Abandoning 'a Lifetime of Habits' to Avoid the 'Sins of the Past'

De-Congregating Institutions with Deeply Ingrained Traditions

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ABSTRACT

While many studies have identified the problem of reproducing small institutions in community settings, few have explored why. This article explores how staff preserve and defend institutionalised beliefs and practices in community settings. We apply the concepts of disruptive and defensive institutional work to analyse the findings of qualitative interviews at six Irish residential institutions that were identified as priority sites for a national de-congregation programme. Reflecting on their roles, staff conceptualised their practices as historical, traditional, and reflective of a bygone era. However, the findings indicate that it would be misleading to represent institutional practices as relics of the past. The programme offered an olive branch for staff members who wanted to distance themselves from a 'lifetime of habits' and 'sins of the past'.

KEYWORDS

De-congregation; defence; disruption; institutional legacy; policy; staff

1. Introduction

This article explores how deeply embedded institutionalised practices and traditions are preserved and defended by staff members, even when the very core of the

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institution has been challenged or de-legitimised. The first part of this article gives an in-depth account of how the de-legitimisation of institutions for people with disabilities*1 has been driven by a shift in historical consciousness of institutionalisation in the Republic of Ireland following the public scandal surrounding revelations of gross human rights violations in Irish institutions. In the 1950s Ireland had the highest number of institutionalised citizens per capita in the world, with an estimated 1% of the population under coercive control in an institution (O'Sullivan & O'Donnell, 2007). We situate de-congregation within broader traditions, attitudes, and in relation to the painful abuses that occurred in Irish institutions such as mother and baby homes, psychiatric hospitals and reformatory schools for children. We propose that these associations with a painful history have not necessarily resulted in a change in deeply embedded institutional traditions, beliefs, and practices towards people with disabilities in institutions. To unpack the reasons for the preservation of institutional traditions, beliefs and practices, we explore research that has identified how members of disgraced or delegitimised organisations sustain valued elements of the organisation even after its closure (Walsh & Bartunek, 2011; Walsh et al., 2019).

The second part of the article draws on concepts from organisational studies (Lawrence et al., 2013) to explore how these valued institutional elements are preserved despite shifts in policy. It explores the concepts of disruptive and defensive institutional work (Oliver, 1992; Lawrence & Suddaby, 2006; Maguire & Hardy, 2009; Hardy & Maguire, 2008). The phenomena of being 'loyal after the end' describes a sense of belonging to an organisation outlasting the organisation itself (Walsh et al., 2019). Oliver (1992: 582) suggests that understanding de-institutionalisation 'depends on an investigation of the processes by which organisations reconstruct reality when existing values and practices are rejected or invalidated'.

The third section introduces the qualitative research. The article is based on 36 qualitative interviews at six Irish institutions that were identified as 'priority sites' for a national de-congregation plan (moving people from institutions of 10 or more people). Many of these six institutions were at the centre of public scandal and others received closure orders from the courts following inspections by the national independent regulatory authority (HIQA) at the time of the research. The findings section focuses on how staff dynamics and their loyalty to the former models of practices preserve institutions beyond the large, congregated settings. We argue that addressing this commitment to preserving traditions is a critical step in any de-institutionalisation.

2. Shifting Consciousness Towards Institutions

Institutional norms are legitimised by the wider normative structures of the society in which the institution exists (Parsons, 1956; Scott, 2003). Irish attitudes and beliefs towards disability are historically entangled with religious values. Even the Irish language reflected the deeply embedded religious norms, values, and beliefs about people with disabilities. In the Irish language Duine le Dia (Person with God) was widely used to describe people with intellectual disabilities. Religious orders were

