TOWARDS OPTIMAL SUPPORT FOR
PEOPLE WITH MILD INTELLECTUAL DISABILITIES
AND SEVERE CHALLENGING BEHAVIOUR

Unconditional, contextual and safe

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TABLE OF CONTENTS

CHAPTER 1

1

General introduction

David

David is 25 years old and has a mild intellectual disability. In addition, he has autism, is addicted to drugs, and has attachment problems. David has had a difficult youth. He often felt unsafe because his parents neglected him, making him feel he was on his own. His father left the family when he was two, and his mother often drank under the pressure of financial problems. David would regularly get into a rage and cry. Since the age of twelve he has received professional support from a range of care services, but his mild intellectual disability went unnoticed until he was 20. In response to his aggressive behaviour, these services would repeatedly send David away to a different service, telling him and his mother that they were not able to provide the support he needed. As a result, David has already lived in ten different places, including facilities for child and youth psychiatric care, youth care, ambulant care, prison, residential services for people with mild intellectual disabilities and forensic care. David was able to build positive relationships with a few staff members during his stay at care facilities, but either the personnel left the facility or he had to leave. He does not have much faith in staff anymore. He sees the despair in the eyes of support staff and therapists, at a loss as to how to support him, or staff make fun of him, do not understand him and restrict him. The negative experiences of his youth and the way he has been treated at care services sometimes overwhelm David with negative emotions and thoughts, which he finds hard to control. This is why he can at times become very angry and aggressive.

Currently, David is living at a forensic care facility, where he is often involved in incidents with other service users or with staff. Because of his fights and threats, staff often use coercive measures, like physical restraint. In addition, he must stay in his room by himself almost all day because a group setting is considered unsuitable for him. The long days are boring for David and make him feel useless. He has only sparse contact with his mother because she keeps off additional communication. David feels lonely, isolated, and misunderstood, and has little hope for a better life in the future.

People with mild intellectual disabilities or borderline intellectual functioning and severe challenging behaviour

David's life story is illustrative of people with mild intellectual disabilities or borderline intellectual functioning who exhibit severe challenging behaviour (CB). Many grow up unsafe because of adverse childhood experiences (ACE) (Hassiotis et al., 2019; Nouwens et al., 2017a, 2017b). These potentially traumatic events during childhood include emotional, physical, and sexual abuse and neglect, and problems in the living environment (e.g., parental domestic violence, substance abuse, mental illness, household poverty) (Hassiotis et al., 2019; Hughes et al., 2017). The adverse experiences

during childhood have a big impact on later life, both physically and mentally (Hughes et al., 2017; Kalmakis et al., 2015). As a result of ACEs and other risk factors, many people with mild intellectual disabilities or borderline intellectual functioning are more likely to have comorbid psychopathology, like addiction problems, impulse control disorders, personality disorders, psychoses, and posttraumatic stress disorders (van Duijvenbode & VanDerNagel, 2019; Hassiotis et al., 2017; Nieuwenhuis et al., 2019; Tsiouris et al., 2011; Wieland et al., 2015). Their sense of safety is affected by negative experiences with professionals and local authorities (Neijmeijer et al., 2020). They are frequently transferred within and between settings while their intellectual disability tends to go unnoticed for a long time and the care received is mostly inadequate (Nouwens et al., 2017a, 2017c; Olivier-Pijpers et al., 2019, 2020; Philips & Rose, 2010*).* They often have financial problems or debts, and have recurring encounters with the police, which regularly results in prison sentences and criminal or civil measures on admission (Fogden et al., 2016; Nouwens et al., 2017a, 2017b; Neijmeijer et al., 2019).

People with mild intellectual disabilities have "significant limitations in both intellectual functioning and adaptive behaviour which originated before the age of 22" (www.aaidd.org). They have a reduced general mental capacity to learn, reason and solve problems, among others. In addition, they have limited conceptual, social, and practical adaptive skills, which people learn and use in daily life, such as literacy, interpersonal skills, and personal care (www.aaidd.org). In the Netherlands, 2.1% of the adult population is estimated to have a mild intellectual disability (IQ 50-70) and 4.1% to have borderline intellectual functioning (IQ 70-85) combined with insufficient social and life skills to be self-reliant (Woittiez et al., 2019). Those with borderline intellectual functioning often face the same challenges in participating in the complexity of society and have individual and family characteristics and needs similar to those of people with mild intellectual disabilities (Nouwens et al., 2017a; Snell et al., 2009). Unlike most countries, in the Netherlands people with borderline intellectual functioning and limitations in adaptive functioning have access to the same care and support services as people with an intellectual disability, which are more adjusted to their cognitive abilities and skills (Woittiez et al., 2018; Zorginstituut Nederland, 2024).

There is a high prevalence of CB in people with mild intellectual disabilities or borderline intellectual functioning[1] (Bowring et al., 2017; Lundqvist, 2013; Nieuwenhuis et al., 2022). CB can be expressed as externalising behaviour, such as verbal or physical aggression, or internalising behaviour, such as self-injurious behaviour (e.g., cutting, head-banging) or suicidal behaviour (van den Bogaard et al., 2019; Bowring et al., 2017). Behaviour is defined as challenging when in a particular social and cultural context it is considered

[1] Henceforth, for readability referred to in this chapter as mild intellectual disabilities.

inappropriate and of such an intensity, frequency, or duration to be aversive, stressful, or harmful for the person exhibiting the behaviour and/or others (Embregts et al., 2019; Emerson & Einfeld, 2011). In the case of severe CB, the impact of the behaviour involves serious damage or threats to the individual, others involved and/or society (Bowring et al., 2017; Embregts et al., 2019). Individuals who exhibit CB may experience negative physical and psychological consequences because of injuries, social exclusion, increased physical restrictions and off-label use of psychotropic medications. In addition, they often have to cope with repeated transfers across or between settings (care or judiciary) (Emerson & Einfeld, 2011; Heyvaert al., 2015; Jonker et al., 2024). To others in the environment (e.g., family carers and support staff), CB can also have a significant impact on quality of life through physical harm and stress (Griffith & Hastings, 2014; Smyth et al., 2015). Among support staff it can contribute to emotional exhaustion and depersonalisation, which may eventually result in burnout (Ryan et al., 2019; Smyth et al., 2015).

CB is seen as the result of a complex interplay of biopsychosocial, developmental, and environmental factors (Embregts et al., 2019; McGill et al., 2020). These factors include ACEs, psychological disorders and the type and quality of support given by the environment (Embregts et al., 2019; McGill et al., 2020; Nijs et al., 2022). Persons with mild intellectual disabilities who have complex problems and exhibit CB have other support needs than people with mild intellectual disabilities in general (Dowse et al., 2020; Nouwens et al., 2017c). This is why professionals in the Netherlands frequently refer to these individuals by using a specific label (i.e., LVB+). Embregts et al. (2023) have described the characteristics and support needs of people with LVB+. A first Dutch guideline to support professionals in how to identify the causes of CB and how to provide care and treatment was also published (Multidisciplinaire Richtlijn Probleemgedrag bij volwassenen met een verstandelijke beperking, Embregts et al., 2019).

Difficulties in providing a context that meets service users' support needs

In the Netherlands, most people with mild intellectual disabilities and severe CB receive long-term care and support in residential facilities for persons with intellectual disabilities, in (secure) forensic or mental healthcare settings, or through outreach ambulant treatment from multidisciplinary (flexible) assertive community treatment teams (FACT) (Neijmeijer, 2020). Within these forms of care, aligning with service users' support needs can be challenging for several reasons. First, the combination of problems (mild intellectual disabilities, severe CB, and psychiatric disorders) places great demands on staff members which are sometimes difficult to fulfil. For example, staff working in mental health care facilities, addiction services, or the criminal justice system regularly

lack knowledge and skills to recognise service users' mild intellectual disability or on how to adjust communication and support (van Duijvenbode & VanDerNagel, 2019; Nieuwenhuis et al., 2017; Pouls et al., 2023; Whittle et al., 2017). Staff working in residential facilities for people with intellectual disabilities might lack expertise to identify symptoms of psychiatric disorders. As a result of these deficits, service users might receive no or inadequate treatment and incorrect diagnoses (Pouls et al., 2023; Whittle et al., 2017; Wieland & Zitman, 2016). Furthermore, it can be difficult for staff to manage CB adequately (Neimeijer, 2021; Olivier-Pijpers et al., 2019). Staff may exercise control, including restrictive measures, because they need to follow organisational procedures (Neimeijer, 2021; Ravoux et al., 2012). Consequently, service users may experience pain and emotional discomfort (Griffith et al., 2013; McKenzie et al., 2018; Olivier-Pijpers et al., 2020). Staff may also show inadequate behaviour when they experience negative emotional reactions (e.g., fear, anger) and stress in response to service users' CB (Ryan et al., 2019). Negative emotions are associated with much more support-seeking, assertive control, and hostile behaviour towards service users, which can trigger service users to exhibit CB (van den Bogaard et al., 2018, 2023; Willems et al., 2016). Negative emotions additionally increase the risk of staff burnout, absenteeism and turnover (Rose et al., 2004; Ryan et al., 2019; Smyth et al., 2015). Staff are more likely to experience (more) negative emotions and stress in the case of persistent CB, externalising CB, low self-efficacy for managing CB, and when they have difficulty understanding CB (Bromley & Emerson, 1995; Mills & Rose, 2011; Rose et al., 2004; Ryan et al., 2019; Zijlmans et al., 2012).

At the organisational level, providing care and support that meets service users' needs is challenging because organisations need to take numerous aspects in service users' direct and indirect environment into account. These include interactions between service users and staff, interactions between people around service users (e.g., support staff, other staff, family), the organisational context (e.g., vision and policies), and aspects in the environment outside the organisation (Olivier-Pijpers, 2020). In all these different contexts challenges may arise, such as staff turnover, which is particularly a problem among staff engaged with service users that exhibit CB (Bureau Bartels, 2020). Instability in staff teams interferes with a consistent staff approach and with building and maintaining meaningful relationships between service users and staff, both important for CB management and service users' well-being (Clarke et al., 2019; Deveau & Rickard, 2024; Olivier-Pijpers et al., 2019; 2020). In addition, the collaboration and cooperation between different healthcare providers, which is necessary to deal with the complex multiple problems of service users, is not always optimal (Nouwens et al., 2017c). Meeting the needs of service users can also be complicated because of laws and regulations (Chester et al., 2017; MacDonald et al., 2011; Neimeijer, 2021). As such, providing optimal care and support to people with mild intellectual disabilities and severe CB – while managing all aspects in their direct and indirect environment and the interplay between them – is challenging,

and organisations do not always succeed in their mission/task. When care facilities feel incapable of providing support that meets the needs of service users, service users are often transferred to other facilities in often more restricted (forensic) settings or end up in prison (Nouwens et al., 2017b; Olivier-Pijpers et al., 2020; Philips & Rose, 2010). For some service users this process repeats itself, leading to recurrent transfers and discontinuity between different settings (e.g., youth care, intellectual disability services, forensic care, prison), including a loss of trust in professionals and hope for a better future – like David experienced.

Project Pro

In 2014, it was observed in practice and by an independent Dutch service that provides advice and support in cases of severe CB (Centre for Consultation and Expertise, CCE) that some people with mild intellectual disabilities, psychopathology and severe CB continuously experienced involuntary transfers because their behaviour could not be managed adequately. To reflect on a possible solution for these individuals, healthcare professionals with expertise in the field of care for people with mild intellectual disabilities, intensive support needs and CB came together. They proposed an approach of unconditional, lifelong care by multiple residential care providers with a focus on service users' needs, whereby CB does not translate into forced transfers. Part of the approach was to deploy competent and stable staff teams. In addition, the healthcare professionals advocated for strong staff support to prevent negative emotions among staff, meet service users' needs and manage CB adequately. A supportive context at other levels of the organisation was also considered important. There should be a strong organisational commitment, also from board members. As a result, in 2017 the project Pro was started by six organisations: three residential facilities for people with mild intellectual disabilities (ASVZ, Pluryn, Trajectum), two care administration offices (VGZ, Zilveren Kruis) and the Centre for Consultation and Expertise, with funding of the Dutch Ministry of Health, Welfare and Sports. The two care administration offices selected 24 adults with mild intellectual disability, comorbid psychopathology and severe CB, based on advice given by the CCE. The selected individuals had to satisfy a range of criteria. In addition to severe CB, comorbid psychopathology and recurrent transfers, criteria included a lack of positive prospects for the future, a lack of self-efficacy in the current organisation to manage CB and a need for long-term housing and support. An allowance to receive care under the Long-Term Care Act (Wlz) and having no current detention under hospital order were also part of the criteria. The care administration offices assigned the 24 individuals evenly to the three residential facilities, so each facility would provide housing and support to eight service users. These service users were divided over two residential homes (i.e., four

service users per residential home). At one of the residential facilities, four service users do not live in a group setting but in individually clustered apartments.

Pro principles

To improve the quality of life of Pro service users, Pro formulated eight principles, the first six aimed at service users. Pro: (1) focuses on establishing "a life as ordinary as possible"; (2) is not primarily focused on CB or its prevention, but rather aims to meet service users' needs as much as possible; (3) puts the pedagogical environment first and adapts it to the individual needs of service users; (4) encourages the development of (self-)confidence; (5) offers unconditionality in the support relationship; and (6) offers unconditionality in terms of housing and residence (Pro, 2023; Valenkamp, 2020). Pro therefore focuses on providing a context that meets the needs of service users with respect to different domains of quality of life (e.g., emotional and physical well-being, social inclusion, interpersonal relationships). Key aspects of the context are unconditional housing and unconditional relationships. Therefore, Pro organisations seek committed support staff with whom service users can build meaningful relationships based on respect, sincere interest, humanity and trust. Staff who are available and show proximity make service users feel understood, likewise providing autonomy and clear boundaries (Griffith & Hastings, 2013; Neimeijer et al., 2020; Nijs et al., 2022; Simons et al., 2021; Wolkorte et al., 2019). Moreover, they want to provide a day structure with meaningful daily activities, and meaningful relationships, and a physical living environment that is safe, predictable (i.e., clear, spacious, ordered), homely and personalised (van den Bogaard et al., 2019; Casson et al., 2021; Neijmeijer et al., 2020; Roos et al., 2022).

The residential facilities implemented the Pro principles according to their own methods. One of the facilities (ASVZ) developed and applies the Triple-C intervention (Tournier et al., 2020). This values-driven intervention for people with intellectual disabilities and CB is focused on providing an ordinary life as much as possible by fulfilling their human needs. To that end, Triple-C consists of three main pillars: an unconditionally supportive relationship with staff; looking at CB as an expression of unfulfilled need; and providing meaningful daily activities (van Wouwe & van de Weerd, 2021). Successfully performing meaningful activities together is an important mechanism of Triple-C, while it is assumed to contribute to relationship-building, competencies and trust in the environment. Another mechanism is clear guidance and assistance for support staff given by the "support triangle" of the team leader, manager and psychologist. To that end, Triple-C is focused on a strong collaboration between these professionals, and on regular reflection on whether they are working according to the Triple-C values. Last, an important pillar is a shared collective ambition by all professionals in the organisation to work according to the Triple-C vision and values (Tournier et al., 2020).

One of the other two residential facilities (Trajectum) applies many elements of the Triple-C intervention, albeit with some differences. For example, they use beepers and early recognition methods for CB (Fluttert et al., 2008), which are not part of the Triple-C intervention. The third residential facility (Pluryn) does not use the Triple-C intervention, but their vision of care shows many resemblances. The facility aims to give service users a meaningful future perspective by providing a safe and stable environment that is as non-restrictive as possible. As in Triple-C, the facility focuses on fulfilling service users' needs instead of their CB (Rasing, 2018). However, Pluryn differs by applying an individual approach, while the other two facilities use a group-based approach. The individual approach consists of a specified daily programme for each service user, aligned to personal capabilities, needs and interests. In the group-based approach, especially in the beginning, activities are performed together to build trusting relationships between service users and support staff (and with other residents) while also taking personal capabilities, needs and interests into account (Valenkamp, 2020).

The seventh Pro principle pertains to the healthcare professionals: Pro pays attention to staff's well-being and competency development. The Pro organisations consider competent and resilient staff as essential to providing Pro care. Therefore, staff members are supported by a multidisciplinary team, including close involvement of a team leader (or coordinating staff member), manager and psychologist. In addition, the Pro organisations invest in training and coaching to develop support staff's skills and help them understand and work according to the vision of Pro (Pro, 2023; Valenkamp, 2020).

The eighth and last Pro principle concerns the organisational level, namely that professionals in all positions, including board members and managing directors, must take responsibility for Pro care in terms of content, support and cooperation (Pro, 2023). Providing long-term Pro care requires board members and managing directors to be committed to the Pro vision and to facilitate where necessary. They must dare to stick to the principle of unconditional care when severe CB occurs instead of turning to a controlling approach, invest in skilled staff and collaborate with stakeholders to increase their understanding of the Pro vision (Valenkamp, 2020).

The present thesis: aims and outline

The overall aim of this thesis was to expand the knowledge of how residential facilities and stakeholders outside the facility can provide a context that improves the quality of life of people with mild intellectual disabilities, comorbid psychopathology and severe CB. As explained above, some individuals with mild intellectual disabilities and severe CB face a vicious cycle of lack of appropriate support, severe CB, and transfers to new

environments, resulting in despair and low confidence in a positive future life. It is therefore important to acquire additional knowledge about how residential facilities and stakeholders outside the facilities can provide a supportive context that prevents transfers. In the present thesis we focus on project Pro, whose objective is to improve quality of life by providing a context that meets service users' needs. The main aim of the thesis is to gain insight into what is important in bringing the Pro principles into practice and how the principles are operationalised. While exploring the operationalisation of principles, aspects of safety inside as well as outside the Pro residential facilities will be investigated in more detail. One of the initial aims of this thesis was to explore experiences with Pro and its outcomes over time from the perspectives of both service users and professionals. However, comprehensive analyses could not be conducted due to limited data[2].

More specific research questions are formulated in separate studies. **Chapter 2** presents the results of a concept mapping study with the following central question: What is important when setting up a new team of support staff to work in a new residential home for service users with mild intellectual disabilities and psychopathology who display severe challenging behaviour, according to the vision of Pro? Knowing what contributes to a solid start can positively affect service users and their context in the short and longer run. For example, it may limit negative experiences and negative emotions in the beginning and foster trusting relationships. The perspectives of (1) service users, (2) support staff, and (3) psychologists and a team leader were considered in this study.

Chapter 3 is about giving and perceiving support as professionals. In this chapter we report results of a quantitative study on (1) staff's perceived team climate and staff's experienced support from team leaders, managers, psychologists and other staff members, and (2) the associations between support at work and team climate versus support staff's job satisfaction and well-being. In addition, we test whether a more positive mutual collaboration between professionals around a team (team leader, manager, psychologist) relates to more experienced support and a better team climate among staff.

Chapters 4 to 6 concern the subject of safety. From qualitative data collected as part of a mixed-method longitudinal study on Pro, safety appeared to be an important and recurrent theme in relation to providing support to Pro service users according to the Pro principles (e.g., because of traumatic past experiences of service users and the impact

[2] A longitudinal study was designed to explore experiences and outcomes. However, because of a substantial amount of missing data, no thorough quantitative analyses could be performed, which are required to meet the aptitude test for the thesis. As an alternative, a Dutch fact sheet will be published in 2025 with more details on the longitudinal study to Pro study and a reflection on the available results.

of service users' severe CB). **Chapter 4** addresses the feelings of safety of Pro service users. Feeling safe is a human need, which Pro aims to fulfil. There are two research questions. The first focuses on the meaning of feeling safe for people like service users in Pro according to professionals in various roles (from support staff to board members) and service users themselves. The second research question concerns the identification of factors that affect the feelings of safety among Pro service users (i.e., individuals with mild intellectual disabilities and severe CB in residential care). To answer the research questions, qualitative data were analysed from a longitudinal study on Pro (fieldnotes of non-participant observations and informal unstructured interviews, and document analyses) and from additional semi-structured interviews and focus groups among service users and professionals in various roles.

Next, **Chapter 5** describes how the Pro organisations provide safety and quality of life to service users without reverting to a controlling support style after severe CB. Qualitative data collected during longitudinal research on Pro and during additional semi-structured interviews and focus groups among professionals were also used for this chapter.

In **Chapter 6** safety aspects are also discussed, but in relation to community participation by service users as in Pro. Based on qualitative research, the chapter describes what residential facilities and their stakeholders outside the facility do to promote safe community participation by people with mild intellectual disabilities and severe CB, taking the feelings of safety of service users and their environment into account. Qualitative data for this study consisted of transcripts of interviews and focus groups. Professionals in various roles of the Pro residential facilities and stakeholders of Pro outside the facilities participated.

Finally, the general discussion in **Chapter 7** presents a summary of the main results, the strengths and limitations of the present thesis, and directions for future research. Implications of the results for policy and practice are also discussed.

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CHAPTER 2

2

Setting up a new team of support staff for people with mild intellectual disability or borderline intellectual functioning and severe challenging behaviour: A concept mapping study

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Abstract

Background

Studies about teams of staff supporting people with intellectual disability have focused on team performance of existing teams. This study aimed to examine important factors in the process of setting up a *new* team of support staff. Specifically, we considered the process for a team that supports service users with mild intellectual disability or borderline intellectual functioning who display severe challenging behaviour from the orthopedagogical perspective (i.e., with a focus on contextual factors).

Method

Three participant groups (service users, support staff, and professionals supporting a team) participated in a concept mapping procedure, including generating statements in interviews and focus groups, sorting, and rating. An expert group interpreted the results.

Results

Important factors to one or more groups were: service users and support staff getting acquainted early, team safety, social support, a shared vision, and a positive reputation of the new home.

Conclusions

Four core outcomes were addressed that may help service organisations to provide an environment matching the needs of service users who show severe challenging behaviour from the start.

About 10%–25% of the people with intellectual disability display challenging behaviour (e.g., aggression), some (4%–10%) in severe forms (Bowring et al., 2017; Lowe et al., 2007; Sheehan et al., 2015). The development and maintenance of challenging behaviour can be ascribed to a complex interplay of factors. These factors relate to characteristics of the individual with intellectual disability, such as co-occurring psychopathology, interactions with others, such as support staff and family, and the environment, such as organisational vision and values (Embregts et al., 2019; Olivier-Pijpers et al., 2018; Schalock et al., 2010). Challenging behaviour can seriously affect the lives of individuals due to physical injury, increased use of restrictive practices, and frequent transfers to or between residential and/or forensic services (Emerson & Einfeld, 2011; Griffith et al., 2013). Individuals who show severe challenging behaviour and experience repeated transfers continually need to adapt to new, sometimes even more restrictive settings with unfamiliar support staff. This can create feelings of helplessness and fear about the future (Griffith & Hastings, 2014). Moreover, these transfers make it hard to build trusting therapeutic relationships that are necessary to provide feelings of safety and support in dealing with stress (Hamadi & Fletcher, 2021; Janssen et al., 2002). To break this pattern and improve the quality of support, some healthcare organisations decide to set up a new (residential) home with a new team of support staff for people with intellectual disability who display severe challenging behaviour.

Several factors have been reported that may affect the quality of support and/or the occurrence of challenging behaviour displayed by people with intellectual disability. At the level of support staff, many studies have found that positive meaningful interactions and high-quality interpersonal relationships between support staff and people with intellectual disability can reduce challenging behaviour and improve support (e.g., Nijs et al., 2021; Olivier-Pijpers et al., 2020a). These interpersonal relationships appear to be affected by various factors. Examples of such factors are interactive principles (e.g., trust), staff's attributions towards the causes of challenging behaviour, and emotional reactions (van den Bogaard et al., 2019; Simons et al., 2021; Willems et al., 2016). At the team and organisational level, factors such as power imbalances, high staff turnover, and effective leadership have been related to challenging behaviour (Olivier-Pijpers et al., 2020a). Effective leadership, as well as a positive organisational culture with shared values, also appear to contribute to high-quality support (e.g., Bigby et al., 2015; Gomes & McVilly, 2019). Furthermore, coaching, support, and appreciation of support staff have been shown to enhance the support of people with intellectual disability who show challenging behaviour (Nijs et al., 2021; Olivier-Pijpers et al., 2018).

The most relevant studies usually focused on factors that influence the support provided by existing long-standing teams (e.g., Buljac-Samardžic et al., 2012; Gomes & McVilly, 2019; Knotter et al., 2013). To our knowledge, no studies in the field of intellectual disability

have focused on the process of setting up a new team of support staff for new service users with intellectual disability who display challenging behaviour. However, knowledge regarding the process of setting up a new team of support staff seems relevant as well. This might help service organisations to provide a solid start, optimising their support in the short and longer run. A good start may for example limit negative (failure) experiences and negative emotions. On the contrary, a difficult start with negative interactions between the new service users and support staff can increase challenging behaviour (van den Bogaard et al., 2019) and hinder the development of trusting relationships. In the present study, we therefore explored the experiences of service users and professionals involved in the Dutch collaborative Pro (see Setting). The organisations in Pro established residential homes in 2018–2019 for new residents with mild intellectual disability (IQ 50–69) or borderline intellectual functioning (IQ 70–85) who show severe challenging behaviour. We aimed to identify what needs to be taken into consideration in the process of setting up a new team of support staff for new service users from the perspectives of three groups (i.e., service users, support staff, and other professionals). To this end, we explored their insights and experiences by a mixed-method concept mapping procedure (Trochim, 1989).

Methods

Setting: Pro

We conducted the study among people who were involved in de project Pro. Pro has been established in 2017 by three large Dutch residential service organisations for people with intellectual disability, two care administration offices, and the Dutch Centre for Consultation and Expertise (CCE). The aim of Pro is to increase the quality of life of people with mild intellectual disability or borderline intellectual functioning who display severe challenging behaviour, have co-occurring psychopathology, and long histories with frequent transfers from one (forensic) location to the other. To that end, the Pro-organisations put an end to their relocations to improve their perspective of life. At Pro, a core principle is to be unconditional in the support offered to service users with respect to their residence and their relationships with support staff. The Pro-organisations take the orthopedagogical perspective (van Gennep, 1997), which means that they focus on contextual factors. They consider challenging behaviour to be often a product of the interaction between an individual and his/her environment. To this end, Pro concentrates on fulfilling service users' needs by trying to influence the environment rather than striving to control challenging behaviour (Tournier et al., 2020; Valenkamp, 2020).

Participants

A total of 23 adult participants took part in the study. During the time of data collection all participants lived or worked at a Pro residential home or had just recently left (i.e., their involvement ended within 3 months before the data collection). The participants were divided into three groups: (1) service users with mild intellectual disability or borderline intellectual functioning and diagnosed and undiagnosed psychopathology (e.g., substance use disorders or personality disorders), who display severe challenging behaviour, (2) support staff, and (3) professionals supporting a team of support staff (i.e., 5 psychologists, 1 team leader), referred to as *supporting professionals*. The invited professionals were involved in Pro since the start, except one. However, this professional had been working at a Pro home for more than a year. The invited service users were (1) living at a Pro home for at least 6 months, (2) had the mental capacity to decide for themselves whether they wanted to participate, and (3) capable to conduct the concept mapping tasks according to their psychologist. To decide on the service users' capability, the psychologist took their cognitive skills, adaptive skills, and psychopathology into consideration. Socio-demographic details about the participants are provided in Table 1.

Table 1. *Characteristics of Participants*

	Service users (*n*=11)	**Support staff (*n*=6)**	**Supporting professionals (*n*=6)**
Gender			
Male	10	4	3
Female	1	2	3
Age in years	34 (Range: 24-57)	27 (Range: 24-30)	51 (Range 36-66)
Years of experience in field of intellectual disability	-	4 (Range: 2-7)	22 (Range 10-36)
IQ[a]	65.8 Range: 46-86)	-	-
Diagnosis		-	-
Autism spectrum disorder	4		
Trauma- and stressor-related disorders	3		
Attention-deficit hyperactivity disorder	2		
Depressive disorders	2		
Personality disorders	2		
Schizophrenia spectrum	2		
Substance-related disorders	2		

[a] *The IQ of one service user was missing. The health psychologist confirmed a DSM-5 diagnosis of mild ID for this service user.*

Design

The procedure of concept mapping was used to collect the data. Concept mapping is a structured, stepwise, participatory method that combines qualitative and quantitative research components (Trochim, 1989). It is a suitable approach to integrate the perspectives of individual group members into shared visual maps (Burke et al., 2005; Kane & Trochim, 2007), also in the field of intellectual disability (e.g., Nijs et al., 2021). The method consists of five steps: (1) preparation, (2) brainstorming, (3) clustering and prioritising of statements, (4) statistical analyses, and (5) interpreting the maps.

Ethics

Participants were recruited after ethical approval was given by the Ethics Review Board of Tilburg University (RP81). The first author visited the service users to explain the study using an information letter. This letter was composed based on feedback that experts by experience with mild intellectual disability provided to our academic collaborative centre. A key support staff member joined the conversation if preferred by the service user. Service users were asked to participate in the study and to sign an informed consent form. Support staff and supporting professionals received an invitation by email, including an information letter and informed consent form. All participants, as well as service users' legal representatives (if applicable), provided written informed consent. After consent was obtained, the five concept mapping steps were followed. Data collection was conducted from September 2020 to January 2021.

Stepwise procedure of concept mapping

Step 1: Preparation

During the phase of preparation, we carefully formulated the focal question that was central during the concept mapping procedure. The wording was drafted in a way that the question was sufficiently specific (e.g., including the focus on a new team of professionals and the definition of the target group), without being suggestive (e.g., avoiding words like safety.). Finally, we formulated the focal question for professionals as: "When setting up a new team of support staff to work in a new residential home for service users with mild intellectual disability or borderline intellectual functioning and psychopathology who display severe challenging behaviour, using the orthopedagogical perspective, it is important that …?". Since this sentence was relatively long, we made a critical assessment of whether the service users would have trouble understanding it. We also looked for ways to personalise the question to make identification easier. Therefore, we adapted the focal question for service users into: "Imagine that here at <name organisation> a new home like this one will be set up, for people like you. That means a new team of support staff will work in the home. What do you think matters most?" (as participating service users were all service users with mild intellectual disability or borderline intellectual

functioning and psychopathology who display severe challenging behaviour, and who received support from the orthopedagogical perspective). In addition, we formulated five questions for service users to use as prompts (see Appendix S1). For professionals, no prompts were used, because professionals' responses to the focal question during the brainstorming (step 2) indicated that they understood the question well.

