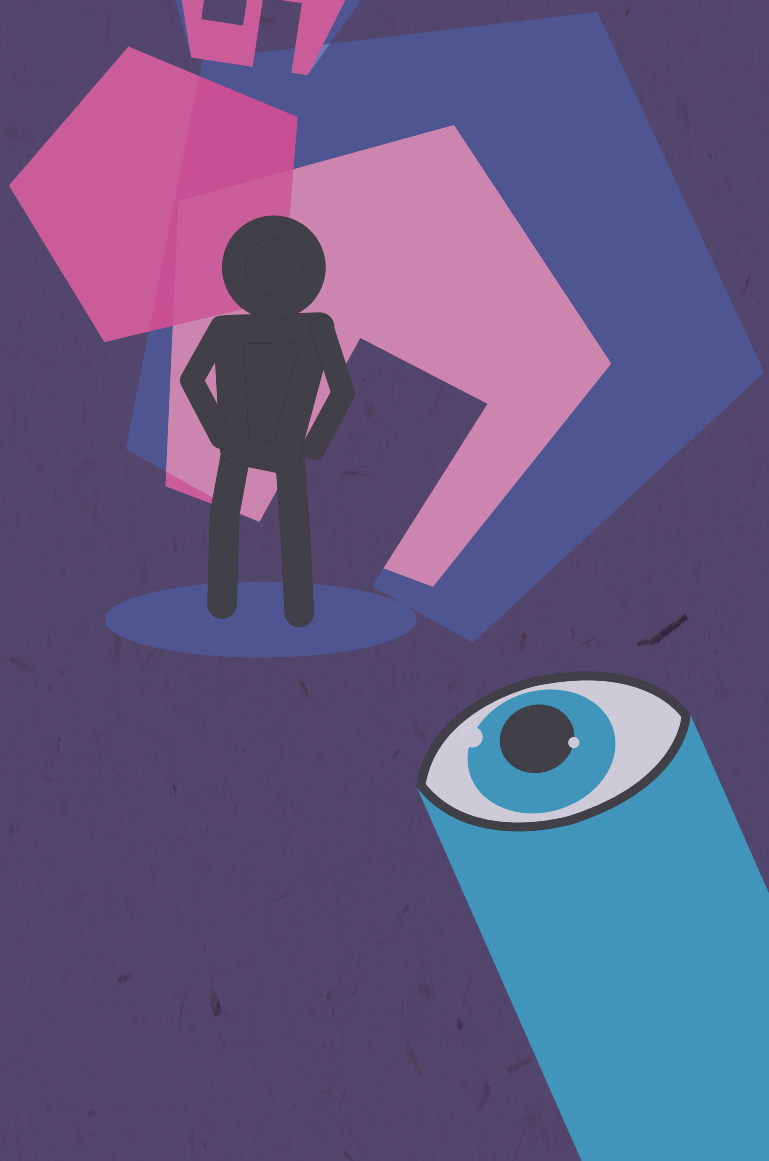
Chapter 6

Social inclusion in the neighbourhood and the professional role identity of group home staff members: views and experiences of staff regarding neighbourhood social inclusion of people with intellectual disabilities



Abstract

Background

During the last decades, people with intellectual disabilities have moved to ordinary neighbourhoods and policies have incorporated goals related to social inclusion. However, people with intellectual disabilities are still experiencing social isolation. We investigated the role of group home staff members, on the assumption that neighbourhood social inclusion cannot be considered a standard element of their professional role identity. The aim of our study was to gain insight into the individual perceptions of staff and the institutional environment in relation to staff's professional role identity in dealing with neighbourhood social inclusion.

Method

We conducted semi-structured group interviews with staff from nine group homes in three neighbourhoods in The Netherlands.

Results

Our analysis yielded five themes: (1) staff perceptions of residents' neighbourhood contacts: positive and negative experiences (2) staff perceptions of residents' needs and capabilities, (3) staff perceptions of neighbours and neighbourhood, (4) staff perceived role in social inclusion in the neighbourhood, and (5) staff perceived role of service provider.

Conclusions

Our study showed that individual perceptions of a professional role identity primarily focused on care tasks and the (lack of) experienced support from service providers hinder staff in creating opportunities for social inclusion in the neighbourhood. To enhance social inclusion in the neighbourhood we recommend service providers invest in supporting staff in acquiring the necessary skills.