held in 'reverence' in the overwhelmingly Catholic country, 'part of the common consciousness of the nation' (Ryan, 1999, referenced in Linehan et al., 2014). The Church dominated social services in areas such as hospitals, the care of orphaned and homeless children, the 'rescue of fallen women' and a limited range of services for the poor and unemployed women (Fahey, 1999). Ireland's disability services developed for adults and children with intellectual disabilities in the 1850s as part of religious run organisations (Health Service Executive, 2011). The heavy reliance on the voluntary and religious sectors shifted responsibility from the state and gave a large amount of control to religious orders (Quin & Redmond, 2003; Sweeney, 2010). Church-run institutions were part of a collective identity project that emphasised Catholic moral values (Robinson & Veale, 2021; Smith, 2007). Sweeney (2010: 104) documented the 'struggle between the Catholic Church and the medical profession, specifically psychiatrists for control over the management of intellectual disability in pre-colonial Ireland'. Despite this struggle, such was the scale of the expansion of residential homes for persons with intellectual disabilities that the Church had to recruit lay medical professionals, including psychiatrists and intellectual disability nurses, to work in the institutions alongside the Clergy (Sweeney, 2010). Hence, the medical model and religious values co-existed within institutions. The medical model of disability in this context refers to the privileging of medical diagnosis and the denial of the capacities of people with disabilities to justify their segregation from the rest of society. The medical model of disability gained strength in the latter half of the 20th century, with the increasing influence of medical professionals, including psychiatrists and intellectual disability nurses. Association with the medical profession carried some prestige, yet 'the formation of institutional pride, belonging and identity, such forms of identity can result in institutional compliance; with the associated risk of ritualistic practice, poor levels of transparent accountability and barriers to whistle blowing should substandard practice arise' (Brennan & Timmins, 2012: 747).

The beginning of the 21st century has seen a shift in public consciousness regarding the role of the church in institutionalisation. Arguably, public scandal had the most significant impact on public attitudes towards institutions. A shift in historical consciousness of institutionalisation was driven by public scandal following revelations of physical, sexual, and psychological abuse in Catholic-run institutions (McCoy, 2007; Ryan, 2009). The Report of the Commission of Investigation into Mother and Baby Homes (2021) documents the deaths of more than 9,000 children (approximately 15% of the children in the institution) in institutions for 'unmarried mothers'. While mother and baby homes and reformatory schools for children are considered a dark period of Irish history, there is a direct lineage between these institutions and modern institutions for people with intellectual disabilities that exist today. In fact mother and baby homes, and former industrial schools for children, were closed and converted into institutions for people with intellectual disabilities. The *Ryan Report of the Commission to Inquire into Child Abuse* (Ryan, 2009) identifies a direct lineage between former industrial schools being at the centre of sexual, physical, and psychological abuse allegations and current

disability services. For instance, a former industrial school that was closed in 1966 was reopened the same year as an institution for people with intellectual disabilities and was still operating when the report was published in 2009. More recently, institutions for people with intellectual disabilities have been at the centre of public scandal. An expose by the national broadcaster, RTÉ, revealed hidden camera footage of abuse and neglect within a residential setting for people with intellectual disabilities (RTÉ, *PrimeTime Investigates*, 2014). The public outrage that followed the exposé forced the agenda to reform institutions.

The shift in public consciousness of institutional abuses has been met with a change in the policy landscape in Ireland, particularly regarding Church-State relations. Increased regulation in the disability sector has been introduced where previously there was little or no state regulation. A landmark Irish policy laid out plans to close congregated settings and move people to smaller settings of less than 10 people (Health Service Executive, 2011). The following extract describes the national policy for moving people out of large institutions:

> *All housing arrangements for people moving from congregated settings should be in dispersed housing in ordinary neighbourhoods in the community, with supports designed to meet their individual needs and wishes. Dispersed housing may be defined as apartments and houses of the same types and sizes as the majority of the population live in, scattered throughout residential neighbourhoods among the rest of the population (Health Service Executive, 2011: 101).*

The latest report from 2019 recorded 1,953 people living in congregated settings in the Republic of Ireland (Health Service Executive, 2020). Two institutions closed in 2019, 116 people moved to smaller settings in the community, 97 people passed away, and 23 people were admitted to institutions (Health Service Executive, 2020). 73% of people in congregated settings have spent more than 15 years in the institution and many are older people. These figures reflect earlier international studies which show that people with the highest support needs are typically the last to leave the institutions (Wing, 1989) and are the most likely to be readmitted to the institutions (Mansell, 2006; Willer & Intagliata, 1983). Based on the demographic, the original report accepts the urgency of removing older people from the institutions, stating that 'the time to act on their behalf is now' (Health Service Executive, 2011). The latest report, from 2019, also outlines the housing arrangements of the people who transitioned from the institutions. 29% of the people who moved now share accommodation with three other people. 27% share accommodation with two other people. 10% accommodation with one other person and just 7% live alone (Health Service Executive, 2011).