Step 2: Brainstorming statements

In order to gather statements to the focal question, participants took part in brainstorming. Statements of professionals were generated in two focus groups, one for support staff and one for supporting professionals. Because of COVID-19 restrictions, the focus groups were held online. The focus groups were facilitated by the platform Jitsi (https://jitsi.org), which provided the opportunity to exchange ideas and experiences in a secured environment. Two researchers joined the online focus groups to guide the process. They started the session with an introduction about the method and objective of the study and elaborated on the meaning of the term "orthopedagogical perspective" (i.e., focusing on tailoring the service users' environment to their needs). When presenting the focal question, the researcher who moderated the focus group referred to the context of Pro for further clarification (e.g., "like the service users in Pro"). She only used probes if the answers of respondents were too unspecific or to confirm whether the answers of respondents were interpreted correctly. Furthermore, the probes served to structure the conversation to receive input from all participants. To keep the focus on the focal question, the moderator repeated the focal question a few times. The other researcher entered the statements directly into a spreadsheet of Microsoft Excel. In this way, the participants could see and check the statements as they evolved. After the focus group, the researchers removed duplicates and added the statements into the Concept Systems groupwisdom software (Concept Systems Incorporated, 2021). Both focus groups were audio-recorded and lasted about 1½ hour when data-saturation was reached.

Service users gave answers to the focal question during individual face-to-face interviews at their residential home. The first author conducted all interviews. She had met the service users before in light of other research to Pro. Attendance of a support staff member was allowed to provide support if preferred, but staff members were requested to keep from interfering during the interview. The interviews lasted 13–31 min and were audio-recorded. One interview was not audio-recorded because the service user gave no consent. The first two authors initially screened 20% of the interviews independently to extract relevant statements by listening to the audio-recordings. Statements were included if they applied to (1) characteristics, behaviour, or attitudes of support staff or supporting professionals; or (2) things that the organisation should arrange for support staff (e.g., giving support staff time to become familiar with the residential home). Statements were excluded if they (1) referred to material subjects that were beyond the responsibility or control of support staff

(e.g., good internet facilities in the group home), (2) were unspecific (e.g., the home is nice) or (3) were not applicable to all participating service users. Comparison of the number of extracted statements with a similar content resulted in a high degree of consensus (i.e., 90%). For example, both researchers considered the following two statements of the first and second author as similar, and thus reached consensus: "The team of support staff is there for you if you have any question" versus "There are support staff who can help me if I have any questions". Consequently, the first author extracted the statements given in the remaining 80% of the interviews. In order to avoid possible bias, if the first author had any doubts about whether to include or exclude a statement from these remaining interviews, it was discussed with the second author. In total, 124 statements of service users were identified. To have a workable number for the sorting and prioritising task, the first two authors reduced this number. They used a spreadsheet in Microsoft Excel to list all statements in a convenient way, to combine duplicate ones, and to remove statements that were of limited generalizability across service users.

Step 3: Clustering and prioritising statements

After the brainstorming, participants individually performed two tasks using the generated statements of their group. The first task involved a sorting (clustering) task where participants were asked to sort the statements into piles with a similar theme or meaning. Professionals also named the piles. There were no restrictions regarding the number of piles, but it was not allowed to put all the statements into one pile, to make new piles for every new statement, or to put the same statement in different piles. The second task consisted of a rating task. Participants rated the statements on priority to the focal question on a 5-point Likert scale from not important at all (1) to very important (5). All professionals completed the sorting and prioritising tasks within 2 weeks after the focus group, using the Concept Systems groupwisdom software. For service users, the time between the interview and the tasks varied between five to eight weeks. To explain and help service users perform the tasks, a researcher visited all service users at their residential homes. In a few cases, support staff gave additional assistance. Service users were supported by giving instructions on how to use the software, by reading the statements aloud, and by recapturing during the sorting task what kind of statements had been grouped together in piles so far. Service users could choose between conducting the tasks on the computer or by statements on paper. One of the researchers added the outcomes of tasks completed on paper into the Concept Systems groupwisdom software afterwards. Of the eleven service users, nine completed both sorting and prioritising tasks. One service user refrained from participating in the tasks, and one decided to quit during the tasks because of the experienced difficulty. Additionally, after careful consideration, we decided not to include the data of three of the remaining nine participants in the further analyses. These three service users finished the tasks, but also appeared to struggle with the tasks. The decision was based on their remarks (e.g., "I find it difficult; I have trouble concentrating"); observations of the researcher during the tasks (e.g.,

immediately sorting cards to a pile without looking at the meaning of the pile, and sorting every new card to the same pile); or the apparent randomness of sorted statements into a pile.

Step 4: Statistical analysis

The outcomes of the sorting and prioritising tasks of step 3 were used for statistical analysis. Facilitated by Concept Systems' groupwisdom software, quantitative analyses were performed to construct concept maps for each group. By means of multidimensional scaling analysis, each statement was located as a point on the map. Statements closer to each other on the map were sorted together more often. Next, by hierarchical cluster analysis, points close to each other were grouped together into clusters representing apparent similar concepts. Two researchers explored the optimal number of clusters by considering 4–12 clusters. Starting with 12 clusters, they step by step merged a cluster until the next merge did not result in a sensible cluster structure anymore. The average of the ratings given in the prioritising task defined the relative importance of the statements and clusters (Kane & Trochim, 2007; Trochim, 1989).

Step 5: Interpreting the maps

An expert group interpreted the three concept maps that resulted from the statistical analysis. They looked in detail at the concept maps of the different groups in relation to the focal question during an online meeting. Six experts with scientific and clinical knowledge regarding intellectual disability and people who show severe challenging behaviour and/or support teams operating in long-term care took part in the expert group. Together they discussed the titles of the clusters and the signification of the axes. To determine the titles of the axes, the expert group looked at overarching themes of clusters that were close to each other on the concept map. For all titles consensus was reached.

Analyses

In concept mapping, the analysis is integrated into the procedure (see step 4). Hence, no further statistical or qualitative analyses were performed.

Results

The three groups in total generated 165 statements: 36 by service users, 59 by support staff, and 70 by supporting professionals (see Appendix S1). The statements of service users were combined into six clusters, and those of both professional groups into eight clusters. Per group the meaning of the clusters is summarised below. Those outcomes are highlighted that are particularly relevant with respect to service users with mild intellectual disability or borderline intellectual functioning who display severe challenging behaviour and receive support from the orthopedagogical perspective.

Perceptions of service users

The six clusters of service users are shown in Table 2 in order of importance, including the number of statements and mean average rating of importance. Figure 1 visualises how the clusters in the concept map relate to each other. The two most important clusters for service users are shown to the right of the concept map and refer to the relationship between the service user and support staff. The cluster *Support staff are closely involved and reliable* (cluster 1) includes statements about support staff being honest, and support staff who are there for you when you need help (statements 3 and 5 in Appendix S1). Additionally, services users consider it important that *Staff know who I am and make arrangements that suit me* (cluster 2). As reflected by one of the statements in this largest cluster, service users think that it is of relevance to be introduced to your new support staff while still at your previous organisation so you can build a relationship (statement 29, Appendix S1). One of the service users explained: "That really calms things down. And that means that there's a kind of familiar face from the moment that you arrive". As indicated by the title of cluster 2, the cluster also includes statements about (new) arrangements, such as having staff who consult you in making agreements (statement 11, Appendix S1). At the top of the concept map, the third cluster reflects service users' wish for support staff to *Make me feel secure and take me seriously* (cluster 3). Statements in this cluster indicate that services users prefer support staff who feel confident in dealing with challenging behaviour. Support staff should not easily be fazed and remain calm in case of tensions (statements 6 and 9 in Appendix S1).

Next, service users want *To be and feel welcomed* (cluster 4). This not only applies to statements about a warm welcome, but also involves that you get at least the same freedoms as you had before (statements 12 and 22 in Appendix S1). More generic statements in this cluster are about providing structure and activities (statements 17 and 18 in Appendix S1). The cluster, called *Give me time to settle in, get to know me, and spend some time with me* (cluster 5), represents the importance to service users of having continuity in support staff. Also, service users prefer the presence of extra support staff when a new service user arrives. As expressed in one of the statements, the presence of an additional staff member can help the residents deal with any tensions and help them get to know one another (statement 23, Appendix S1). Finally, statements about additional criteria that support staff should comply with when they start working at the new home, make up the cluster *Support staff are well trained* (cluster 6). One of the statements that service users mentioned, referred to support staff being a good fit for the home (statement 32, Appendix S1).

Table 2. *Clusters in order of importance, including the number of statements and mean average rating – Service users*

Cluster	Service users (n=6)	Number of statements (n=36)	Mean average rating
1	Support staff are closely involved and reliable	6	4.5
2	Support staff know who I am and make arrangements that suit me	9	4.2
3	Support staff make me feel secure and take me seriously	6	4.1
4	I am welcome and feel welcome	6	3.89
5	Give me time to settle in, get to know me and spend some time with me	5	3.83
6	Support staff are well trained	4	3.46

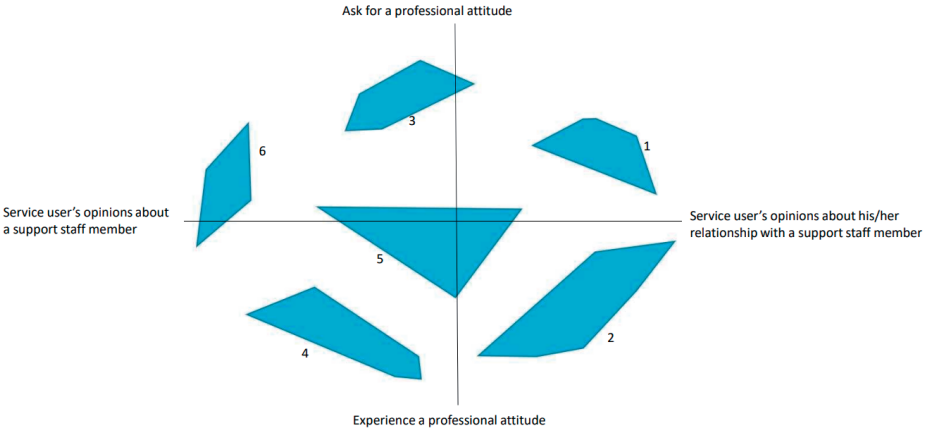

Figure 1. Concept map of service users. The cluster titles in the figure correspond to the cluster numbers listed in Table 2.

Perceptions of support staff

As shown in Table 3, support staff regarded issues relating to *Team safety* (cluster 1) as the most important factor in the process of setting up a new team. This cluster consists of statements related to having a sense of openness in the team, about feeling safe to share vulnerabilities, and about support staff being able to trust one another (statements 44, 46, and 47 in Appendix S1).

Table 3. *Clusters in order of importance, including the number of statements and mean average rating – Support staff*

Cluster	Support staff (n=6)	Number of statements (n=59)	Mean average rating
1	Team safety	11	4.56
2	Support staff receive support and feel supported	4	4.42
3	Support staff feel that supporting professionals are closely involved and there is good communication	7	4.17
4	All support staff have work and life experience	5	4.13
5	Active preparation before service users arrive	12	3.99
6	Support staff know in advance what is expected of them	8	3.94
7	Ensure that the new home has a positive reputation through the professional use of safety measures	6	3.94
8	Diversity in team composition	6	3.83

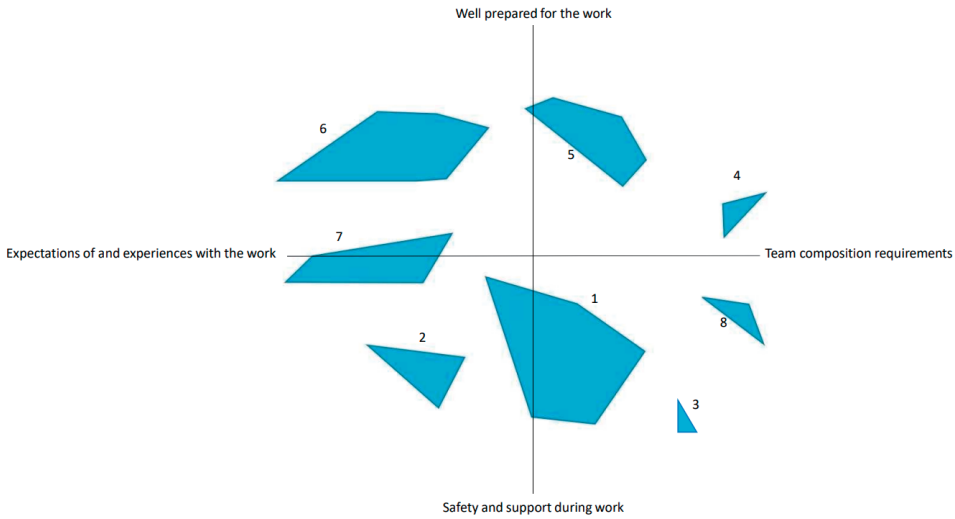

Figure 2. Concept map of support staff. The cluster titles in the figure correspond to the cluster numbers listed in Table 3.

Trust is, for example, enhanced if you know that your colleagues will intervene in case of challenging behaviour, as illustrated by one of the support staff members: "I also think that because you go through intense situations with each other, you learn what makes the other person tick and you learn to trust each other in situations like that". With regard to team safety, support staff also came up with statements regarding the

importance of having a manager and/or team leader who makes you feel safe, and of keeping to the agreements made together to present a united front (statements 26 and 48 in Appendix S1).

Subsequently, and visualised at the bottom of the concept map in Figure 2, the clusters *Social support* (cluster 2) and *Close involvement of supporting professionals and good communication* (cluster 3) address the importance of social support, and the involvement, and approachability of supporting professionals around the team of support staff (e.g., team leader, manager, and psychologist; e.g., statements 14, 17, and 24 in Appendix S1). Support staff in this study specifically linked the need for social support from supporting professionals to challenging behaviour. They included in their statements that it is important to know that you can turn to your manager if there has been an incident (statement 14, Appendix S1). Furthermore, support staff indicated that it is important to view mistakes as learning opportunities (statement 38, Appendix S1).

To the right of the concept map are the clusters *All support staff members have work and life experience* (cluster 4) and *Diversity in team composition* (cluster 8). These clusters represent statements about what characteristics support staff members should have and how the team as a whole should be composed when starting a new team. For example, support staff stated that life and work experience and not easily being fazed are important staff characteristics (statements 55–57, Appendix S1). This means that support staff are resilient and not deterred by severe challenging behaviour incidents. One support staff member explained "I think it's definitely important that people with those competencies are recruited. That they can handle something and that an extreme incident doesn't scare them off". With respect to the team, statements of support staff were gathered about a good balance on the team and during each shift between experienced support staff and support staff in training (statements 53 and 54 in Appendix S1). Support staff believe this balance is necessary to create a safe work environment. One of the support staff members reasoned: "If you work with support staff who have never experienced an incident, they can freeze up".

At the top, the concept map visualises clusters 5 and 6 with issues that should get attention during the phase of preparation according to support staff. One of the statements in *Active preparation before service users arrive* (cluster 5) refers to conflict resolution and aggression management training for support staff, which should be offered before the first service user arrives (statement 52, Appendix S1). In addition, statements in cluster 5 indicate that support staff believe that it is important that team members visit the referring organisation beforehand to meet the new service user, and to observe the kind of support the service user receives (statements 32 and 41 in Appendix S1). *Support staff know in advance what is expected of them* (cluster 6) addresses,

for example, that supporting professionals have a clear vision of the orthopedagogical approach beforehand, and a clear plan for the longer term (statement 31, Appendix S1).

At last, *Ensuring that the new residential home has a positive reputation* (cluster 7) was important to support staff to successfully recruit future support staff, such as colleagues and students. One of the participating support staff members explained: "Nobody from the flex pool wanted to work for us. Especially in the beginning, there were lots of rumours flying around about there being one incident after another. Though they didn't really know how and what". As reflected by one of the statements, staff believe that you should invite potential future staff to come and take a look at the new residential home to dispel rumours (statement 6, Appendix S1).

Perceptions of supporting professionals

The clusters at the bottom of the map, that is, *Working based on shared values and principles* (cluster 1), *Putting yourself in the service user's shoes* (cluster 2), and *An organisation-wide vision and strong commitment* (cluster 3), received the highest average ratings, see Table 4 and Figure 3. The overall topic of these clusters is about having a shared vision. Statements relate to agreement on shared values, knowledge about the shared values and to staff who rely on the vision and see themselves as part of it (statements 46, 47, and 64 in Appendix S1). Furthermore, statements about the vision include that service users are seen as human beings with human needs and positive characteristics instead of persons who display challenging behaviour (statements 11 and 13 in Appendix S1) (cluster 2). Moreover, all levels of the organisation need to be intrinsically motivated to get started (statement 16 in cluster 3, Appendix S1).

The orthopedagogical approach is a theme that is intertwined in clusters 4 (in the *Support for support staff*) and 6 (*Daily life is shaped directly*). According to statements of supporting professionals it is important to think about what the context from the orthopedagogical perspective should look like (cluster 4, statement 45, Appendix S1). All professionals involved should explore who the service user is, and which patterns have evolved in other contexts in the past that triggered and maintained challenging behaviour (statements 18 and 20 in cluster 6, Appendix S1). Supporting professionals also responded that you should decide from the beginning how the service user's needs can be met within their home's orthopedagogical approach and vision (statement 19, Appendix S1).

Table 4. *Clusters in order of importance, including the number of statements and mean average rating – Supporting professionals*

Cluster	Supporting professionals (n=6)	Number of statements (n=70)	Mean average rating
1	Working based on shared values and principles	6	4.33
2	Putting yourself in the service user's shoes	6	4.28
3	An organisation-wide vision and strong commitment as a basis for a good start with the service user	8	4.10
4	Support for support staff with the orthopedagogical approach	12	4.10
5	Emotionally supportive in relation to the service user	11	4.08
6	Daily life is shaped directly by knowledge of service user and context	6	3.86
7	The organisation sees, appreciates, and rewards support staff	8	3.83
8	Experienced support staff as human beings	13	3.63

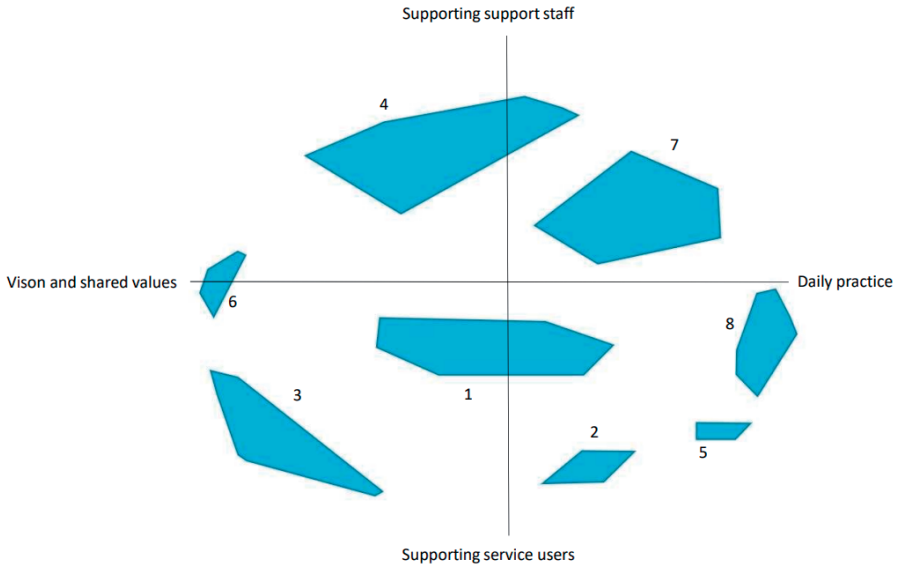

Figure 3. Concept map of supporting professionals. The cluster titles in the figure correspond to the cluster numbers listed in Table 4.

Part of the translation of the orthopedagogical approach to daily practice is reflected in the statement about having a clear daily programme from the beginning (statement 21, Appendix S1). This offers stability to both service users and support staff. In relation to the orthopedagogical approach, supporting professionals also mentioned that support staff should be convinced that they can create an environment that will have an impact on

the service user (statement 8 in cluster 4, Appendix S1). In addition, statements referred to the need for supporting professionals to be involved, visible, and available from the beginning (statements 37–39, Appendix S1).

The organisation sees, appreciates, and rewards support staff (cluster 7), addresses what the organisation should do to gain and keep support staff who are willing and qualified to work with service users with mild intellectual disability or borderline intellectual functioning who display severe challenging behaviour. For example, this cluster entails the statement that it is important that supporting professionals offer support staff emotional support (statement 22, Appendix S1) to help them talk about and cope with what they have experienced. One of the supporting professionals explained: "So there's a place and a space for them to discuss the things they're going through, to get some perspective on them, and be able to move on again". The two clusters to the right of the map (cluster 5 and cluster 8) consist of a list of required characteristics of support staff members. One of characteristics in the statements concerns the importance of being a team player (statement 49, Appendix S1). According to supporting professionals, support staff must be able to rely on one another, provide support and give feedback.

Discussion

The aim of this study was to identify what service users, support staff, and supporting professionals consider important when setting up a new team of support staff for service users with mild intellectual disability or borderline intellectual functioning and co-occurring psychopathology, who display severe challenging behaviour, when an orthopedagogical approach is used. To this end, we generated and described a concept map for each group. The concept maps were based on the statements that every group gave, clustered and prioritised. All three participant groups mentioned factors that referred to the relation between the service user and support staff. More specifically, they all named characteristics that support staff should have to enhance feelings of safety and trust among service users. For example, they reported that support staff need to be experienced (life as well as work experience), confident, have a low level of expressed emotions (e.g., show no fear), and stay calm in case of tension. These characteristics are in line with research about support to service users with intellectual disability who display challenging behaviour (Nijs et al., 2021; Willems et al., 2016). Nearly all the statements of service users applied to activities and interpersonal relations with a direct impact on the service user, described by Bronfenbrenner as the microsystem (Bronfenbrenner, 1994). On the other hand, few statements from support staff related to their direct relationship with service users. Next to staff and team characteristics, support staff hardly mentioned any other statements about the service users' microsystem. Their statements mainly referred to the relation between

support staff with each other and with supporting professionals, and to preparations that should be made. In other words, support staff especially highlighted factors in the mesosystem (Bronfenbrenner, 1994). Statements of supporting professionals concerned both the microsystem and mesosystem, but also the exosystem (i.e., social relations that involve people who do not regularly interact with service users, such as interactions between upper management and support staff) (Bronfenbrenner, 1994). Taken together, the three groups came up with different kinds of statements, all from their own angle. This underlines the relevance of involving different participant groups in research. Overall, our results confirm outcomes of research that it is important to invest in building relationships between service users and support staff (e.g., Nijs et al., 2021; Olivier-Pijpers et al., 2020a). This includes respect, trust, and getting to know each other well. Our study adds to previous studies that organisations should invest in building relationships from the start. Next to this overall finding, we will highlight four core outcomes into more detail.

First, all participant groups reported that it is important that the service user and support staff are introduced to each other before the transfer of the service user to the new home. In that way, service users will have familiar people around on the day of arrival. The importance of getting acquainted with new support staff early may seem obvious and might be viewed as a general need for all service users with intellectual disability. Nevertheless, given our clinical experiences within Pro, this is not common practice when it concerns service users who show severe challenging behaviour, mainly to avoid tension and incidents. Service organisations are recommended to seek opportunities to enable early acquaintance between support staff and service users, starting to build relationships in an early phase. This can help service users to deal with stressful moments (e.g., a transfer to a new home), and decrease the likelihood of challenging behaviour (De Schipper et al., 2006; De Schipper & Schuengel, 2010).

Second, support staff considered team safety to be important. This finding is in line with previous research about a psychologically safe team climate in which opinions are openly expressed and mistakes discussed (Buljac-Samardžic et al., 2012; Olivier-Pijpers et al., 2019). Providing room for mistakes and learning from them can help support staff members to respond differently in future demanding situations with service users and is associated with less challenging behaviour (Olivier-Pijpers et al., 2019, 2020a). It is notable that support staff mainly named safety aspects in relation to colleagues (e.g., being able to count on each other). They stressed the importance of using the same working methods, which provide clarity to service users and prevent challenging behaviour (van den Bogaard et al., 2019; Wolkorte et al., 2019). This is in line with the view of the supporting professionals who indicated that all professionals in the organisation need to work based on shared values and principles from the start. Other studies about the support to service users with intellectual disability who display challenging behaviour have also highlighted

the relevance of having the same vision and shared values. to meet the needs of service users and manage their challenging behaviour (Olivier-Pijpers et al., 2019; Tournier et al., 2020). To this end, support staff need training and coaching to reflect on how they put the vision and values into practice (Olivier-Pijpers et al., 2019; Tournier et al., 2020).

A third factor that both support staff and the supporting professionals found important is social support, particularly provided by the manager, team leader, and psychologist. Social support can be defined as "actions of others that are either helpful or intended to be helpful" (Deelstra et al., 2003) and can have different functions. Various studies have made a distinction between instrumental support (e.g., giving practical assistance) and emotional support (e.g., providing empathy and care; e.g., Shakespeare-Finch & Obst, 2011). Both types appear relevant in relation to social support from the supporting professionals. Based on the statements of support staff, they prefer instrumental support like good communication as well as emotional support by supporting professionals who show interest in how you are doing, and who you can turn to. In line with this, supporting professionals indicated that they should provide emotional support to support staff if needed and be involved, committed, and approachable from the early beginning. Literature in the field of intellectual disability has addressed the relevance of social support at work extensively, especially in relation to support staff's wellbeing (e.g., Devereux et al., 2009; Vassos et al., 2017). However, only a few studies have reported the importance of support by the psychologist towards staff members in case of service users with intellectual disability who show severe challenging behaviour (Nijs et al., 2021; Olivier-Pijpers et al., 2019). Our study endorses the view that a psychologist is one of the professionals that should be included when considering social support needs for teams working with service users with mild intellectual disability or borderline intellectual functioning who show severe challenging behaviour.

A fourth factor that was highlighted in our study is the positive reputation of the new residential home. According to support staff, rumours induce fear with an adverse impact on the recruitment of new support staff in the future. Given the high staff turnover and difficulties that service organisations already have in finding enough competent staff members to fill up the teams (Olivier-Pijpers et al., 2020b; Stevens et al., 2021), it is important to give both a realistic and positive view. Next to fear, rumours that magnify the challenging behaviour may also lead to an increase of stigmatising attitudes among support staff towards service users with intellectual disability who display challenging behaviour. In their scoping review, Pelleboer-Gunnink et al. (2021) reported that care providers working in intellectual disability services appear to have a particularly stigmatising attitude regarding choice and inclusion of people with intellectual disability and high support needs, such as people who display challenging behaviour or have comorbid psychiatric diagnoses. Rumours might enhance this attitude.

Strengths and limitations

A strength of our study is the inclusion of the views of three different groups, that is service users with mild intellectual disability or borderline intellectual functioning who show severe challenging behaviour, support staff, and supporting professionals around the team. As stressed in previous studies, including the views of service users is desirable. These views can increase organisations' understanding of the needs of service users, which may help in the creation of a (social) environment that prevents and/or reduces CB (van den Bogaard et al., 2019; Griffith et al., 2013). The service users in our study gave many answers to the focal question. They thus seemed well capable of expressing what they believe to be important when a new residential home is set up.

A limitation of our study is that the sorting and prioritising tasks of the concept mapping appeared difficult for several service users despite the effort of the researchers to make the tasks as accessible as possible. They gave service users the option to do the tasks on paper, read the statements aloud, and recapitulated the statements per pile during the sorting task. Nevertheless, difficulties for some service users remained. Perhaps, the tasks in relation to our focal question were difficult to apply to their personal situation and/or the number of statements in the sorting and rating tasks required too much concentration. Future research using concept mapping with people with intellectual disability might consider reducing the number of statements. Another limitation is the small number of participants per group. Considering the research question, we wanted to include professionals who had experienced the start-up process of residential homes in the project Pro and were still involved in Pro or just left Pro. This applied to a limited number of professionals. Moreover, some had left Pro during the postponement of the research project due to COVID-19, and some had to withdraw last minute because of sickness or emergencies at work. A third limitation is that mainly psychologists represented the group of supporting professionals, instead of also (more) team leaders and managers.

Conclusion

Regularly, organisations face difficulties in the support to service users who display severe challenging behaviour. This results most often in a transfer of the service user to another facility. With this study, we identified important factors that may help disability service organisations in the process of setting up a new team of support staff for a new residential home to provide an environment that matches service users' needs from the start. The results are in alignment with previous findings in the literature and provide insights into what is particularly important with regard to people with mild intellectual disability or borderline intellectual functioning who show severe challenging behaviour, and organisations that use an orthopedagogical approach.

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Appendix S1 Statements per participant group, grouped by clusters

Focal question for service users

Imagine that here at <name residential service organisation> a new home like this one will be set up, for people like you. That means a new team of support staff will work in the home. What do you think matters most?

Prompts that were formulated for the interviews with service users

1. If there's going to be a new home. And there will be a new team of support staff. What factors should <name residential service organisation> consider?
2. Imagine that you are going to move into a new home tomorrow. And there will also be a whole new team of support staff, what factors should the organisation consider?
3. Are there things that the people who work here need to do before the first residents move into the new home?
4. Imagine that all the support staff leave here tomorrow. And a whole new team of people takes their place. What do you think matters most?
5. Imagine that you are the director of <name residential service organisation>. And the organisation wants to open a new home like this with a new team of support staff. What would you do? What needs to be arranged and what needs to be done?

Clusters and statements of service users (people with mild intellectual disability or borderline intellectual functioning and severe CB) and their mean importance

ID	Statement	Mean importance
Cluster 1: Support staff are closely involved and reliable		**4.50**
3	Support staff are there for you when you need help	4.83
4	Support staff understand you	4.50
5	Support staff are reliable, honest and communicate clearly	4.67
7	Support staff operate as one team	4.33
19	There are many experienced support staff	4.67
20	Experienced support staff train new support staff and show them the ropes	4.00
Cluster 2: Know who I am and make arrangements that suit me		**4.24**
10	If you're new, you're given time to settle in	4.33
11	Support staff consult with you and make arrangements with you	4.67
14	The team are well prepared (e.g., read files, meets beforehand)	3.67
15	The team and the residents get to know one another well	4.00
24	Things that are important to the new resident are taken care of quickly and to the resident's satisfaction	4.00
29	As a new resident, you are introduced to your new support staff while still at your previous organisation so you can build a relationship	4.17
31	If you're new, you get to decide where everything goes in your new room	4.50
33	Support staff allow you to slowly get used to new freedoms	4.17
36	The team tailor their approach to individual residents	4.67
Cluster 3: Support staff make me feel secure and take me seriously		**4.06**
2	Pagers are only used in extreme situations	4.50
6	Staff are not easily fazed	3.67
9	If there are tensions, support staff will remain calm and talk to you	4.33
26	Support staff do not make jokes at your expense	3.67
30	Support staff give you compliments	4.00
34	The team includes a woman (maternal figure)	4.17
Cluster 4: I am welcome and feel welcome		**3.89**
12	When you arrive at your new home, the support staff and your fellow residents make you feel welcome	4.33
13	When you arrive at your new home, your room is clean and tidy	4.33
17	Support staff make sure that residents have things to do during the day	3.67
18	Support staff provide structure	3.67
21	Support staff encourage you to interact with others	3.50
22	If you're new, you get the same freedoms you had before, you might also get additional freedoms	3.83

Continued

ID	Statement	Mean importance
Cluster 5: Give me time to settle in, get to know me and spend some time with me		**3.83**
1	Support staff remain at the home for an extended period of time	4.17
16	Support staff draw up a plan to help residents overcome obstacles they face (after support staff and residents have got to know one another)	4.00
23	When a new resident arrives, there are extra support staff on hand to help the residents deal with any tensions, and to help them get to know one another	4.33
28	Residents do not all arrive at the same time but at intervals	3.50
35	Trusted support staff from the previous home are present to advise the new team	3.17
Cluster 6: Support staff are well trained		**3.46**
8	Before support staff start their work, they have completed relevant training, such as a first aid course	4.33
25	Allow support staff to get to know the building and make necessary modifications (e.g., locks on doors)	3.67
27	The team also includes Dutch support staff	2.50
32	The organisation hires support staff that are a good fit for the home (no ex-police, ex-military or ex-wardens)	3.33

Focal question for support staff and supporting professionals

When setting up a new team of support staff to work in a new residential home for service users with mild intellectual disability or borderline intellectual functioning and psychopathology, who display severe challenging behaviour, using the orthopedagogical perspective, it is important that …?