Introduction

Over the last decades social inclusion of people with intellectual disabilities has become an important goal of policy makers. Historically, the Netherlands has a long tradition of institutional care for people with intellectual disabilities. People with intellectual disabilities were placed in large institutions, often separated from society (Schuurman, 2002). These institutions aimed to provide a safe and secure environment which was not ensured in society (Mans, 1998). From the 1950s onwards, models of social care were developed. In these social models, people with intellectual disabilities are considered part of society and, as a result, in subsequent decades people with intellectual disabilities became more visible in society. As in many other Western countries, the large institutions were closed, and care provision increasingly became organized through small-scale group homes situated in ordinary neighbourhoods (Beadle Brown et al., 2007; Nieboer et al., 2011). These group homes house people with mild to moderate intellectual disabilities who receive 24-h residential care.

National, local and institutional policies also started to incorporate goals related to social inclusion (e.g. Jones, Ouellette-Kuntz, Vilela, & Brown, 2008). However, there seems to be a large gap between these policies and the realities of daily life people with intellectual disabilities are confronted with. They still experience high levels of social isolation (Forrester-Jones et al., 2006; Jones et al., 2008; Milner & Kelly, 2009; Tøssebro et al., 2012). These findings show that physical integration does not necessarily lead to social inclusion (e.g. Nieboer et al., 2011; Cummins & Lau, 2003; Overmars-Marx et al., 2014).

Our study addresses social inclusion in the neighbourhood. Based on the conceptualization of Cobigo et al. (2012) we define neighbourhood social inclusion as 1) having access to neighbourhood facilities, 2) being able to perform social roles in the neighbourhood, 3) being recognized in these social roles, and 4) having meaningful contacts in the neighbourhood (Overmars-Marx et al., 2014). We stress the importance of neighbourhood social inclusion because relationships between neighbours have a positive effect on health and well-being. Although most interactions between neighbours can be considered as superficial, they are of significance to neighbours. Neighbours are inclined to see each other as possible sources of support they can rely on in times of need (e.g. Forrest & Kearns, 2001; Unger & Wandersman, 1985; Völker, et al., 2007, Van Alphen et al., 2009; 2010). Studies show that people with intellectual disabilities also benefit from encounters with neighbours or other actors in the neighbourhood; being recognized provides people with a feeling of belonging (e.g. Van Alphen et al., 2009; Wiesel & Bigby, 2014; Bredewold et al., 2015).

There are individual differences in the way neighbourhood social inclusion is experienced and perceived, and so the concept must always be considered in relation to the social and institutional setting in which a person functions (Overmars-Marx et al., 2014). This setting can either be supporting or thwarting for social inclusion (Schwartz & Rabinovitz, 2001). Therefore, we consider neighbourhood social inclusion the product of the interaction between a person with intellectual disabilities' individual characteristics and the neighbourhood where he or she is located (e.g. Cobigo et al., 2012). The various actors involved in achieving social inclusion in the neighbourhood, people with intellectual disabilities, neighbours, and the staff members working in group homes (Cobigo et al., 2012; Simplican et al., 2015) all have their own perspective on the neighbourhood and the opportunities for social inclusion it provides.

This study focuses on the role of group home staff members. The attitudes of staff determine a successful implementation of inclusive policies and directly affect the lives of people with intellectual disabilities (Jones et al., 2008). Group home staff members play a pivotal role in enabling and mediating inclusion (e.g. Van Alphen et al., 2009; Overmars-Marx et al., 2014). Such a role requires paying attention to tasks related to social inclusion. For example, staff can facilitate inclusion by supporting residents in developing social contacts in the neighbourhood by being open to neighbours (e.g. Abbot & McConkey, 2006; Van Alphen et al., 2009; Bigby & Wiesel, 2015). However, staff members of group homes for people with intellectual disabilities primarily focus on the provision of personal care to their residents (McConkey & Collins, 2010a). This could be explained by the fact that most staff members have been traditionally educated to care for their residents within these sheltered settings (e.g. Jones et al., 2008). To enhance social inclusion, a shift from 'caring for' to 'supporting' people with intellectual disabilities is necessary (Council for National Health and Care, 2002; Schuurman, 2002; Abbott & McConkey, 2006). To achieve such a shift, in-depth information is needed on all factors relating to the performance of group home staff members in supporting social inclusion.