3. Disruptive and Defensive Institutional Work

The concepts of 'disruptive institutional work' and 'defensive institutional work' offer an insight into the erosion of and the defence of institutional traditions and practices (Lawrence & Suddaby, 2006; Hardy & Maguire, 2008; Maguire & Hardy, 2009). 'Disruptive' and 'defensive' institutional work emerged from

organisational studies (Lawrence et al., 2013) and is a body of scholarly work focusing on 'the purposeful action of individuals and organisations aimed at creating, maintaining, and disrupting institutions' (Lawrence & Suddaby, 2006: 215). While the body of literature on disruptive and defensive work primarily focuses on business organisations, some studies have suggested that there is value in applying these concepts to other areas. For instance, focusing on the extreme case of the Holocaust, Martí and Fernández (2013) suggest that institutional work can help to understand more contemporary instances of oppression and resistance to change.

The concept of 'disruptive institutional work' describes 'both the adoption of new practices and the abandonment of old ones' (Maguire & Hardy, 2009: 169). Disruptive institutional work can be triggered by a number of events including abuse scandals, airline crashes, or other catastrophes that disrupt the legitimacy of an organisation (Shrivastava et al., 1988; Desai, 2011). To understand how institutions are disrupted, scholars have expanded their definition of institutions beyond the reductionist notion of a physical place or building. According to Scott (2001: 48) 'institutions are composed of cultured-cognitive, normative, and regulative elements that, together with associated activities and resources, provide stability and meaning to social life'. Understanding institutions in this way has implications for those who wish to challenge them. Disruptive institutional work occurs when one of the three elements or 'pillars' that hold the legitimacy of the institution in place are undermined or challenged (Scott, 2001; Maguire & Hardy, 2009). The cultural-cognitive pillar describes the 'shared conceptions that constitute the nature of social reality and create the frames through which meaning is made' (Scott, 2001: 48). The normative pillar defines the norms, societal values, and social expectations (Hoffman, 1999; Caronna, 2004; Maguire & Hardy, 2009; Scott, 2003) that 'provide not only continuity between past and present but define what is deemed appropriate in the present' (Dacin & Dacin, 2008: 329). The regulative pillar 'of the institutional environment recognises the authority of certain organisations and governments to formally constrain and enable organisational behaviour' (Caronna, 2004: 46).

Defensive institutional work describes 'the purposive action of individuals and organisations aimed at countering disruptive institutional work' (Maguire & Hardy, 2009: 169). This kind of resistance aims to reproduce 'existing norms and belief systems' (Lawrence & Suddaby, 2006: 230). Defensive institutional work occurs when there is 'opposition and resistance from insiders whose interests are threatened by the abandonment of existing practices' (Maguire & Hardy, 2009: 150). 'During radical change that threatens fundamental beliefs about oneself, attempting to unfreeze those beliefs may simply sharpen them and increase the resistance to change' (Fiol & O'Connor, 2002: 543). Defensive institutional work is not only about retaining power, status, or dominance. It may also occur when actors have strong cognitive and emotional investment in the institution (Voronov & Vince, 2012; Linehan et al., 2014; Wright et al., 2017). Defensive institutional work provides a powerful insight into how institutional practices can be carried through to community settings. 'Institutional elements move from place to place and time to time with the

help of carriers' (Scott, 2003:879). Its impact can be seen in the outcomes of de-institutionalisation when 'institutional remnants of the original tradition, or the reinvention or re-emergence of the original tradition or institutional practice' occur (Dacin & Dacin, 2008:334).

4. Methods

This article aims to explore how deeply embedded institutional practices are challenged, eroded and, in some cases, defended by staff, even when the very core of the institution has been de-legitimised. This article draws on the findings of a larger ongoing national research programme which aims to explore how change happens in complex reform programmes in disability, mental health, and homelessness.