Clusters and statements of support staff and their mean importance

ID	Statement	Mean importance
Cluster 1: Team safety		**4.56**
11	Take into account that it takes a long time to build a relationship/get to know a service user	4.00
22	Quick and efficient communication between support staff and team leader	4.33
26	Cluster leader and team leader make you feel safe and secure	5.00
33	Get to know the service user and shape their support and treatment as a team (do not just copy the previous location)	4.50
39	Support staff are not afraid to talk about mistakes	4.67
44	Support staff are not afraid to talk about their vulnerabilities	4.67
45	Support staff know that they can count on one another	4.83
46	The team is open and honest; people do what they say and say what they do	4.83
47	Support staff must be able to trust one another	5.00
48	Support staff present a united front; everyone has their own way of doing things but based on the same agreements	4.50
58	Support staff are patient with service users (small steps)	3.83
Cluster 2: Support staff receive support and feel supported		**4.42**
10	Team members continuously engage in critical self-evaluation	4.5
14	Knowing that you can turn to your manager if there has been an incident	4.33
16	Being able to turn to your manager or team leader; being able to be yourself	4.67
38	The team view mistakes as learning opportunities	4.17
Cluster 3: Support staff feel that supporting professionals are closely involved and there is good communication		**4.21**
17	Psychologist shows interest (in how you are doing)	4.33
18	Manager shows interest (in how you are doing)	4.67
19	Team leader shows interest (in how you are doing)	4.33
20	Good communication between support staff and manager	4.17
21	Good communication between manager and team leader	4.00
23	Good communication between support staff and psychologist	4.17
24	Team leader is often on the work floor and helps support staff during their shifts	3.83
Cluster 4: All support staff have work and life experience		**4.13**
37	Psychologist and manager are involved in the preparation phase	4.17
55	Recruit staff who have experienced impactful situations in their previous work	3.67
56	Recruit staff who are not easily fazed	5.00

Continued

ID	Statement	Mean importance
57	Recruit staff with life experience	3.67
59	Staff are experienced/familiar with the type of service users	4.17
Cluster 5: Active preparation before service users arrive		**3.99**
2	Invite curious prospective staff to work a trial shift during the start-up phase	4.17
4	Send new staff to work at similar homes to gain experience	3.33
12	Consider the entire first year as a start-up phase: adjust initial agreements as you go along	4.00
13	In the team meetings, plan lots of time for the discussion of individual cases right from the start	4.50
15	Get to know one another as a team beforehand, including the team leader, psychologist and manager	4.00
32	Observe what kind of support a future service user receives at their current location	3.50
36	Make sure that support staff know what to expect beforehand to avoid dropouts (e.g., about the group or specific working methods)	4.33
41	Meet a new service user beforehand with a number of team members	3.67
42	Organise a team day beforehand to allow everyone to get to know one another	4.33
43	Ensure proper handover between the service user's previous location and your own, make sure their file is complete	4.17
50	Complete a company first aid course beforehand	3.33
52	Offer conflict resolution and aggression management training beforehand	4.50
Cluster 6: Support staff know in advance what is expected of them		**3.94**
1	Ensure that the new home is not branded as 'too intense' or as a bad place to work	3.83
7	Ensure that staff know from the start that agreements can be adjusted if necessary	4.00
8	Make clear agreements	4.83
9	Ensure that every team member knows their role from the start	3.67
25	Offer attractive salaries	4.50
31	The psychologists and managers have a clear vision of the orthopedagogical approach beforehand, and a clear plan for the longer term	4.17
40	Work together as a team beforehand by preparing the home/office	3.17
Cluster 7: Ensure that the new home has a positive reputation through the professional use of safety measures		**3.94**
5	Ensure that the home does not acquire a bad reputation	3.67
6	Dispel rumours; invite people to come and take a look, visit other groups	3.50
27	An effective pager system	4.50
34	Be careful when it comes to how much freedom service users get when they arrive (taking away freedoms creates resistance)	4.17
35	As a member of the support staff, you know that rumours about service users/ the home are not true (it is not just fights and isolation, as the stories suggest)	4.00
49	Support staff know restraining techniques, how to use isolation as a form of punishment and that male and female service users require different approaches	3.83

Continued

ID	Statement	Mean importance
Cluster 8: Diversity in team composition		**3.83**
3	Support staff are extra flexible (e.g., willing to work late to ensure minimal reliance on unknown support staff)	3.67
28	Age diversity within the team (older support staff sometimes preferable for older service users)	3.17
29	Gender diversity within the team (both male and female team members)	4.00
30	Diversity of personality types within the team (e.g., when it comes to creativity, response to different types of service user behaviour)	4.00
53	Each shift has a good balance between experienced support staff and support staff in training	3.67
54	A good balance on the team between experienced support staff and support staff in training	4.50

Clusters and statements of supporting professionals (i.e., psychologists and team leader) and their mean importance

ID	Statement	Mean importance
Cluster 1: Working based on shared values and principles		**4.33**
23	Have a vision on the kind of support your staff need, and on how colleagues can keep an eye on and support one another (preventative and during recovery)	4.17
46	Agree on shared values	4.67
47	Have shared values and principles and know what they are	4.50
59	Attention for the recruitment campaign	4.00
64	Staff rely on the vision and see themselves as part of it	4.67
66	Recruitment process involves more than just posting a job ad	4.00
Cluster 2: Putting yourself in the service user's shoes		**4.28**
11	Show real interest in service users	4.17
12	See the good in service users	4.17
13	See service users as human beings (people who need help rather than people who are dangerous)	4.67
14	Make service users feel welcome	4.67
60	See things from the service users' perspective	4.33
61	Personal values and norms are aligned with the team's shared values and norms	3.67
Cluster 3: An organisation-wide vision and strong commitment as a basis for a good start with the service user		**4.10**
2	As an organisation, make an effort to involve the service user in everything that goes on at their new home	4.00
3	Team invests in contact with new service user and gets to know him/her before he/she arrives	4.17
6	Think about how you want to introduce the new group within the organisation (avoid labels)	3.83
7	Support staff involve the service user in everything that goes on at the home and allow him/her to decide where everything goes in their new rooms	3.83
16	The entire organisation is intrinsically motivated to get started	4.33
17	It is known throughout every layer of the organisation that a new group is being set up	3.50
62	There is a vision on how the group is structured at different levels: service users, staff, organisation	4.67
63	There is a shared vision	4.50
Cluster 4: Support for support staff with the orthopedagogical approach		**4.10**
4	Invest in team meetings before the first service users arrive	4.17
5	Send team members to other organisations that work with these types of service users from the orthopedagogical approach (from all layers of the organisation)	3.33
8	Support staff are convinced that they can create an environment that will have an impact on the service users	4.50
10	The support staff know their way around the home before the first service users arrive	3.17

Continued

ID	Statement	Mean importance
30	The organisation offers support staff room to develop	3.83
37	The supporting professional remains involved after the group is up and running	4.17
38	The supporting professional is involved in the team from the beginning , sense of unity	4.50
39	People supporting the team are visible and available from the beginning	4.17
40	Organise a get-together to allow team members to get to know one another and talk to one another (create team spirit)	4.00
41	Multidisciplinary sense of unity (do not rely on own assumptions)	4.33
43	Collaboration with and between professionals supporting the team	4.33
45	Think about what the context according to the orthopedagogical approach should look like	4.67
Cluster 5: Emotionally supportive in relation to the service user		**4.08**
27	Able to connect with the service user socially and emotionally – being there for the service user, not getting caught up in their feelings, being their anchor	4.00
28	Support staff express their emotions but are able to control them	4.50
35	Support staff are authentic; you must be yourself	3.67
48	Able to connect with service users	4.67
50	Support staff are emotionally available	4.17
52	Responsiveness and sensitivity; being able to empathise and relate to the service user	4.33
53	Have empathy	4.17
54	Staff are energetic	3.83
58	Staff are people persons	3.33
69	Support staff are motivated	4.17
70	Support staff show interest in service users	4.00
Cluster 6: Daily life is shaped directly by knowledge of the service user and context		**3.86**
9	The home is ready before the first service users arrive (all the essentials are there)	3.83
15	Start by immediately offering support (instead of 'guarding' service users): daily programme and vision	4.33
18	You analyse how the service user's behavioural patterns started in previous living environments	3.17
19	Agree beforehand how a service user's needs can be met within your home's orthopedagogical approach and vision	4.17
20	Be familiar with service users' files before they arrive: be aware of the survival strategies they have developed and know how to deal with them	3.33
21	Have a clear daily programme from the beginning (offers stability to service users and support staff)	4.33
Cluster 7: The organisation sees, appreciates and rewards support staff		**3.83**
22	Offer support staff emotional support	4.33
24	Keep challenging staff to retain them	3.50
25	Think about how the organisation will deal with departing support staff beforehand	3.17

Continued

ID	Statement	Mean importance
26	Think about how to retain support staff beforehand (keep them interested and invested); supporting professionals have a shared responsibility in this	3.67
34	Personal values match shared values: people identify with the shared values	4.33
36	Clear job description (number of hours, responsibilities)	3.50
42	Clear division of roles	3.83
44	Collaboration within the team	4.33
Cluster 8: Experienced support staff as human beings		**3.63**
1	Do not think that your team must be made up entirely of large male support staff	4.00
29	Support staff have their own ideas about what their professional development should look like	3.33
31	Support staff are able to self-reflect	4.33
32	Support staff meet the minimum education requirements (MBO-3)	2.67
33	Support staff have some life and work experience (work experience does not have to be in healthcare)	3.67
49	Support staff must be team players (they must be able to rely on one another, provide support and give feedback)	4.33
51	Support staff do not have major psychological challenges of their own (complicated personal lives, finding it hard to say 'no')	3.33
55	Do not hire muscle – look for staff who can make a substantive contribution to the team (good instincts)	3.83
56	Support staff have the hearts and souls of healthcare professionals	3.33
57	Support staff love a challenge	3.50
65	Support staff know who their service users are	3.83
67	Leaders who lead the way and can motivate others (these can be people in various roles)	3.67
68	Leaders who lead the way and can spark others' interest (these can be people in various roles)	3.33

CHAPTER 3

3

Experienced support at work, team climate and collaboration in teams working with people with mild intellectual disabilities and severe challenging behaviour in residential care: A cross-sectional study

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Abstract

Background

This study explored the perceptions of staff for people with mild intellectual disabilities or borderline intellectual functioning and severe challenging behaviour in relation to the support they received at work from four groups of professionals (i.e., team leaders, managers, psychologists and other staff members). The team climate, such as the workplace having clearly defined goals for staff, was also explored. In addition, the associations between the support from each of the professionals and team climate with the well-being and job satisfaction of staff were examined. We hypothesised that staff would perceive higher levels of support from professionals around a team (i.e., team leaders, managers and psychologists) and a more positive team climate when professionals around a team experience more positive mutual collaboration.

Methods

An online questionnaire about support at work, team climate, well-being and job satisfaction was completed by 201 staff members from 32 teams at 10 residential service organisations. In addition, professionals surrounding these teams rated their mutual collaboration.

Results

Both support received at work from all four groups of professionals and team climate showed significant small to moderate positive associations with job satisfaction. Well-being was associated with support from team leaders, psychologists and other staff members in the team, as well as with team climate. We did not find support for the hypotheses that staff would perceive higher levels of support or a more positive team climate when professionals around a team experience more positive mutual collaboration.

Conclusions

This study highlights the importance of investing in staff support and creating a positive team climate for promoting staff well-being and job satisfaction. Implications for future research regarding staff support, team climate and the collaboration between professionals around a team are discussed.

Challenging behaviour of people with mild intellectual disabilities (IDs) or borderline intellectual functioning is often triggered by interactions with their environment (Embregts et al., 2019). Staff who work with service users with mild IDs or borderline intellectual functioning and severe challenging behaviour and/or mental health problems (hereinafter briefly referred to as CB) may, for instance, unintentionally provoke such behaviour by their reactions (or lack thereof) towards service users (van den Bogaard et al., 2019). The extent to which staff members experience negative emotions, such as fear, distress and anger, in response to service users' CB can significantly affect their behaviour towards service users. Staff may experience these emotions, amongst others, if they have not had appropriate training in emotion-regulation techniques (Mills & Rose, 2011; Willems et al., 2016). It is important to minimise staff's negative emotions, while they lead to more support-seeking, assertive control and hostile behaviour (Willems et al., 2016) and have negative consequences on staff's well-being, with risks on a burnout, absenteeism and turnover (Hastings, 2005; Smyth et al., 2015). Perceiving support at work, which refers to the extent to which staff feel that their work environment, including other staff members and managers, cares about and provides help to support their well-being (Kossek et al., 2011), is crucial to prevent or mitigate such negative outcomes. According to social exchange theory (Blau, 1964), employees who perceive support from their colleagues or managers are also likely to support their colleagues and managers in return (e.g., Eisenberger et al., 2002; Winslow et al., 2009).

To date, most studies conducted within the field of IDs about support at work to staff have focused on support from team leaders and/or other staff members (i.e., in the same team) (e.g., Deveau & McGill, 2016a, 2016b; Vassos et al., 2017). Support from team leaders and other staff members has been reported to have positive effects on the well-being and job satisfaction of staff (e.g., Deveau & McGill 2016a, 2016b; Ryan et al., 2019). More recently, researchers have been directing increasing attention to support from managers. For example, Deveau & McGill (2019) showed that staff who experienced more practice leadership (e.g., providing feedback, modelling good practice and problem solving) from their managers also perceived more well-being and job satisfaction. In addition to support from team leaders and managers, staff who work with people with mild IDs or borderline intellectual functioning and severe CB receive support from psychologists in their daily work (Olivier-Pijpers et al., 2019; Stenfert Kroese & Smith, 2018). Practice leadership by psychologists is critical in managing CB and in promoting a coherent team culture (Olivier-Pijpers et al., 2021; Stenfert Kroese & Smith, 2018). However, as far as we know, only two studies have explored staff perceptions of support from psychologists. These studies found that staff valued psychologists who are accessible, approachable and interested in their well-being, as evidenced during the COVID-19 pandemic (Embregts et al., 2021; Lokman et al., 2022). While the body of knowledge about staff's satisfaction with support from psychologists and its association with staff's well-being and job satisfaction

is limited, the present study includes an investigation of perceived support from psychologists. More precisely, we explored the perceptions of staff concerning support received at work from four distinct groups of professionals (i.e., team leaders, managers, psychologists and other staff members), as well as the associations between the support from each of these types of professionals and the well-being and job satisfaction of staff.

Professionals who support teams of staff, such as team leaders, managers and psychologists – hereinafter referred to as professionals around a team – collaborate. That means that they actively and reciprocally work towards achievement of a shared goal or common task (Bedwell et al., 2012; Hoegl & Gemuenden, 2001). A good collaboration between professionals around a team may have a positive impact on staff support. For example, a recent study on the impact of the organisational environment on CB highlighted the significance of effective communication between psychologists and managers in addressing critical issues within the group home and staff's support needs (Olivier-Pijpers et al., 2019). On the other hand, if a good collaboration fails and psychologists feel restricted by managers to access the staff team, it can hinder psychologists in supporting staff adequately (Stenfert Kroese & Smith, 2018). As previously mentioned, collaboration involves reciprocity, which relates to returning a benefit (e.g., support) that one has received (Gouldner, 1960). A study in the context of elderly care found that supervisors who felt more supported by their peers were more likely to reciprocate support to their subordinates (Winslow et al., 2009). Similarly, if professionals around a team perceive more support from one another, staff members are likely to perceive more support from these professionals in turn. To the best of our knowledge, no previous studies have been conducted on the relationship between the collaboration of professionals around a team and the support provided to staff members. The present study therefore explores this relationship, with the expectation of finding a positive association between the quality of the collaboration amongst professionals around a team and the extent to which staff feel supported.

The collaboration between professionals around a team may also affect the team climate, which has been shown to be positively associated with the well-being of staff (Rose & Schelewa-Davies, 1997; Rose et al., 2006). As described by Anderson & West (1996), team climate is composed of four factors: vision (e.g., clearly defined goals), participative safety (e.g., an interpersonal atmosphere of trust and support), task orientation (e.g., commitment to excellence in task orientation) and support for innovation (e.g., supporting the introduction of new and improved ways of doing things). Team climate is influenced by the way in which a team is led. For instance, by demonstrating openness and inviting team members to share their ideas and provide feedback, a team leader can foster participative safety, which refers to the level of encouragement and psychological safety team members feel to propose new and improved methods (Anderson & West,

1996; Buljac-Samardžić et al., 2012). In addition, if a manager shares information in a way that helps a team to make sense of the objectives, plans and activities of the organisation, staff in the team have more positive perceptions of team vision and innovation support (Odoardi et al., 2015). Based on these findings, we hypothesised that professionals around a team who experience positive mutual collaboration (e.g., who share the same vision and goals) will coach staff in a positive and consistent way, thereby resulting in a positive staff team climate.

In summary, this study is based on two hypotheses: (1) staff perceive higher levels of support from professionals around a team (i.e., team leaders, managers and psychologists) when professionals around a team experience more positive mutual collaboration, and (2) staff perceive a more positive team climate when professionals around the team experience more positive mutual collaboration. In addition, we explored the extent to which support from team leaders, managers, psychologists and other staff members contributes to perceived support and the extent to which the support provided by each type of professional and the team climate are related to well-being and job satisfaction.

Methods

Participants and setting

The study was conducted amongst professionals working in Dutch residential service organisations for people with mild IDs or borderline intellectual functioning and severe CB. About one-fifth of the professionals participating in the study were working in organisations collaborating in the Pro project. Established in 2017 by three residential service organisations, two care administration offices and the Dutch Centre for Consultation and Expertise (Lokman et al., 2022) and funded by the Dutch Ministry of Health, Welfare and Sport, this project aims to enhance quality of life for people with mild IDs or borderline intellectual functioning and severe CB by breaking the pattern of recurrent transfers to new locations (of a forensic and, in many cases, more restrictive character). In addition to the professionals working in the three residential service organisations collaborating in Pro, the participants included professionals serving people with mild IDs or borderline intellectual functioning and severe CB from seven other residential service organisations. Teams of staff were eligible for participation if at least half of the residents in the group home were adults with mild IDs or borderline intellectual functioning and severe CB, as ascertained by a psychologist or manager. In addition to the team of staff, the study included professionals around a team related to the participating teams. In all, 201 staff members, 18 team leaders, 21 managers and 22 psychologists from 32 teams in 10 organisations participated in this study.

The mean age of all participating professionals was 35 years, and 57% were male (Table 1). On average, they had been working in ID services for 8 years and in their current organisations for about 6 years. Their mean involvement in their current team was almost 3 years, and the mean appointment was for 32 h/week. Most participants (55%) had completed secondary vocational, senior general secondary vocational or pre-university education.

Table 1. *Characteristics of staff and professionals around a team*

	Staff	**Team leaders**	**Managers**	**Psychologists**	**Total**
	N = 201	*N* = 18	*N* = 21	*N* = 22	*N* = 262
Gender, n (%)					
Female	82 (40.8)	6 (33.3)	5 (23.8)	20 (90.9)	113 (43.1)
Male	119 (59.2)	12 (67.7)	16 (76.2)	2 (9.1)	149 (56.9)
Age (years)					
Mean (*SD*)	33 (10.1)	38 (8.5)	48 (10.8)	32 (5.4)	35 (10.5)
Range	20-65	28-60	33-66	24-47	20-66
Education, n (%)					
Pre-vocational secondary education	17 (8.5)	0	0	0	17 (6.5)
Secondary vocational/ senior general secondary vocational/ pre-university education	130 (64.7)	13 (72.2)	1 (4.8)	0	144 (55.0)
Higher professional/ postgraduate education	54 (26.9)	5 (27.8)	20 (95.2)	22 (100)	101 (38.5)
Work experience in the field of intellectual disabilities (years)					
Mean (SD)	7 (7.5)	12 (6.3)	19 (9.6)	8 (5.8)	8 (8.1)
Range	.2–45	5–30	.3–40	2–24	.2–45
Time working in the organisation (years)					
Mean (SD)	4 (5.0)	11 (6.6)	11 (7.5)	5 (3.8)	6 (5.7)
Range	.2–38	3–30	.3–25	1–13	.2–38
Time working in the team (years)					
Mean (SD)	3 (2.8)	2 (1.7)	4 (4.0)	2 (2.0)	3 (2.8)
Range	.2–19	.3–7	.3–13	.7–9	.2–19
Appointment (hours per week)					
Mean (SD)	31 (4.1)	35 (3.3)	36 (2.2)	34 (3.0)	32 (4.1)
Range	16–40	28–40	32–40	28–36	16–40

All teams provided support to people with IDs or borderline intellectual functioning and severe CB. Nine of the 32 teams had only a manager and a psychologist as professionals around a team, without a team-leader position (or a senior staff member/coordinator with similar tasks as a team leader). Because of non-response and missing consent from service users and/or legal representatives, we obtained background data from psychologists on only 22 group homes and 78 service users. Based on the available data, the number of service users in the group homes ranged from 3 to 18 (median 5.5). Most of the residents with IDs or borderline intellectual functioning and severe CB were male (77%), with an average age of 34 years and a mean IQ score of 64. All had diagnosed and/or undiagnosed mental disorders (e.g., schizophrenia, psychotic disorder, attention-deficit hyperactivity disorder and autism spectrum disorder). Additional information about the service users is provided in Table 2.

Table 2. *Characteristics of service users*

	Service users
	N = 78
Gender, n (%)	
Female	18 (23.1)
Male	60 (76.9)
Age (years)	
Mean (*SD*)	34 (12.9)
Range	18-67
IQ	
Mean (*SD*)	64 (10.2)
Range	47-86
Diagnosis	
Autism spectrum disorder	34
Schizophrenia spectrum and other psychotic disorders	14
Trauma- and stressor-related disorders	14
Attention-deficit hyperactivity disorder	9
Disruptive, impulse-control, and conduct disorders	8
Substance-related and addictive disorders	4
Bipolar and related disorders	2
Depressive disorders	2
Obsessive-compulsive and related disorders	2
Personality disorders	2

Procedure

After obtaining approval from the Ethics Review Board of Tilburg University (RP294), chief executive officers from 31 residential service organisations were approached that had expressed interest in the Pro project and/or were providing support to service users with the same support needs as those involved in Pro. They received an email containing a brief explanation of the study and an invitation to participate. When an organisation expressed interest in participating, the researchers discussed further details with the organisation's point of contact (e.g., manager or research coordinator) and verified whether the teams that were willing to participate met the inclusion criteria. If the inclusion criteria were met, the contact person sent the information letter and consent form to staff and the professionals around a team. Those agreeing to participate provided written informed consent. Participants received an email with a personal link to an online questionnaire using QUALTRICS software (version 2023, May 2023, Qualtrics, Provo, UT, USA), along with a request to complete the questionnaire within 4 weeks. The researchers sent up to three reminders during this period. Thirty-five of the participants failed to complete the questionnaire within this time frame, in most cases because the email addresses initially provided were incorrect or because the participants were on holiday. On average, these participants completed their questionnaires 20 days later.

Measures

Support from professionals around a team

The six-item Leader Support (LS) scale (Borrill et al., 1996; Haynes et al., 1999) was used to assess support from team leaders, managers and psychologists, as perceived by staff. The scale was originally developed for use in studies focusing on the psychological well-being of health-services employees (e.g., nurses and doctors), and it has previously been applied in studies within the field of IDs (e.g., Vassos et al., 2017). The following is an example item: "How much does your team leader/manager/psychologist offer new ideas for solving job-related problems?". Respondents rated the items along a 5-point Likert scale: four items ranged from "very small extent" (1) to a "very great extent" (5), and two items ranged from "not at all' (1) to "a great deal' (5), with higher scores reflecting higher levels of perceived support. Previous studies have reported high values of internal consistency (four items: Cronbach's alpha score of 0.94/0.93; two items: Cronbach's alpha score of 0.91) (Vassos & Nankervis, 2012; Vassos et al., 2017).

Support from other staff members

Support from other staff members in a team was measured according to the Peer Support (PS) scale (Borrill et al., 1996; Haynes et al., 1999). The scale consists of four items scored along a 5-point Likert scale from "not at all" (1) to "completely" (5). The following is an example item: "To what extent can you count on your colleague staff members to back

you up at work?". Higher scores on the PS scale indicated higher levels of support from other staff members. In line with the LS scale, the internal consistency of the PS scale has shown to be high (Cronbach's alpha: 0.94) (Vassos et al., 2017). For the purposes of this study, a certified translation agency translated the LS and the PS into Dutch using a forward–backward translation procedure.

Team climate

The short version of the Dutch Team Climate Inventory (TCI-14; Strating & Nieboer, 2009) was used to measure team climate. Strating & Nieboer (2009) derived the TCI-14 from the Team Climate Inventory, originally developed by Anderson & West (1996). This short version consists of 14 items divided over four sub-scales: (1) vision (e.g., "To what extent do you think your team's objectives are clearly understood by other members of the team?"), (2) participative safety (e.g., "People feel understood and accepted by each other"), (3) task orientation (e.g., "Are team members prepared to question the basis of what the team is doing?") and (4) support for innovation (e.g., "In this team, we take the time needed to develop new ideas"). Responses were provided along a 5-point Likert scale, with scores ranging from "strongly disagree" (1) to "strongly agree" (5). For each scale, the items were summed to calculate the scale score. Higher scores are indicative of a more positive team climate. The psychometric properties of the Dutch TCI-14 have shown to be satisfactory in teams working within the field of IDs and elderly care, with Cronbach's alpha coefficients on the sub-scales ranging from 0.73 to 0.80 (Strating & Nieboer, 2009).

Psychological well-being

Psychological well-being was measured along the five-item Mental Health Index (MHI-5) (McCabe et al., 1996), as derived from the Dutch translation of the RAND 36-item Health Survey (van der Zee et al., 1996; van der Zee & Sanderman, 2012). Items were rated along a 6-point scale ranging from "all of the time" (0) to "none of the time" (5). The following is an example item: "How much of the time during the past four weeks have you felt calm and peaceful?". The sum of the five items is multiplied by four to obtain a final score ranging from 0 to 100. Higher scores represent better mental health (van der Zee et al., 1996; van der Zee & Sanderman, 2012). The MHI-5 has shown to be a valid and reliable measure in non-patient populations, with Cronbach's alpha coefficients of 0.88 and 0.89 (Elovanio et al., 2020; McCabe et al., 1996).

Job satisfaction

Job satisfaction was rated according to the widely used Michigan Organizational Assessment Questionnaire Job Satisfaction Subscale (MOAQ-JSS; Bowling & Hammond, 2008). A Dutch version of this scale was developed and validated by Malfait et al. (2016). The three items of the MOAQ-JSS were scored along a scale ranging from "strongly

disagree" (1) to "strongly agree" (7), with higher scores reflecting greater job satisfaction. The following is an example of the three items: "In general, I like working here". Based on meta-analyses, Bowling & Hammond (2008) demonstrated that the MOAQ-JSS is reliable (Cronbach's alpha: 0.84), face valid and construct valid. Cronbach's alpha reported by Malfait et al. (2016) ranged from 0.67 to 0.94.

Collaboration

The Teamwork Quality (TWQ) construct, originally developed by Hoegl & Gemuenden (2001) and slightly rephrased by Lindsjørn et al. (2016), was used to operationalise mutual collaboration amongst professionals around a team. For the purpose of this study, the TWQ was translated into Dutch using a forward–backward translation procedure conducted by a certified translation agency. The instrument consists of 38 items, divided over six scales: communication (10 items; e.g., "There is frequent communication within the team"), coordination (4 items; e.g., "The work done on subtasks within the project is closely harmonized"), balance of member contributions (3 items; e.g., "Imbalance of member contributions causes conflicts in the team"), mutual support (7 items; e.g., "The team members help and support each other as best they can"), effort (4 items; e.g., "Our team put much effort into the teamwork") and cohesion (10 items; e.g., "The teamwork is important to the team"). To align the questions to the context of the professionals around a team, we replaced 'team members' with "the two/three of us", depending on whether there was or was not a team-leader position. Items were rated along a 5-point scale ranging from 'strongly disagree' (1) to 'strongly agree' (5), with higher scores indicating more positive collaboration. Internal consistencies (Cronbach's alpha scores) for the scales in previous studies ranged between 0.58 and 0.97 (Hoegl & Gemuenden, 2001; Valentine et al., 2015; Lindsjørn et al., 2016).

Analyses

Four types of analyses were performed. First, we conducted descriptive statistical analyses using SPSS software (version 27.0, IBM Corp., Armonk, NY, USA) to examine how staff perceived support, team climate, well-being and job satisfaction. Descriptive statistics were also used to analyse how the professionals around a team perceived their mutual collaboration. Second, while managers may be more distant to staff if the professionals around a team have a team-leader position, we tested for differences between teams that did and did not have a team leader. The means for support from the manager, support from other staff members and team climate for these two groups were compared with t-tests for independent samples. Because scores for support from psychologists were not normally distributed, we performed a Mann–Whitney U-test. Third, Spearman's rank correlation was computed to assess the strength of the associations of perceived support from each type of professional and team climate with well-being and job satisfaction. Spearman correlation was chosen instead of the Pearson correlation, as the variables

exhibited strong outliers. Fourth, given that the participants were nested in teams, thereby generating interdependence within the data, we applied multilevel analyses to test the two hypotheses at two levels (teams) and calculated intraclass correlation coefficients (ICCs). In four mixed models with fixed effects, the scores of individual staff members were matched with the average score for collaboration on the part of the professionals around that team. In each model, the mutual collaboration of the professionals around a team was added as the predictor variable. Each of the four variables (i.e., perceived support from team leaders, managers, psychologists and team climate) was added separately as the dependent variable in the models. We included the gender of staff as a control variable, as some studies have reported indications of an association between gender and perceived support (e.g., Drummond et al. 2017). Because 9 of the 32 teams did not include a team-leader position, the collaboration scores for these teams were computed as the average of the responses of the manager and the psychologist. For five teams, not all professionals around a team completed the measures. In these cases, we used only the available data to calculate the collaboration scores. In five organisations (12 teams), the same team leader, manager and/or psychologist rated the mutual collaboration more than once, as they were supporting more participating teams. The ratings for each collaboration were nevertheless analysed as if they were independent. In line with the recommendations of Armstrong (2014), we did not apply Bonferroni corrections, as we were interested in the results of the individual tests.

