 2021; McPherson et al., 2018). Studies on the 'housing first' model demonstrate consistent evidence for improvements in housing retention and stability and, where appropriate, often diminishing use of clinical services (McPherson et al., 2018). Yet these findings should be generalised with caution regarding different contexts and situations of vulnerable adults.

4.1. Triggers, Principles, and Benefits of the 'Home Turn'

The 'home turn' policy emphasises a human right to housing; here, it is believed that everyone should have their own affordable and safe place to live, regardless of economic status, life situations and care needs (Magnusson et al., 2003; Padgett, 2007). This policy also emphasises several other philosophical underpinnings, such as client-centred care, self-determination, freedom of choice and flexibility, individualisation, and voluntary-based services (Keet et al., 2019; Lydahl & Hansen Löfstrand, 2020; Magnusson et al., 2003; Wiker et al., 2019, p. 211). One premise is to advance the normality and ordinary life of people living in vulnerable and complex life situations by enabling them to have their own private space and promoting active participation in one's everyday life in and around home (Beadle-Brown et al., 2007; Magnusson et al., 2003; Padgett, 2007). Home-based services, well-resourced public services, and benefits are considered to address everyone's basic human needs and support social inclusion in the community. The 'home turn' is realised in a way where housing and support are not bundled up in one care package provided by onsite facilities. Instead, services are increasingly brought to service users' homes alongside outpatient clinical and office-based services.

The most apposite justification of the 'home turn' is that people often want to live as independently as possible in their homes (e.g., Burns et al., 2006; Davidson et al., 1996; Padgett, 2007). There is evidence that living in independent and scattered housing instead of institutions and group homes advances one's experience of autonomy, stable family contacts, belonging, and ability to use local services (De Heer-Wunderink et al., 2012; McConkey, 2007; Padgett, 2007; Stancliffe & Lakin, 2006). As McConkey and Collins (2010, p. 691) mention: "Past studies have found that people supported in more individualised housing options tend to have higher levels of community participation and wider social networks than those in other accommodation options." Having one's home, status as a tenant, and being a user of ordinary public services strengthen social inclusion in the community.

The 'home turn' is also seen to avoid hospitalisation if home-based services are well-resourced and intensive. For example, Burns et al. (2006) identify six components of effective home-based care for people with mental problems: small case loads, regularly visiting at home, a high percentage of contacts at home, responsibility for health and social care, multidisciplinary teams,

and a psychiatrist integrated in the team. The 'home turn' has the potential to improve service accessibility, especially if workers conduct home visits. When workers enter the service users' homes and, hence, do not need to travel for appointments or treatments, disabilities do not hinder the service uptake. It has also been argued that the home space brings a positive atmosphere for service user–worker interaction and communication (see, e.g., Juhila et al., 2020, 2021; Raitakari et al., 2018; Ranta & Juhila, 2020). The home space may equalise power relations between service users and workers, facilitating therapeutic relationships (Kuluski et al., 2017; Magnusson et al., 2003). Homes are service users' own territories, so they also have the position of a host, not just a service user (Juhila et al., 2016, 2021).

The home space also enables discussions that are relevant to service users' everyday lives. For instance, it can create opportunities to discuss personal issues and memories related to pets and material artefacts, such as paintings and photos, which can be brought into home visit interactions (Juhila et al., 2016, 2020). Accordingly, the home space may be more congenial than the office for sensitive discussions and troubling topics. For workers, the home space provides a lot of information related to service users' wellbeing, strengths, and lifestyles (Juhila et al., 2020; Magnusson et al., 2003). It reveals what is meaningful, essential, and potentially difficult in their everyday lives. Thus, home visits become a vital working and information-gathering encounter. Workers entering service users' homes are justified, among other things, by the importance of meeting service users in their own contexts and learning their abilities to function at home and in the community (Magnusson et al., 2003; Muzicant & Peled, 2018; Winter & Cree, 2016).

4.2. Doubts and Limits of the 'Home Turn' Regarding Social Inclusion

There are many benefits of the 'home turn.' However, it has also been questioned. The 'home turn,' such as institutionalisation and deinstitutionalisation, can mean experiences of being the stigmatised 'other' and an 'outsider' in the neighbourhood (Padgett, 2007). It is not easy to create relationships, for example, with neighbours if they are nonresponsive or even hostile. If moving out of home and taking part in social activities are challenging, there is a risk of isolation. Overall, social inclusion in the community is not possible if the community itself is not inclusive and welcoming.

