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SOCIAL INTEGRATION AND DEINSTITUTIONALIZATION: CONTEMPORARY CHALLENGES AND PATHWAYS FOR THE INCLUSION OF PERSONS WITH DISABILITIES

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ABSTRACT: *The paper examines the relationship between social integration, deinstitutionalization, and the inclusion of persons with disabilities in contemporary society. It aims to provide a theoretical and policy-oriented perspective on the transformation of social care systems and the shift toward community-based services. The analysis is structured around key concepts such as accessibility, participation, autonomy, and social capital, which frame the evolution from a medical to a biopsychosocial model of disability. The paper argues that effective integration requires not only the development of community support networks, but also a change in social attitudes and institutional culture. Emphasis is placed on the role of social policies in promoting human rights, dignity, and active citizenship, as well as on the need for interdisciplinary approaches that connect social work, education, and public health. Through a conceptual synthesis of policy frameworks and contemporary theories of social inclusion, the paper highlights the main challenges and strategic directions for strengthening social cohesion and supporting the independent living of persons with disabilities.*

Key words: *social integration; deinstitutionalization; disability; inclusion; social policy.*

1. Introduction

Institutionalization has historically constituted a central pillar of social protection systems designed to respond to the needs of persons with disabilities and other vulnerable groups [1]. For much of the twentieth century, institutional care was regarded as a legitimate and efficient solution for ensuring protection, supervision, and access to basic services, particularly in contexts characterized by limited community resources and dominant medicalized understandings of disability. However, the long-term effects of institutionalization have increasingly been questioned in the scientific literature, especially concerning social exclusion, dependency, loss of autonomy, and diminished quality of life [2].

Over the past decades, a substantial body of interdisciplinary research has documented the social, psychological, and structural consequences of institutional care, highlighting its limited capacity to support meaningful social integration and participation [3]. These findings have contributed to a paradigm shift in both theory and practice, reinforcing the transition from institutional models toward community-based systems of care. Deinstitutionalization has thus emerged not merely as an organizational reform, but as a profound transformation in the philosophy of social intervention, closely linked to human rights, social inclusion, and active citizenship [4].

At the policy level, deinstitutionalization has been strongly promoted by international and European frameworks, particularly those advancing a rights-based and biopsychosocial approach to disability. Documents and strategies developed under the auspices of organizations such as the World Health Organization and the European Union emphasize independent living, participation in community life, and equal access to mainstream services as core principles of social policy [5,6].

These orientations reflect a growing recognition that disability is not solely an individual condition, but a socially constructed phenomenon shaped by environmental, attitudinal, and structural factors [5].

Despite these normative commitments, the implementation of deinstitutionalization policies remains uneven and often contested. The persistence of institutional cultures, insufficient community services, limited intersectoral coordination, and enduring social stigma continue to pose significant challenges to effective social integration [7]. Moreover, the transition from institutional to community-based care does not automatically guarantee inclusion, particularly in the absence of coherent social policies, adequate funding, and sustained professional support.

In this context, the relationship between institutionalization, deinstitutionalization, and social integration requires ongoing critical examination. Understanding these processes as interconnected dimensions of social care reform allows for a more nuanced analysis of both their potential and their limitations. The present article contributes to this debate by examining institutionalization and deinstitutionalization as key mechanisms shaping the social integration of persons with disabilities, situating the discussion within contemporary theoretical perspectives and policy frameworks. By doing so, it aims to highlight the structural conditions and strategic directions necessary for strengthening inclusive social care systems and promoting genuine community participation.

2. Conceptual and Theoretical Framework

2.1. Social Integration and Deinstitutionalization

Social integration constitutes a core concept in contemporary social sciences and social policy, referring to the extent to which individuals are able to participate meaningfully in social, economic, cultural, and civic life [8]. Within the field of disability studies and social work, social integration is closely linked to concepts such as participation, autonomy, social capital, and community belonging [9]. Rather than implying mere physical presence in the community, integration presupposes access to social roles, reciprocal relationships, and equal opportunities within mainstream social structures.

Deinstitutionalization has emerged as a key strategy for promoting social integration, particularly for persons with disabilities who have historically been segregated in residential institutions [1]. The literature emphasizes that deinstitutionalization should not be understood solely as the physical relocation of individuals from institutional settings to community environments, but as a multidimensional process involving structural reform, service transformation, and cultural change [10]. Empirical studies have demonstrated that long-term institutionalization is associated with social isolation, dependency, and limited opportunities for self-determination, whereas community-based living arrangements can contribute to improved quality of life, social functioning, and subjective well-being, provided that adequate support systems are in place [2,12].