Results

Descriptive statistics

Table 3 provides an overview of means, standard deviations (SDs), ranges and Cronbach's alpha scores regarding the support received at work from various groups of professionals, as well as team climate, well-being and job satisfaction, as collected from staff. The same descriptive information is presented in Table 4 for the data gathered from professionals around a team about their mutual collaboration. Cronbach's alpha scores for the measures taken from support staff and professionals around a team ranged respectively between 0.67 to 0.95 and 0.72 to 0.93.

Perceived support and team climate

Perceived support from other staff members was significantly more positive for teams with a team leader ($M = 4.45$, $SD = 0.27$) than for teams without a team leader ($M = 4.09$, $SD = 0.33$, $t(30) = 3.23$, $P = 0.003$). A similar result was obtained for team climate ($M = 3.90$, $SD = 0.46$ respectively $M = 3.53$, $SD = 0.38$, $t(30) = 2.12$, $P = 0.042$).

Table 3. *Means, medians, standard deviations, range and Cronbach's alpha scores for variables measured amongst staff*

Variable	*N*	Mean (median)	SD	Range	Alpha
Support					
Support from team leaders	141[a]	4.15 (4.17)	0.59	1.67–5.00	0.88
Support from managers	201	3.61 (3.83)	0.96	1.00–5.00	0.95
Support from psychologists	201	3.93 (4.00)	0.67	1.67–5.00	0.89
Support from other team staff members	201	4.35 (4.50)	0.59	2.50–5.00	0.88
Team climate	199	53.4 (54.00)	9.43	24–70	
Vision	199	15.18 (16.00)	3.15	4–20	0.88
Participative safety	199	16.09 (16.00)	2.97	8–20	0.89
Task orientation	199	11.03 (11.00)	2.35	5–15	0.85
Support for innovation	199	11.14 (11.00)	2.23	6–15	0.88
Well-being	199	76.92 (80.00)	15.66	28–100	0.88
Job satisfaction	199	5.95 (6.00)	0.94	2.33–7.00	0.67

[a] *60 staff members were not working in a team with a team leader.*

Table 4. *Averages of the means, medians, standard deviations, range and Cronbach's alpha scores for the quality of collaboration between team leaders, managers and psychologists (N = 73)*

Variable	Mean (median)	SD	Range	Alpha
Total collaboration	4.04 (4.16)	0.45	2.84–4.58	
Communication	4.08 (4.20)	0.37	3.17–4.57	0.86
Coordination	3.81 (4.00)	0.57	2.42–4.75	0.81
Balance of member contributions	4.07 (4.11)	0.54	2.56–4.78	0.72
Mutual support	4.09 (4.29)	0.54	2.86–4.86	0.93
Effort	3.97 (4.13)	0.53	2.63–4.67	0.79
Cohesion	3.98 (4.07)	0.51	2.73–4.73	0.91

Relationship between support from professionals and team climate with well-being and job satisfaction

As shown in Table 5, support received at work from all four groups of professionals and team climate showed a significant small to moderate positive association with job satisfaction: support from team leaders ($r = 0.34$, $P < 0.001$), support from managers ($r = 0.27$, $P < 0.01$), support from psychologists ($r = 0.37$, $P < 0.001$), support from other staff members ($r = 0.39$, $P < 0.001$) and team climate ($r = 0.49$, $P < 0.001$). Well-being was associated with support from team leaders ($r = 0.18$, $P < 0.034$), support from psychologists ($r = 0.20$, $P = 0.005$), support from other staff members ($r = 0.23$, $P < 0.001$) and team climate ($r = 0.36$, $P < 0.001$), but not with support from managers ($r = 0.02$).

Collaboration of professionals around a team and staff's perceived support and team climate

As presented in Table 6, the hypothesis that staff would perceive higher levels of support from professionals around a team (i.e., team leaders, managers and psychologists) when the professionals around a team experienced better mutual collaboration was not confirmed. More specifically, the models for support from team leaders, managers and psychologists were all non-significant [team leaders: b = -0.11, standard error (SE) = 0.22, P = 0.62; managers: b = -0.36, SE = 0.26, P = 0.18; and psychologists: b = 0.17, SE = 0.19, P = 0.39. The ICCs for support from team leaders, managers and psychologist ranged from 0.31 to 0.36, indicating that a considerable amount of the variance in these variables could be explained at the team level.

We further hypothesised that staff would perceive a more positive team climate when professionals around a team experience more positive mutual collaboration. Multilevel analyses showed that the data did not support this assumption (b = 0.16, SE = 0.19, P = 0.40) (Table 5). The ICC for team climate was 0.37, suggesting that there was a high degree of similarity amongst the perceptions of staff members within the same team with regard to team climate.

Table 5. *Spearman's rank correlation for perceptions of staff concerning support received from professionals around a team, other team staff members, and team climate with job satisfaction and well-being*

Variable	Job satisfaction		Well-being	
Support	r_s	*p-value*	r_s	*p-value*
Support from team leaders	0.341	< .001	0.180	0.034
Support from managers	0.270	< .001	0.024	0.740
Support from psychologists	0.365	< .001	0.200	0.05
Support from other team staff members	0.391	< .001	0.229	0.001
Team climate	0.488	< .001	0.355	< .001

Table 6. *Multilevel regression analyses for mutual collaboration of professionals around a team and the perceptions of staff concerning support received from professionals around a team and team climate*

Variable	Effect β/SE	*p-value*
Support from team leaders	-0.11/0.22	0.62
Support from managers	-0.36/0.26	0.18
Support from psychologists	0.17/0.19	0.39
Team climate	0.16/0.19	0.40

Discussion

In this study, we investigated perceptions of staff serving people with mild IDs or borderline intellectual functioning and severe CB living in residential service facilities concerning support received at work from their team leaders, managers, psychologists and other staff members. We also explored perceptions of team climate and examined the extent to which their perceptions of support and team climate were associated with well-being and job satisfaction. Moreover, we investigated whether staff perceived higher levels of support from professionals around a team (i.e., team leader, manager and psychologist) when professionals around a team experienced more positive mutual collaboration (Hypothesis 1) and whether they perceived the team climate as more positive when the professionals around a team experienced more positive mutual collaboration (Hypothesis 2).

In particular, support from other staff members and team climate were positively associated with the well-being of staff. These results confirmed outcomes of studies conducted within the field of IDs and CB based on smaller sample sizes (e.g., Leyin & Wakerly, 2007; Rose et al., 2006). With regard to job satisfaction, positive correlations were found for support at work from all four groups of professionals as well as for team climate. Previous studies have identified associations between job satisfaction and support from supervisors or other staff members, both within and outside the ID literature (Charoensukmongkol et al., 2016; Hatton et al., 1999). While the relationship between team climate and job satisfaction has received less attention in the ID field, positive associations have been reported in healthcare settings, such as staff in general practices (e.g., Harris et al., 2007). Prioritising staff support and fostering a positive team climate can have significant benefits for the well-being and job satisfaction of staff, as well as contribute to staff retention, given that such support and climate have been negatively linked to turnover (Mascha, 2007; Zhu et al., 2017). The importance of a positive team climate has been noted in previous research, including in the context of ID research (e.g., Willems et al., 2016), but there is limited research on effective strategies for achieving this climate in practices. Rose et al. (2006) identified staff's attitudes towards other professionals (e.g., psychologists, doctors and therapists) as a factor influencing team climate, suggesting that fostering strong relationships between professionals around a team and staff members can be crucial. One approach that could be applied is interprofessional education, defined as 'occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services' (CAIPE, 2016), which has been shown to enhance professionals' attitudes of collaboration (Reeves et al. 2016; Spaulding et al., 2021).

On average, staff assigned high ratings to the support from other staff members. This might have been due to the challenging nature of their working environment. Under these circumstances, the ability to vent frustrations or fears and to discuss complexities with other staff members who share the same situations may be of even greater value (Judd et al., 2017; Simons et al., 2021). Previous studies conducted amongst staff have also indicated the important role that other staff members play in the provision of support (Judd et al., 2017; Leyin & Wakerly, 2007). Organisations should therefore create opportunities for staff to talk about insights, problems or difficulties, in addition to investing in good relationships between staff. To this end, it is important to allow time for staff to debrief each other after stressful situations or to engage in peer-consultation sessions ("intervision") to share insights and reflect with each other (Judd et al., 2017; Simons et al., 2021).

Contrary to our expectations based on social exchange theory, which has been supported in previous studies conducted in a range of settings (e.g., Baran et al., 2012; Halbesleben & Wheeler, 2015), the data did not confirm either of our hypotheses. One reason for this finding may be that professionals around a team tried to reciprocate support, but that staff did not perceive it as such. This could be attributed to characteristics of staff members (e.g., personality traits; see Barańczuk, 2021), as well as to the manner in which professionals around a team provided support (Deelstra et al., 2003; Johnsen et al., 2018). For example, staff might have perceived the attempts of professionals around a team to help them resolve work-related problems as the imposition of particular solutions or perspectives, instead of as the provision of support. If this was indeed the case, a more non-directive style of support might have been more fruitful, in which professionals around a team cooperate with staff instead of taking control, thereby supporting self-determination (Harber et al., 2005; Johnsen et al., 2018). The effectiveness of support could be enhanced by aligning support to the personal needs and preferences of staff members (Johnsen et al., 2018; Nurullah, 2012). Second, a reciprocal relationship between collaboration and perceived support might not have been found, simply because professionals around a team might, in case of a good collaboration, do not reciprocate support to staff but only to each other. In other words, the extent of reciprocity that professionals around a team show towards staff depends on the relationship that they have with staff and not on the relationship and collaboration that supporting professionals have with each other. Another reason for the absence of a reciprocal relationship between collaboration and perceived support could be that supporting professionals were willing to provide more support but were not able to do so because of lack of resources (e.g., time) or skills (Harber et al., 2005; van Oorsouw, 2013; Stenfert Kroese & Smith, 2018). For example, professionals around a team (e.g., psychologists) may not have possessed the characteristics and competencies required in order to coach staff. It is therefore important to evaluate coaching processes to determine whether they are being provided in an effective

manner and to invest in reinforcing the qualifications of professionals around a team if necessary (van Oorsouw, 2013). Professionals around a team could benefit from training or coaching on how to provide constructive feedback to staff, which is an area they often find challenging (Beadle-Brown et al., 2014). A combination of in-service training and coaching on the job, which has been found to be an effective approach to staff training, may also be a suitable format for professionals around a team (van Oorsouw et al., 2009). Other variables (e.g., high turnover in teams) may also have had a strong influence on the perceptions of staff about their team climate, thus interfering with possible positive associations between collaboration and team climate. Future research could explore the potential benefits of reciprocal relationships between professionals around a team on the support and team climate perceived by staff. Specifically, additional research could help identify the conditions under which such relationships are most likely to be effective.

Finally, perceived support from other staff members and the team climate were more positive in teams with a team leader than for those without a team leader. These results endorse the need for a practice leader close to the frontline of service delivery (e.g., Bigby et al., 2020). As reported by Deveau & McGill (2019), significant administrative demands could make it difficult for managers to offer supervision and support to staff. Other professionals who are more involved in a team (e.g., team leaders) could provide practice leadership to fill this gap. In essence, organisations that aim to realise their vision of providing high-quality support to service users must prioritise that vision over financial considerations (Olivier-Pijpers et al., 2019). Achieving high-quality support for service users demands that staff themselves are well supported. This requires facilitating team leaders, managers and psychologists with adequate time and resources to provide effective support to staff.

This study was subject to several limitations. First, in the multilevel analyses, we were not able to correct for nesting at the organisational level as one organisation participated with only one team. This did not seem to have had an impact on the outcomes, however, as the amount of variance in perceived support and team climate that could be explained at the organisational level was negligible. Second, the study was conducted during the COVID-19 pandemic, which may have affected the ratings given by participants. For example, staff may have experienced less support because regular meetings with managers and psychologists could not be kept or were held online because of COVID-19 restrictions (Embregts et al., 2022). The pandemic also interfered with the recruitment of teams to participate in the study and with data collection because of the additional work pressure for staff and the absence of on-site team meetings. Furthermore, the recruitment of teams meeting the inclusion criterion of working in a group home in which at least half of the service users had mild IDs or borderline intellectual functioning and severe CB was difficult. To have as many teams as possible, we included some teams from the same

organisation that had the same team leader, manager and/or psychologist. As a result, the data obtained from some professionals around a team were not completely independent, although they were treated as such in the analyses. A third limitation is that, despite the inclusion of these teams in the study, the total number of participating teams was 32. This constitutes a limitation on the multilevel analyses, and caution is therefore advised when generalising the findings to other teams. Another limitation is related to the fact that data from professionals around a team were missing for five teams because of non-response. This means that the average collaboration scores for these teams did not reflect the views of all these professionals. Fifth, the 35 participants with a lag in the response time may have rated the measures differently than participants who completed the questionnaire on time, thereby affecting the results. However, the number of participants with a late response was too small to draw any firm conclusions based on statistical tests. Finally, the amount of variance explained in our study was limited. In future research, it would therefore be relevant to explore other variables in relation to the perceptions of staff concerning the support that they receive. Variables to explore could include the extent to which the professionals around a team felt supported by the organisation themselves and the extent to which they were equipped to provide support to staff.

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CHAPTER 4

4

Factors affecting the feelings of safety among individuals with mild intellectual disabilities and severe challenging behaviour in residential care: A qualitative study of professional and service users' perspectives

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Abstract

Background

This study focuses on what feeling safe means for people with mild intellectual disabilities and severe challenging behaviour, and which factors affect their sense of safety.

Method

Thematic analysis was used to analyse data collected during (1) ethnographic longitudinal research and (2) interviews and focus groups among professionals and service users.

Results

Feelings of safety can relate to three main themes: (1) a physical environment that reduces risks and temptations; (2) a reliable, predictable, and supportive environment; and (3) an accepting environment that enables service users to establish a normal life. An analysis of which factors affect service users' sense of safety identified 20 themes (e.g., team climate) and 34 subthemes (e.g., interactions with other service users).

Conclusions

A range of interconnected factors can affect service users' feelings of safety. Future research should explore what organisations and external actors (e.g., the police) can do to promote those feelings.

Safety is a basic need in every human individual (Maslow, 1943), but because the meaning of safety in studies depends on the characteristics of the participants and the context, there is no generally accepted definition of safety. Safety has been associated with the absence of accidents or conceived as the antonym of risk (Aven, 2014; Aven & Renn, 2009). Defined in more positive terms, safety is the capacity to achieve successful outcomes under varying conditions (Aven, 2022). Several aspects can affect perceived safety. In healthcare settings, including (forensic) psychiatric care, perceived safety among patients can relate to the quality of interaction with support staff, such as the interest that support staff show towards patients, the extent to which patients perceive that they are taken seriously, and the level of communication with support staff (Kenward et al., 2017; Pelto-Piri et al., 2019). In addition, psychiatric patients' feelings of safety have been shown to be affected by other patients, who can engender feelings of anxiety and a lack of safety through threatening or aggressive behaviours (Pelto-Piri et al., 2019; Verstegen et al., 2022a). Moreover, patients can feel unsafe due to a lack of information about other patients (e.g., about another patient's mental state after an incident, so that they can ascertain the likeliness of future risky situations) (Pelto-Piri et al., 2019; Stenhouse, 2013).

The impact of relationships with support staff on service users' feelings of safety has also been identified in studies involving children and adults with intellectual disabilities (Bambara et al., 2001; Tournier et al., 2022). Relationships with others, such as family, friends and other service users, also appear to affect the perceived safety of service users with intellectual disabilities (Griffith et al., 2013; Neimeijer et al., 2021; Robinson, 2014). For example, children and young people with intellectual disabilities and complex (mainly physical) needs were found to associate emotional and physical conflicts at home and social exclusion by other children with feelings of fear and anxiety (Robinson & Graham, 2020). Being in a familiar environment was another aspect that promoted feelings of safety and security. In a study by Robinson (2014), adults with intellectual disabilities mentioned many factors relating to physical safety in response to what 'feeling safe at home' means, such as locks on doors to stop strangers from entering.

In those with intellectual disabilities and challenging behaviour (CB), feeling safe is a particularly relevant issue, because the CB may be triggered or prolonged when they feel unsafe (van den Bogaard et al., 2019). In turn, CB can have negative consequences on their quality of life due to restrictive interventions, social exclusion and transfers to another, often more restrictive setting, for example (Embregts et al., 2019; Heyvaert et al., 2015; Nankervis et al., 2019). CB can also have an impact on the well-being of significant others around those with CB, such as other patients, support staff and family members (Olivier-Pijpers et al., 2018; Vassos & Nankervis, 2012). As a consequence, support staff may, for instance, develop negative emotions, which can result in a burn-out (Mills & Rose, 2011; Zijlmans et al., 2012). When support staff do not feel safe, this can also lead

to more coercive methods of control and a more hostile attitude towards service users (Willems et al., 2016).

To help people with intellectual disabilities with CB to feel safe, it is important to know what feeling safe means to them and which factors promote or undermine this. However, to our knowledge, this has not yet been explored. In this qualitative study, we have therefore aimed to understand feelings of safety in people with mild intellectual disabilities or borderline intellectual functioning and severe CB from the perspective of both service users and professionals in various roles. More specifically, we formulated the following two research questions:

(1) What does feeling safe mean for individuals with mild intellectual disabilities or borderline intellectual functioning in a residential setting who display severe CB?
(2) Which factors affect the feelings of safety among these individuals?

Method

Setting: Project Pro

The study was conducted at six Dutch organisations involved in the project Pro, including three residential service organisations for people with intellectual disabilities, two care administrative offices and the Centre for Consultation and Expertise (CCE). These organisations started working together in Pro in 2017 in order to prevent a constant stream of transfers between care settings and to enhance the quality of life of 24 people with mild intellectual disabilities or borderline intellectual functioning combined with psychopathology, who exhibited severe CB and of whom many have had a forensic background (Pro, 2023). The three residential service organisations each provide support to eight Pro service users following agreed principles: a) unconditionality regarding service users' residential status and their relationships with support staff; b) striving for a life that is as normal as possible; c) adapting the environment to the needs of service users (e.g., safety, autonomy) rather than the primary focus being on preventing their CB; and d) promoting the service user's self-confidence (Pro, 2023). As well as these principles relating to the service users, the Pro organisations also focus specifically on the well-being of healthcare professionals and developing their competencies. Additionally, they underline the mutual responsibility of professionals in all positions (e.g., care workers, psychologists), including the board members of their organisations, to provide support according to these "Pro principles".

Design

Non-participant observations and informal unstructured interviews were used to collect qualitative data and explore which factors affect the feeling of safety of service

users with severe CB (research question 2). These data were gathered by the first author during ethnographic longitudinal research in Pro, focusing on the practical implications and long-term outcomes of applying the Pro principles outlined above. Documents (meeting minutes) were also analysed. Data analysis produced a range of themes that appeared to play a role in service users' sense of safety. These themes were validated using triangulation among service users and professionals involved in Pro through semi-structured interviews and focus groups. Interviews and focus groups were also used to gain more insight into what safety means for service users with mild intellectual disabilities or borderline intellectual functioning who display severe CB (research question 1).

Participants

Data were collected from service users and professionals who lived or worked at one of the organisations involved in Pro. The participants in the interviews and focus groups included four service users, 42 support staff members from six teams, one team leader, four managers, six psychologists, two managing directors, three board members, and six other professionals (e.g., head of treatment, quality advisor) (Table 1). The service users were all male with an average age of 40 years (SD = 14.6, range 26-59), and had been resident with a Pro organisation for 3 to 4 years ((M = 3.5, SD = 0.4). Of the professionals, about two-thirds were male, and their ages ranged between 21 and 64 years (M = 38, SD = 10.0) (Table 2). The professionals had been involved in Pro for an average of 2 years (SD = 1.5) and had an average of 8 years of work experience in the field of care for those with intellectual disabilities (SD = 8.9).

Procedure

Data for the study were collected in two steps: 1) the collection of qualitative data from ethnographic longitudinal research in Pro through non-participant observations, informal unstructured interviews, and document analysis; and 2) the collection of data through interviews and focus groups with people involved in Pro. We will describe these steps in more detail below.

Step 1: Exploration of qualitative data from ethnographic longitudinal research to Pro

Between 2019-2022, the first author collected qualitative data through ethnographic fieldwork as part of longitudinal research into Pro. To this end, she regularly visited each of the locations of the three residential service organisations involved in Pro and contacted team leaders, managers and psychologists by telephone or online (around once a month). She also attended a regular two-monthly meeting of the steering committee of Pro, consisting of treatment directors and managing directors, as well as the monthly meetings for team leaders, managers and psychologists working at the three residential service organisations, where the care being provided was discussed. Finally, she joined a couple of working conferences organised by the organisations involved in Pro.

Table 1. *Overview of how qualitative data in step 2 were collected from which participants.*

Type of participants (*N* = 68)	**Method**	**Number of interviews/ focus groups**
Service users (*N* = 4)	Interview	4
Support staff (*N* = 43)	Focus group Dual interview	4 1
Psychologists, team leader (*N* = 7)	Focus group	1
Managers (*N* = 3)	Interview	3
Managing director, other professionals (e.g., head of treatment, quality advisor) (*N* = 7)	Focus group	1
Board members (*N* = 3)	Interview	3
Managing director (*N* =1)	Interview	1

Table 2. *Characteristics of participants of the interviews and focus groups.*

	Service users (*N* = 4)	**Professionals (*N* = 64)**
Gender, n (%)		
Female	0 (0)	20 (31.3)
Male	4 (100)	44 (68.8)
Age (years)		
Mean (SD)	40 (14.6)	38 (10.0)
Range	26-59	21-64
Years of experience in field of intellectual disability		
Mean (SD)	N/A	8 (8.9)
Range	N/A	0-40
Time involved in Pro (years)		
Mean (SD)	3 (0.4)	2 (1.5)
Range	3-4	0-5

Data was collected through non-participant observations and informal unstructured interviews, two commonly used techniques in ethnography (Jones & Smith, 2017). Data collection was aimed at gaining insight into the experiences of service users and professionals in Pro and the work that Pro organisations do to further the quality of care. The aim was not to collect data on the theme of safety specifically but the theme emerged throughout the data collection, which is common in long-term participant observation (Hoey, 2014). A total of 80 fieldnotes were made for the interviews and observations. In addition, 20 documents (meeting minutes, mostly drafted by Pro) were included as data.

Step 2. Data collection through interviews and focus groups

In addition to the data from the ethnographic longitudinal research in Pro, eleven semi-structured interviews, one double interview and six focus groups were held (see Table 1), with the focus now specifically on the theme of safety. Most of these interviews and focus groups were conducted face-to-face to help create a safe and comfortable atmosphere and facilitate non-verbal communication (Saarijarvi & Bratt, 2021). For practical reasons (e.g., to reduce travel time for participants with busy schedules, and to align with existing online meetings), some interviews and focus groups were held online with a video connection (using Microsoft Teams). These interviews were conducted by the first author using an interview guide. For each group of participants (e.g., service users, managers, board members), the base interview guide was adapted to the context (e.g., the role and tasks) of the participants. The interview guide for all the participants included the question of what sprang to mind when safety for Pro service users was mentioned. The interview guide for service users was developed using feedback from experiential experts with mild intellectual disabilities from the Academic Collaborative Centre Living with an Intellectual Disability.

The focus groups were moderated by the first author together with either the second author or an experienced co-researcher. The first three authors prepared several statements relating to the themes identified in the longitudinal data in order to encourage focus group participants to join in the conversation. The statements were again adapted to the roles of the professionals in the focus group. Following an introduction to the study, as a validation and form of member check, the moderators first showed the themes identified in step 1 and asked the participants whether they recognised these and whether they would like to add any more. Subsequently, participants were asked to complete the sentence 'Safety for Pro service users is…', similar to the question asked in the interviews. For the remainder of the focus group, the participants were shown the predefined statements. The interviews lasted an average of 75 minutes and the focus groups 83 minutes; three interviews were split into two meetings – one due to limited time during the first meeting (diary commitment of a board member) and two because of limited concentration span and responses (service users). All the conversations were recorded and transcribed verbatim.

Analysis

The authors conducted a thematic analysis with a constructionist perspective to identify, report and analyse themes emerging from the data (Braun & Clarke, 2021). Thematic analysis consists of moving back and forth through the data in six phases. The first three steps in thematic analysis (familiarising oneself with the data, generating initial codes, searching for themes) were completed twice, once during step 1 (longitudinal data) and

once during step 2 (data from interviews and focus groups). The other steps in thematic analysis were completed using the full data set.

In step 1 (ethnographic longitudinal study), familiarisation with the data occurred during the data collection period (approximately two and a half years), when the first and second authors thematically analysed and discussed fieldnotes several times in an iterative manner to identify which factors affect the feeling of safety of Pro service users. To this end, they annotated relevant data using an inductive approach while comparing the findings with studies into safety experiences of people with intellectual disabilities and people who exhibit CB. Several themes that affect the perceived safety of service users were identified in the data and discussed with the other authors. To ensure that no themes were missed in the analysis, the first author systematically coded the field notes and Pro documents into subthemes using Atlas.ti software at the end of the data collection period. She then clustered the subthemes into themes in Microsoft Excel, and discussed these with another researcher. No new themes were identified in addition to the themes identified during data collection.

In step 2 (interviews and focus groups), thematic data analysis started with an exploration of the data. The first author familiarised herself with the data from the interviews and focus groups by carefully reading the transcripts. In addition, the first author listened to the audio recordings while also reading the text to check the transcripts and amended these where necessary. Next, she coded the transcripts using Atlas.ti software, keeping the two research questions in mind. In Microsoft Excel, the first author merged the codes and established potential subthemes and themes for both research questions in an iterative process. An experienced researcher reviewed the subthemes and the associated codes, including those identified in step 1, ensuring internal homogeneity (consistent coding within subthemes) and external heterogeneity (clear distinctions between subthemes). The first author and other researcher engaged in discussions to reach consensus on the titles of the subthemes and themes, which were subsequently presented to the other authors for further discussion. Finally, all the authors worked together to define and refine the final (sub)themes and select accompanying narratives, working towards achieving consensus.

Ethical procedure

This study regarding safety is part of a longitudinal study involving the Pro project approved by the Ethical Review Board at Tilburg University (EC-2019.37). Participants received written and verbal information about the aims of the study. They all provided informed consent in writing regarding their contribution to the study and the sharing of (personal) data, as did those legally responsible for the service users who participated.

Results

The participants' responses regarding what safety means for people with mild intellectual disabilities or borderline intellectual functioning and severe CB (research question 1) were categorised into three main themes. The thematic analysis of which factors affect feelings of safety among service users resulted in 20 themes (henceforth also referred to as factors) and 33 subthemes (research question 2) (see Table 3).

The meaning of feeling safe

An environment that reduces risks and temptations

The first of the three main themes relating to the meaning of feeling safe *a physical environment that reduces risks and temptations*. Participants mentioned a safe living environment where service users have their own room that they can retreat to, for instance, and the safety of service users was associated with an environment free of the risk of injury or being exposed to drug dealing.

> *But regarding safety, I also think of: what is the home like? What is the layout? A safe space in his or her own room […], because I think that it is important that service users are able to withdraw to their own safe environment. (Manager 3)*

A reliable, predictable, and supportive environment

The second main theme can be summarised as *a reliable, predictable, and supportive environment that service users have confidence in*. Codes belonging to this theme refer to feeling psychologically safe in a reliable, structured and predictable environment. This includes support staff who provide unconditional support, security, and a predictable daily routine. Many participants also mentioned that, in their experience, safety for service users means support staff who are always around and available for them.

> *A fixed team. A fixed programme. That comes back every time. That they know what is expected from them, and what they can expect from support staff. (Support staff 5)*

An accepting environment that enables service users to establish a normal daily life

The third main theme, *an accepting environment that enables service users to establish a normal daily life*, refers to an environment where service users feel appreciated, recognised, and like they can be themselves. It is also linked to the opportunity for phased societal integration and a positive outlook for the future, described by one of the service users as "things you can look forward to". Examples relate to forming a loving relationship or a positive transfer to a home with less intensive support and restrictions.

... because you want to have a good position in life, you want a good position... That's what I mean, that's my definition of feeling safe... That you're making progress in life and that you have things to look forward to instead of standing still, using drugs, or constantly fighting. (Service user 3)

Which factors affect the feeling of safety among service users?

The themes and subthemes identified as playing a role in service users' sense of safety involve the levels of 1) service users, their living environment and the people around them (5 themes, 10 subthemes), 2) individual staff members (3 themes, 4 subthemes), 3) a team of support staff (5 themes, 11 subthemes), 4) the organisation (3 themes, 6 subthemes) and 5) the external environment of residential service organisations (4 themes, 2 subthemes). Considering the high number of themes, we have limited the descriptions in this section to themes that are made up of subthemes. A complete overview of all the themes and subthemes for each level is provided in Table 3.

Table 3. *Themes and subthemes affecting the feelings of safety among service users.*

Theme	Subtheme	Brief description
Characteristics and behaviour of service users and others in their living environment	Challenging behaviour	Challenging behaviour reduces service users' sense of safety. Challenging behaviour has a negative impact on service user-support staff relationship. Challenging behaviour has a physical and psychological impact on staff members, leading to absenteeism and staff turnover.
	Mental health and addiction problems and reductions in psychotropic medication	Psychological problems reduce service users' self-confidence and increase the risk of challenging behaviour. Influence of reductions in psychotropic medication on tension. Substance abuse and craving substances increase the risk of challenging behaviour.
	Design and layout of the living environment	Design and construction of the home and living environment affect service users' sense of safety and the risk of challenging behaviour. The design of the home is important in preventing injury.
	Behaviour of and interactions with other service users	Substance abuse and challenging behaviour of other service users reduce service users' sense of safety. Interactions with other service users affect service users' sense of safety and can lead to challenging behaviour.