We use the concept of professional role identity to understand the performance of group home staff members in supporting social inclusion in the neighbourhood. Group home staff's perceived professional role identity determines how they view their role in neighbourhood social inclusion, and the way they act in the neighbourhood and towards neighbours (Pratt et al., 2006; Weick, 1995). This professional identity results from their self-definition as a member of their profession, i.e. whether they consider it part of their professional task to contribute to the process of neighbourhood social inclusion. This professional role identity is influenced by institutional forces (Chreim et al., 2007): professionals adjust the way they express their professional identity to their perception of the organization's

expectations. These expectations are based on the support they perceive in their performance of tasks within their professional role. This support is, for example, reflected in training opportunities related to neighbourhood social inclusion. Service providers can either support or frustrate the development of a professional role identity that supports social inclusion.

Therefore, to understand the performance of group home staff members in promoting their residents' social inclusion in the neighbourhood, we have to focus on the way social inclusion is embedded in 1) their perceptions on whether and how they should contribute to the process of social inclusion, and 2) the expectations concerning social inclusion in their institutional environment and the level of support they experience from this environment in promoting it.

Our study was conducted among staff members in nine group homes in three municipalities in the eastern part of The Netherlands. The staff members are employed by four different service providers that run the group homes. The involved service providers formulated policies towards social inclusion. They work with independent or self-managing teams. Such teams usually consist of about eight staff members and are responsible for organizing and providing the appropriate care and support to their residents. On average, each team has 15 residents in its care. Although these self-managed teams are autonomous in terms of how they manage and carry out their work, they are supported by a manager.

Method

Neighbourhoods, group homes and group interviews

To obtain more insight into the perspective of staff members, we conducted group interviews with nine teams working in group homes located in three different neighbourhoods in three municipalities in the Netherlands. The group homes were selected by the first author in cooperation with the four service providers involved in the research project. The selection criteria were a representation of the four service providers and variation in neighbourhoods in terms of the presence of facilities and the socio-demographic characteristics of inhabitants.

Two of the neighbourhoods were situated in small towns with approximately 15,000 to 20,000 inhabitants in low-urbanized areas. The neighbourhoods differed in their level of facilities. Both offered shopping, catering and leisure facilities, but one had a greater availability of the various facilities that attracted people from across the region, while the other had more of a village-like atmosphere. Both neighbourhoods had fairly similar sociodemographic characteristics, with a relatively high percentage of people aged above 65 years (23% and 26%, compared to 17%

of the Dutch general population) (Centraal Bureau voor de Statistiek, 2014). The average income of neighbourhood residents was defined as just below the average income of the general Dutch population (€29,500): between €24,400 and €26,600 gross per year.

Both neighbourhoods were known as sites neighbourliness traditionally played an important role. Supporting each other and reciprocity are still key elements of this neighbourliness. However, nowadays the obliging character of *noaberschap* is replaced with a mutual sense of responsibility and mutual trust (Abbas & Commandeur, 2012). Both neighbourhoods located four group homes in different streets within the two neighbourhoods.

The third neighbourhood was a suburb of a small town with a population of 55,000 inhabitants. This neighbourhood had high levels of socio-economic deprivation. Neighbourhood residents had an average gross yearly income of €21,200 – below the national average – and a relatively high percentage (47%) of residents were in the 40% of the lowest incomes in the Netherlands (Centraal Bureau voor de Statistiek, 2014). Like the other two neighbourhoods, this neighbourhood contained a relative high percentage of people aged above 65 years (25%). The group home included in our study was situated in an apartment building and residents have their own apartments spread over three blocks of flats.

We also aimed for variation in the types of disabilities among the residents in the care of group home staff members. In general, the staff members included in our study care for residents with mild to moderate intellectual disabilities. In two group homes, there are some residents who also have mental health problems and in nearly half of the homes (four) there are a few residents with an increased need of physical care.

On average, each group interview involved eight staff members, guided by two researchers. The interviews took the form of planned discussions aimed at eliciting diverse viewpoints and experiences. One of the advantages of such a group interview is that informants tend to inspire one another, which increases the richness and scope of the data (Weiber et al., 2016). We tried to create on a non-judgemental atmosphere in which informants could feel confident and secure enough to freely speak their minds (Krueger & Casey, 2009).

To encourage group discussions, a topic list was used. This list was based on the literature cited in our introduction. Questions were asked about contacts residents had in the neighbourhood, staff members' perception of neighbourhood social inclusion and their professional role in promoting it and on how they were supported by their service provider.