The research reported in this article was undertaken as part on the Service Reform Fund (SRF) which was established in Ireland by the Health Service Executive (HSE), the Department of Health, the Atlantic Philanthropies and Genio. A significant part of this disability programme involves supporting large, congregated sites to transition to community-based settings (Genio, 2021). Frontline staff were introduced to social and inclusive work practices, forcing them to identify systemic barriers, confront a medical 'care' ideology, derogatory paternalistic attitudes and the segregation of the people living in institutions. Internally and externally, change agents were recruited to lead the transition from the large institutions to smaller homes in the community. These change agents were interviewed as well as frontline staff, senior and middle management.

4.1 Data Collection and Participants

Interviews were conducted with 36 management and frontline staff members using purposive sampling based on their experience of de-congregation. Although this is a relatively small sample, the participants were selected for their expertise in priority de-congregation in the Irish context. They were responsible for overseeing the transition from institutions to community settings. Their roles included social care workers, nurse managers, area managers, community transition co-ordinators and persons in charge (PIC) of designated centres.

The people living in and moving out of the institutions were not interviewed as part of this study. The aim of the study was to focus on staff dynamics and attitudes towards the de-congregation programme, and the implications that this has for de-congregation.

	Number of participants	Participant profiling	De-congregation status
Site 1	17	• 6 Senior management • 4 middle management • 3 community transition coordinators • 2 team leaders • 1 nurse • 1 board member	Closure order from the Courts. In the process of moving people into the community. Approximately three quarters of the people had moved out of the institution.

	Number of participants	Participant profiling	De-congregation status
Site 2	3	• 1 person in charge • 1 service manager • 1 community transition coordinator	One third of the people have moved out of the institution.
Site 3	4	• 3 frontline staff • 1 manager	Closure order from the Courts. All people have moved to smaller community settings.
Site 4	5	• 2 area managers • 1 team leader • 1 nurse • 1 community transition co-ordinator	More than one third of the residents have moved from the large campus to smaller homes in the community.
Site 5	5	• 3 nurse managers • 1 person in charge • 1 speech and language	Approximately one third of the people moved out of the institution.
Site 6	2	• 1 assistant manager • 1 team leader	One third of people moved to smaller homes in the community.

4.2 Data Analysis

Data was audio transcribed verbatim and the transcripts were sent to the participants for member checking. Once the transcripts were approved, they were entered into NVivo. Open coding was conducted on all transcripts. This was followed by focused coding, whereby initial codes were combined (Charmaz, 2006). A further targeted analysis was performed to refine key themes emerging from the data. Core themes included: 'the institutionalisation of "lifers"', 'change champions' and 'the clashing of cultures'. The major categories were compared with the relevant literature (Charmaz, 2006).

4.3 Ethics

Ethical approval for the study was granted by the Trinity Business School, Trinity College Dublin on 20th July 2017. All participants were required to give informed consent prior to taking part in the research. The interviews were audio recorded and permission was granted by all participants. All parties were informed that they were free to have their information removed from the research programme records at any time.

5. Findings

5.1 'For many years I suppose we did think we were doing the right thing'

The findings suggest that there was a historical consciousness around the institutional abuses of the past.

> *I think it's bigger than just disability, to be honest with you. I think it is the way people who were different or whatever were institutionalised in either buildings or in mindsets. So, there's a cultural thing, I think, in Ireland and in the history of it where we think 'that's okay' and I think all the stuff that's come out recently about, as I said the mother and baby homes, industrial schools … the church, the State issues ... It's all a function of that, to be honest with you. I think it sits in that. It's not out on its own, it's all part of that mindset. And that mindset is 'Sure that's okay'. (Site 3, senior manager).*

Indeed, several of the priority sites were named as part of a network of institutions in the *Report of the Commission of Investigation into Mother and Baby Homes* (2021) and the *Ryan Report of the Commission to Inquire into Child Abuse* (2009). People who worked in the institution for decades were finding themselves on the wrong side of history and at the centre of public condemnation. A change agent described 'the very history of this room that we are, this house we are in, just drags people down' (Site 1, community transition manager). Participants acknowledged the context of institutional abuse and malpractice. Participants described 'legacy issues' of historical abuse and malpractice associated with religious orders. 'We have some legacy issues that have suffered here which is a whole other area having to deal with legacy abuse issues … the (order of nuns) could be on the hook for legacy matters' (Site 1, board member).