Table 3. *Continued*

Theme	Subtheme	Brief description
	Interactions with family and friends	Interactions with family and friends affect service users' sense of safety and the risk of challenging behaviour.
Characteristics, behaviour and knowledge of individual staff members	Competencies and resilience of staff members	Competent staff members are important to service users' and staff members' sense of safety and reduce the risk of challenging behaviour. Fear, stress and fatigue among staff affect service users' sense of safety and increase the risk of challenging behaviour and staff turnover.
	Support style of staff members	A reliable staff member who is clear promotes the building of a trusting relationship and service users' sense of safety. A staff member who is present and available for service users enhances service users' safety and reduces the risk of challenging behaviour.
	Staff members' knowledge of service users	Knowledge of service users is helpful in responding to their needs and identifying and acting on tension.
Characteristics and behaviour of the team of support staff	Providing clarity and structure as a team	Unambiguous communication and a consistent approach by the team of support staff provide clarity and predictability to service users and reduce challenging behaviour. A regular daily structure is important for the sense of safety of service users and support staff and reduces the risk of challenging behaviour.
	Team stability	Permanent staff members know what agreements have been made and increase the likelihood of unambiguous communication and a consistent approach by the team. Permanent, familiar staff members that service users know well are important to service users' sense of safety. Team stability leads to better relations within the team and higher work satisfaction, which in turn contribute to the retention of staff members.
	Team climate	A close team improves staff members' work satisfaction, reducing staff turnover. An open, safe atmosphere contributes to support staff's sense of safety.
	Team composition	The balance between new, inexperienced staff members and experienced staff members affects the risk of challenging behaviour. The ratio of male to female staff members in the team can affect the sense of safety of service users and support staff.

Table 3. *Continued*

Theme	Subtheme	Brief description
	Use of restrictive measures	Restrictive measures can protect service users from themselves and from negative influences in the outside world, reducing the risk of challenging behaviour. Restrictive measures can reduce service users' feeling of autonomy and increase the risk of challenging behaviour.
Perceptions, policies and practices of the organisation	Shared organisational vision and policies	Organisational vision affects how care professionals view service users. An organisational vision that is widely shared enhances team support. Human resource policies affect the recruitment and retention of care professionals.
	Organisational support	Emotional support contributes to the resilience and work satisfaction of care professionals, which affects staff retention. Ensuring the basics are taken care of enhances the sense of safety of service users and care professionals. Facilitating perceived autonomy of staff members is important for their work satisfaction.
	Negative perceptions of service users in organisation	Negative perceptions of service users in an organisation affect the sense of safety among care professionals.
Perceptions and behaviour of the external environment of residential service organisations	Impact of the behaviour of the police and legal system	Approach of the police in cases of challenging behaviour can have a negative impact on service users' sense of safety. Penalties imposed by judges determine whether service users can continue to live at their residential home.
	Negative media attention	Negative media attention reduces staff members' sense of safety.
	Perceptions of society	Perceptions of society about service users have an adverse impact on service users' sense of safety.
	Shortage on the labour market	A tight labour market has a negative impact in the recruitment and retention of staff.

Characteristics and behaviour of service users and others in their living environment

An analysis of the longitudinal data, interviews and focus groups revealed that at the level of the service user, perceived safety was affected by challenging behaviour, mental health and addiction problems and reductions in psychotropic medication, the design and layout of the home and living environment, the behaviour of and interactions with other service users, and interactions with family and friends.

Challenging behaviour. It appears that perceptions of a lack of safety can trigger CB in service users, and also that CB leads to a perceived lack of safety. One of the service users explained that during an episode of CB, he feels unsafe and that feelings of safety are taken away from him.

CB may reduce service users' sense of safety indirectly as well, in cases where the CB has a negative impact on the relationship between service users and support staff – for instance, because service users feel mistrust of support staff or because support staff avoid contact with the user or are hostile in response to service users' CB. As the data analysis showed, following an episode of CB it can be difficult for support staff to resume daily activities and be available for service users, as if nothing had happened. In some cases, support staff have even refused to continue working with a particular service user.

CB can also affect the physical and psychological safety of staff. Several staff members have sustained significant physical and psychological damage because of CB, which led to long-term absence or even leaving their position.

Mental health and addiction problems and reductions in psychotropic medication. As well as service users' CB, professionals and one service user indicated that service users' sense of safety can be adversely affected by their mental health problems. Some of these problems relate to their complex life history, including the frequent transfers they faced due to severely challenging behaviour in the past. For example, one manager and board member mentioned that attachment-related problems and the revival of negative memories reduce service users' sense of safety and increase the risk of unwanted behaviour and unsafe situations.

> *… if somebody is reliving certain memories, or… yes that doesn't hold up their treatment, but yes briefly, it actually does stagnate briefly, yes that can be a short interruption in the treatment, and it can also lead to unsafe situations, for both the resident and the staff member. (Manager 2)*

Many service users are used to taking psychotropic medication to deal with their mental health issues. According to professionals, reducing this medication can cause service users to become tense because it removes one method of coping.

Alcohol and drug addictions among service users have also been shown to affect their sense of safety, because their cravings can lead them to run away. Without supervision, they are tempted to relapse and drink or use drugs excessively, which can trigger their CB.

Design and layout of the living environment. According to professionals in various positions, a quiet, well-organised, predictable living environment enhances service users' sense of safety. They also explained that the living environment should be pleasant and homely. Members of the steering committee of Pro (e.g., managing directors, head of treatment) indicated that such a homely environment invites normal behaviour (i.e., without CB), as opposed to a bare, low-stimulus environment. In addition, one manager added that a private room or apartment where service users can feel at home gives them a place to retreat to, which can reduce tension.

> *Your living environment also needs to be a place where you like to be. That means that it needs to be pleasant. That you can't get injured by anything, you're not inclined to destroy it in that sense, and that it's a nice place to be. That doesn't mean that it has to be a very restrictive, controlled environment, where everything is locked up, or that, for instance, with a bread knife and making sandwiches, that you say: well, no knives, because that makes things more complicated. (Board member 1)*

At the same time, the living environment should be a place where service users cannot get injured. The home should be robust, for example.

Behaviour of and interactions with other service users. Other residents in the living environment can also influence the sense of safety among service users, as shown in the analysis of longitudinal data, interviews and focus groups. First, other residents can exhibit behaviour that elicits feelings of anxiety or an unsafe feeling – by dealing drugs, attempts to run away or aggressive behaviour, for example. In addition, support staff explained that seeing restraint measures imposed on other residents who are exhibiting CB can affect service users (seeing another resident placed in a seclusion room, for instance).

> *Some time ago, when [name of client] was still living at the other residential home, when he was restless, other service users also felt unsafe if he started throwing things, that kind of stuff. In any case, if there is an escalation I think other service users feel unsafe, they'll withdraw to their own room in certain situations. (Support staff 1)*

Second, the data analysis showed that interactions with other service users can affect service users' sense of safety. They can feel unsafe or tense because of microaggression (Verstegen et al., 2022a), including negative interactions with other residents, and feeling irritated, bullied or belittled. At the same time, however, support staff and members of the steering committee also described how interactions with other residents can enhance the sense of safety among service users, such as when social bonds are formed. These

positive interactions can help service users feel seen and supported, which increases their self-confidence.

Characteristics, behaviour and knowledge of individual staff members

When it comes to support staff members, their competencies and resilience, and their support style can be identified as factors that can affect the sense of safety among service users. In addition, as shown in Table 3, staff's knowledge of service users appears to play a role.

Competencies and resilience of staff members. According to professionals in various roles, support staff working with service users with intellectual disabilities and severe CB demands a particular skillset and abilities. In order to promote a sense of safety among service users with CB, support staff need to be self-confident and should not become overwhelmed or afraid too easily. At the same time, however, they need to be sensitive and responsive. Professionals and service users indicated that it is important that support staff can read, hear and understand service users. In addition, they need to be able to regulate their own emotions and avoid arguments with service users.

> *I think that people, they definitely need to have empathy and be able to sense what a service user is experiencing, and their tension and habits, but also to be very good at navigating what a service user needs. (Manager 1)*

As well as these competencies, resilience in support staff was highlighted as significant to the sense of safety of both service users and support staff. Both professionals in various roles and service users stated that service users feel unsafe when support staff feel unsafe. Anxiety, stress, and fatigue mean that support staff become irritated more easily, are less alert, and adopt a more controlling support style, all of which increases the risk of CB.

> *I think that if you don't feel safe as a staff member, you are not able to provide, or convey, or ensure, or demonstrate a sense a safety to residents. (Manager 2)*

Support style of staff members. All types of participants explained at length how the support style of staff plays a role in service users' sense of safety and their CB. One service user, support staff, psychologists and managers all indicated that support staff should be respectful, reliable, and clear to service users, and that support staff members need to be authentic. According to the professionals, this provides predictability and contributes to building trusting relationships and enhancing feelings of safety.

The fact that you do what you say you will. I think that's also an important factor, especially for service users, and it helps them feel safer. He says something, and then he does it, so he's reliable, yes. (Support staff 2)

I would like them [support staff] to be honest and sincere and understanding. Being able to say what I want, that's important. I should not have to be thinking about – can I say this or not, in order to prevent escalation. (Service user 4)

Furthermore, professionals in various roles explained that support staff who are available for service users and close to them enhance the sense of safety experienced by service users. This is true at both good moments and bad moments, as one of the managers explained:

... also a certain sense of security that you experience, that you feel close to them, that as a service user you can say things freely and you'll be listened to, even if you are not doing so well, that you feel listened to, and that's about times when you're not doing so well, but also that somebody notices what make you feel better and what keeps you feeling okay. (Manager 1)

Characteristics and behaviour of the team of support staff

At the team level of support staff, we identified providing clarity and structure, team stability, team climate, team composition, and the use of restrictive interventions as factors that can affect service users' sense of safety.

Providing clarity and structure. Providing clarity and predictability appeared to be significant for service users' sense of safety, and support staff and managers also explained that the team as a whole should communicate and act in a consistent manner. That means, for example, that all support staff members should be unafraid to set boundaries for service users and then stick to the boundaries that have been agreed. Otherwise, service users can become upset and the risk of CB increases.

... that is challenging, because I agreed with one person [support staff member] something different to what they agreed on as a group [team], and that's difficult to deal with, to react well to that is very hard. (Service user 4)

One of the managers added that a good handover between shifts and all being present at team meetings also contribute to clear communication.

Professionals in various roles also mentioned that having a clear programme for the day improves predictability and supervision for both service users and support staff. Sticking to a structured daily programme is especially important when there is high staff turnover in the team, because service users need time to develop a trusting relationship with new or temporary staff members to help them feel safe and secure. Nevertheless, professionals indicated that if new or temporary staff provide stability in the service users' daily activities, they can still help them to feel safe.

> *...so that kind of daily programme, if it's consistent and, well, done as it is supposed to be done, then that can also provide some safety even when there's someone who may not know the service user very well yet, because the programme for the day still remains the same. (Working group content of care)*

Filling the day with activities also fosters a sense of safety among service users because it leaves less time to dwell on problems and reduces cravings for alcohol or drugs.

Team stability. Another factor that helps support staff to act and communicate in a consistent way, and therefore promote a sense of safety, is having a stable team of support staff with permanent staff members. Permanent staff members generally know what is expected of them (e.g., they know the daily programme), what agreements have been made within the team, and what the overall aims are.

> *If they see different faces every day, people who do not know what the agreements are, that is perceived as just about the most unsafe situation there can be. (Managing director)*

Team stability also contributes to service users' sense of safety because they have a better opportunity to build trusting relationships with staff who are around for longer. On the other hand, a team in which there are frequent changes reduces service users' sense of safety. A constant stream of new faces makes it more difficult for service users to develop trusting relationships with staff. Service users indicated that they have been reluctant to up to another new staff member and start building a new relationship all over again.

> *If he doesn't know me, or anybody, then I don't speak to anyone. Then service users and support staff just have a problem with me. (Service user 1)*

In addition, support staff explained that a stable team contributes to the well-being and team climate of support staff. When staff have been working together for a longer time, they experience more safety during the shift because they know what to expect from each other. When there is frequent staff turnover, on the other hand, the job becomes

more demanding for permanent staff members, who need to support new colleagues who are still learning the ropes.

> *Obviously, we have many staff changes in the team, new people all the time, that is... if I've worked several shifts with a certain person, then I know at a certain point how they will respond, and you only need to look at each other and you know enough. That is different to someone who is working in the group for the first time. That does give me some sense of safety. (Support staff 1)*

Team climate. Team climate also appears to have a positive effect on team stability, and therefore on service users' sense of safety. According to the participants, a strong, close-knit team is an important reason to continue working in a team. Support staff explained that in a strong team you can support each other and build trust, experience a sense of togetherness, and get to know each another well.

Participants also mentioned that it is also important to have a team climate that is open and safe, because that enhances staff members' sense of safety and helps to prevent CB. When support staff feel free to discuss their insecurities or reduced resilience openly, other staff members can take on certain tasks and risky situations can be prevented.

> *You have to be honest when you don't feel comfortable about doing something, that's also important. Because if you just say "Don't worry, I'll do it" and you're not open about it, and then your colleagues are standing there without the extra person, then you do have a problem. (Support staff 5)*

Team composition. The composition of the staff team affects the sense of safety among service users and support staff, as shown in the transcripts of professionals (e.g., support staff, managing director) and longitudinal data. When the team includes many new staff and hardly any permanent staff members, the risk of CB increases because there are fewer experienced staff to provide coaching and guidance.

Regarding team composition, some staff members and one manager also indicated that the gender ratio in the team can play a role in the sense of safety among service users and staff. For instance, they mentioned that the physical strength and appearance of male staff members increases the sense of safety when dealing with physically stronger service users (who may become physically aggressive). On the other hand, some also argued that certain service users feel safer with female staff members, who can become maternal figures.

Use of restrictive interventions. Another relevant factor of a different order is the presence of restrictive interventions (i.e., interventions that restrict the rights or freedom of movement of a person). Both service users and professionals in various roles mentioned that restrictive interventions can be useful in setting boundaries for service users and preventing CB and all its negative consequences (such as physical injury and psychological harm). Moreover, restrictive interventions, such as a perimeter fence around the site and locking doors at night can also increase the perceived safety of service users because they feel protected from negative external influences (such as narcotics).

> *I've spoken to people, including Pro service users, and they also felt that it kept them safer, that they can be themselves, so to speak, and that certain people they know cannot come onto the site, but it also stops them from doing things they shouldn't be doing, so that physical barrier does apparently help for some people. (Board member 2)*

However, participants explained that restrictive interventions can also have an adverse effect on service users' sense of safety, by reducing their sense of autonomy. This can lead to frustration, tension and aggression, increasing the likelihood of CB. Whether restrictive interventions affect service users' sense of safety seems to depend on how they are implemented and on how service users perceive the intentions of support staff. For example, one of the service users pointed out that restraint interventions do not reduce his feeling of safety because he believes support staff take those measures to help him, as illustrated below:

> *I: And what do you think of it when they do that [restrain you]? Do you think that is a good thing or not such a good thing?*
>
> *R: Good. Because otherwise something will happen that I don't want to happen myself.*
>
> *I: It is necessary in those cases?*
>
> *R: Yes. Then it is… I really push it to the limit then. They just want to help me again, that's all, to help and give me support. (Service user 1)*

Perceptions, policies and practices of the organisation

At the level of the organisation, the organisation's vision and policies, support and negative perceptions were identified as factors that influence service users' sense of safety. The effect of these factors on service users' sense of safety seems to be mostly indirect, through the behaviour, safety feelings and well-being of staff members.

Shared organisational vision and policies. From the analysis of longitudinal data, interviews and focus groups, it emerged that the organisational vision affects how support staff and other care professionals view service users and their behaviour, and the way they act, thereby influencing the sense of safety among both service users and care professionals. For example, one of the board members explained that when service users are viewed as people with a low level of socio-emotional development and there is a focus on fulfilling their needs, service users are approached differently. Staff then aim to build unconditional relationships with service users, for example. In organisations where 'safety' means putting people with severe CB behind bars, this is quite different.

> *We do sometimes find that people say about service users: no, low socio-emotional development age, of a five or six-year-old, but you know that's sometimes as low as two years old. So you want to look at safety from that perspective, what somebody needs, which also creates a safe environment for staff members. (Board member 1)*

But it is not only the vision of the organisation that is relevant, but also the extent to which it is shared and adopted throughout the organisation. One managing director indicated that if professionals from all departments adopt the same mindset, they feel more supported by each other, which helps to make the vision into a reality.

Furthermore, the organisational vision influences decisions made regarding terms of employment (opportunities to develop and progress, wages, and travel allowances), and which type of employees to recruit (which qualifications or characteristics are deemed important). For instance, support staff explained that the willingness of staff to join the organisation and stay there is influenced by the wages they receive.

Organisational support. According to professionals in different positions, the extent to which staff receive emotional and practical support also affects staff retention and therefore service users' sense of safety. Better support enhances staff's well-being and job satisfaction. Professionals explained that staying resilient requires training for staff in how to manage aggression as well as giving staff enough time to recover and recharge their batteries. The importance of recognising and valuing staff members' willingness to continue working in the organisation also became apparent from the data analysis.

> *But the most important thing is, and this is what I've always found and I know that it actually has to be that way, you also notice that if you look at other residential homes, if there's a positive team climate, so if people enjoy their work and feel that they are listened to and feel acknowledged, well I think that those really are the most important things when it comes to retaining people. (Manager 2)*

Organisational support in the sense of ensuring that the basics are properly taken care of can also affect staff's sense of safety, and therefore that of service users too. For example, one of the managers indicated that when service users are more tense, higher staffing levels during shifts can improve the feeling of safety among staff. Participants also mentioned the importance of technical facilities that work properly, such as beepers and communications systems, in order for staff to work safely.

Lastly, in relation to organisational support, participants mentioned that it is important to ensure that staff experience a high degree of autonomy in order to keep them satisfied with their job and make them more likely to stay at the organisation.

> *There are some really talented people among them, and you need to give them space, because if you try to tie them up, you'll lose them. (Working group content of care)*

Perceptions and behaviour of the external environment of residential service organisations

In addition to factors relating to the residential service organisation itself, factors in the outside world also appear to affect the feeling of safety among service users, including the behaviour of the police and legal system, negative media attention, perceptions of society, and labour market conditions.

Impact of the behaviour of the police and legal system. According to support staff, managers, and one managing director, the stricter and more demanding approach adopted by the police, irrespective of the socio-emotional level of functioning of the service user, can affect their sense of safety.

> *In November, we suspected that [name of service user] was carrying some kind of a blade, so a police officer came […]. That's pretty invasive for someone who is a young boy of seven inside. Yes, then he experiences quite a different approach. (Support staff 5)*

The legal system, including public prosecutors and judges, can also affect the sense of safety among service users through their decisions to initiate prosecution or impose sanctions on service users for past episodes of CB. If a judge, for example, decides that service users must spend time in a secure setting or in prison, that service user is forced to move to an unfamiliar and unpredictable environment where a controlling, risk-based approach is prevalent.

The other factors that come from the external environment, such as negative media-attention, perceptions of society, and labour market conditions, relate to the perceptions of other citizens or difficulties in recruiting and retaining staff. According to professionals

in various roles, negative views of service users or overestimating their capabilities can make them anxious of going outside and participating in society. With respect to the shortage on the labour market, professionals explained that creating team stability is very challenging under the current conditions.

Discussion

The first goal of this study was to improve our understanding of what feeling safe means for individuals with mild intellectual disabilities or borderline intellectual functioning living in residential care and who present with co-occurring psychopathology, severe CB, and a long history of transfers within the care system. To that end, service users and professionals in a range of positions (from support staff to board members) discussed their views on the meaning of safety in interviews and focus groups. Their comments were categorised into three main themes: (1) *a physical environment that reduces risks and temptations*; (2) *a reliable, predictable, and supportive environment that service users have confidence in; and* (3) *an accepting environment that enables service users to establish a normal daily life*. The importance of a predictable, supportive, and physically safe environment has been highlighted in other research into safety, such as in psychiatric inpatient care (Pelto-Piri et al., 2019). However, an accepting environment where service users do not feel rejected but valued and able to be themselves seems particularly relevant to people with intellectual disabilities. Robinson and Graham (2020) also conclude that feeling valued contributes to a sense of safety among children and young people with intellectual disabilities and complex care needs. For people with intellectual disabilities, the importance of being accepted can be explained by the rejection and stigmatisation that they often face (e.g., Giesbers et al., 2019; Griffith et al., 2013). This stresses the importance of not seeing people with challenging behaviours solely in terms of that behaviour, and of treating them as human beings (McKenzie et al., 2018; Neimeijer et al., 2021; Olivier-Pijpers et al., 2019). Part of the third theme also relates to helping service users establish a normal life and giving them a positive outlook for the future, such as the prospect of a positive transfer to a different type of care and becoming better integrated into society. Giving service users more positive prospects has also been highlighted by the relatives of people with intellectual disabilities who exhibit CB (Olivier-Pijpers et al., 2020). At the same time, for the service users in this study, participating in society independently can be very challenging. This involves resisting the temptation to use alcohol or drugs when often they also lack emotional and adaptive skills and are frequently unable to cope on their own (Chapman & Wu, 2012; Nieuwenhuis et al., 2022). If service users cannot overcome these challenges effectively, they may have an episode of CB in public. This raises the question to what extent they can participate in society safely on their own, from the perspective of both the service users and of society. Given the

relevance of social inclusion for service users' sense of safety and wellbeing, and the fact that exclusion often remains the norm (Bigby, 2012), it would be interesting to examine how the safe social participation of the service users in this study could be facilitated.

The second goal of this study was to identify which factors play a role in service users' feeling of safety. We looked for factors that affect service users' feelings of physical or psychological safety. By using triangulation with data from ethnographic research (i.e., observations, informal interviews, document analysis), and additional data from interviews and focus groups, we identified a range of themes. These were ascribed to different levels – from the level of the service user through to the level of the organisation and the external environment. Factors that related to service users themselves included their mental health and addiction problems, the design of their living environment, and their interactions with other residents, family and friends. Regarding support staff, factors such as their competencies and resilience and their support style were identified at the individual level, and team stability and team climate at the team level. With respect to the organisation, the vision and support of the organisation were relevant. Lastly, attitudes in the police and legal system were among the themes at the level of the external environment. The data showed interconnectedness, meaning that changes in one factor can affect others. For instance, improvements in the team climate may improve team stability and the sense of safety among support staff, which may in turn improve the consistency and quality of the support provided, enhancing the sense of safety among service users too. It is relevant that residential service organisations are fully aware of these interactions when they are considering the impact of their policy decisions (e.g., with regard to investing in teams).

The results of this study also illuminate the interrelationship between service users' sense of safety and that of support staff. Some participants stated that as a staff member, feeling safe is a prerequisite for creating a sense of safety for service users, and this has also been argued in previous studies (Haugvaldstad & Husum, 2016; Verstegen et al., 2023). In order to manage negative emotions in staff members such as fear, organisations could start by raising staff's awareness of their own emotional responses, such as by facilitating reflection moments, mindfulness-based interventions or providing training on emotional intelligence and interacting with service users (Haugvaldstad & Husum, 2016; Zijlmans et al., 2015). In addition, individual coaching and training, such as aggression management and positive behavioural approaches, can enhance staff members' sense of safety by increasing their confidence in managing challenging behaviours (Davies et al., 2015; Martin & Daffern, 2006; Verstegen et al., 2022b).

The findings of this study are in line with previous studies that indicate that higher staffing levels can enhance staff's sense of safety (Marshall et al., 2019; Mulligan & Pitts, 2022). At

the same time, organisations are finding it increasingly difficult to attract and retain staff and keep staff teams at full capacity in the current labour market. Although organisations are exploring some promising new approaches in order to retain staff and optimise the use of current staff, such as onboarding programmes and skills-mix changes increasing the staff-client ratio still is a challenge (Frögéli et al., 2023; Sibbald et al., 2004). Therefore, other approaches to promoting a sense of safety among staff, such as investing in staff support, would seem more easily attainable.

Regarding the use of restrictive measures, organisations should exercise caution since these can cause service users to display aggression (Griffith et al., 2013), thereby reducing the sense of safety among staff and service users rather than enhancing it. This does not imply that restrictive measures always have an adverse effect. Our study confirms previous findings that, in some cases, restrictive measures may not have a negative impact on the feeling of safety among service users (Kanerva et al., 2013; Neimeijer et al., 2021). Provided they are applied in a respectful way and explained properly, and service users perceive the restrictive measures as reasonable or even beneficial to them, they do not appear to reduce service users' sense of safety or undermine the relationship with staff (Neimeijer et al., 2021). This means that decisions on whether to use restrictive measures are a balancing act, and professionals should be able to anticipate service users' behaviour and take their perspective into account (Embregts et al., 2018; Neimeijer, 2021). In addition, it is important not only to register the frequency of the use of restrictive measures, but also how service users perceive these measures (Bisschops et al., 2023).

This study contributes to our knowledge of *which* factors play a role in service users' sense of safety. In future research, it would be worth exploring *how* these factors can be managed in order to enhance service users' sense of safety. Most of the factors identified in this study fall within the sphere of influence of residential service organisations. However, some factors concern the external environment of the organisation, including the perceptions, attitude and actions of society, media and police. It would also be interesting to explore what can be done in relation to these external factors to promote a feeling of safety among service users.

Our study has some limitations. First, it was conducted in organisations that were all involved in the project Pro. Pro has formulated and implemented a number of principles, such as trying to meet the human needs of service users rather than focusing on preventing CB. That means that the professionals who participated in this study likely had these principles in mind. Qualitative research among professionals who approach their work from a different angle may have emphasised different aspects with respect to the meaning of safety for service users who display severe CB. Another limitation concerns the difficulty that two service users had in discussing feeling safe. They found it hard to

explain when they did and did not feel safe, although the first author was able to solicit responses by using additional prompts relating to experiences of safety, like 'feeling anxious, scared or tense'. Finally, the service users who participated in the interviews were all male, as were almost all service users involved in Pro. Therefore, we might have missed factors which are more applicable to women. Sexual assault, for example, is highly prevalent among women with disabilities and has been related to safety (Araten-Bergman et al., 2017, 2023; Robinson, 2014).

Conclusions

This study has explored what safety means for service users with mild intellectual disabilities or a borderline intellectual functioning who exhibit severe CB. Participants in our study framed safety in a positive way with a focus on what promotes a sense of safety (i.e., a protective, predictable and accepting environment) rather than on preventing risks that can lead to a lack of safety. Also, our study revealed a range of factors that can play a role in the sense of safety among service users. As such, they can provide guidance for residential service organisations regarding where to focus in order to promote a feeling of safety among service users.

The study was conducted among professionals and service users involved in the project Pro. Pro provides support and treatment for a specific group of service users: those with mild intellectual disabilities or borderline intellectual functioning who exhibit severe CB, have not received adequate care in the past and have a history of frequent transfers between more restrictive care settings. This study on the sense of safety among service users should be seen in this perspective.

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CHAPTER 5

5

Promoting feelings of safety among individuals with mild intellectual disabilities or borderline intellectual functioning who display severe challenging behaviour: A qualitative study within residential care

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Abstract

Introduction

Feeling safe is important but not self-evident for people with mild intellectual disabilities or borderline intellectual functioning who exhibit severe challenging behaviour. The present study explores how organisations promote feelings of safety among their service users in residential care.

Methods

Qualitative data from ethnographic longitudinal research, eight semi-structured interviews and six focus groups were thematically analysed. Data were primarily collected at three residential care service organisations.

Results

Three themes were identified from the data: (1) All levels of the organisation subscribe to the vision of providing unconditional support, (2) Providing stability in teams and support within a dynamic environment, (3) Striving to give service users as normal a life as possible.

Conclusion

Promoting service users' safety requires the active commitment of all professionals in the organisation. Future research into the actual work done by organisations may provide valuable insights into how to further enhance service users' safety.

Promoting safety among people with mild intellectual disabilities or borderline intellectual functioning (henceforth referred to as mild intellectual disabilities) who exhibit severe challenging behaviour (CB) is of great importance. Feelings of safety are positively associated with this group's quality of life (Gómez et al., 2021). In addition, feelings of unsafety can potentially trigger CB, including the risk of physical and psychological harm (e.g., fear, distress), both for those who display the CB and others in their surrounding environment (van den Bogaard et al., 2019; Verstegen et al., 2023). Despite the importance of feeling safe, the life histories of people with mild intellectual disabilities who exhibit severe CB are often characterised by being in unsafe environments. Many have experienced recurring and/or forced transfers to new settings (e.g., detention or incarceration, secure forensic care) with unfamiliar care professionals and service users, adverse childhood events, and late identification of their intellectual disabilities (Morris et al., 2020; Nieuwenhuis et al., 2017; Olivier-Pijpers et al., 2020a).

A multitude of factors can affect how safe people with mild intellectual disabilities who exhibit severe CB feel, ranging from the level of service users to the external environment of residential care service organisations (Lokman et al., 2024). Amongst these factors are the safety feelings and support style of staff. In addition, service users' sense of safety is reduced when fear causes staff to display hostile and higher levels of assertive control towards service users, rather than being emotionally available and maintaining closeness to service users in a respectful, honest, and reliable manner (Clarkson et al., 2009; Willems et al., 2016). Research within secure forensic care for people with mild intellectual disabilities also indicates that service users who experience a positive living climate, which, among other things, is characterized by high-quality relationships (e.g., staff who acknowledge and recognize service users), exhibit less CB (Neimeijer et al., 2021). However, studies in forensic care have also highlighted that building and maintaining positive relationships with service users is challenging for support staff because of the dual role they perform. That is to say, besides cultivating a therapeutic relationship, support staff must also ensure a physically safe environment for service users and everyone else present in the setting. However, given that, generally speaking, the primary focus in forensic care is on physical control and coercive measures, this can impinge upon the fostering of positive relationships with service users, which, in turn, reduces service users' sense of safety (Hui et al., 2013; Neimeijer, 2021).

Recently, Sollied et al. (2023) investigated how care professionals in forensic settings attempt to create a safe and caring environment for their service users. They identified, among other things, that balancing daily activities to meet service users' needs, acting as a team, and observing changes in service users' conditions helped to cultivate a caring atmosphere. Within inpatient psychiatric care, research has also been conducted on how ward managers strive to prevent violence and create a safe living and working

environment (Lindow et al., 2022). The results showed that managers promoted key values and de-escalation techniques, and acknowledged and sought to improve staff's abilities and competencies. Insights into how professionals in various roles (e.g., support staff, managers, board members) can contribute towards engendering a sense of safety among service users are useful, insofar as both treatment and care and support services for people with CB regularly experience difficulties in providing a safe living environment (Bigby et al., 2014; McGill et al., 2020). However, there is a relative dearth of research into how residential service organisations for people with mild intellectual disabilities and severe CB promote feelings of safety among their service users. Such settings differ from forensic or psychiatric care facilities in that they are not geared towards recovery or cure, but rather seek to provide quality care and support (Kersten et al., 2022; Simpson et al., 2018). In addition, earlier research into (forensic) psychiatric care focused on specific perspectives (i.e., of service users, support staff, and managers), whereas an organisational perspective across disciplines can be of added value as it also takes into consideration interactions between various levels of the organisation. Therefore, in this study, we aimed to explore how residential care service organisations for people with mild intellectual disabilities and severe CB promote feelings of safety among their service users. To that end, we conducted qualitative research among care professionals operating at different levels of the organisation (from support staff to board members) who were involved in the Dutch project Pro (see Setting).