There are also problems getting the necessary services outside the home. Especially, service users with complex and special needs who require integrated and intensive health and social care interventions instead of occasional service encounters tend not to find their places in the fragmented system of outpatient community services (Kuluski et al., 2017; Novella, 2010). On occasion, adults in vulnerable life situations are stuck in their homes against their own will because of the reduction of institutional care. The 'home turn' benefits more competent service users with less severe conditions and limited service needs. The advantage of institutional care is that it allows all-inclusive care packages in which nutrition, housing, medical, and social care, rehabilitation, and social activities are provided onsite, whereas in community care, these services are usually provided by different service providers, often in different locations (Novella, 2010).

Furthermore, there are doubts about home-based services conducted via home visits. For instance, the so-called hard-to-reach service users—who are not cooperating participants in their care and support processes and who do not let workers enter their homes or respond to calls—are not seen as benefiting from home-based support services but as in danger of drifting outside the existing, unfit service systems (see Saario et al., 2021). It is also problematic that service users need to compromise the privacy of their home spaces and the rights to govern it when workers bring along their professional tasks, working tools, and expectations to the home space (Juhila et al., 2016; Winter & Cree, 2016). Thus, in extreme cases, the 'home turn' can mean an intrusion of the 'institutional' paternalistic and controlling practices to home spaces, even though they were originally planned to be demolished in the 'community of care' policy (Fallow & Nissen, 2019; Hall, 2011). In every case, it is unavoidable that visiting workers will not only be guests but also professionals with responsibilities to ensure service users' safety and support their wellbeing, always somehow weakening service users' self-determination in their own homes (Fallow & Nissen, 2019; Muzicant & Peled, 2018). This can involve, for example, the use of normalising power (Foucault, 1982). Juhila et al. (2020, p. 13) point out workers' power in service users' private space:

> Observing and commenting on the clients' home environments does not just reflect sensitive and skilful ways to interact and use 'soft' power; it is also highly hierarchical and coercive, involving strong cultural norms and assessments of what is considered a normal enough home and living environment and what is condemned as too deviant to be acceptable.

Home space is also recognised as a potentially risky and unsafe environment for both service users and workers (Denton et al., 2002; Kuluski et al., 2017; Pink et al., 2015; Sawyer et al., 2009). For instance, service users can fall down, or their conditions can deteriorate without anyone knowing. They can cause a fire or damage the residence in another way. For workers, home as a workplace may mean exposing themselves to unpleasant smells, dirt, messiness, and bugs (e.g., Muzicant & Peled, 2018). They cannot know what they will confront in home spaces and how home visits will proceed (Denton et al., 2002; Juhila et al., 2021): Service users may be intoxicated, agitated, sleeping, or undressed, or there

can be other people present besides the service users. In the 'home turn,' workers lose their 'professional territories,' such as office rooms or wards, and take on the burden of being on the move from one home to another (Muzicant & Peled, 2018). Sawyer et al. (2009, p. 363) argue how the 'home turn' intensifies the risks of community care:

> It is also important to note that both de-institutionalization and NPM [new public management] have significantly intensified the risks community care professionals and their employers face in their daily operations. Risks were previously absorbed within the routines and procedures of state-run and charitable institutions.

5. Conclusion

In the present article, we described two phases of the 'care in the community' policy: deinstitutionalisation and the 'home turn.' Deinstitutionalisation has seen large institutions and asylums replaced by group homes and communal-supported housing units in the community (Cummins, 2020). The second phase, the 'home turn,' emphasises well-developed community care services and everyone's right to have their own home. Accordingly, care and support are brought to the service users' homes and provided in outpatient health and social care settings. Although these two policy phases—deinstitutionalisation and 'home turn'—exist side by side, the 'home turn' represents the future direction of the 'care in the community' policy. From the literature, we have mapped widely shared incentives, premises, and criticisms of deinstitutionalisation and the 'home turn.' In addition, we have reflected on the possibilities of and hindrances to social inclusion in both policy phases. There exists a wide consensus that small housing units and supported housing with devoted workers enhance social inclusion better than big institutions.

The two policy phases can be interpreted either positively or negatively. It is important to pose, for instance, the question of whether home-based support services achieve security, wellbeing, and quality of life for the service user. Although home-based services are a strengthening way of providing services, they should not be taken as a given solution for every vulnerable adult with complex needs because needs are different and individual circumstances change (e.g., Tuokkola & Katsui, 2018, p. 17). In the 'care in the community' era, there is still a place for institutional care and housing (Chow & Priebe, 2013).