Data analysis

All group interviews were audiotaped and transcribed verbatim. The interview transcripts were content analysed by the first author using ATLAS.ti software (Scientific Software Development GmbH Berlin, Germany). The coding process was based on elements of the grounded theory techniques (Strauss & Corbin, 1990). Our approach aimed at providing staff members' perspectives on their professional role in neighbourhood social inclusion. The first stage of our analysis was open coding (Glaser & Strauss, 1967). During the coding process, we engaged with the material by reading the transcripts over and over again. This increased familiarity with the stories of informants and provided a basis for categorizing the data. During the next stage we performed axial coding (Strauss, 1987) and classified the codes into categories, or subthemes. The coding process was an iterative process: categories were adjusted during the process by comparing them within and across different transcripts. After the axial coding, the codes were grouped into broader themes. While analysing the interviews transcripts, the first author continuously reflected on the process and the findings obtained (Yanow, 2003). A sample of the interviews was analysed by a second researcher to test inter-rater reliability. A comparison of the outcomes led to minor adjustments in the labelling of the themes that had emerged.

Results

Five themes emerged from our data analysis: (1) perception of residents' neighbourhood contacts: positive and negative experiences (2) perception of residents' needs and capabilities, (3) perception of neighbours and neighbourhood, (4) perceived role in social inclusion in the neighbourhood, and (5) role of service provider (see table 6.1). The themes are described separately but the links between the themes will be noted in the separate descriptions.

(1) Staff perceptions of residents' neighbourhood contacts: positive and negative experiences

First, informants told stories about the kind of contacts they saw between their residents with intellectual disabilities and neighbours. They told stories about different forms of contact. According to informants from all nine group homes, contact between people with intellectual disabilities and their neighbours is usually limited to greeting each other. Informants from one group home emphasized the importance of shops and shop assistants. They know their residents and therefore residents can visit shops by themselves.

Table 6.1 – Overview of themes and codes relevant to social inclusion in the neighbourhood

	Theme	Codes
Individual perceptions	Perception of residents' neighbourhood contacts: positive and negative experiences	Type of contact between residents and neighbours Joining activities Difficulties experienced in neighbourhood contact
	Perception of residents' needs and capabilities	Perceived needs of residents regarding the neighbourhood Perceived social skills of residents regarding the neighbourhood
	Perception of neighbours and neighbourhood	Possible negative influence of neighbours Perceived characteristics of neighbours and related needs Expectations regarding neighbours Atmosphere in the neighbourhood
	Perceived role in social inclusion in the neighbourhood	Opportunities for social contact with neighbours Intermediary role – disturbance Psycho education Discussing needs with residents Perceived obstacles related to available time and training Collaboration with the neighbourhood
Institutional environment	Role of service provider	Perceived support from service providers Experienced available time Perceived training opportunities

Informants noticed some difficulties where more extensive individual contacts and activities were concerned. They related these difficulties to the needs and behaviours of some of their residents. Residents can be unreliable; they do not keep appointments, exhibit claiming behaviour; e.g. stopping by every day, and can become very disappointed if someone does not visit them regularly. However, informants also mentioned positive examples of more extensive individual contacts and (one-on-one) activities: drinking coffee together, going out together, having contact through social media or working as a volunteer at the local soccer club. There were also examples of neighbours who volunteer to drive residents, for example to attend leisure activities.

All informants could provide examples of people with intellectual disabilities joining regular activities and using neighbourhood facilities. Some residents, for example, were active in sports clubs or visited the general practitioner. One informant presented an example of social inclusion in which people with intellectual disabilities participated in a regular activity: '*We joined the toddler gym….so that toddlers could get acquainted with other people on the planet.*' Informants also told stories about taking the initiative in organizing a neighbourhood activity or neighbour contact themselves, in some cases together with residents. In one group home, where residents live in their own apartments, it is standard practice they introduce themselves to neighbours. Also, informants mentioned a barbecue or an

introductory meeting they organized. Two group homes had positive experiences with organizing an activity. In one of them, staff organized 'Neighbours Day' together with the neighbourhood: '*We organized this on a small scale…Neighbours liked it and when we meet them in the shops now, our contact is positive.*' In most cases, neighbours only visited the introductory meeting and showed little interest in the follow-up activities which were organized. Informants did not know the reasons behind this lack of interest but they experienced it as frustrating. In these initiatives, the role of people with intellectual disabilities varies. In some cases, they participate in organizing them, but in most cases staff members play a leading role, according to our informants.

(2) Staff perceptions of residents' needs and capabilities

The second theme in our analysis relates to the residents supported by the group home staff members. This theme can be divided into two subthemes: informants told stories about the needs of people with intellectual disabilities and they discussed their capabilities.