At the same time, research cautions against overly simplistic interpretations of deinstitutionalization. The transition to community living does not automatically result in social integration, particularly in contexts characterized by insufficient services, fragmented support networks, or persistent social stigma [3]. In this sense, deinstitutionalization represents a necessary but not sufficient condition for integration. Its success depends on the availability of accessible community services, professional support, inclusive social policies, and favorable societal attitudes [12]. From a theoretical perspective, this underscores the need to conceptualize social integration and deinstitutionalization as interdependent processes embedded within broader social and policy frameworks.

2.2. Institutionalization and Social Care Systems

Institutionalization has traditionally functioned as a dominant organizational model within social care systems, reflecting broader societal responses to vulnerability, dependency, and perceived social risk [14,15]. Large-scale residential institutions were designed to centralize care provision, standardize interventions, and manage populations considered unable to live independently. While such systems were often justified in terms of efficiency, protection, and professional control, critical scholarship has highlighted their structural limitations and unintended consequences [14].

From a sociological and social policy perspective, institutionalization tends to reinforce hierarchical power relations between care providers and beneficiaries, limit personal autonomy, and prioritize organizational routines over individual needs [16]. The homogenization of care practices within institutional settings often neglects personal histories, preferences, and social identities, thereby undermining the prospects for social integration. Moreover, institutional care has been shown to produce forms of secondary exclusion, as individuals become disconnected from community networks, labor markets, and informal social relations [3,14].

Contemporary social care reforms increasingly challenge institutional models, advocating instead for diversified, community-based systems that emphasize person-centered planning, individualized support, and intersectoral collaboration [1,17]. This shift aligns with broader transformations in welfare state governance, including decentralization, deinstitutionalization, and the expansion of mixed welfare regimes involving public, private, and non-governmental actors. Within this context, social care systems are expected not only to provide protection and support, but also to actively facilitate social inclusion, participation, and empowerment.

Nevertheless, the persistence of institutional practices within reformed systems highlights the resilience of institutional logics and the difficulties inherent in systemic change. Institutionalization can re-emerge in new forms, such as segregated housing, over-medicalized services, or overly standardized community programs [18]. Theoretical analyses therefore emphasize the importance of examining institutionalization as a dynamic process that extends beyond physical settings and encompasses organizational cultures, professional practices, and policy discourses.

2.3. Disability and Social Inclusion

The conceptualization of disability has undergone significant transformation over recent decades, moving from an individual and deficit-oriented understanding toward a relational and socially grounded perspective [4]. Contemporary theories of disability emphasize the interaction between individual impairments and social, environmental, and attitudinal barriers [5]. Within this framework, social exclusion is not viewed as an inevitable consequence of disability, but as the result of structural inequalities and discriminatory practices embedded in social systems.

Social inclusion represents a central normative goal of disability policy and practice, encompassing equal access to resources, opportunities, and rights, as well as recognition of diversity and human dignity [19,5]. Inclusion implies that persons with disabilities are supported to live independently, participate in community life, and exercise control over decisions affecting their lives. This approach is strongly reflected in international and European policy frameworks, which promote inclusive education, employment, housing, and social services as key dimensions of social cohesion [19,6].

The relationship between disability, social inclusion, and deinstitutionalization is therefore fundamentally interconnected. Institutionalization has historically functioned as a mechanism of exclusion, separating persons with disabilities from mainstream social life and reinforcing stigmatizing representations [14,25]. Deinstitutionalization, when grounded in inclusive policies and supported by adequate community services, offers the potential to dismantle these exclusionary structures. However, the literature consistently highlights that inclusion requires more than structural reform; it necessitates changes in social attitudes, professional practices, and power relations [4,7].

From a theoretical standpoint, the integration of disability studies, social policy analysis, and social work theory provides a comprehensive framework for understanding these processes [20]. By situating disability within broader social systems and policy contexts, this perspective enables a critical examination of how institutional arrangements, care practices, and inclusion strategies shape the lived experiences of persons with disabilities. Such an approach is essential for informing evidence-based policies and for advancing social care models that are both effective and ethically grounded.