Research on the 'care in the community' policy with various accommodation, care, and support solutions often displays opposing conclusions, with little unanimity, leaving workers and policy makers with little guidance as to which models work and for whom (Mansell, 2005; McPherson et al., 2018; Priebe et al., 2009; Wiker et al., 2019). Hence, it is not surprising that the discussion on deinstitutionalisation has often emphasised polarised

positions, such as the expansion of hospital care or its elimination, rather than searching for an optimal balance and integration of diverse service modalities (Hudson, 2019, p. 70). 'Either or' policy does not enable, for example, service users' smooth movements back and forth between institutional care and staying at home according to changing support needs. Future research on what types of service, support, and housing models are the most helpful for particular service users is clearly needed, along with what kinds of innovations are needed to provide better care and support in the community and service users' homes (Mansell, 2005; Priebe et al., 2009, p. 814). The possibilities and limits of the 'care in the community' policy are also questions that need to be studied more from a grassroots perspective, from the service users' and workers' points of views, and the encounters between them (e.g., Davidson et al., 1995, 1996; Juhila et al., 2016; Kuluski et al., 2017).

The central question in community care is how to balance providing the necessary care and protection for service users, on the one hand, and fulfilling the aims of normalisation, choice, self-determination, and social inclusion, on the other hand (Lambri et al., 2012). Occasionally, these aims settle in a conflicting way, causing an ethical burden to workers (e.g., Magnusson et al., 2003). It seems that the biggest challenge for the 'care in the community' policy is to ensure full social inclusion of the most excluded service users. The pervasive view is that deinstitutionalisation has not fulfilled its promise of social inclusion (e.g., Ashley et al., 2019, p. 699). Although the 'home turn' is a step in the right direction, there are still problems in strengthening service users' involvement and creating inclusive and accepting communities. Social inclusion may be the Achilles heel of 'care in the community' policies. Accordingly, advancing social inclusion could be seen as the third phase, or next step, of the 'care in the community' policy. For example, in Padgett's (2007) study, in their personal lives, former homeless service users recognised the 'next step' challenge after settling down into their own homes: Traumas, adversity, societal stigma, and discrimination make engagement with others in the community demanding.

Priebe et al. (2009, p. 811) make a crucial point by stating that "the lack of social contacts outside the housing project and of regular work may be more a result of the severity of many patients' disability than of insufficient support through staff in the housing services." Service users' ability to function and engage with others is an important factor to consider when assessing and supporting social inclusion. The question of what is sufficient and wanted from the service user's viewpoint regarding social inclusion in each case also becomes crucial. Another relevant factor to take into consideration is the workers' possibilities, skills, and abilities to promote social inclusion at the frontline of care and support in the community. Better implementation of the 'care in the community' policy relies considerably on workers'

possibilities, efforts, and skills to enhance social inclusion, not so much on the accommodation and care models per se (McConkey & Collins, 2010).

Advancing practices that are in line with the 'care in the community' policy require, among other things, a renewed focus on the training of and support for frontline workers (Mansell, 2005, p. 25), as well as developing leadership and resources to facilitate workers' social inclusion work. Workers' contributions and endeavours to facilitate social inclusion have received relatively little attention in research and in implementing 'care in the community' policy (McConkey & Collins, 2010, p. 691). However, research that examines the everyday practices of the 'home turn' shows the skill, creativity, commitment, and willingness to 'do good' for the service users, as well as the control and presence of power in encounters (e.g., Brodwin, 2013; Juhila et al., 2016, 2021; Kuluski et al., 2017; Lydahl & Hansen Löfstrand, 2020; Magnusson et al., 2003; Raitakari et al., 2018; Ranta & Juhila, 2020; Sawyer et al., 2009). The 'home turn' is indeed a demanding and comprehensive change process that requires major financial investments and human resources. It influences the locations, frameworks, and practices of care and support work, as well as service users' positions in the community. Thus, it requires persistent development, time, and support from all participants—policymakers, managers, service users, frontline workers, and researchers—to take the next step towards full inclusion of all members of the community.

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Conflict of Interests

The authors declare no conflict of interests.

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About the Authors

Christopher Hall is Visiting Senior Research Fellow at the Department of Social Work and Social Care at Sussex University, having held research posts at Durham, Huddersfield and Bristol universities. His research examines policy and practices in child welfare and mental health, especially professional-client interaction. He is currently engaged in research on home visits in social work and social care.

Suvi Raitakari is Senior Lecturer in social work at the Faculty of Social Sciences, Tampere University, Finland. Her research covers issues, such as worker-client interaction in multiparty meetings, homelessness pathways, and home-based service encounters and vulnerability. She is a member of the Margi Research Group, and currently leads research projects concentrating on Covid-19 at the margins of the welfare state.

Kirsi Juhila is Professor in social work at the Faculty of Social Sciences, Tampere University, Finland. Her research interests include institutional interaction in social welfare settings and the issues of user participation, social exclusion, marginalisation and homelessness. She has methodological expertise in discourse analytic approaches. She is a member of the Margi Research Group and currently leads research projects concentrating on home visit interactions at the margins of welfare and on the processes of forced relocation of public housing residents.