All informants mentioned the importance of meeting the needs of their residents. In their opinion, some residents do not feel the need for increased contact with neighbours, because they are already busy or have their own contacts. Informants in one group home mentioned that residents have no need for increased contact, because they already have strong relations with family in the neighbourhood. Also, within another team, informants told stories about residents who do not want to be associated with the group home, for example when organizing or participating in an activity. However, according to our informants, many of the residents did explicitly mention the need for individual contact, but this could also be with someone from outside the neighbourhood.

The group home staff members did not only discuss their residents' needs, but also their capabilities. Most informants believed residents do not have sufficient social skills to develop contacts with neighbours. According to our informants, residents have communicational or psychological problems which form an obstacle to social contacts: '*Some residents easily become aggressive…neighbours expectations in social contact are sometimes higher than residents can fulfil, which leads to problems.*' Informants also mentioned residents that are in permanent need of care and cannot go out unaccompanied.

As far as neighbourhood activities were concerned, informants mentioned that people with intellectual disabilities have difficulties visiting these activities on their own and developing social contacts during these activities. In most cases, residents need some support at the outset and, in some cases, they need continuous support during these activities.

(3) Staff perceptions of neighbours and neighbourhood

Whether social interaction between people with intellectual disabilities and their neighbours is encouraged or held off also depends on staff members' perceptions of the neighbours and the neighbourhood. Informants' stories varied from fearing possible negative influences of neighbours (e.g. alcohol abuse) to the idea that neighbours were old and unable to undertake activities with residents. Despite these reservations regarding the neighbourhood, the neighbourhood context is also seen as positive. Informants from two neighbourhoods expressed they feel welcome and neighbours are familiar with the group of people with intellectual disabilities. Residents often feel a connection with the village because they know a lot of people and are well known in the shops. In one neighbourhood the situation is different. Here, residents are less familiar with neighbours and the neighbourhood, which is characterized by a high turnover rate and a very diverse population. However, informants mentioned that residents reported they do feel they fit the character of the neighbourhood.

According to informants, neighbours' expectations of people with intellectual disabilities are sometimes too high, for example in terms of reciprocity. Informants reported that this particularly applied to people with a mild and often invisible disability. Some informants mentioned they had the idea that neighbours generally are not very keen on making contact or find it difficult to interact or socialize with people with intellectual disabilities.

Informants, for their part, also had their own expectations regarding the neighbours' behaviour. This was clear from informants' remarks that they expected neighbours to visit joint meetings and to show some patience while their complaints were being dealt with. On the topic of joint activities, one team stressed that neighbours could also take the initiative to involve the group home in an activity. Within another team, there was disappointment about the fact that residents were not invited to an activity while the neighbours involved were always welcome at group home activities. According to informants, residents were also disappointed. Other informants stressed the importance of neighbours communicating any problems directly to them, instead of complaining to other neighbours: '*Neighbours should come to us personally if there are any complaints, otherwise we might deny a resident contact with neighbours because we anticipate neighbours' needs based on rumours.*'

According to the informants, the neighbourhood context as a whole can also be a factor obstructing social contact with neighbours. Some group homes are located in neighbourhoods in which neighbours generally have little contact with each other and opportunities to make contact are scarce, for example because one hardly sees any neighbours outside the home. In one case, informants mentioned a high

turnover of tenants in the flat where the group home is situated. Two other group homes are located on a main road, so many people who pass by are not neighbours.

(4) Staff perceived role in social inclusion in the neighbourhood inclusion

Most group home staff members have a 'wait-and-see attitude' concerning their role in social inclusion and how they would like to incorporate promoting social inclusion in their daily work. However, in three group homes, one or two informants were actively seeking opportunities to participate in the neighbourhood. Various aspects of group home staff's perceived role in neighbourhood social inclusion are described in this section.

Most informants have limited contact with neighbours. They greet each other and in some cases, there is a short conversation. Some informants are thoughtful and bring neighbours Christmas cards, for example. In some cases, informants explicitly mentioned they find it important to establish contact with neighbours and to develop and maintain good relations, for example by helping older neighbours or making an effort to greet neighbours: '*I use every opportunity to make contact with neighbours…. I keep saying hello and in some cases this leads to short conversations*'.

Staff members' intermediary role in disturbances caused by residents was an important topic during all group interviews. However, when there is an increasing number of incidents, informants react in different ways. Some stop investing time and energy in neighbours who complain excessively because they do not see any benefit in it, whereas others consider it their professional duty to stay friendly no matter how unreasonable neighbours react: '*You have to stay friendly to neighbours you would not even consider a friend in your private life*'. In some cases, the disturbance is caused by the neighbours themselves, for example when they are drunk, and informants mentioned the importance of protecting their residents in such situations.