3. Institutionalization as a Social Response

3.1. Forms and Functions of Institutional Care

Institutional care has historically functioned as a structured social response to vulnerability, disability, and long-term dependency, emerging at the intersection of welfare policy, medical practice, and social control [14,15]. Large residential institutions were designed to centralize care provision, concentrate professional expertise, and ensure continuous supervision of individuals deemed unable to live independently within the community. From this perspective, institutionalization was justified as a protective and rational solution, particularly in contexts marked by limited community resources and underdeveloped social services [22,21].

The primary functions of institutional care have traditionally included meeting basic needs, providing medical and psychosocial support, and maintaining public order by segregating populations perceived as socially or economically dependent [23]. Institutions also played an administrative role, allowing states to manage care provision through standardized procedures and hierarchical organizational structures. In many welfare systems, institutionalization became deeply embedded as a default response to disability and long-term care needs, shaping professional practices and public perceptions alike [24].

However, critical analyses have emphasized that the formal functions of institutional care often coexist with latent effects that undermine individual well-being and social participation [14,16]. While institutions may provide physical security and continuity of care, they frequently do so at the expense of personal autonomy, self-determination, and social identity. The routinization of daily life, rigid organizational rules, and limited opportunities for meaningful choice contribute to the erosion of individual agency and weaken the prospects for social integration beyond the institutional setting [16].

3.2. Risks of Exclusion and Dependency

A substantial body of empirical and theoretical research has documented the risks associated with long-term institutionalization, particularly in relation to social exclusion and dependency [1,3,14]. Prolonged residence in institutional settings is consistently linked to reduced social networks, limited community participation, and diminished life skills. As individuals become increasingly detached from family, labor markets, and informal social relations, institutionalization may generate forms of social isolation that persist even after discharge [24].

Dependency constitutes another central risk of institutional care. Institutional environments often foster reliance on professional staff for daily activities and decision-making, reinforcing passive roles and limiting opportunities for autonomy [14,16]. Over time, this dynamic can lead to institutional dependency, whereby individuals experience difficulties adapting to less structured environments and exercising independent choice.

Such processes are not merely individual outcomes, but are shaped by institutional cultures that prioritize control, efficiency, and risk management over empowerment and participation [16].

Moreover, institutionalization has been critically examined as a mechanism of social exclusion that reproduces inequality and stigma. By separating persons with disabilities from mainstream social life, institutions contribute to the normalization of segregation and reinforce societal attitudes that frame disability as incompatibile with community living [25,19]. This exclusionary logic is further amplified when institutional care is combined with limited access to education, employment, and community-based services, thereby constraining long-term inclusion trajectories [26].

The literature also highlights the phenomenon of transinstitutionalization, whereby individuals are transferred from one form of institutional care to another, such as forensic settings, nursing homes, or homeless shelters, without achieving genuine community integration [3,11]. This underscores the importance of understanding institutionalization not solely as a physical setting, but as a broader system of practices and policies that can perpetuate exclusion across different care environments.

3.3. Deinstitutionalization and Community-Based Alternatives

Deinstitutionalization has emerged as a strategic response to the recognized limitations and risks of institutional care, aiming to replace segregated residential models with community-based alternatives [1,10]. Conceptually, deinstitutionalization involves more than the closure of institutions; it entails a comprehensive reconfiguration of social care systems, including the development of individualized support services, accessible housing, and integrated community resources [17].

Community-based alternatives are grounded in principles of autonomy, participation, and inclusion, emphasizing support within natural living environments rather than segregated facilities [12]. These models include supported living arrangements, community outreach services, and multidisciplinary support networks designed to address diverse needs while maintaining social connectedness. Research indicates that, when adequately resourced and coordinated, community-based services can contribute to improved quality of life, greater social participation, and enhanced subjective well-being for persons with disabilities [2,12,27].

Nevertheless, the transition from institutional to community-based care presents significant challenges. Inadequate planning, insufficient funding, and fragmented service provision can undermine the objectives of deinstitutionalization and expose individuals to new forms of vulnerability [3,7]. The absence of accessible housing, employment opportunities, and community support may result in marginalization or unstable living arrangements, thereby reproducing exclusion in different forms [3].

Theoretical and policy-oriented analyses therefore stress that deinstitutionalization must be understood as a long-term, systemic process rather than a discrete policy intervention [1,18]. Its effectiveness depends on sustained political commitment, cross-sectoral coordination, and the active involvement of service users in decision-making processes [19]. When embedded within inclusive social policies and supported by cultural change, community-based alternatives offer a viable pathway for transforming social care systems and reducing the structural reliance on institutional responses.