The medical model and religious dominance were described as systemic. Reflecting on the institutional legacy, many frontline staff and management believed that the institutionalisation of people with disabilities reflected Irish norms 'years ago when (the institution) opened' (Site 3, nurse manager). Institutionalisation of people with disabilities was seen as the way things were done, traditionally and historically. A participant who worked for more than 20 years explained that 'a long time ago, where things were very different. But that's the way things were then … nationally' (Site 5, nurse manager). One participant described 'a culture whereby there was no accountability' (Site 4, person in charge). A further participant described how the service was supposed to provide schools for children with disabilities, but the Catholic nuns were under pressure to keep populating the institution.

> *It's really like a boarding school … And it was run by an order of nuns. There would be pressure put on the nuns to keep them. So, therefore, by default, it became an adult service. (Site 5, middle management).*

Hence, the participant explained that 'years ago, the concept would be from cradle to grave' (Site 2, service manager). Another nurse who had worked at an institution for more than four decades described the inaction of nuns when staff members reported abuse. 'Consecutive managers that didn't listen because they were nuns. They didn't listen because they didn't see … I don't know, they're selective in the way they think' (Site 1, nurse).

Participants described the dominance of the medical model of disability.

> *Traditionally here on site before people moved it was very much a different, it was a medical led model of care. And to be honest with you the disability or the medical condition that the person was experiencing very much defined the person. (Site 4, area manager).*

Some participants worked in the institution for many decades. In this case, the interviews provided a space for introspection. Reflecting on their own mindsets and practices, participants admitted that they thought that they were doing the right thing at that point in time. One participant recalled: 'I have worked in a residential area for many, many years and I would have been of the old school' (Site 4, person in charge). Participants who worked in the institutions for decades said that many of the malpractices were a result of underfunding, understaffing, and a lack of management, or accountability. Another participant who was working at an institution for more than 40 years described the implications of understaffing on the culture of the organisation as one of 'impoverishment … at the time, in the 70s, 80s and the 90s and the 2000s. We didn't have the personnel' (Site 1, nurse).

5.2 'You are not going to change that culture and mindset as quick as you can pack a bag and move'

While Irish policy focuses on de-congregation, participants raised concerns that de-congregation is 'not just a matter of changing address' (Site 2, service manager). As one participant explained 'there's no point in a person moving out to a house in the community to be institutionalised in their own home' (Site 6, team leader). The findings illustrate why reform and policy needs to go a lot further than simply moving people out of buildings. An institution is not merely a physical space. In addition to moving out of the buildings, the erosion of deeply embedded practices was considered critical to sustain the reform in the longer term. If the institutionalised practices were not abandoned there was a risk of 'replicating what you have or not being future proof' … 'the moving out part is sometimes the easier part. It's maintaining and growing that culture in a new community' (Site 4, community transition co-ordinator). In addition to moving, change agents who were responsible for the transition aimed to disrupt the historical legacy of deeply embedded institutional mindsets, habits and practices which were preserved for decades.

> *The institutional mindset that comes with a large campus or the practices … people have a lifetime of habits and routines… 'this is what we have always done'. (Site 1, community transition co-ordinator).*

These mindsets and practices were considered major barriers to contemporary de-congregation. Traditions and practices were preserved and 'untouched for many years, culture and tradition … a lot of really good care, loving relationships but also a lot of poor practices and laziness, unchallenged' (Site 1, senior manager). Without challenging these taken for granted practices, participants feared continuity between past, present, and future (Dacin & Dacin, 2008). As one participant put it, there was a 'risk that you would replicate the sins of the past and create mini-institutions' (Site 1, person in charge) and staff would 'slip back into (their) old ways' (Site 4, area manager).

5.3 'A collision of different cultures': the 'lifers' and the new staff

Participants positioned themselves as either insiders or outsiders in relation to deeply embedded institutional practices that were challenged. This division often led to a

'blame culture' between staff. The staff who had been working in the institutions for decades were labelled as 'lifers'. The 'lifers' were viewed as the people who were culpable for the historical legacy of the institution. One participant explained that these 'staff are institutionalised rather than the service users' (Site 1, middle management). Some 'had come out of college and had gone straight into (the institution). They had never experienced anything else either. So, they were as institutionalised as the people they were supporting' (Site 4, person in charge). Some older staff were accused of blocking the reform efforts and putting up a serious barrier to de-congregation.