Materials and methods

Setting: Project Pro

Data were primarily collected at three Dutch service organisations who provide residential care to people with mild intellectual disabilities and severe CB. These service organisations participate in Pro. Alongside this, data were collected at two care administration offices as well as at the Centre for Consultation and Expertise (CCE), who are also participants of Pro. Pro was established in 2017 with the express purpose of both breaking the cycle of recurrent forced transfers of people with mild intellectual disabilities and severe CB and improving their quality of life. Therefore, the participating organisations of Pro agree upon eight founding principles. The first six principles are aimed towards service users, where Pro: (1) focuses on establishing "a life as ordinary as possible", (2) is not primarily focused on (preventing) CB, but rather the support aims to meet service users' needs as much as possible, (3) puts the pedagogical environment first and adapts it to the individual needs of service users, (4) encourages the development of (self-) confidence, (5) offers unconditionality in the support relationship, and (6) offers unconditionality in terms of housing and residence. The other two principles pertain to the healthcare professionals and the organisation: (7) Pro pays attention to staff well-

being and competency development, and (8) professionals in all positions, including board members and managing directors, must take responsibility for Pro care in terms of content, support, and cooperation (Pro, 2023). A total of 24 service users are involved in Pro, eight in each organisation, who are divided over two residential homes for each organisation.

The characteristics of the service users involved in Pro, that is, their mild intellectual disabilities, psychopathology, and severe CB, history of recurrent transfers, and their stay in a residential setting, combined with the focus within organisations in Pro on fulfilling service users' needs (i.e., for both safety and autonomy), makes Pro a relevant context for this study.

Participants

The participants in the study were all involved in Pro. Professionals in various roles (e.g., support staff, team leaders, psychologists, managers) and service users were the subject of the ethnographic research. The interviews and focus groups were held with forty-two support staff members from six teams, one team leader, four managers, six psychologists, two managing directors, three board members, and six other professionals (e.g., head of treatment, quality advisor) (Table 1). Around two-thirds of the professionals were male, while the average age of the professionals was 38 (*SD* = 10.0, range 21-64) (Table 2). The mean duration of their involvement in Pro was two years (*SD* = 1.5), while the mean duration of their work experience in the field of care for service users with intellectual disabilities was eight years (*SD* = 8.9).

Table 1. *Overview of type of participants and numbers of interviews and focus groups*

Type of participants (*N* = 64)	**Method**	**Number of interviews/ focus groups**
Support staff (*N* = 43)	Focus group Dual interview	4 1
Psychologists, team leader (*N* = 7)	Focus group	1
Managing director, other professionals (e.g., head of treatment, quality advisor) (*N* = 7)	Focus group	1
Managers (*N* = 3)	Interview	3
Board members (*N* = 3)	Interview	3
Managing director (*N* =1)	Interview	1

Table 2. *Characteristics of participants of the interviews and focus groups*

	***N* (%)**	**Mean**	**SD**	**Range**
Gender				
Female	20 (31.3)			
Male	44 (68.8)			
Age (years)		38	10.0	21-64
Years of experience in field of intellectual disability		8	8.9	0-40
Time involved in Pro (years)		2	1.4	0-5

Procedure

To gain greater insight into how care professionals and board members involved in Pro foster a sense of safety among service users, the qualitative data deriving from ethnographic longitudinal research related to Pro was first explored. The first author collected qualitative data between 2019-2022 through non-participant observation and informal unstructured interviews, which are data collection methods that are frequently applied within ethnography (Jones and Smith, 2017). In addition, the minutes of Pro meetings were analysed. The first author collected data during their visits to the three residential care service organisations, through online or telephone contact (around once a month for each organisation over a period spanning approximately two and a half years), and by attending recurring meetings and working conferences of Pro. These meetings were held every two months from the outset of the project, when Pro established two types of committees. The first of these was a steering committee in which treatment directors and managing directors participated, while the other committee consisted of team leaders, managers, and psychologists, who discussed the content of the care provided to service users in Pro. In total, the data in the first stage of the research amounted to eighty field notes and twenty documents (minutes of meetings).

The evaluations of the data indicated that although the data deriving from the longitudinal research were rich and informative, additional data were needed to obtain a more comprehensive picture of what residential care service organisations do to promote a sense of safety among service users in Pro. To that end, an additional seven semi-structured interviews, one double interview and six focus groups were held with professionals from different positions (e.g., support staff, managers, and board members) (see Table 2). With the exception of two interviews and two focus groups, the conversations with the participants took place face-to-face, which helped to establish a safe and comfortable atmosphere as well as enabling the identification of any non-verbal signs (Saarijarvi & Bratt, 2021). The other two interviews and focus groups were conducted online via Microsoft Teams. Video conferencing was opted for in these cases in order to make it easier and less time-consuming (while saving travel time) to

schedule the meetings in light of the tight schedule of the participants. Moreover, both the participants of the steering committee and the committee focused on the content of care were used to conducting their recurring Pro-meetings via Microsoft Teams (especially during and after the COVID-19 pandemic). In total, the data collection proved to be integral to conducting a comprehensive study of service users' sense of safety, and resulted in multiple publications (Lokman et al., 2024, 2025).

The first author conducted all of the interviews using an interview guide. The authors jointly composed a basic interview guide and customized the guide to the specific context (e.g., the role and tasks) of each participant group (e.g., managers, board members). The participants were asked to comment on how their residential care service organisations deal with those factors that can impact upon their service users' feelings of safety. For example, managers were asked to elaborate on how the team of support staff provides predictability to their service users, and what the specific role of the manager is in facilitating this process.

The focus groups and double interview were facilitated by the first author with assistance from either the second author or an experienced researcher. Both the focus groups and double interview began with a short introduction about the nature of the study. Next, as per the process in the interviews, the researchers used predefined statements that were shown in either a Microsoft PowerPoint presentation or on paper to elicit responses from the participants. The content of the statements reflected the themes in the interview guide and were also tailored to the specific roles of the professionals in the focus groups (e.g., support staff, steering committee). The interviews and focus groups lasted between 52 to 104 minutes and had a mean duration of approximately 75 minutes. They were all recorded and transcribed verbatim. One of the interviews was split into two separate sessions, as there was limited time to discuss all the topics during the first meeting.

Analysis

The research team used inductive thematic analysis to analyse the longitudinal data and the data from the additional interviews and focus groups (Braun & Clarke, 2021). In the first phase of the analysis, the first two authors familiarised themselves with the data from the longitudinal study by regularly reading and discussing the field notes data that was written during the time of data collection. They identified relevant aspects in relation to the research question and generated initial impressions of themes. After data collection, the first author systematically coded all the data in the software package Atlas.ti. In the second phase of the data analysis, which concerned transcripts from the interviews and focus groups, the first author started the familiarisation process by listening back to the audio recordings. Next, both the first and second author thoroughly read the two interview transcripts and the transcript from the a focus group (one that

they both attended). The first author coded, and the second author annotated relevant data, which they then discussed together in order to reflect upon both the earlier themes that they had identified in the longitudinal data and the new themes that they had generated. The first author systematically coded all of the other transcripts again in Atlas.ti. Thereafter, she exported the assigned codes of both the longitudinal data and the data from the interviews and focus groups into Microsoft Excel. In an iterative process, she merged the codes into potential themes and subthemes, which were then reviewed and discussed with an experienced researcher on several occasions in order to ensure internal homogeneity (consistent coding within subthemes), external heterogeneity (clear distinctions between subthemes), and to define the themes and subthemes. In discussion with the second author, and subsequently with all the authors, the final themes and subthemes were then formulated, and accompanying narratives were selected.

Ethical procedure

The Ethical Review Board of Tilburg University approved the longitudinal study on Pro and the amendment for this study about safety (EC-2019.37). All participants received written and verbal information about the aims of the longitudinal study, or if they only participated in the data collection about safety, about the research of that part. Written informed consent was obtained from all participants.

Results

From the thematic analysis of what professionals in residential care service organisations do to foster a sense of safety among service users with mild intellectual disabilities who display severe CB three overarching themes were identified: (1) All levels of the organisation subscribe to the vision of providing unconditional support, (2) Providing stability in teams and support within a dynamic environment, (3) Striving to give service users as normal a life as possible. The overarching themes consist of fifteen subthemes, as presented in Table 3.

All levels of the organisation subscribe to the vision of providing unconditional support

The first overarching theme concerns the commitment of the whole organisation to provide unconditional support. Not only support staff, but at all layers of the organisation, professionals are dedicated to offer unconditional support to service users to foster their feelings of safety, especially when they display CB.

Tabel 3. *Overview of main themes and subthemes*

Main themes	Subthemes
All levels in the organisation subscribe to the vision of unconditional support	Offering an unconditional place to live, within the boundaries of the law
	Investing in building relationships with service users grounded in unconditional support
	Ensuring that the vision of unconditional support is regarded as a shared responsibility
	Organising mutual support between professionals at all layers of the organisation
Providing stability in teams and support within a dynamic environment	Being diligent in the selection of staff members
	Attracting and retaining staff by giving them opportunities for development, support, and autonomy
	Committing to establishing a positive team climate
	Team aims to provide service users with a sense of predictability
Striving to give service users as normal a life as possible	Continuously adapting to service users' personal needs and capabilities
	Offering a private, homely living environment
	Enhancing service users' confidence in both themselves and the future

Offering an unconditional place to live, within the boundaries of the law

Firstly, the organisations in Pro aim to promote a sense of safety among their service users by providing them with an unconditional place to live, which is to say that they offer service users lifelong accommodation, irrespective of whether they exhibit CB. The three residential care service organisations all agreed to adhere to this commitment at the outset of Pro without having any say over which types of service users (e.g., [forensic] background, mental health problems) are assigned to their organisation. Instead, the two care administration offices involved in Pro select and assign service users to each of the three residential service organisations.

> *…that you are actually providing care under rather unique circumstances, because, firstly, you did not choose the service users, so you did not have any say over selecting service users based on their file, the intensity of care required, and whether this is manageable or not, and secondly, you promise unconditionally to provide lifelong care, and that is rather special [...]. Both in terms of the content and this promise regarding their care, you have to stick to it, because you cannot ring them up and say "we are not doing this anymore". (Steering committee)*

The board members and directors indicated that it is important that they adhere to this principle rather than shifting their focus onto risks, especially during challenging times. How the organisations respond to CB varied from case to case, as illustrated by the following extract:

> *...because the service user is here and lives here even, then it becomes about what the team needs, or how can we change the context to make sure that the service user is able to stay. This process is highly customised, there is no regular answer, and so there's a lot of puzzle solving and looking at how best to deal with the situation we are in now. (Steering committee)*

This may mean, for example, that support staff members transfer to another residential home, rather than the service users doing so, if the staff members appear to have difficulties in working with service users after instances of CB.

In order to ensure compliance with the principle, one of the board members emphasised the relevance of cultivating a non-blame culture. To establish and maintain such a culture, the board member reported that CB incidents are investigated and viewed as an opportunity to learn, irrespective of what external social or political pressures might be at play.

Professionals in various roles indicated that providing an unconditional place to live should not be confused with setting no boundaries. If service users commit a criminal offence, then the boundaries of the law still apply, and it is up to the legal system to decide on the consequences of their actions. Nevertheless, when service users have to spend time in a secured setting, support staff still provide unconditional support by visiting service users or working shifts at that setting.

Investing in building relationships with service users grounded in unconditional support

Next to an unconditional place to live, professionals and board members also embrace the principle of providing unconditional support to service users. Professionals working in various roles explained that unconditional support means that they should always be available to service users on a daily basis. By providing such unconditional support, staff are investing in building trusting relationships and feelings of attachment that in turn foster feelings of safety, as explained by one of the psychologists who reported:

> *Unconditional support is a precondition for the development of attachment, and the degree of attachment in turn determines the degree of safety.*

Given that the repeated rejections stemming from recurrent forced transfers in the past had led service users to distrust healthcare professionals, gaining service users' trust takes time.

Providing unconditional support also means that professionals in Pro must not reject service users as a person when they exhibit CB, which often occurred to them in the past. Instead, professionals must continue to stay close and remain in contact with service users after they display CB. One way in which support staff do this is to resume the daily program with service users where they left off as soon as possible after the CB occurred.

Psychologists coach staff to take the context in which the CB occurred into account, and to focus on their own role in terms of either the maintenance or prevention of service users' CB. One of the psychologists explained that raising this awareness among support staff is particularly important given how frequently they are confronted with CB. In those cases, providing unconditional support can in some instances be difficult emotionally for staff, which, in turn, may lower their acceptance of service users' CB.

Ensuring that the vision of unconditional support is regarded as a shared responsibility

To enhance the sense of safety felt by service users through providing them with unconditional support, professionals in various roles indicated that all levels of the organisation must know, understand, and subscribe to the vision of unconditional support. According to members of the steering committee, the conscious decision made at the beginning of Pro to offer unconditional support to service users is one of the principal reasons why professionals at all levels must take shared responsibility. Both board members and managing directors considered the promotion of the vision of unconditional support, both inside and outside their organisation, to constitute part of their responsibility:

> *I feel that it's my role to communicate the vision at all times, and that this eventually helps to provide a sense of safety among service users. I have to ensure that I do this every day. [...] that's very important in my role, that I keep on communicating and ensuring that the vision is clear. However, this also applies to our board of directors... this is what we do and this is what we communicate. (Managing director)*

Furthermore, the board members and managing director embedded this vision explicitly and implicitly within numerous aspects of the organisation, such as compulsory training, team meetings, case discussions, and key performance indicators.

Staff also have a key role to play with respect to orienting each other's attention towards maintaining the vision. Especially in situations in which there is instability within the team, it is critical that the remaining staff members have a clear understanding of the vision and impart their knowledge and experience to new staff. Professionals around a team, such as psychologists or managers, monitor this process.

> *You have to keep actively working on what vision and policy you want to realise with each service user and with the team as a whole, or a whole department even, and then keep on communicating this in order to make sure that support staff buy into this and also mutually reinforce it with each other, despite the high turnovers [...]. However, in unstable teams you do notice as a psychologist or manager that you need to be on top of this even more. (Working group content of care)*

Board members also consistently monitor the implementation of the vision. One of the board members explained how during meetings with professionals in various roles, she is always looking out for any signals indicating that the professionals are deviating from the vision (e.g., a repressive support style), which may have potentially negative consequences upon service users' feelings of safety. As such, she expressed that she pays close attention to how the triumvirate of a team leader, manager, and psychologist support a residential home and collaborate with one another:

> *I always ask in those situations [when things are not going well at a residential home]: How about the triumvirate? [...] Because a lot is depending on it. Whether you pay enough attention to supporting the team leader, whether there are sufficient multidisciplinary meetings... (Board member)*

Organising mutual support between professionals at all levels of the organisation

According to Pro organisations, professionals must feel mutually supported in providing unconditional support to service users. Therefore, professionals at all levels of the organisation (including board members) must make themselves readily available to engage in short lines of communication with each other.

> *When care professionals have to support a service user who is exhibiting highly complex behaviour, it is helpful if the care professionals can turn directly to a coach, resilience trainer, psychologist, or a doctor, for example. So, it is also about the ready availability of the support system that is organised within such a home [...], that is, having the opportunity to receive a real direct approach to help them keep going in that moment, and to have somebody who is asking you questions that encourage you to reflect upon yourself. (Steering committee)*

To enable healthcare professionals to provide support to one another, board members and managing directors strive to ensure that the required conditions are in place. For example, they negotiate with care administration offices about finances and ensure that staff have the time and resources they need, including additional time for team meetings, training, and time for reflection.

The relevance of mutual support was sharply underscored via certain cases in which a lack of mutual support was experienced. Some support staff and one of the managers recounted situations in which support services in their organisation (i.e., night shift, facility services) failed to give assistance either as a result of fear or negative views towards Pro service users or because they were simply unfamiliar with the meaning of unconditional support.

> *Unsafe situations can occur because of ambiguities, for example in the case of the night shift. When somebody tells you: "We [the night shift] won't come, that has been agreed". I didn't hear anything about it, I haven't read anything about it...(Support staff)*

Providing stability in teams and support within a dynamic environment

The second major theme pertaining to enhancing service users' sense of safety concerns providing stability to them. The organisations in Pro aim to provide stability to service users via team stability (i.e., a team with the same permanent staff members), stability in support (i.e., support that is provided in a consistent, predictable way), and through a structured daily program. From the data, it appeared that providing stability in a home with residents who all have one or more disorders (e.g., autism, schizophrenia) and engage in severe CB is a dynamic and demanding process. One reason for this is because planned daily activities are regularly disrupted. In addition, recruiting and retaining care professionals is challenging within the current tight labor market.

Being diligent in the selection of staff members

The analysis of the longitudinal data, as well as the interview and focus group data revealed that one of the ways in which organisations strive to achieve team stability is through being diligent in the selection of staff. First, managers select staff members who appear to be committed to working for a minimum number of hours at the residential home. They believe that having regular staff members is integral to building trusting relationships, which, in turn, inculcate a sense of safety among service users. In addition, staff members need to show a commitment and motivation to providing support that adheres to the foundational values and principles of Pro.

The managers in this study also indicated that they select support staff members based on certain personal characteristics and competencies. Specifically, managers seek

staff members who appear, among other things, self-confident, trustworthy, sensitive, responsive, and who can keep their emotions under control and let go of the work once they are home. They explained that these characteristics and competencies are accorded more value than having a degree. In practice, the organisations have recruited many people who have changed careers (e.g., former door attendants or swimming coaches).

Attracting and retaining staff by giving them opportunities for development, support, and autonomy

Board members, a managing director, and managers indicated that they also attempt to create stability in their organisations by investing in the development of the knowledge and competencies of their staff. The organisations do this via offering education, training, and reflection opportunities for staff support, which both serve as incentives to attract and retain support staff and ensure that staff feel resilient and safe.

Professionals in various roles elaborated on the important role played by team leaders, managers, and psychologists in the support structure. They are closely involved with the team, namely in terms of providing on-the-job coaching and acting as sparring partners. The psychologists explained that in situations in which there is instability within a team, which is inevitable at times, their close presence is particularly important. During instances of team instability, staff experience a greater sense of unsafety. Therefore, psychologists need to clarify more, and instill confidence in staff by confirming to them that they are doing the right things, as illustrated by one of the psychologists.

> *That you take the time for development, take the time for the team, for the stability of the team, because I do think that the greater shortage there is in terms of staff members, or the higher the level of unsafety among service users there is, then the more I notice that they need me, or have more questions, or adopt a more controlling support style. (Working group content of care).*

The organisations in Pro also attempt to retain staff by granting them a strong degree of autonomy over the type of activities they engage in with service users during their shift. This, according to a managing director, psychologists, and support staff themselves, is grounded in the belief that having the freedom to explore and take initiative is important to job satisfaction. At the same time, the psychologists indicated that they keep a close eye on whether the activity is in alignment with the needs, wishes, and capabilities of service users.

Despite the Pro organisations' efforts to retain staff, several staff members expressed dissatisfaction with their wage and travel allowance, which they perceived as being in

conflict with the stated goal of their organisations to both provide a sense of stability within teams and retain staff.

Committing to establishing a positive team climate

Furthermore, the professionals and board members involved in Pro are committed to establishing a positive team climate that serves to create stability. A positive team climate contributes towards staff retention (i.e., team stability) and stability in the support provided to service users. Once again, the team leaders, managers, and psychologists play a pivotal role in terms of cultivating this positive team climate. For example, support staff emphasised how their team leader sought to create a close-knit team in the aftermath of high staff turnover. According to staff members, their team leader achieved this by both operating as a team player (i.e., no hierarchy) and keeping to the arrangements made (i.e., by acting as a role model). In addition, the way team leaders give direction to their teams affects the team climate, as one of the managers explained:

> *I believe that it is largely the team leader who is responsible for the stability within such a home [...]. A large part is thus dependent on how you give direction within your home, and what you feel is important in that respect, and how complicated you can make it sometimes, at least in terms of battles, if you argue about anything, then you know for sure that you will have trouble, but sometimes it's not necessary.*

The managers in Pro also feel that they bear a responsibility for cultivating a positive team climate, which they achieve by giving team leaders support and a sense of shared responsibility, for example. One of the managers also reported that they contribute towards a positive team climate by organising social activities for teams to help them bond with each other as staff members.

To create an open team climate, team leaders, managers, and psychologists encourage the support staff to share their emotions and talk about difficulties they encounter as well as to give and receive feedback. During team meetings, for example, but also at the start of a shift and/or after an instance of CB, staff are encouraged to reflect with each other upon their mental well-being, so that other staff members are able to take over in the event that they feel less resilient.

> *Often, when [challenging] situations have occurred, those are evaluated, that's just an open, honest communication with each other. I believe those also strengthen the team and provide a sense of safety for everyone involved. (Support staff)*

One of the managers explained that if staff are judgmental towards each other, then it is the responsibility of the team leaders or psychologists to both shift the conversation in a

more positive direction and encourage support staff to be more receptive towards each other's input.

Team aims to provide service users with a sense of predictability

Finally, the professionals in Pro aim to give service users a sense of stability by ensuring that they experience a predictable and structured day. Members of the Pro steering committee explained that keeping to the daily activities is one way of providing stability to service users, which is of additional importance in the event of team instability.

> *It's not only about people; indeed, for many of the service users it's also about the importance of daily routine, how is the home being taken care of, etc. If the home looks fine, then the routines continue, and there is minimal unpredictability for service users. On Tuesday, I cook, so that continues for example, and can contribute a lot to a successful course despite more staff changes. (Steering committee)*

Some staff members noted that they have improved as a team with respect to ensuring predictability by being consistent in their communication to service users. While, of course, staff members have different opinions at times, these differences are not discussed in front of the service users.

Striving to give service users as normal a life as possible

Service users in Pro have not led normal lives. They have had to move to many different living environments, have often lived in secure settings, and are not used to engaging in normal daily activities (e.g., going out for dinner) due to the risk of exhibiting CB. Therefore, as per one of the foundational principles of Pro, the organisations seek to offer their service users as normal a life as possible, on the basis that this contributes towards them feeling a greater sense of safety.

Continuously adapting to service users' personal needs and capabilities

The professionals involved in Pro strive to make service users' lives as normal as possible by adapting to the specific needs and capabilities of the service users. Fulfilling these needs can reduce service users' tension, thereby increasing the likelihood of service users experiencing a normal life. Professionals in various roles explained that in order to meet the needs of service users, it is essential to have knowledge about them (e.g., their capabilities) and their individual life story (e.g., life events, former living environments). The psychologists indicated that both themselves and other staff gain knowledge about service users from talking to each other, but also get a deeper understanding of their service users through what they themselves share with them. Particularly if trusting relationships have been built, service users feel more at ease with sharing their personal experiences of significant events from their past. In addition, care professionals increase

their knowledge of service users' needs through observation and a process of "trial and error".

> *Also, from experience, just do it and see what happens, see whether it aligns with someone [a service user]. Whether someone is completely agitated by it or needs it a lot. (Working group content of care)*

Furthermore, diagnostics and therapy are also utilised in order to increase both professionals' knowledge of their service users and service users' knowledge of themselves.

> *We also have service users who just started recently, after three years, with therapy, which gives them a whole new level of insight into themselves, but also gives us greater insight into them. (Working group content of care)*

Gaining knowledge about service users includes getting to know and recognise early signs of tension among every service user and figuring out which personal approach works best. One of the managers explained that in their organisation plans are drawn up for service user, which contain information about (early) warning signs of tension and which reactive strategies to adopt. From the moment staff members begin working at the residential home, they are expected to know the content of these individual plans for each service user.

The mood and behaviour of service users can change suddenly and frequently, according to both our own observations and the account of one manager. During both handover moments between shifts and team meetings, the support staff discuss service users' state of mind and behaviour and assess whether any adjustments in their approach or activities are required. For example, if service users are more tense, then their daytime activities might be changed, both in terms of content and location, and/or the support staff may keep a closer proximity to them.

Offering a private and homely living environment

Professionals in various roles explained that living a normal life includes living in a private and homely environment. To create a homely living environment, service users are given a say on how their rooms are decorated (color of the walls, which furniture, etc.), and the rooms are designed "in a normal way" (e.g., with glass windows, plant pots, etc.). In addition, the organisations in Pro are keen to keep the living environment normal, which means that after an instance of CB, any broken furniture or windows are supposed to be quickly repaired as often as required. However, in practice, the assistance from the facility services has not always been adequate, as one of the managers explained:

> *What you often hear is: "Do I have to mount this television back on the wall again?" Yes, you have to do that again. "Or do I have to replace that window again? That is not normal, is it, again...".*

To develop a deeper understanding of the relevance of adequate support among colleagues from the facility services, the manager invited them to team meetings in order to explain the principles of Pro (e.g., offering service users as normal a life as possible).

Enhancing service users' confidence in both themselves and the future

Although CB involves risks, the organisations in Pro focus on what can be done to enhance service users' positive expectations regarding the future. Professionals in different positions indicated that together with service users they aim to identify what their dreams are and to assess what is feasible.

> *Meanwhile, we are also still looking for things that really make someone [service user] feel enthusiastic and to identify what someone really wants to do in the future, and how can we translate this big dream into something that is already attainable this week. (Working group content of care)*

To increase service users' faith in the possibilities open to them in the future, the professionals also attempt to boost service users' self-confidence. The support staff explained that they have taught service users what they can do to regulate their emotions in order to prevent CB, for example, complying with the rules (e.g., going to their own room, smoking a cigarette), focusing on themselves (staying away from confrontations with other residents), and talking to support staff about things that are bothering them. In addition, one of the managers indicated that the self-confidence of service users can be enhanced by allowing them to make mistakes, letting them learn from these mistakes, and allowing them to experience unconditional support. In this way, service users are given new opportunities to develop themselves, which, in turn, gives them the opportunity to look positively towards the future.

Discussion

In this study we explored how residential care service organisations promote a feeling of safety among their service users with mild intellectual disabilities or borderline intellectual functioning, who present with psychopathology, severe CB, and a long history of transfers, both within and between a range of settings (e.g., foster care, detention, intellectual disability services). We used data triangulation by collecting qualitative data during ethnographic longitudinal research, which was supplemented by interviews and

focus groups with professionals in various roles. Data were collected at organisations that are involved in Project Pro, which aims to improve the quality of life of its service users. Three main themes were identified in the data: (1) All levels of the organisation subscribe to the vision of providing unconditional support, (2) Providing stability in teams and support within a dynamic environment, and (3) Striving to give service users as normal a life as possible.

The themes that were identified in this study appear to be applicable to service users with intellectual disabilities in general. However, truly adhering to the goals of providing unconditional support, stability, and as normal a life as possible for service users becomes less straightforward in the context of care for people with mild intellectual disabilities and severe CB. For example, providing unconditional support is challenging in the aftermath of CB. This is especially the case when care professionals attribute the cause of CB as being inherent to service users themselves, which is a relatively frequent occurrence with people with mild intellectual disabilities who exhibit CB (Tynan & Allen, 2002). In situations in which support staff attribute CB as being inherent to service users, they are more likely to show controlling and hostile behaviour towards them (Zijlmans et al., 2012). Therefore, as also confirmed by our study, it is vitally important that staff take the context in which service users' CB occurred into consideration (Olivier-Pijpers et al., 2020b). The organisations in Pro seek to address the organisational factors that influence such attributions by offering training, coaching, and monitoring, in addition to encouraging (self-)reflection from staff. Earlier research also highlighted how organisational factors can influence the attributions made by staff (Dilworth et al., 2011; Lowe et al., 2007). Training in Positive Behavioral Support has been shown to yield short-term positive effects in terms of changing such attributions (Davies et al., 2015; Lowe et al., 2007).

Although research on attributions has thus far concentrated on support staff, the present study indicated that the attributions and emotions of other professionals within residential care service organisations (e.g., from facility services) are also important with respect to providing unconditional support to service users. For example, when professionals working the night shift are hesitant to provide support at a residential home because they consider the service users to be too dangerous and feel insecure, unsafe situations may occur. Organisations should therefore not only regularly monitor the perceptions and attitudes of their support staff but of *all* the professionals in their organisation towards service users who display severe CB, and, when necessary, provide additional support, such as training or reflection, to change these perceptions.

One of the themes of this study pertained to the principle of normalisation, which played a significant role in the development of the Triple-C model of care that one of the Pro organisations founded (Tournier et al., 2020). The principle also forms part of the basics of

Positive Behavioral Support (PBS) and Active Support (Gore et al., 2022; Totsika et al., 2008). Generally speaking, physical and social integration, autonomy and rights, development and growth, and personal identity are core components of normalisation (Gore et al., 2022). Among other things, the organisations in Pro put normalisation into practice by providing a homely environment for service users that afforded them opportunities for personalisation. Both Casson et al. (2021) and Roos et al. (2022) also reported in their scoping reviews on the positive influence of these aspects upon the emotional well-being (including safety and security) of people with intellectual disabilities and autism and/or CB. Their reviews indicated that robust materials should be used and that access to risky materials should be denied (e.g., furniture with sharp edges), thereby preventing reduced confidence among service users when they are confronted with the harmful consequences of their CB (Casson et al., 2021; Roos et al., 2022). Alongside this, using other materials or denying access to normal materials or spaces may exacerbate service users' sense of being different, when what they truly want is to live a normal life (McKenzie et al., 2018). The Pro organisations make a conscious decision to both not lock away everything so that it is out of reach from service users and use common materials (e.g., glass in windows that can be broken), in conjunction with ensuring that broken things are quickly repaired after an instance of CB. In future research, it would be interesting to explore how these seemingly conflicting issues can be combined best.

Alongside experiencing as normal a life as possible in the present, the organisations in this study also seek to promote a sense of safety among service users by giving them confidence that they will live a more ordinary life in the future. In other words, Pro organisations aim to give service users hope that their life will also include growth. The associations between hope and feeling safe have been explored in research across a variety of disciplines (e.g., palliative care and mental health recovery) (Murphy et al., 2023; Olsman et al., 2014). For example, a safe environment and safety via having trust in others have been identified as facilitating the development of hope (Pleeging et al., 2022). Snyder's (2002) definition of hope is divided into two goal-related components: pathways (perceived capability to generate routes to desired goals), and agency (motivation to begin and continue along these routes). As explained by patients in outpatient forensic care, professionals can keep service users motivated in the process of goalsetting and recovery by both listening to them and reminding them of what they have accomplished (Waxell & Gustin, 2021). Furthermore, mental health services have been shown to foster hope among service users by improving their understanding of their own situation, teaching them effective strategies to manage challenges, recognising their progress, developing future-focused plans, and by reassuring them that tailored support is available when needed (Honey et al., 2023). Considering the relevance of hope, it would be worthwhile to explore whether similar practices also give people with mild intellectual disabilities and CB living in residential care hope.