4. Social Integration and Community Inclusion

4.1. Dimensions of Social Integration

Social integration is a multidimensional concept that encompasses individuals' participation in social, economic, cultural, and civic domains of community life [8]. Within contemporary social theory and social policy, integration is understood not as a static state, but as a dynamic process through which individuals establish social roles, build relationships, and gain access to resources and opportunities on an equal basis with others [8,19]. For persons with disabilities, social integration is closely linked to autonomy, self-determination, and recognition as full members of society [19].

The literature commonly distinguishes several interrelated dimensions of social integration. Structural integration refers to access to mainstream institutions such as education, employment, housing, and healthcare [19,5]. Relational integration emphasizes the quality and reciprocity of social relationships, including family ties, friendships, and community networks [9,13]. Functional integration concerns the ability to use public spaces, services, and infrastructures, while symbolic integration relates to social recognition, identity, and the absence of stigma and discrimination [25].

These dimensions highlight that integration cannot be reduced to physical presence in the community. Individuals may reside in community settings while remaining socially isolated, economically inactive, or excluded from meaningful participation [24]. Consequently, effective integration requires coordinated interventions across multiple domains, addressing both individual support needs and broader structural conditions [12]. This perspective reinforces the argument that social integration must be embedded within comprehensive social policies rather than treated as an ancillary outcome of deinstitutionalization [1].

4.2. Barriers to Integration

Despite policy commitments to inclusion, numerous barriers continue to hinder the social integration of persons with disabilities. Structural barriers include limited access to affordable and accessible housing, restricted employment opportunities, and fragmented service provision [26]. Inadequate transportation systems, inaccessible public spaces, and insufficient assistive technologies further constrain participation in community life [5].

Social and attitudinal barriers also play a significant role. Persistent stigma, discriminatory practices, and low expectations regarding the capacities of persons with disabilities contribute to social exclusion and marginalization [25,28]. Such attitudes may be embedded not only in broader society, but also within professional cultures and institutional practices, influencing decision-making processes and limiting opportunities for empowerment [16].

Another critical barrier relates to the legacy of institutionalization itself. Long-term institutional care often disrupts social networks, weakens life skills, and fosters dependency, making the transition to community life particularly challenging [1,14]. Without targeted support, individuals may struggle to navigate complex social environments, access services, or establish meaningful relationships [11]. Research has shown that these challenges are exacerbated when deinstitutionalization is implemented without adequate preparation, continuity of care, and community-based supports [3,7].

From a policy perspective, barriers to integration are frequently associated with insufficient intersectoral coordination. Education, employment, housing, health, and social services often operate in silos, resulting in fragmented interventions that fail to address the holistic needs of individuals [26,29].

This fragmentation undermines the potential of community inclusion strategies and reinforces patterns of exclusion.

4.3. Role of Social Services and Social Policies

Social services play a central role in facilitating social integration and community inclusion, acting as intermediaries between individuals, communities, and institutional systems [20]. Contemporary approaches emphasize person-centered planning, individualized support, and the active involvement of service users in decision-making processes [12,19]. Such practices aim to strengthen autonomy, build capacities, and support participation across multiple life domains.

Community-based social services are particularly critical in supporting transitions from institutional care. Outreach programs, supported living arrangements, and multidisciplinary teams can provide flexible and responsive support tailored to individual needs [2,12]. When effectively coordinated, these services contribute to continuity of care, reduce the risk of social isolation, and enhance opportunities for participation in education, employment, and community activities [13,27].

At the policy level, social integration is increasingly framed as a cross-cutting objective of social development and social cohesion strategies. European and international policy frameworks promote inclusive approaches that integrate disability considerations into mainstream policies, rather than confining them to specialized services [5,6,19]. In this respect, the policy orientation of the European Union emphasizes equal opportunities, accessibility, and participation as foundational principles of social inclusion [6].

However, the effectiveness of social services and policies depends on sustained political commitment, adequate funding, and robust governance mechanisms [29]. Policies that formally endorse inclusion may have limited impact if they are not accompanied by clear implementation strategies, monitoring systems, and professional training [29].

Moreover, the involvement of local communities, civil society organizations, and persons with disabilities themselves is essential for translating policy objectives into meaningful social change [19].