> *If you have a staff that's a strong member of the team or have been here quite a while if they have a negative slant on the move it ripples throughout the whole team and that's very difficult then just to change the way of thinking. (Site 5, person in charge).*

The commitment to the older models of practice were seen as significant barriers to de-institutionalisation. In some cases, this resistance to the reform manifested formally when trade unions were involved. In many cases, participants believed that the institutionalised staff did not want to change.

> *There have been issues with staff and maybe older staff that would be like,'well I'm not going cleaning and it's not in my contract to clean' and the union's been involved. (Site 5, nurse manager).*

Union engagement was seen as a huge barrier to reform and participants emphasised the need to engage with the union representatives. 'If you don't take on the unions you will end up with institutions in the community and I've seen it in a number of services' (Site 1, senior manager).

In some cases, staff resigned when they were unhappy with the changes in their working conditions. 'There was staff who were unhappy to continue working in [the organisation] … we actually had a lot of people who left' (Site 6, team leader).

> *Many people went on stress/sick leave. Others as you know were put on administrative leave and we had a very minute, a very small group that maintained that resilience and stayed at work and worked with the smaller staff teams to move with [the reform]. (Site 4, area manager).*

Many felt that the resignations of the staff who identified with the old ways of working paved the way for reform. A manager explained that while a lot of management had left, they were lucky that 'the people who stayed and weren't in the same mindset' (Site 6, assistant manager). This feeling was common in many of the sites, those who stayed on were more likely to engage with the reform.

Yet not all staff who opposed the changes resigned and the recruitment of new staff and management provoked a 'collision' with the staff and management who defended the old ways of working. Management often described a 'battle' with the older staff.

> *My God, it's a battle. It's a continuous battle because invariably it's one of the hardest aspects of the de-congregation process. Because particularly where you have people have been in positions for the last 40/50 years and it's just, the negativity has been horrendous. (Site 1, middle management).*

The new staff could disassociate themselves with the old, traditional practices in the institution. This disassociation often led to blame and finger pointing at the staff who defended the old practices. This was referred to as a 'blame culture' whereby certain staff cohorts were condemned (Site 4, person in charge). A participant described the clash between new and old staff:

> *It's like a collision of different cultures in that way because you've got the built-up culture of people who have been working here 30, 40 years of people working here and then you've got this new culture that is trying to be implemented by senior management. (Site 1, senior management).*

From the change agent's perspective, the recruitment of new staff who had no association with past practices accelerated the reform programme. For instance, one participant described it as breaking 'the ice barrier between the new and the old':

> *We saw a huge amount of staff coming on board, and I have to say that was the best thing that ever happened – to have new eyes, to have youth, new education, new training, up to date information brought in (Site 4, manager).*

Yet, staff members who had worked at the institutions for four decades expressed a different point of view. For instance, one participant argued:

> *The people coming in are new people and they just like to be on computers.They don't see the hands on or the interaction with the service user … the young people coming in with degrees don't want to hear from some old fogies like me. (Site 1, nurse).*

Similarly, another participant who had worked at the same institution for more than 40 years complained that 'the heart' had been taken out of the work by modern technology:

> *I think because of the computer now is more important than the person … it's sad really, because but that's the way I feel … I'm an old school, computers weren't invented when I was young. (Site 1, healthcare assistant).*

5.4 The clash between 'them' and 'us': medically versus socially orientated staff

Participants also described a clash between nurses and social care workers. Again, this tension was often represented as the old and the new, a collision between the medically and socially orientated staff. For instance, a manager who trained as a social care worker explained 'because I was a social care worker … a lot of the nurses didn't like us coming into (the institution)' (Site 4, area manager). The divide was described as 'a clash of two different cultures, the one that's trying to break through and the one that's already there' (Site 1, community transition co-ordinator). In some instances, this division led to the defence of the old medical practices. 'Even though there's nurses out in the community houses now, and working through the social model, they're still fighting it' (Site 3, social care worker). One participant suggested a shift towards socially orientated practices was difficult for staff because

'there's comfort in having even nurses looking after you as opposed to social care staff. So, it's a huge change of mindset for both staff' (Site 4, person in charge). Others suggested that there was a divide based on the professional identities.