The willingness to provide information to neighbours (psycho education) about how to cope with certain behaviours and providing general information about people with intellectual disabilities is mentioned by some informants. However, informants of one team were very clear about their unwillingness to divulge any personal information to neighbours: '*That goes against your oath of secrecy. You do not have the right to inform neighbours about individual residents*'.

In general, all informants take the perceived needs of their residents as their starting point. If residents express a need for social contacts in the neighbourhood, informants support them in their social skills, if necessary. Informants discuss with residents what is appropriate behaviour and neighbours' expectations and explain that it is not desirable to visit a neighbour every day, for example. In most cases, residents must be accompanied, but informants stressed that they often do not have

enough time to do so. However, some informants explicitly mentioned they try to find time for these kinds of activities. Some informants, for example, initiated a collaboration with the local football club, which resulted in one of the residents starting as a volunteer at the club. Informants also explained how they encourage social inclusion during an activity such as shopping together: '*First, the shop assistants asked ME questions. I told them: these are not MY groceries. Now, they do not ask ME anymore.*'

Contact in the neighbourhood is not a standard part of the individual support plans of people with intellectual disabilities, unless residents have stated their needs for contact with the neighbourhood. Informants mentioned that having a social network in general and/or doing volunteer work are aspects of the individual support plan but that there is no direct link with neighbours or the neighbourhood.

During the group interviews, informants were asked to reflect on their role as a team in furthering social inclusion. Informants supported the goal of promoting social inclusion but experienced a lack of time to focus on neighbour relations: '*We have to make contact with them and maintain these contacts. This takes a lot of time, on top of our other tasks*…' Lack of time was mentioned by most informants. Two teams had experiences with a special staff member who could dedicate time to social inclusion. This so-called ambassador could initiate contacts and set up collaborations with local organizations, according to the informants. In one case, the ambassador also lived in the neighbourhood/village where the group home was located. This created extra opportunities because, as informants said, one's personal network has great potential for e.g. the recruitment of volunteers. During one group interview, it emerged that the function of inclusion ambassador had been cancelled because of financial reasons. Informants within this team were obviously disappointed about this decision, because there was not enough time to embed activities related to social inclusion in their regular work processes. The former ambassador would have liked to develop a training for staff members. These training opportunities are currently not available for staff members, according to all informants.

Collaboration with local organizations (for example, local welfare organizations) seemed to be not very common within the interviewed teams. In some cases there was cooperation with a local organization or association, for example when a resident worked there as a volunteer or when people with intellectual disabilities joined an activity. Informants use their own network and engage the service provider of the group homes to look for suitable activities or voluntary work. However, this does not seem to yield satisfactory results because informants stated there is still a need for more individual contact. During some interviews, initiatives to seek cooperation with local organizations were mentioned. These were, for example, visiting a lunch organized by a local partnership that facilitates activities in a community centre, or contacting the local welfare organization to cooperate in buddy projects.

(5) Staff perceived role of service provider

Informants experience little to no involvement of the service providers running the group homes. For urgent matters, for example related to a disturbance, informants can turn to the manager and issues related to resident care can be passed on to an expert team, which includes a psychologist or a remedial teacher. Informants reported that in most cases they solve issues themselves. They work in self-managing teams and organize the care and support of their residents together. Some informants mentioned that although social inclusion was a spearhead goal of their service provider, in practice these policies did not result in any identifiable activities or support. Informants were asked if they were facilitated in any way in their role in furthering social inclusion. Some mentioned that their service provider did encourage them to look for volunteers but that they were not allowed any extra time or means to do so.

Informants experienced a lack of time to develop activities related to social inclusion. In some group homes, there is only one staff member present, so it is not possible to accompany a resident to e.g. a group activity. In some group homes, there are two staff members present, which allows more room for supporting residents.

Not only is there a lack of time, there is also a lack of appropriate training or counselling, or informants are unaware of possibilities for training. Due to this lack of time many informants are not open to (potential) training opportunities. In one team, staff members had followed a training program which had also covered neighbourhood social inclusion. However, informants mentioned that the knowledge they had acquired had largely been forgotten, possibly because it was not embedded in any ongoing training scheme. In another team, cutbacks had led to the cancellation of the ambassador function and this had created problems for embedding social inclusion in the teams, according to the informants.

During half of the team interviews, informants mentioned the unattractive physical environment of the group homes. The group homes are inaccessible and not particularly inviting to neighbours. As one informant stated: '*The building is like a fortress*'.