Our study adds to existing literature about the work that needs to be done to realise necessary preconditions for high quality support for people with intellectual disabilities and severe CB. Research into what aspects are important in the delivery of high-quality support have been described in detail (e.g., Olivier-Pijpers et al., 2020b). However, as the present study illuminates, in practice, organisations are not able to continually fulfil these preconditions and deliver the work-as-imagined. Instead, organisations need to show resilience in dealing with ever-changing and challenging circumstances (Wiig & O'Hara, 2021). To that end, it is essential to gain a rich understanding of how the actual work (work-as-done) is carried out and to learn from that knowledge (Braithwaite et al., 2015). One of the complex challenges that residential care service organisations are faced with is team instability (e.g., Deveau & Rickard, 2023). The present study demonstrates the actual work performed by Pro organisations in such situations. In times of team instability, professionals within Pro seek to provide stability to service users in other ways, namely by offering stability in terms of both the support and the daily program. The corresponding actual work involves clear routines, time for reflection, and mutual support. In future research, it would be expedient to further explore work-as-done within residential disability organisations to learn from already existing good practices in providing safety. Identifying what is working and what could potentially be improved might further contribute towards the resilience of organisations to deal with changes and challenges (Weenink et al., 2023).

The findings of this study should be interpreted with some limitations in mind. First, we conducted the study from the perspective of professionals (in various roles). That means that we did not verify with service users whether the approaches of the organisations really promoted a feeling of safety. Future research into service users' experiences of the safety strategies applied by both organisations and themselves to feel safe would thus be valuable.

A second limitation pertains to the limited number of organisations that were involved in the data collection. In addition, all organisations participated in project Pro. Consequently, they all worked from the same values and principles. If the data were collected at other organisations, then other themes, including other actual work, might have been revealed. As aforementioned, more research into the actual work of organisations regarding the promotion of safety would be worthwhile.

Conclusions

The goal of this study was to explore how organisations promote the safety of their service users with mild intellectual disabilities and severe CB who live in residential care.

Intertwined with the identified themes was the importance of a shared commitment within the organisation. The provision of unconditional support, stability, and giving service users as normal a life as possible, requires the engagement of professionals from all levels, which testifies to the difficulties involved in implementation. Our study, but also research from PBS and Active Support, shows that even in organisations that are strongly committed to working together towards a shared vision, getting and keeping everybody engaged remains challenging (e.g., Bigby et al., 2019). Further implementation research, focusing on learning from work-as-done as opposed to only adverse events and work-as-imagined might prove fruitful for facilitating the implementation of good practices (Verhagen et al., 2022).

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CHAPTER 6

6

The role of relational work in promoting safe community participation by people with mild intellectual disabilities and severe challenging behaviour living in residential facilities

This chapter has been resubmitted for publication as:
Lokman, S., Bal. R., Didden, R., & Embregts, P. J. C. M. (2024). *The role of relational work in promoting safe community participation by people with mild intellectual disabilities and severe challenging behaviour living in residential facilities.*

Abstract

Background

Promoting the level of community participation by people with mild intellectual disabilities who exhibit severe challenging behaviour is complex due to a variety of safety issues.

Method

This qualitative study explored what residential facilities for people with intellectual disabilities as well as their external stakeholders do to promote safe community participation, taking feelings of safety of service users and their environment into account. Interview and focus group data from professionals of residential facilities and stakeholders from the police and municipality were thematically analysed, resulting in the identification of two main themes.

Results

The first theme concerns taking risks responsibly together, by identifying, weighing up, and managing risks, whilst the second pertains to residential facilities and stakeholders' ongoing efforts to change the perceptions and attitudes of the public and each other. Overall, the significance of relational work in promoting safe community participation was found.

Conclusions

Residential facilities and external stakeholders should invest in strengthening their relationship.

Full and effective participation in society is a human right for people with intellectual disabilities and thus is incorporated within the domain of quality of life (Buntinx & Schalock 2010; United Nations 2006, art. 18). However, the level of community participation by people with mild intellectual disabilities or borderline intellectual functioning (henceforth shortened as mild intellectual disabilities) who exhibit (severe) challenging behaviour (CB) (e.g., verbal and physical aggression), have co-morbid addiction and mental health problems (e.g., schizophrenia, autism), and live in residential facilities, is limited (Bigby, 2012; Murphy, 2009). Particularly safety issues can hinder their community participation (Terras et al., 2019). Those safety issues can both affect service users' willingness to participate, and the willingness of their environment to provide opportunities for community participation. One's willingness is influenced by the perceived rewards and risks of engagement in community participation. People's prior experiences, the images others create for them (e.g., through media messages), and the setting in which community participation takes place all serve to colour these perceptions (Chester et al., 2017; Wiesel et al., 2020). For example, based on their prior experiences, people with mild intellectual disabilities might consider the risk of being abused, patronized, or becoming embroiled in dangerous situations. Moreover, people with mild intellectual disabilities have frequent encounters with the police and legal system (Fogden et al., 2016; Nouwens et al., 2020). Past experiences of police encounters in and of themselves can affect safety perceptions, insofar as numerous studies have reported on the unjust treatment of people with intellectual disabilities by the police, which, in turn, leads to stress and fear (e.g., due to feeling misunderstood, not taken seriously, or being intimidated) (Gulati et al., 2020; Sanyaolu et al., 2022). Similarly, the environment of people with mild intellectual disabilities and severe CB, like the general public, judicial authorities, and staff from residential facilities for people with intellectual disabilities, may weigh-up the likelihood of threatening situations occurring when considering community participation by people with mild intellectual disabilities and severe CB. In practice, this means that because of the complexity and multiple problems in people with mild intellectual disabilities and severe CB, they are often restricted in freedom to leave the residential facility on their own whenever they want (e.g., because they are placed under an order).

Despite low levels of community participation amongst people with mild intellectual disabilities and CB, there is a relative dearth of research about how to promote their participation (Bigby, 2012). Several approaches have been developed to engender greater community participation by people with intellectual disabilities generally (Bigby et al., 2018; Bigby, 2024), and there are some positive indications of the effectiveness of at least some of these approaches (e.g., Positive Behaviour Support, dog-walking program) (Bigby et al., 2018; Bould et al., 2023). However, due to the higher volume of safety issues involved with community participation by people with mild intellectual disabilities and

severe CB, these approaches may not be appropriate in this context. Moreover, little is known about how providers can implement these or similar interventions, and how these can be negotiated within the context of the wider environment.

The present qualitative study aimed to explore through a sociological lens the practices or work that are done to foster safe community participation by people with mild intellectual disabilities who exhibit severe CB and live in residential facilities (Bigby & Wiesel, 2021). In so doing, we addressed the following research question: What do residential facilities and their stakeholders do to promote safe community participation by people with mild intellectual disabilities and severe CB, taking the feelings of safety of service users and of their environment into account? To answer this research question, we conducted semi-structured interviews and focus groups with professionals involved in project Pro in various roles (see Setting) and with external stakeholders of Pro (i.e., members from the police and municipality) who are engaged in ensuring public safety.

Method

Setting

In 2017, in the Netherlands, a consortium of three residential facilities for people with intellectual disabilities, two care administration offices (payers), and the Dutch Centre for Consultation and Expertise started project Pro. Project Pro aims to increase the quality of life of people with mild intellectual disabilities who exhibit severe CB, and to stop their continuous forced transfers both within and between settings (e.g., foster care, forensic care, intellectual disabilities services). The Pro organisations are underpinned by eight principles, which involve the provision of unconditional support and an unconditional place to live, adapting the context to the needs of service users, and helping service users to live "as ordinary a life as possible". Moreover, two principles correspond to staff well-being and competency development, in addition to professionals in all positions bearing a shared responsibility (including board members and managing directors) in Pro care (Pro, 2023). In total, there are 24 service users involved in the project, eight within each residential facility. Most of the service users live in small groups, but four live individually in clustered apartments. All service users receive 24 hour staff support.

Based on ethnographic longitudinal research on Pro (Lokman et al., 2024a), the research team identified the subject of safety in relation to community participation as being a recurrent theme. For example, in informal interviews, both professionals and service users often underscored service users' wishes to go outside the facility without staff supervision. At the same time, these activities (during leaves, which were either permitted or otherwise) relatively frequently ended up in stealing, threats, and aggressive behaviour

because of excessive substance use, followed-up by encounters with the police. Therefore, both the research team and Pro organisations considered Pro to be a relevant case for exploring what residential facilities do to promote safe community participation by people with mild intellectual disabilities and severe CB. To collect in-depth data on this subject, semi-structured interviews and focus groups were conducted with professionals involved in Pro. Alongside this, stakeholders from outside of Pro residential facilities were also invited to participate in an interview.

Participants

Participating professionals involved in Pro care held various positions: there were 42 support staff members from six teams, one team leader, four managers, six psychologists, two managing directors, three board members, and six other professionals (e.g., head of a treatment team, quality advisor) (Table 1). The other four participants were external stakeholders of the Pro residential facilities who are involved in public safety provision. Three stakeholders were police officers, and one stakeholder was a policy advisor at the municipality. The participants were mostly male (68%) and on average were 38 years old (*SD* = 9.8, range 21-64). The mean duration of their involvement in Pro was 2 years (*SD* =1.5), whilst the mean duration of their work experience in the field of care for service users with intellectual disabilities was 8 years (*SD* = 8.9). Stakeholders had on average been working in their organisation for 9 years (*SD* = 7.7).

Table 1. *Overview of study participants and data collection methods*

Type of participants (*N* = 68)	**Method**	**Number of interviews/ focus groups**
Support staff (*N* = 43)	Focus group Dual interview	4 1
Psychologists, team leader (*N* = 7)	Focus group	1
Managing director, other professionals (e.g., head of treatment, quality advisor) (*N* = 7)	Focus group	1
Managers (*N* = 3)	Interview	3
Board members (*N* = 3)	Interview	3
Managing director (*N* =1) Police officer (*N* = 3) Policy advisor from the municipality (*N* =1)	Interview Interview Interview	1 3 1

Procedure

Data were collected between April and December 2022, upon approval from the Ethical Review Board of Tilburg University (EC-2019.37). The participants were informed both verbally and on paper and all provided their written informed consent. Data were collected as part of a comprehensive research project, which consisted of three studies. The first two focused on residents' safety experiences and organisational safety (Lokman et al., 2024a, 2024b). This study contributes to these studies by focusing on safety in relation to community participation.

In total, seven semi-structured interviews, one double-interview and six focus groups were held with professionals involved in Pro (e.g., support staff, managers, and board members), and four semi-structured interviews with stakeholders (see Table 2). Most of the interviews and focus groups were held face-to-face, both to allow for a safe and comfortable atmosphere and to enhance the ability to pick up on non-verbal cues (Saarijarvi & Bratt, 2021). To facilitate participation, three interviews and two focus groups were conducted online via Microsoft Teams, because it was easier to fit this around the tight schedules of participants and was less time-consuming as no travel was required.

All of the interviews were conducted by the first author by means of an interview guide that was prepared with the other authors. The interview guide was tailored to the specific context (e.g., the role and tasks) of the participants, but always included some basic questions. For example, all participants (also those who participated in the focus groups) were asked what they currently do to promote safe community participation. The first author also conducted the focus groups and double-interview, assisted by either the second author or an experienced researcher. After a short introduction about the nature of the study, predefined statements on either a screen or paper were used to encourage participants to engage in interactions. The statements and questions in the interview guide reflected the same themes. Similar to the interviews, the statements used in the focus groups were aligned to the context of the participants (e.g., support staff, psychologists). On average, the interviews and focus groups lasted approximately 70 minutes. They were all recorded and transcribed verbatim.

Analysis

We conducted a thematic analysis informed by an inductive and reflexive approach to analyse the data (Braun & Clarke, 2021). Initially, the first two authors read and discussed parts of the transcripts of the interviews and focus groups to both familiarise themselves with the data and explore relevant sections related to the research question. Consequently, they closely read the transcripts of two interviews. The first author systematically and openly coded the transcript in the software package Atlas.ti and categorised the codes in Microsoft Excel, whilst the second author annotated relevant data to gain preliminary

impressions of the potential subthemes. Together, they discussed and reflected upon these subthemes, before then proceeding to repeat this process on four more occasions. They considered the transcripts of the four interviews (two stakeholders) and one focus group together. All the other transcripts were also systematically coded in Atlas.ti by the first author. Next, she exported the codes into Microsoft Excel and iteratively generated the potential themes and subthemes. These themes and subthemes were then reviewed several times and refined by an experienced researcher and all the authors, followed by giving the final labels to the themes and subthemes, and choosing the analytic narratives.

Results

From the thematic analysis, we generated two main themes: (1) Taking risks responsibly together, and (2) Changing each other's perceptions and attitudes. Both themes consist of two subthemes.

Taking risks responsibly together

The first theme reflects the need to take risks responsibly, which includes determining which risks are acceptable and managing these risks together. Both are important to reduce the likelihood of CB in public while also promoting community participation.

Determining the acceptability of risks

We found that identifying and weighing up the risks for both service users and the public when service users are out in the community is a collective process. The Pro professionals explained the multidisciplinary process whereby the manager and psychologist discuss the risks with others within the residential facility, such as, for example, the head of treatment, support staff, service users and their representatives, psychiatrists, physician for people with intellectual disability, and managing directors. All the potential risks to both service users and society are assessed and weighed, against a background of trying to promote the ability of service users to increase their community participation.

One of the police officers reported having little insight into how the Pro facility makes decisions about service users' level of autonomy, but did state to be confident that these decisions are made with good judgement. At the same time, doubts were expressed about the acceptability of the risks when service users are out in the community who are known to have exhibited severe CB in the past, or who regularly have police encounters, especially if these service users "are always on the verge of exhibiting CB". Another police officer indicated that the residential facility does regularly consult them in order to determine the acceptability of risks.

They do regularly ask me for advice: what is your point of view? And sometimes, I have some background information which they do not have or I just put them in touch with probation or the district attorney's office. (Stakeholder)

The latter is specifically appointed as a police officer "care and safety", and works closely with the Pro facility and other care organisations. To this end, the police officer is present at the residential facility for half a day each week. With the exception of some instances, the police officer perceived community participation by service users to be basically safe for the public.

Police officers and the policy advisor from the municipality (henceforth referred to as stakeholders) and Pro professionals indicated that both the potential risks involved and the acceptability of these risks vary for each service user and for each moment. Therefore, a personalised and situated approach should be used with regards to safe community participation by service users. For example, they mentioned differences between service users in terms of both the type and severity of the mental health or addiction problems, their ability to regulate their own emotions, and the extent to which they want to participate in the community. Furthermore, the role of the emotional state of service users in decisions about community participation was highlighted. One manager explained that when service users are tense, support staff may change the location of activities from an external site to the residential facility. In addition, the potential risks of community participation are also dependent on service users' own feelings of safety, according to stakeholders and professionals. Specifically, when service users feel unsafe, they are more likely to exhibit anti-social behaviour with an increased risk of CB. Therefore, community participation by service users without staff is only considered when service users feel safe and confident, according to one manager.

Pro professionals in various roles explained that in order to determine whether the risks are acceptable, it is important to be realistic about service users' abilities (e.g., to control their craving for substances). If during multidisciplinary team meetings professionals deem that these risks are limited, then service users are allowed to leave the residential facility by themselves, and, as one board member indicated, a "calculated risk is taken"—with "calculation" not referring to an objective assessment in terms of numbers, but rather to a situated judgement that is shared between the participants.

In their decision-making process as to whether or not to allow service users to live in a setting within the community and to leave the doors of the residential home open, residential facilities should carefully consider the risk of service users running away, according to stakeholders. Such situations demand intense police capacity and can pose significant risks to both society at large and service users themselves:

Someone casually ringing the doorbell of a random house and asking for weapons is quite alarming for obvious reasons. Situations like this are, obviously, to be avoided as much as possible.

One stakeholder highlighted that these considerations should include whether a residential home is suitable for service users placed under an order, given that they often run away.

Managing risks together

To promote safe community participation, residential facilities and stakeholders manage risks in several ways, often in relationship with each other or with service users. First, Pro professionals adopt a stepwise approach to expand service users' activities and increase their independence. By taking small steps, they reduce staff involvement or add activities that involve more risks (e.g., temptations for alcohol, crowded places). Service users' ability to handle more independence determines whether they move forward or take a step back, as noted by support staff, managers, and psychologists.

You have a roadmap comprising different phases to help expand their freedom. What you often see are that small steps are taken forward, then there is a small step back again, a small step forward again, and then a small step back again, where you continuously try to work towards giving them more freedom. (Support staff)

The relevance of this approach for enhancing independence was echoed by stakeholders. They emphasised continuously monitoring and taking restrictive measures if service users display risky or challenging behaviour (e.g., running away):

You consider: what is someone capable of? And how is it going? Taking small steps […] and daring to be honest about it: does it work? Is it not working?" (Stakeholder).

However, stakeholders believe residential facilities could improve in taking restrictive measures, suggesting Pro facilities sometimes refrain from responding. In contrast, Pro professionals indicated that stepping back means reducing service users' opportunities to leave the facility on their own.

Second, Pro professionals manage risks together by carefully considering how to create a context in which risks and feelings of unsafety are minimised, both for service users and the public. For example, they indicated that crowds and busy places are avoided, and that staff members provide support to service users during their community participation (via their physical presence or via the phone). Support staff's participation in service users' activities reduces the risks of running away, stealing, engaging in substance abuse and

undesired social behaviour towards other citizens, whilst, simultaneously, increasing service users' feelings of safety. Individual histories of service users are considered in this process:

> *Another service user is afraid of going outside by themselves because he has never done that before. Whilst it may well be safe for him, and he is certainly capable of doing it, because we are a safe haven for him, he does not want to go outside without us. (Support staff)*

Whilst some service users do activities together with support staff as part of a stepwise approach towards greater independence, others do not appear to possess the requisite abilities to participate safely in the near future by themselves. This is because they are, for example, unable to regulate their aggression when community members make fun of them without the presence of staff members, according to support staff.

Third, support staff cooperate with service users to make them jointly responsible for creating positive community experiences without CB incidents. Together, they discuss activities, expectations, and arrangements (e.g., social interactions, timing), which provides predictability for service users. Involving service users in these discussions increases the likelihood of adherence, according to one psychologist.

Fourth, service users participate in preventive activities run by the police. For example, police organise educational projects for people with mild intellectual disabilities to increase awareness of criminal exploitation. The police also play a role in early risk recognition; they quickly identify unusual behaviour through digital systems, cooperation with local partners, and the alertness of local officers. In cases of runaway service users, the police increase visits to common locations.

Fifth, stakeholders and residential facilities together aim to promote safe participation by discussing situations that may be unsafe for service users and/or society, such as, for example, the presence of drug dealers or service users who disturb public order. Moreover, in one of the municipalities, psychologists advise the stakeholder from the police in case of expected CB (either within or outside the residential facility) in advance regarding how each service user should be approached. Next, the stakeholder stores the information in a national digital system so that other police officers know how to respond if and when they are called in.

> *The control room can see immediately when his name pops up on the screen, or when the location is entered. Colleagues can see immediately how we're supposed to act, based on what is entered […]. So, they already have information before they*

get to the location. And that is because we are taking far more steps to safeguard and collaborate. (Stakeholder)

Other stakeholders from the police also reported positive experiences of having such "individually tailored agreements for people". However, the other two Pro residential facilities did not appear to share advice about such individually tailored approaches as regularly with their local police.

Sixth, when service users run away, short communication lines between residential facilities and stakeholders contribute towards rapid reports being written up. In turn, these reports help the police to trace them as quickly as possible and prevent potentially disturbing or CB. In addition, residential facilities and the police jointly decide when a service user who has run away should be deemed high-risk and be reported as urgently missing. As a result, the number of urgently missing service users are reduced, which, in turn, benefits both the police (less police capacity is required) and the opportunities of service users to be in the community, as one manager explained:

When someone wanders off or goes missing, without causing any disruption, then there's no need to deploy the whole system; rather, you can take a different view of this type of care, and also provide greater scope for them to move with greater freedom.

Lastly, Pro residential facilities and stakeholders jointly manage risks by evaluating processes and learning from cases. During meetings, they reflect on what works and identify areas for improvement, including why service users run away or exhibit disorderly behaviour. Stakeholders expressed overall satisfaction with their cooperation with residential facilities. However, they noted that relationships can become strained when there's a perceived lack of shared responsibility or differing views on the appropriate response to CB incidents. Regular and transparent communication to discuss responsibilities and align perspectives is crucial, according to both stakeholders and Pro professionals. Regular contact at different levels (e.g., board members, police commissioners, and mayors, or managers, police officers, and municipality advisors) fosters mutual understanding and better goal alignment.

Changing perceptions and attitudes

The second main theme pertains to changing perceptions and attitudes. The first subtheme concerns the perceptions and attitudes of the public and police regarding people with mild intellectual disabilities and CB. Participants explained how those affect feelings of safety, and their willingness to enable community participation by service users. The second subtheme addresses Pro professionals' perceptions and attitudes

regarding the acceptance of CB. Setting limits can prevent more severe CB, and in turn to more safety, from stakeholders' perspective.

Unfamiliarity breeds suspicion

According to stakeholders and Pro professionals, being unfamiliar with people with mild intellectual disabilities and CB leads to feeling unsafe when they exhibit unusual behaviour. Therefore, connecting with the public to inform them about people with intellectual disabilities and CB is of critical importance.

> *What you do not know or, unfamiliarity breeds suspicion, creates myth-making, so it can also help in certain situations to explain how things work, or to meet someone, or to understand that their [service users] social emotional development is very low. […]. In other words, you look at a situation from a contextual perspective. (Board member)*

Furthermore, residential facilities inform the public, police, and municipality about service users and their CB in order to increase social awareness and engender a sense of acceptance of the fact that it is their shared responsibility to take care of and facilitate the community participation of service users. Greater social acceptance and acknowledgment of shared responsibility by employers would be welcomed, according to one manager, as residential facilities face reluctance from employers to offer job opportunities to service users. Regarding societal views, a board member noted that it is commonly believed that service users with severe CB should be put behind bars, based on the notion that all risks would be prevented. However, society must accept that some degree of risk will always be involved in community participation by service users with CB, and these risks can only be minimized, never completely prevented, according to both Pro professionals and stakeholders.

To increase public awareness, one stakeholder explained that the police and municipality also play a role. For example, the police inform citizens about people with CB via social media and face-to-face contact, while the municipality disseminates guides on how to best respond to individuals with mental health issues. However, board members and stakeholders underscored that informing the public involves risks. Drawing attention to people with CB may engender unnecessary feelings of unsafety. Therefore, Pro facilities and stakeholders must ensure that their communication is well-considered (e.g., during meetings with local residents rather than broadly). As one stakeholder said:

> *It is about finding the right balance regarding what to communicate to the public and what to leave out.*

Pro professionals believe citizens' perspectives are influenced by how support staff interact with service users in public:

> *If support staff remain relaxed and cheerful, even when the client acts strangely, that's less likely to cause concern than if the staff member also panics.*

Pro professionals and stakeholders agreed that direct contact between citizens and service users, both inside and outside the facility (e.g., at supermarkets or events), improves public perceptions and enhances safety for both the public and service users by fostering familiarity.

> *You notice that people have gotten used to it. And maybe also take this into account in their responses, insofar as they are aware that it may be a service user of [name residential service]. So, in other words, they, how do you say? React more calmly? They are somewhat more moderate in their approach. (Stakeholder)*

The Pro professionals we spoke to also experienced a change in the police's approach towards service users when CB occurred, because they had become more familiar with service users:

> *Previously, in the case of an escalation, the police would come with all their might, including shields, if it was a dangerous service user, as they felt they needed to be well prepared in order to be safe. But now, they adopt a different approach and really try to make contact with the service user, look to establish a connection with them instead of immediately resorting to cuffing and taking them away, which does not work in the end. (Support staff)*

Besides gaining familiarity with service users through their role as police officers, one officer also increased their awareness by job shadowing at the residential facility. Additionally, in regular meetings, board members, managing directors, managers, and psychologists educate the police about service users with mild intellectual disabilities who exhibit severe CB and how to approach them. Changing police perceptions is a lengthy process, as noted by two Pro professionals. Moreover, this mainly affects the local police, while service users may encounter officers elsewhere. Stakeholders also highlighted the challenges in shifting police attitudes, attributing it to the police's hands-on mentality, where some officers may prioritise quick resolutions over de-escalation. Nevertheless, one stakeholder mentioned that de-escalation techniques and education about intellectual disabilities and mental health issues are emphasised in refresher courses of the local police.

Limits on what is acceptable

In their relationship with residential facilities, stakeholders also aim to change the perceptions of Pro professionals. They point out to Pro professionals that there are limits to the acceptability of service users' CB. Often, stakeholders outside the facility perceive reluctance amongst care professionals to press charges after CB. Differences appear to exist between stakeholders and residential facilities with respect to how they interpret and manage CB, that is, as an offence that should be proceeded by pressing charges versus an expression of unfulfilled needs.

> *"We do not press charges because the behaviour is a part of their problems and the fault actually lies with the support staff, because they have not searched the service user properly". So, they take responsibility. I think, yes, but that does not justify setting your cell or common area on fire […]. Then you realise: yes, I understand their motives, but these are things that you just cannot accept. (Stakeholder)*

Pressing charges over CB incidents is important, the stakeholders argued, insofar as it sends a signal to service users that they have crossed a line. They proceeded to explain that by setting limits Pro professionals can contribute towards the safety of service users and their environment by preventing more severe CB incidents in the future.

According to one of the stakeholders from the police, their intensified collaboration with residential facilities has resulted in a more positive attitude by Pro professionals towards pressing charges in recent years. Positive experiences of integrating care into criminal justice processes has contributed towards these changed attitudes, the stakeholder explained. Nowadays, psychologists give their expert advice as part of the adjudication in which they explain how the judiciary can support care trajectories. Moreover, in order to align with care trajectories, the stakeholder focuses on the faster processing of police reports by connecting to colleagues from the criminal investigation department after care professionals have pressed charges. Speeding up the process is important insofar as it reduces unnecessary stress for service users, according to the stakeholder.

Discussion

The present study explored what residential facilities and their stakeholders outside of the facility do to promote (experiences of) safe community participation by people with mild intellectual disabilities and severe CB. We conducted interviews and focus groups with professionals from residential facilities who were involved in project Pro. Interviews were also conducted with external stakeholders of the Pro residential facilities, namely from the police and municipality. Two themes were generated from the data: (1) Taking

risks responsibly together, and (2) Changing perceptions and attitudes. The first theme concerns how residential facilities identify and weigh up the risks associated with service users' community participation for the purposes of ensuring safety. Moreover, this theme addresses how residential facilities and their stakeholders jointly manage risks in order to foster safe community participation by service users. The second theme pertains to the ongoing efforts of residential facilities and stakeholders to change the perceptions and attitudes of the general public as well as each other. The participants in this study reported that having greater familiarity with service users in turn leads to more favourable perceptions and attitudes towards them. Specifically, they perceived that increased familiarity with service users positively contributed towards feelings of safety amongst both the public and service users and enhanced the community participation of service users. This latter finding is in line with the results of prior research on community participation with people with (mild) intellectual disabilities who do not exhibit CB (Pelleboer-Gunnink et al., 2021a, 2021b). Pelleboer-Gunnink et al. (2021a) found that people with "no real-life familiarity" with people with intellectual disabilities had more feelings of fear and higher levels of social distance, in comparison to those with familiarity "in passing by", "in work" or "in their private life". Moreover, in another study by Pelleboer-Gunninket al. (2021b), participants who were unfamiliar with people with intellectual disabilities regarded them as being less "in need of help" and more of "a nuisance". Overall, these results appear to call for interventions which aim to increase the general public's familiarity with people with mild intellectual disabilities and severe CB, but also amongst professionals who can play a role in promoting safe community participation by service users.

Close contact with service users is especially important for achieving greater familiarity with them (Blundell et al., 2016). However, orchestrating close contact in the case of service users who display severe CB is challenging (Wiesel et al., 2020). When behaviour is regarded as unacceptable or does not conform to prevailing societal norms, then negative encounters or non-encounters are more likely (Bigby & Wiesel, 2018). Service users with severe CB and comorbid psychopathology are especially more inclined to exhibit such behaviour. Therefore, it appears essential to design and implement interventions or programs that facilitate contact between people with mild intellectual disabilities and severe CB and the public. For example, one avenue would be to explore the extent to which neighbourhood projects that have been developed to enhance community participation by people with mild intellectual disabilities without CB (e.g., walking with a dog) are also appropriate for people with mild intellectual disabilities with CB (Bould et al., 2023; Bredewold et al., 2020). In addition, new interventions or programs could also be developed, preferably co-created with the public and service users themselves, in order to increase the likelihood that the interventions are tailored to the preferences of all involved (Leask et al., 2017). Furthermore, interventions to increase community

participation should focus on finding places that have a shared purpose (e.g., feeding animals at a community farm), built in boundaries (i.e., clarity over both the location and duration of the encounter), and that allow people with and without disabilities the freedom to engage or disengage, as these places appear to be more conducive for convivial encounters (Bredewold et al., 2020; Wiesel et al., 2020). In future research, it would be valuable to explore both the effects of and experiences with such interventions aimed towards increasing the level of contact in the community between people with mild intellectual disabilities and severe CB and the public.

Nevertheless, as all of our respondents noted, risks will always remain, even if such interventions are applied and a stepwise approach is adopted to enhance service users' activities and degree of independence (Robertson & Collinson, 2011; Sawyer & Green, 2013). Therefore, to enable community participation by people with mild disabilities and CB, society must accept some level of risk. In line with previous studies, our study showed that to this end, it is important for residential facilities to build trust amongst the public and other external stakeholders by both sharing information about how they provide support and minimise risks (Chester et al., 2017; Robertson & Collinson, 2011; Sawyer & Green, 2013) and raising community awareness. Overall, the findings of this study testify to the significance of relational work in promoting safe community participation. In particular, the positive effects of good collaboration between Pro residential facilities and stakeholders from the police and municipality were underscored.