> *There is a big 'them' and 'us' and the social care workers are going to come, and I don't know what they thought we were going to do to be honest. There was a lot of resistance. (Site 3, social care worker).*

Some participants were loyal to the long-established medical practices.

> *Really, deep down, my job is that the service user comes first and that it is my job to keep them safe, secure and see that no harm has befall them and that they are medicated. That would be my day. (Site 1, middle management).*

While many participants described a clash between the old and new staff and the medical and social professions, this proved to be an oversimplification. In fact, many of the older and the medical staff supported the de-institutionalisation efforts and wanted to move towards a model that supported people to live in the community. For instance, a nurse who worked at the institution for more than three decades suggested that the reform should have happened a long time ago. 'I think we didn't move with the times here. I really do. I think we should have moved with the times' (Site 1, nurse). She also suggested that some older medical staff were happy to change their role to a more social approach.

> *I'm a nurse and I've always been a nurse, but I would never think of myself as a nurse … I think of myself that I'm here to, as a person to support a person to do what they … I have nursing training. I have that as a background, so you know, that's fine, that's great … I might know what that tablet is about, or I might be able to give that injection or whatever, but it's not my main function. (Site 1, nurse).*

There were staff who had been advocating for change from the inside for decades prior to the reform. Many of the older staff felt that support structures and leadership were not in place to support the staff that wanted to do better for the sake of the people living in the institutions. Staff who tried to challenge the practices said that they were not listened to.

> *We voiced concerns about food, we voiced concerns about staffing, we voiced concerns about social interaction, and I have to say in hindsight, and I suppose something I have learned from it … we didn't put it in writing … We really weren't listened to, and we really weren't supported. (Site 3, social care worker).*

Similarly, a participant who worked at an institution for more than three decades said:

> *I have over 30 years' experience here and have seen it through good time and bad times, and I always had a vision for community living. And that's why I suppose, when the whole de-congregation process began, I was the first to kind of say yes, I want to continue engaging with that … [it] enhanced my sheer determination to get people offsite. (Site 4, area manager).*

5.5 'Trying to convince people that this could be different and better'

Change agents identified ways in which they challenged the defence of the traditional institutional practices by offering an olive branch to staff, an alternative way of working. As one participant explained, management are 'always trying to convince people that this could be different and better' (Site 1, senior manager). In certain sites, participants described a snowball effect, whereby one or two credible staff members would encourage reluctant staff members to accept de-congregation and the transition to the community. 'Identifying champions of change … who are the key people that can deliver what you want to say, to the people who will listen to them. So, we would have had some senior staff here who are fully on board, who are credible' (Site 4, community transition co-ordinator). The group of staff who accepted and embraced the change encouraged the more reluctant or the resistant staff members to embrace de-congregation. Staff members who were trained in socially orientated practices were identified as people who could convince other staff members to change their practices. An area manager at one of the sites explained that there are 'a number of staff that's trained in what they call SSDL (supported self-directed living) … So, we consider them champions of the social model' (Site 4, area manager). However, it was accepted that the de-congregation programme was not going to reach all the staff. 'There's always going to be one or two, you know, with some staff there is going to be resistance, but I'm hoping that the others will maybe carry them' (Site 2, community transition co-ordinator).

6. Discussion

While Irish policy favours the term 'de-congregation' instead of 'de-institutionalisation', the findings of our study show a clear distinction between 'moving address' and the much more complex issue of de-institutionalising practices, traditions, and historical legacies. Hence, we propose that institutions are not only a physical place, and de-institutionalisation is not only a matter of closing large institutions, but it also involves abandoning deeply held beliefs, traditions, and assumptions (Oliver, 1992; Dacin et al., 2008; Maguire & Hardy, 2009). While historical consciousness of institutional abuse has raised public awareness of atrocities in institutions, the institutionalisation of persons with disabilities remains contemporaneous. This raises the question of how institutions survive despite growing condemnation of their very existence. The findings illustrate how institutional norms are upheld and legitimised, not only by the staff working in the institution, but also by the wider society in which the institution exists (Parsons, 1956; Scott, 2003). Irish institutions for people with disabilities do not exist in a vacuum. Our study highlights the wider social structures that supported these institutions. Participants were able to connect their actions to the perceived 'social reality' of the time (Scott, 2001) and fed into a sense of collective identity.