Discussion

The aim of our study was to gain insight into the individual perceptions and the institutional environment of group home staff and in relation to staff´s professional role identity regarding neighbourhood social inclusion. In earlier studies, we did not find any in-depth analysis of the professional role identity of group home staff members

in relation to their individual perceptions and underlying opinions, and the support staff experienced from service providers. On the whole, the stories of our informants show that their individual perceptions and the (lack of) support they experience from service providers do not encourage them to promote social inclusion. Using the concept of role identity, we were able to provide insight into possible reasons for this deficiency, and develop specific recommendations to enhance social inclusion.

Perceptions and professional role identity

Reflecting on the stories of our informants, we found that staff members' perceptions of their residents, the neighbourhood and their own role implicitly create barriers for enhancing social inclusion in the neighbourhood. The neighbourhood is not a standard topic of discussion with residents and they do not seem to view the neighbourhood in terms of opportunities. Group home staff members support the goal of improving social inclusion, but they also want to protect their residents from any harm that may come from the world outside of the institution. Often, this ambivalence results in putting more weight on possible risks and problems than on opportunities and residents' desires for engaging with the neighbourhood. This was illustrated in our study by the dilemma whether or not to share privacy-sensitive information with neighbours when this might provide opportunities for sustainable neighbour contacts. In general, the informants in our study seem to have difficulties coping with the dilemmas they face concerning social inclusion, and therefore often choose not to take the risk their residents might be harmed, which corresponds with their caring role.

The emphasis on protection could be due to the fact that staff are originally trained to provide care, and the larger institutions were developed to protect people from any harm that might befall them in society (Mans, 1998). This caring role is deeply embedded in their professional role identity and in the way they view the needs and capabilities of their residents (see also McConkey & Collins, 2010a; Salmon, Holmes, & Dodd, 2013). Activities to promote social inclusion always involve the risk of being harmed (Jahoda et al., 2010; Bredewold et al., 2016). Striking a balance between the two may pose a considerable ethical dilemma to staff members (e.g. Jenkins & Davies, 2011; Pelleboer-Gunnink et al., 2017). However, the small number of informants that did dare to expose their residents to possible harm and focused on opportunities in the neighbourhood, provided valuable examples of neighbourhood social inclusion. This might suggest that weighing the factors in the ethical dilemma differently could provide opportunities for social inclusion.

Institutional environment and the professional role identity

Although the service providers involved in our study endorse the significance of neighbourhood social inclusion and have developed policies regarding social

inclusion, daily practice shows that group home staff members struggle with creating opportunities for social inclusion in the neighbourhood (see also Forrester-Jones et al., 2006; Tossebro et al., 2012). Staff members in our study are aware of the goal of social inclusion in the policies of their organizations, but in most cases do not experience any active support from the organization in achieving this goal. Our informants experience a lack of time for activities to promote social inclusion, a lack of training opportunities, and in some cases feel that priorities are continuously shifting, for example when the function of inclusion ambassador is discontinued.

Despite the lack of support experienced by all informants, we did find examples of neighbourhood social inclusion in some informants' stories. These staff members seem to make different choices in the dilemma of protecting residents from harm and encouraging involvement in the neighbourhood. Developing a professional role identity in social inclusion requires providing more facilitative, enabling support to residents than in the traditional caring role (e.g. Mansell, 2006). Developing such a role asks for a fundamental change in culture: staff members need to be supported in making different choices regarding the dilemmas they face. To be successful, this fundamental change in the behaviour of staff members must be supported by organizational adjustments and appropriate management (e.g. Salmon et al., 2013).

Apart from the behavioural changes required to enable social inclusion, some of the informants mentioned the physical environment of the group homes. The physical layout is not seen as very inviting to neighbours, for example a building 'that looks like a fortress'. Earlier studies show that some physical features of the group homes, such as a high fence or the absence of a garden, reduce opportunities for social contacts between neighbours and people with intellectual disabilities (e.g. Van Alphen et al., 2010).

Practical implications

We conclude that social inclusion is not a standard element of the professional role identity of group home staff members, and we recommend service providers support staff to encourage neighbourhood social inclusion to become part of their professional behaviour. To create opportunities for neighbourhood social inclusion, staff members need to be supported in developing the necessary skills. Providing training and counselling increases the staff members' commitment to social inclusion (e.g. Meyer & Allen, 1991). We recommend service providers investigate which skills are needed and how these can be acquired.