In sum, social integration and community inclusion represent complex and interdependent processes that require coordinated action at multiple levels.

By addressing structural, relational, and attitudinal barriers, and by strengthening the capacity of social services and policies to support participation and autonomy, social care systems can move beyond formal deinstitutionalization toward genuinely inclusive community-based models [1,19].

5. Contemporary Challenges and Policy Directions

5.1. Deinstitutionalization and Public Policy

Deinstitutionalization has become a central objective of contemporary social policies addressing disability and long-term care, reflecting a broader commitment to human rights, social inclusion, and community participation [5,6,19]. At the policy level, deinstitutionalization is no longer framed as a marginal reform of social services, but as a structural transformation of care systems that challenges long-standing institutional arrangements and professional paradigms [1,10]. This transformation is closely aligned with international and European policy frameworks that promote independent living, equal opportunities, and access to mainstream services [5,6,19].

Despite this normative consensus, the implementation of deinstitutionalization policies reveals significant gaps between strategic objectives and practical outcomes [11,29]. One of the main challenges lies in the persistence of institutional logics within reformed care systems. Even when large residential institutions are formally closed or downsized, institutional practices may continue to shape service delivery through highly standardized routines, limited user participation, and risk-averse professional cultures [18,14]. As a result, deinstitutionalization risks becoming a symbolic policy commitment rather than a substantive change in the lived experiences of persons with disabilities [7].

Another major policy challenge concerns the uneven development of community-based services. In many contexts, deinstitutionalization has advanced faster than the establishment of adequate community infrastructure, leading to situations in which individuals are discharged from institutions without sufficient housing, support, or access to essential services [3,11]. This policy imbalance not only undermines the goals of inclusion and autonomy, but also exposes individuals to new forms of vulnerability, including homelessness, social isolation, or involvement with the criminal justice system [3]. Such outcomes highlight the necessity of viewing deinstitutionalization as a coordinated, system-wide reform rather than a cost-reduction strategy [1].

From a governance perspective, effective deinstitutionalization requires strong intersectoral coordination across social services, healthcare, housing, education, and employment policies [29,26]. Fragmented policy frameworks and administrative silos frequently limit the capacity of public systems to respond to complex and intersecting needs. Consequently, contemporary policy debates increasingly emphasize the importance of integrated care models, shared accountability mechanisms, and participatory governance structures that involve service users and community stakeholders [19].

5.2. Human Rights, Dignity and Autonomy

The contemporary discourse on disability policy is fundamentally grounded in a human rights framework that places dignity, autonomy, and equality at its core [19]. This approach represents a decisive shift away from paternalistic models of care, which prioritize protection and control, toward rights-based models that emphasize choice, self-determination, and participation [4,19]. Deinstitutionalization is a key expression of this paradigm, as institutional care has historically been associated with restrictions on personal freedom, privacy, and decision-making [14].

Respect for human dignity implies recognition of persons with disabilities as autonomous subjects capable of making decisions about their own lives, with appropriate support when needed [19]. In this sense, autonomy should not be understood as complete independence, but as the ability to exercise meaningful choice within supportive social environments. Contemporary theories of supported decision-making challenge traditional assumptions about incapacity and dependency, advocating instead for legal and social frameworks that enable individuals to retain control over their lives [30].

However, translating human rights principles into practice remains a complex challenge. Legal reforms and policy declarations often coexist with everyday practices that continue to limit autonomy, particularly for individuals with high support needs [7]. Overprotective interventions, restrictive guardianship arrangements, and risk-averse service provision can inadvertently reproduce forms of institutionalization within community settings [14]. These tensions illustrate the need for continuous critical reflection on how human rights norms are operationalized in social care systems [19].

At the European level, policy orientations promoted by the European Union and aligned international actors emphasize the obligation of states to ensure not only formal rights, but also the material and social conditions necessary for their exercise [6,19]. This includes access to accessible housing, inclusive education, meaningful employment, and community-based support services. Without such enabling conditions, the promise of dignity and autonomy risks remaining largely aspirational [26].

5.3. Interdisciplinary Approaches and Systemic Change

Addressing the contemporary challenges of deinstitutionalization and social inclusion requires an interdisciplinary approach that integrates insights from social work, sociology, disability studies, public health, and policy analysis [20,4]. Each of these disciplines contributes distinct perspectives on vulnerability, care, power relations, and social participation, enabling a more comprehensive understanding of institutionalization as a complex social phenomenon [14,16].