> *Beliefs about 'who we are' are often embedded in deeply ingrained and hidden assumptions. External attempts to bring about radical collective changes based on reputational beliefs often challenge these*

> *assumptions, making them more conscious for both outside agents and inside recipients, and thereby potentially more problematic (Fiol & O'Connor, 2002: 534).*

The findings illustrate how cognitively, many of the people working in these institutions thought that they were doing the right thing and even took pride in their practices. This fundamental belief was supported by the wider community and social structures. Their work was highly valued in a country where religion and medical institutions were revered (Linehan et al., 2014) and individuals associated with these institutions were pillars of their community. The people working in historically prestigious institutions have found themselves on the wrong side of history. The findings illustrate how the 'change process can often degenerate into heated identity battles' (Fiol & O'Connor, 2002: 543). In this case, battle lines were often drawn between the old and the new, and between those identifying with medical or social professions. The extent of resistance towards the reform suggests that some cohorts and management were 'loyal after the end' and their identification and sense of belonging to the organisation outlasted the organisation itself (Walsh et al., 2019). In other words, certain cohorts of staff were 'carriers' of institutional elements (Scott, 2003). We suggest that this finding has profound implications for de-congregation of people with disabilities. The findings suggest that the closure of an institution alone may not address the staff's loyalty to the former organisation and the comfort in the statement 'this is what we have always done'.

The findings provide an insight into the kinds of approaches that were taken to address the defence of the old ways of working. Those driving the reform programme offered an olive branch to staff who wanted to at the very least symbolically abandon ship and adopt new practices in community settings. The findings also suggest that the staff who were willing to adopt new practices often scapegoated other staff (the 'lifers') who were seen as culpable for 'the sins of the past'. There is research to suggest that blaming individuals or groups serves a purpose in institutional change because it helps channel anger toward change activities (Goodwin et al., 2001; Jasper, 1998; Lively & Heise, 2004; Voronov & Vince, 2012). Scapegoating can serve a purpose in allowing groups to 'purge themselves of unwanted thoughts and feelings and project them onto certain of their members, whom they then marginalise' (McCoy, 2018). In this case, the blame directed at the older members of staff and the medical professionals served a purpose in the reform programme. By blaming cohorts of staff for the institutional practices, staff were able to distance themselves from the 'sins of the past'. However, the findings suggest that the divide between the old and new staff was an oversimplification of the issue. Another way of framing this divide is to consider the extent to which individuals are embedded in the institutional legacies and traditions. This acknowledges the staff's agency beyond their professional role and accepts that some institutional actors are more or less embedded in the institutional norms and practices (Reay et al., 2006; Seo & Creed, 2002). The findings illustrate examples of staff who exercised their agency to challenge the institutions but were restricted by the wider social norms and institutional practices of the time.

7. Conclusions

The findings highlight the complexity of creating sustainable reform in systems that have deeply embedded legacies and traditions which were entangled with staff's sense of identity. Irish institutions for people with disabilities did not exist in a vacuum. They were entangled with other institutional traditions and legacies, including mother and baby homes and residential 'reformatory' schools for children. The reform programme introduced new ways of thinking about service delivery in the community. Despite the de-legitimisation of previous practices, the reforms were not universally embraced, and there was evidence of resistance to de-congregation. While participants conceptualised their behaviours as historical, traditional, and reflective of a bygone era, it is important to consider that large and small institutions exist in Ireland. Hence, it would be misleading to represent the institutional practices as relics of the past. Expressing '"shame for what was done back then", a phrase that at once claims the emotional impact of the mother-and-baby home scandal and distances it from the present' (O'Toole, 2019).

NOTE

*1. We chose the term 'people with disabilities' because it is commonly used in Ireland by the disability movement and in policy documents. Other terms used in verbatim quotes are those of the participants, not the authors.

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