One promising method could be peer-to-peer coaching. Working in a team is conducive to managing the difficulties inherent in change, removing opposition against change and increasing the motivation to work on a change such as actively promoting social inclusion (Salmon et al., 2013). During the group interviews, we

found that discussing the topic of social inclusion inspires staff members to think about creating and developing opportunities for social inclusion in the neighbourhood. Staff members came up with ideas like adding 'social inclusion' to their annual workprogramme, putting more effort into getting acquainted with neighbours, and discovering the needs of their residents regarding the neighbourhood, as well as ideas such as organizing group activities and inviting neighbours to specific activities. This illustrates that peer-to-peer coaching (including sharing good practices) is helpful in discussing barriers staff experience and suggesting possible ways of encouraging social inclusion. Creating a safe environment is an important condition for discussing these topics and it is therefore important that service providers invest in developing and maintaining strong relations within the teams working in a group home (e.g. Hensel, Hensel, & Dewa, 2015; Hutchison & Kroese, 2015). Team cohesion is a strong determiner for staff members' motivation and greatly influences how staff members perform (e.g. Hutchison & Kroese, 2015).

Offering training opportunities to staff members in shifting from a caring to supporting role seem to be essential. It suggest a change in culture of the professional development of group home staff members supporting people with intellectual disabilities. This implies that not only service providers have to take their role in initiating relevant training but also educational institutions that train professionals should pay attention to this cultural shift. The study of Jones et al. (2008) shows the role of education in how staff members perform their professional role. We would recommend educational institutions to reflect on the content of their curriculum related to social inclusion and to develop modules that focus on social inclusion together with service providers.

The lack of skills experienced by staff was also evident from the fact that neighbourhood social inclusion is not a standard topic of discussion with residents or included in their individual support plans. Group home staff members emphasize the needs of residents as a starting point in their support, but since social inclusion is only a limited part of their professional role identity, the neighbourhood plays hardly any role in their communication with residents. Service providers could encourage staff members to include the neighbourhood in individual support plans. To achieve this, the goal setting method might be useful (McConkey & Collins, 2010b). McConkey and Collins (2010b) found that goal setting can be an effective way to enhance social inclusion. Neighbourhood social inclusion can be translated into well-defined support needs and goals within the individual support plan. This goal setting can be tailored to the needs of residents. Supervision on staff's focus on uncovering and meeting the needs of residents is recommended (e.g. Salmon et al., 2013; Bradshaw, 2000).

Group home staff members mentioned the physical layout of the group home as a barrier for social interaction between residents and neighbours. Therefore, we

suggest that service providers involve neighbours, staff members and (potential) residents in the development of the physical layout of a group home. Many group homes located in the neighbourhood had an unattractive appearance and did not seem very inviting to neighbours. Besides involving all stakeholders in the construction of a group home, service providers could think of ways to transform the existing group homes into more attractive, more inviting buildings by removing fences and creating open spaces where residents and neighbours can see each other (see also Van Alphen et al., 2010).

Limitations and future research

The group interviews proved a rich source of information and created an environment in which informants inspired one another. Possibly, some informants were not able to tell their story freely because they felt unsafe within the group context. Although we have no reason to assume our data lack valuable information, further research using individual interviews might add new perspectives.

Our study was conducted among nine group homes supported by four service providers. Even though these service providers have an inclusion agenda, group home staff members did not experience social inclusion as an important aim in their job. Future research might focus on the interaction between service providers and group home staff members and including a more diverse range of service providers could also be recommended.

As mentioned above, we did not find any earlier studies which focused on the behaviour of staff members vis-à-vis social inclusion in relation to their professional role identity. It is important to realize that the professional role identity of the staff members included in our study is determined by the Dutch context. Our findings corroborate findings from studies conducted in other Western countries, which also point to the importance of a shift from a caring to a supporting role to enhance social inclusion (e.g. Abbott & McConkey, 2006; Hunter & Perry, 2006). However, we have not addressed any cultural differences in the organization of care that may affect individual role perceptions or the institutional context. Therefore, we cannot assure that our findings are directly transferable to other countries.

Finally, we would recommend future research on the role of peer-to-peer coaching in enhancing social inclusion. We cited some literature that shows how team support can help staff members in adopting skills during an evolving situation (e.g. Salmon et al., 2013) but these studies did not specifically focus on a change such as incorporating (neighbourhood) social inclusion. The experiences during the group interviews are in line with these studies but measuring the effect of peer-to-peer training was not an aim of this study. We would recommend further study of its effects and of how service providers can support this kind of training.