Social work theory and practice play a particularly important role in operationalizing deinstitutionalization at the individual and community levels. Person-centered approaches, strengths-based interventions, and community development strategies offer practical tools for supporting transitions from institutional care and fostering social integration [20,12]. At the same time, social workers operate within organizational and policy constraints that can limit their capacity to promote empowerment and participation, underscoring the need for systemic reform [29].

Public health and health policy perspectives highlight the social determinants of health and the impact of living conditions, social support, and access to services on well-being and quality of life [5]. From this viewpoint, institutionalization and exclusion are not merely social issues, but also significant public health concerns with long-term consequences for individuals and communities. Integrating health and social care policies is therefore essential for ensuring continuity of support and preventing adverse outcomes associated with poorly managed transitions [12,31].

Finally, disability studies contribute a critical lens that challenges dominant narratives of dependency and deficit, emphasizing instead diversity, rights, and social justice [4,19]. This perspective draws attention to the power dynamics embedded in institutional arrangements and calls for the active involvement of persons with disabilities in policy design, service development, and research [19]. Such participatory approaches are increasingly recognized as essential for achieving sustainable and legitimate policy change [20].

In sum, contemporary challenges related to institutionalization and deinstitutionalization cannot be addressed through isolated interventions or sector-specific reforms. They require a systemic and interdisciplinary response that aligns policy objectives, professional practices, and societal attitudes. By integrating human rights principles, inclusive policy frameworks, and evidence-based community interventions, social care systems can move toward models that genuinely support autonomy, participation, and social inclusion [1,19].

6. Conclusions

The analysis undertaken in this article highlights institutionalization, deinstitutionalization, and social integration as interdependent processes that reflect broader transformations in social care systems and disability policy [1,14,4]. Historically embedded institutional models have played a central role in responding to vulnerability and long-term care needs, yet their structural limitations and exclusionary effects have increasingly been documented in both theoretical and empirical research [1,3,14]. As a result, deinstitutionalization has emerged as a normative and strategic priority within contemporary social policy frameworks [5,6,19].

The findings synthesized in this paper underscore that deinstitutionalization cannot be reduced to the physical closure of institutions or the relocation of individuals into community settings. Rather, it constitutes a complex and long-term process that requires systemic change across policy design, service delivery, and institutional culture [1,10,18]. Without adequate community-based services, coordinated support mechanisms, and inclusive social policies, deinstitutionalization risks reproducing new forms of exclusion, dependency, or transinstitutio-nalization [3,11].

Social integration and community inclusion emerge as critical benchmarks for evaluating the effectiveness of social care reforms. Integration must be understood as a multidimensional process encompassing structural access, social relationships, functional participation, and symbolic recognition [8]. The analysis demonstrates that meaningful inclusion depends not only on individual support interventions, but also on the broader social, economic, and cultural contexts in which persons with disabilities live [12,5]. Persistent structural barriers, stigmatizing attitudes, and fragmented policy approaches continue to constrain integration outcomes, despite formal commitments to inclusion [25,29].

From a theoretical perspective, the article reinforces the value of interdisciplinary frameworks that connect social work theory, disability studies, and social policy analysis [20,4]. Such approaches enable a more nuanced understanding of institutionalization as a dynamic social process shaped by power relations, professional practices, and policy discourses [14,16].

They also emphasize the importance of shifting from paternalistic and deficit-oriented models toward rights-based and person-centered paradigms that prioritize autonomy, participation, and dignity [19].

In terms of policy implications, the analysis points to the necessity of aligning deinstitutionalization strategies with comprehensive community development and inclusive governance mechanisms. Effective reform requires sustained political commitment, adequate funding, intersectoral coordination, and the active involvement of persons with disabilities in decision-making processes [19,26,29]. Only through such integrated and participatory approaches can social care systems move beyond formal compliance with policy objectives toward genuinely inclusive and sustainable models of support.

In conclusion, institutionalization as a social response remains a critical issue in contemporary debates on social care and disability policy.

By critically examining its forms, risks, and alternatives, this article contributes to a deeper understanding of the conditions under which deinstitutionalization can support social integration and community inclusion [1,4]. Strengthening inclusive social care systems ultimately depends on the capacity of societies to transform not only their services and policies, but also the underlying values and assumptions that shape responses to disability and vulnerability [20].

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