Relational aspects have frequently been highlighted in extant literature about safety and people with (mild) intellectual disabilities and CB, as well as in research about patient safety outside the field of intellectual disabilities. For example, studies have reported on the importance of building relationships based on mutual trust and respect, good communication, and cultivating a positive climate (e.g., Sutton et al., 2023; Tournier et al., 2022). Our study has shown that differences in the visions and goals of residential facilities and stakeholders from the police and municipality can lead to different perspectives about how they both deal with and balance the risks associated with CB. Specifically, external stakeholders are more inclined to respond to CB through judicial measures or placing restrictions upon service users' freedom in order to prevent future CB (i.e., a risk-aversive approach). Conversely, residential facilities are more accepting of (the possibility of) CB, and seek out ways through which to change the context in order to minimise risks or negative impact (Wiesel et al., 2020). By intensifying their collaboration, residential facilities and stakeholders have created more empathy for each other's views and approaches. To build trusting relationships, various participants underscored the importance of investing in (personal) contact before situations escalate. They explained that in such circumstances there is more openness towards each other's visions and interests than in tense situations.

Our study demonstrates that local police officers play a bridging role in this relational work by connecting to the public, residential facilities, service users, other collaboration partners (e.g., social teams, the judiciary), and colleagues. This was especially the case with one local police officer, who was specifically appointed to provide care and safety to one of the Pro facilities. Compared to the other police officers who participated in this study, the appointed police officer "care and safety" had more time and opportunities to cultivate and optimise the relationship between the police and the Pro facility. This in turn led to shorter communication lines, improved procedures, and different attitudes and approaches towards service users. These benefits call for a broader implementation of local police officers 'care and safety'.

Altogether, even if society becomes more familiar with people with mild intellectual disabilities and severe CB and the work of residential facilities, police, and municipalities, the question nevertheless remains of how tolerant society will be regarding community participation if and when service users exhibit CB in public. As was addressed in this study, seeing service user's aggressive or violent behaviour as an offence and/or as a deliberate action will evoke different attitudes than when CB is regarded as an expression of an unfulfilled need (i.e., a context that does not meet service users' needs) (Hounsome et al., 2016). However, when CB is aimed at the environment, even professionals who work with people with (mild) disabilities and CB are sometimes inclined to perceive CB as within the control of service users rather than being an expression of an unfulfilled need (ZijImans et al., 2012). Consequently, increasing the understanding that CB is strongly related to the context is challenging but vitally important. Changing the context can reduce and prevent CB, and thereby the negative experiences for people with mild intellectual disabilities who exhibit CB as well as people in their environment (Olivier-Pijpers, 2020). One interesting topic for future research to explore would be the public's emotional reactions and attitudes towards service users' CB when they are aware that they are people with mild intellectual disabilities, who have low social and emotional skills, and mental health disorders.

Some limitations should be taken into consideration when interpreting the findings of this study. First, the number of external stakeholders who participated was limited, and involved only one person who was working at the municipality. Whilst we were interested in how Pro residential facilities foster safe community participation with their stakeholders, we opted to restrict the inclusion of stakeholders to those who were proposed by the Pro residential facilities themselves in response to the question who their contacts are with regard to safe community participation. Second, only stakeholders from the police and municipality were included in the study. Although they play a prominent role in ensuring citizens' safety and wellbeing, other stakeholders also affect the opportunities of service users to participate in the community as safely as possible. Therefore, we recommend

that future research includes a broader sample and other types of external stakeholders. For example, potential employers could be included as participants in order to explore whether relationality can also contribute towards increasing (paid) work opportunities for service users who exhibit severe CB.

Conclusion

To promote community participation by people with mild intellectual disabilities and severe CB, a balance must be struck between the rights of people with mild intellectual disabilities to participate, and their safety as well as that of their environment (Chester et al., 2017; Wark et al., 2019; Wiesel et al., 2024). The present study explored what residential facilities and their external stakeholders at the police and municipality do to promote safe community participation by people with mild intellectual disabilities and severe CB. Relational work through cooperating with each other, but also through connecting with the public, was identified as a key theme. Residential facilities and stakeholders should therefore invest in strengthening their relationships and developing joint approaches. One interesting avenue for future research would be to explore interventions that may promote safe community participation by people with mild intellectual disabilities and severe CB.

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CHAPTER 7

7

General discussion

People with mild intellectual disabilities or borderline intellectual functioning[3] are at a higher risk of developing psychopathology and challenging behaviour (CB) than people without intellectual disabilities (Bowring et al., 2017, 2019; Gigi et al., 2014; Grey et al., 2010; Pouls et al., 2023). Despite an increased knowledge base about what fosters high-quality support for people with mild intellectual disabilities and severe CB (i.e., impact behaviour that involves serious damage or threats to the individual, others involved and/or society (Bowring et al., 2017; Embregts et al., 2019)), care and support often remain unaligned with their support needs, as a result of which they face recurrent involuntary transfers within and between organisations and settings (e.g., Neijmeijer et al., 2020; Olivier-Pijpers, 2020; Pouls et al., 2023). It is therefore important to expand the knowledge on what residential facilities and stakeholders outside the facilities can do to promote a context that meets service users' needs. This can contribute to the prevention of CB and future involuntary transfers, thereby increasing the quality of life of service users and staff and reducing costs to society (Allen et al., 2007; Olivier-Pijpers et al., 2019).

To stop transfers and improve the quality of life of 24 people with mild intellectual disabilities and severe CB, six organisations started the project Pro: three residential facilities for people with mild intellectual disabilities, two care administration offices, and the Centre for Consultation and Expertise. At the heart of the Pro principles for service users are the provision of an unconditional place to live and unconditional support, a context that meets service users' needs, the development of self-confidence, and a life as ordinary as possible. Pro principles also focus on the competencies and well-being of staff, and on a shared responsibility among all disciplines, including board members. As it appears difficult to provide a context that meets service users' needs, and as Pro focuses especially on providing an appropriate context, Pro seemed to be a relevant case to explore.

We therefore aimed to gain insight into what is important in bringing the Pro principles into practice and how the principles are operationalised. In addition, while exploring the operationalisation of principles we aimed to investigate aspects of safety inside as well as outside the Pro residential facilities in more detail. The subject of safety received particular attention, as service users may be triggered to show CB when they feel unsafe, which can have significant consequences for themselves and their environment (van den Bogaard et al., 2019). In addition, when individuals in the service users' environment feel unsafe, this can have adverse effects on their behaviour towards the service users (Willems et al., 2016; Zijlmans et al., 2012).

3 Henceforth, for readability referred to in this chapter as mild intellectual disabilities.

To meet the objectives of the thesis, we conducted five studies. In the first study, we explored what is important at the start to bring the Pro principles into practice – when a new team and new service users start together at a new residential home. The second study also focused on the first part of the thesis' aim by examining how perceived support and team climate of support staff are related to their well-being and work satisfaction (Pro, 2023). The last three studies were about safety. We first identified what factors affect service users' feelings of safety to understand what is important towards meeting service users' need to feel safe. The other two studies about safety addressed how Pro residential facilities operationalise Pro principles to promote service users' need to feel safe and safe community participation.

The present chapter summarises and integrates the main findings of the five studies. In addition, the strengths and limitations of this thesis are discussed along with directions for future research. The last part describes the implications for policy and practice and ends with a general conclusion.

Summary of main findings

Important factors to consider when setting up a new team of support staff

In the first study (Chapter 2), we explored what service users (N = 11), support staff (N = 6), and psychologists supporting a team (N = 6) involved in project Pro considered important when setting up a new team of support staff for Pro service users (henceforth used to denote people with mild intellectual disability and severe CB) while focusing on contextual factors. In this concept mapping study, all three participant groups mentioned aspects connected to relationships, including the necessity for certain characteristics of support staff (e.g., experience, confidence, low-key emotional expression) to provide safety and trust among service users. Relationships not only concerned those between service users and support staff, but also mutual relationships between support staff members as well as between support staff and professionals supporting a team (team leader, manager, psychologist). Overall, four main outcomes were identified as important. First, service users and support staff should get to know each other before the relocation of the service user to the new home. Second, support staff care deeply about team safety and therefore need to be reliable and provide support together in a consistent way, based on shared values and principles. Third, social support for support staff is important, particularly from the team leader, manager and psychologist. Last, a realistic and positive view of service users in the new residential home is of relevance, as rumours whereby their CB is taken out of context can lead to stigmatisation of service users and

affect the recruitment of new staff. To dispel rumours, support staff who participated in the study noted that potential future staff should be invited to come and visit the new residential home.

Experienced support at work, team climate and collaboration

In Chapter 3, we examined how support staff perceived support at work from team leaders, managers, psychologists and other staff members, and studied their team climate. We investigated the relationship of these variables with well-being and job satisfaction. In addition, we tested two hypotheses: that staff would perceive higher levels of support from professionals around a team (team leaders, managers, and psychologists) and a more positive team climate when professionals around a team experience more positive mutual collaboration. A total of 201 staff members who work with service users with mild intellectual disabilities and severe CB and/or mental health problems from 32 teams and 10 residential facilities for people with intellectual disabilities plus 61 professionals around a team filled out an online questionnaire. About one-fifth of these participants was involved in Pro.

Support staff perceived most support from other staff members in their team. Support staff from teams with a position of team leader gave higher scores to support from other staff members and team climate than support staff from teams without a position of team leader. It was also support from other staff members and team climate in particular which were positively associated with staff's well-being. With respect to staff's job satisfaction, positive relations were found for support from all four different types of professionals at work, and from team climate. Contrary to our expectations, the hypotheses were not confirmed by the data. Overall, the study highlighted the importance of investing in staff support and in creating a positive team climate to enhance staff's well-being and job satisfaction. Moreover, the results endorsed the positive effects of having a practice leader close to the frontline of service delivery.

Meaning of feeling safe for service users with severe challenging behaviour and factors affecting their feelings of safety

Chapter 4 focused on the meaning of feeling safe for Pro service users. In addition, we identified which factors affect their feelings of safety. To that end, we first thematically analysed qualitative data from ethnographic longitudinal research to Pro (i.e., 80 field notes of informal unstructured interviews and non-participant observations, and analysis of 20 documents (meeting minutes)). Second, a thematic analysis was performed on additional data about safety collected during additional semi-structured interviews and focus groups. Participants – 64 professionals in various roles (from support staff to board members) and four service users – were all involved in Pro.

The meaning of safety was related to three themes: a physical environment that reduces risks and temptations; a reliable, predictable, and supportive environment that service users have confidence in; and an accepting environment that enables service users to establish a normal daily life. The analyses of factors playing a role in service users' feeling of safety resulted in 20 themes and 34 subthemes. Factors ranged from the level of the service user (e.g., their mental health and addiction problems) and the level of the organisation (e.g., shared organisational vision and policies) to the external environment (i.e., perceptions of society). Interconnectedness was found between those factors, which implies that changes in one factor can affect others. Residential service organisations were thus advised to take these interactions into account when making their policy decisions. The overall results also highlighted that in order for support staff to create a sense of safety among service users, it is a prerequisite that they feel safe themselves.

Promoting feelings of safety among service users with severe challenging behaviour within residential care

While the previous chapter focused on which factors can affect feelings of safety among service users with mild intellectual disabilities and severe CB, Chapter 5 explored how Pro residential facilities promote feelings of safety among their service users while taking these factors into account. A thematic analysis of data collected during ethnographic longitudinal research and during interviews and focus groups among professionals (see Chapter 4) resulted in three main themes. The first theme addressed the organisation's subscription to the vision of providing unconditional support at all levels. The findings showed that Pro professionals are committed to offering unconditional support to service users, especially when service users exhibit CB. To that end, they focus on shared responsibility and mutual support between professionals at different organisational levels. The second and third themes related to providing stability in teams and support within a dynamic environment (theme 2), and to their pursuit to give service users as normal a life as possible (theme 3). Although these themes may be perceived as common and generalisable to all service users with intellectual disabilities, in the context of people with mild intellectual disabilities and severe CB plus a history of multiple transfers, unconditional support, stability, and as normal a life as possible are far from straightforward.

As elucidated in the study, support staff's negative emotions and attributions can interfere with providing unconditional support. In addition, negative views about Pro service users among other professionals in the organisation led to a lack of assistance on their part, and thereby a lack of unconditional support. Fear and unfamiliarity with Pro and its service users were given as reasons for their negative views. It was therefore recommended to coach and monitor emotions and attributions of professionals at *all* levels, to ensure commitment to the vision of unconditionality within the entire

residential facility. Moreover, the study highlighted the value of exploring the actual work that is done by residential facilities instead of merely focusing on the work that should be done. In the ever-changing and challenging circumstances in which support to people with mild intellectual disabilities and severe CB is being provided, it is valuable to gain insights into how residential facilities demonstrate resilience, and to learn from that.

The role of relational work in promoting safe community participation

The last study (Chapter 6) explored what residential facilities and their external stakeholders (i.e., members from the police and municipality) do to promote safe community participation by people with mild intellectual disabilities and severe CB. In doing so, feelings of safety of service users who exhibit severe CB and feelings of safety of their environment were taken into account. To answer the research question, we used part of the data that were collected during semi-structured interviews and focus groups among Pro professionals (N = 64) for the former two studies about safety. In addition, we conducted semi-structured interviews with external stakeholders (N = 4). The first main theme of the thematic analysis concerned responsible risk-taking. Its first subtheme describes how residential facilities determine the acceptability of risks when service users are in the community, to enhance the safety of the service users and their environment. The second subtheme discusses how residential facilities and stakeholders manage risks with each other and with service users. The second main theme was about changing perceptions and attitudes. On the one hand, this concerned the effort to change perceptions and attitudes of the public and stakeholders towards service users and their CB. Participants in the study reported that having greater familiarity with service users leads to more favourable perceptions and attitudes towards service users. This in turn can lead to more acceptation of community participation by service users. More favourable perceptions and attitudes boost service users' feelings of safety. The second main theme also included stakeholders' intentions to change perceptions and attitudes in residential facilities about the acceptance of CB and pressing charges. According to stakeholders, setting limits is important for the sake of service users' safety and their environment while preventing more severe CB.

Overall, relational work through mutual cooperation and through connecting with the public was identified to play a key role in promoting safe community participation. To that end, it is recommended that residential facilities and stakeholders invest in strengthening their relationships and in joint approaches.

Reflection on the findings

This section discusses three main overarching findings of the studies. First, to provide unconditionality and a focus on service users' needs instead of CB, the findings pointed to the importance of a strong commitment to a shared vision at *all* organisational levels. Second, a recurrent theme throughout the studies was the role of investing in relationships to provide feelings of safety. Third, the adverse impact of negative views and a lack of knowledge about people with mild intellectual disabilities and severe CB surfaced regarding service users' quality of life.

A strong commitment to a shared vision at *all* organisational levels is required to bring Pro principles into practice

In this thesis, the Pro principles addressing the provision of unconditionality and having a focus on service users' needs were frequently highlighted as being important for the support of Pro service users (see Chapters 2, 4, 5). The literature about people with intellectual disabilities and CB also reports on how these aspects are essential (McGill et al., 2020; Neijmeijer et al., 2020; Olivier-Pijpers et al., 2019). However, the recurrent transfers of people with mild intellectual disabilities and severe CB illustrate how truly keeping to these support intentions when severe CB is displayed is not straightforward. In other words, it is not a question of *whether* support should be based on unconditionality and a focus on service users' needs, but *how* these principles can be successfully implemented. To that end, insights are relevant into what hinders successful implementation and what can be done to promote it. This thesis demonstrated that a strong commitment to a shared vision at *all* organisational layers is essential for bringing the Pro principles into practice (see Chapters 2, 5). Research in this field also reports on the importance of shared values and organisational commitment to provide a supportive context and prevent CB (Olivier-Pijpers et al., 2019, 2020a; Walker, 2012). Based on the widely used Consolidated Framework (Damschroder et al., 2009; Kirk et al., 2016) for Implementation Research, a strong commitment to a shared vision in project Pro can be attributed to characteristics of the process, the "intervention" (i.e., Pro principles), the inner setting of the residential facilities, and the characteristics of the individuals involved. We elaborate on each reason below, followed by some examples in which commitment to a shared vision appeared difficult:

Process

The Pro organisations took a long preparation time, during which they were thinking through how to provide a context that is in line with their vision. For example, they discussed the daily programme, what kind of support staff was needed, and how support staff should be supported (e.g., time for reflection, close involvement of managers and psychologists).

Intervention

The Pro principles were not imposed on the Pro organisations but were developed internally with the involvement of professionals at different organisational levels, including leadership engagement (by board members, head of treatment, managers, team leaders, psychologists). Hence professionals in various roles from all Pro organisations supported the principles. In addition, although the meaning of the principles is clear and leaves no room for different interpretations (e.g., service users can stay where they are regardless of their CB unless they cross the boundaries of the law), there are no standardised procedures or approaches. This means that there is freedom in how each Pro residential facility translates the principles into practice (Damschroder et al., 2009; May et al., 2016).

Inner setting

All Pro organisations felt an urgent need to provide unconditionality to stop the recurrent involuntary transfers of people with mild intellectual disabilities and severe CB and improve their quality of life. This means there was a shared sense of the purpose of the Pro principles, which gave rise to a favourable implementation climate. The implementation of Pro principles is enhanced by their explicit and implicit embedding within numerous aspects of the organisation, such as compulsory training, team meetings and case discussions. Pro residential facilities have invested in staff competencies and resilience through staff support and reflection opportunities to bringing these principles into daily practice. Last, with respect to inner setting, the culture in the Pro residential facilities contributes to the implementation: it has elements of a "just culture", also referred to as psychological safety. In a just culture, professionals feel free to open up about feelings and emotions and to admit mistakes, and there is a focus on what is going well instead of wrong (van Baarle et al., 2022; Khatri et al., 2009; Weenink et al., 2022). A just culture is fostered when there is a commitment-based (instead of control-based) management philosophy, a flat organisational structure, involvement of professionals, teamwork and cooperation, as well as open and extensive communication (van Baarle et al., 2022; Khatri et al., 2009). Within Pro organisations such elements are reflected in short communication lines, close involvement of professionals at different levels, a learning climate and use of multidisciplinary reflection to assess causes of service users' CB.

Involved individuals

In selection procedures for new staff, but also when staff already operate in a team, Pro residential facilities carefully consider whether staff members' vision is congruent with the vision of Pro. Especially when support staff are frequently confronted with service users' CB, providing unconditionality appeared to become more challenging. In those situations, psychologists and managers offer more proximity and support to staff and try to change negative emotions or unwanted attributions. However, when it appears that

negative emotions of staff cannot be turned, and they are no longer able or willing to provide support according to the Pro principles, staff members leave the team. To ensure that professionals' daily practices are congruent with the vision, board members are also involved in monitoring. In case of deviations from the vision, they initiate corrective actions (e.g., a change in team leaders, managers or psychologists).

Despite a strong commitment within Pro residential facilities to a shared vision, some situations were also discussed in which operationalisation of the principles was hindered. Especially in the first phase of Pro, some teams have struggled with how to provide or keep providing unconditionality in practice. For example, at the start some support staff associated unconditional support with setting no boundaries, which led to severe CB. A few other service users also exhibited severe CB. During stays in judicial settings, it was difficult for staff members to find a balance in supporting the vision of unconditionality while dealing with negative emotions (e.g., fear, anger).

Service users who ended up in judicial settings did not return to Pro residential facilities, except for one. Preventing future forced transfers by keeping to a vision of providing unconditionality did not succeed in these cases, because the boundaries of the law also apply to Pro service users. In addition, other professionals in residential facilities who were not directly involved in the project sometimes obstructed the provision of unconditionality. This related mainly to a lack of assistance by support services in the organisations (i.e., night shift, facility services). Fear or negative views towards Pro service users plus unfamiliarity with Pro service users and the principle of unconditional support were given as reasons for incongruent perceptions and attitudes. Residential facilities should therefore regularly monitor the perceptions and attitudes of *all* professionals in their organisation towards service users who display severe CB, and when necessary provide additional support.

Many of the elements outlined above as contributing to bringing the Pro principles into daily practice have also been identified in research on other approaches to support people with intellectual disabilities who exhibit CB, like Positive Behaviour Support, and Active Support (Denne et al., 2015; McKenzie et al., 2021). For example, a planning of strategies and the need to involve *all* organisational levels have been addressed (Gore et all., 2022; Hayward et al., 2021; McKenzie et al., 2021). All those involved should understand why and how the vision contributes to service users' quality of life in order to accomplish a system-wide approach (Denne et al., 2015; Hayward et al., 2021).

However, as indicated, transforming "what should be done" into real practice remains challenging in a complex and dynamic environment. Additional research on *how* residential facilities deal with challenging situations, and learning from that knowledge,

may increase such facilities' resilience in dealing with challenging situations and in staying committed to a shared vision.

Investing in relationships is key to providing feelings of safety

The second overarching finding relates to the promotion of feelings of safety while bringing the Pro principles into practice. With respect to CB, safety is increasingly being associated with relational aspects (e.g., Neimeijer, 2021; Nijs et al., 2022; Verstegen et al., 2024). This thesis stresses the importance of investing in relationships to promote feelings of safety of service users who exhibit severe CB, as well as their environment. Investing in relationships appeared significant at various levels – service users, professionals, and the organisation. Moreover, this thesis showed that stronger relationships with external stakeholders, such as the police, foster feelings of safety (Chapter 6).

One of the relationships at the level of service users that affects their sense of safety is their relationship with support staff (Chapters 4, 5). Relationships with staff often belong to the closest and most significant relationships they have (van Asselt-Goverts et al., 2013; Giesbers et al., 2019). The value of positive relationships between service users with CB and support staff has often been highlighted in the literature (e.g., Clarke et al., 2019; Olivier-Pijpers et al., 2020b; Willems et al., 2014). Service users experience safety with support staff members who are reliable and available, who really listen to and understand service users, and with whom service users can be themselves. In addition, staff members should recognise and appreciate service users and be unafraid to set boundaries. To provide such service, support staff need to be self-confident, sensitive, responsive, and able to regulate their emotions, among other things (Chapters 2, 4, 5). These characteristics of support staff have also been identified to be important in support to people with CB in general (i.e., instead of specifically for feelings of safety; McKenzie et al., 2018; Neijmeijer et al., 2020; Neimeijer et al., 2021; Nijs et al., 2022; Tournier et al., 2023). Training and coaching in emotional intelligence, positive attitudes towards service users, self-awareness and coping styles can change staff's attitude and competencies in the desired direction (Davies et al., 2015; van Oorsouw, 2013; Zijlmans, 2014).

In order for support staff to be self-confident and not easily fazed, they need to feel safe themselves (Haugvaldstad & Husum, 2016; Verstegen et al., 2023). Consistent with findings of Knotter et al., 2018, relationships with team leaders, managers and psychologists were highlighted as contributing to support staff's feelings of safety through their provision of instrumental and emotional support (Chapters 2, 4, 5). For example, close involvement and attention to the emotions of support staff after CB were mentioned to be supportive. However, support staff who participated in the studies of this thesis associated their feelings of safety mainly with their collaboration with other staff members, as Sollied et al. (2023) also highlighted in a study in forensic mental health wards. To feel safe, they

expressed a need to be able to rely on team members to keep to arrangements and set boundaries. They also mentioned a team climate in which everyone feels comfortable to share their insecurities and diminished resilience. If staff members are aware of colleagues' reduced mental well-being, they can take on certain tasks to prevent risky situations (Knotter et al., 2018). Team stability was experienced as important to achieve a positive team collaboration. In that case, staff members know what to expect from one another, are more inclined to act upon agreements, and have more knowledge and expertise on how to support service users (Chapters 2, 4, 5). A positive team climate and team stability are thus essential for promoting the feelings of safety of service users and support staff, as other studies in residential and forensic care have also addressed (Knotter et al., 2016, 2018; Neimeijer, 2021; Olivier-Pijpers, 2020; Ravoux et al., 2012; Sollied et al., 2023).

However, team stability and a positive team climate are hard to realise because of high staff turnover (Chapters 4, 5). A challenging work environment and tight labour market conditions particularly cause high turnover in work settings that involve people with intellectual disabilities and CB (Bureau Bartels, 2020; Deveau & Rickard, 2024). Even in the Pro residential facilities with a strong focus on retaining staff, turnover of staff was high. Team leaders, managers and psychologists can nevertheless enhance team climate, team processes and team stability, for example by encouraging support staff to view mistakes or CB incidents as opportunities to learn, by coaching them in giving and receiving feedback, and by arranging opportunities for positive informal interactions (Chapters 2, 4, 5). These findings are in line with previous research (Buljac-Samardžic, 2012; Deveau & McGill, 2016).

In Chapter 6 it was found that investing in relationships can also promote feelings of safety at the level of residential facilities and their external stakeholders. The study showed that improved relationships can boost feelings of safety among service users and their environment (e.g., the public). Pro professionals and external stakeholders of the police and municipality explained how their strengthened collaboration resulted in improved procedures to minimise and manage risks with regard to community participation by service users. Furthermore, they perceived that their improved collaboration and connection to the public led to changed perceptions and attitudes, with favourable effects on the feelings of safety of service users and the public. Although there is a dearth of research about collaborations between residential facilities and external stakeholders such as the police, a small number of studies have also reported on the importance of enhancing collaboration between intellectual disability facilities and the legal system (Raggi et al., 2013; Viljoen et al., 2017)

Negative views and a lack of familiarity with people with mild intellectual disabilities and severe challenging behaviour interfere with their quality of life

The third overarching finding addresses the adverse impact of negative views and a lack of familiarity with people with mild intellectual disabilities and severe CB on their quality of life, especially their feelings of safety (Chapters 2, 4, 5, 6). The adverse impact concerned situations with both a direct and indirect effect on service users. In addition, negative views and a lack of familiarity applied to people inside and outside residential facilities. First, unfamiliarity among the public with Pro service users and stigmatising attitudes were observed to affect service users' feelings of safety. A lack of familiarity was also associated with a reduced sense of safety among the public, thereby affecting the level of community participation by service users. These findings are consistent with research concerning people with intellectual disabilities in general, with dementia, and with mental health issues (Corrigan et al., 2012; Pelleboer-Gunnink et al., 2021a; Terras et al., 2019). Second, as in previous studies, Pro professionals and external stakeholders indicated that police officers seem to be more inclined to use an inadequate approach in response to CB in case of unfamiliarity with Pro service users (Sanyaolu et al., 2022; Viljoen et al., 2017). Such an approach may also reduce service users' sense of safety. Third, studies on Pro show that rumours induced negative views and fear among support staff of other residential homes and support services in residential facilities (Chapters 2, 4, 5). Their unfamiliarity with Pro service users led to reluctance to provide support in case of escalations, and a low willingness to work in residential homes with Pro service users. Consequently, staff experienced reduced feelings of safety and support.

Studies in this thesis also indicated that increased familiarity can result in more positive attitudes and behaviour towards service users (Chapters 2, 5, 6). This finding is in line with research of Pelleboer-Gunnink et al. (2021a, 2021b) on stigma towards people with intellectual disabilities. The authors found that more familiarity with people with intellectual disabilities predicted more positive attitudes and lower levels of fear towards them. In turn, lower levels of fear were associated with reduced discrimination. Increasing familiarity with people with mild intellectual disabilities and severe CB (i.e., unfamiliarity with service users' limited intellectual functioning and adaptive behaviour, their history and co-occurring psychopathology, and the influence of the context on CB) therefore seems important. Greater familiarity of the public and professionals with people with mild intellectual disabilities and CB may make them more likely to adopt a risk-enabling attitude. That would open up more opportunities for service users to participate in the community (Carr, 2011; Wiesel et al., 2020).

Strengths, limitations and directions for future research

This thesis consists of studies with different research designs (quantitative, qualitative, mixed-method) and various data collection methods (formal semi-structured interviews and informal unstructured interviews, focus groups, non-participant observations, self-report questionnaires, document analysis). In addition, an integrative approach was used, combining the perspectives of Pro services users, Pro professionals in various roles (from support staff to board members) and external stakeholders of Pro residential facilities (i.e., the police and municipality). Including the voices of people with mild intellectual disabilities and severe CB on what is important in the operationalisation of Pro principles is important, as they are the ones who are directly affected by how the principles are operationalised. Based on their experiences, they may highlight other aspects than professionals (van den Bogaard, 2019; McDonald et al., 2016). Service users in Chapter 2, for example, indicated that it is of value for service users that there be extra support staff on hand when a new service user arrives, to help them deal with any tensions and to help them get to know each other. This aspect was not mentioned by professionals.

Despite these strengths, there were also some limitations that should be addressed. First, the studies in this thesis were conducted in the context of Pro with the participation of three residential facilities (next to two care administration offices and the Centre for Consultation and Expertise). Therefore, their values and beliefs have played a prominent role in the results. Had data been collected at other residential facilities, other results may have been found, for example with respect to how residential facilities promote service users' sense of safety. Nevertheless, the studies do reflect the perspectives and experiences of three different residential facilities that operationalised the Pro principles in their own way, in alignment with their own organisational vision, procedures and context. In practice, this means for example that Pro residential facilities all focus on providing as ordinary a life as possible with meaningful activities and meaningful relationships, albeit with differences in how these are organised. Differences relate, amongst others, to individualised versus group programmes and to the location of work activities (at or outside the premises of the residential facility). Further, residential facilities have no uniform way in which they provide training, coaching and reflection opportunities. In future research it would be interesting to explore if these differences in operationalisation affect outcomes at the level of service users, professionals and the organisation. For example, quality of life outcomes such as interpersonal relations, emotional well-being, social inclusion, and self-determination might be compared between service users who are supported via a group versus an individualised approach.

Second, insights into the operationalisation of attention to staff's well-being and competency development concerned almost exclusively support staff. Chapter 3

addressed support staff's experienced support, and Chapters 2, 4, and 5 described how other team members, team leaders, managers, and psychologists provided or can provide a supportive context. However, in order for team leaders, managers and psychologists to provide a supportive context to support staff, they themselves also need to be well-supported. Studies in the intellectual disabilities field have explored the experiences of front-line managers (i.e., team leaders) in providing practice leadership (Deveau & Rickard, 2024; Rickard & Deveau, 2024), senior managers' views of their activities and their relationships with staff practice and experience (Deveau et al., 2020), and psychologists' experiences of working with staff in residential care homes (Stenfert Kroese & Smith, 2018). Research on their perceived support and their perceived ability to provide support (e.g., whether they feel competent, resilient, facilitated) appears to be lacking though. Future research could contribute by further examining this topic and exploring how support to team leaders, managers and psychologists can be optimised.

Third, this thesis does not include a study presenting results of a longitudinal quantitative study of Pro. In the initial phase of Pro, a mixed-method longitudinal study with four repeated measures on a range of outcomes measures was started among Pro service users and Pro professionals (support staff, team leaders, managers, psychologists). However, there were a significant number of missing data. Due to this high amount of missing data in combination with the relatively small number of service users and professionals involved in Pro, it was not possible to perform thorough quantitative analyses. Nevertheless, a Dutch fact sheet is in preparation with more details on the longitudinal study to Pro study and a reflection on the results (Lokman et al., 2024).

Still, it would be productive for future research to gain insight into long-term results of support delivered via Pro principles. As longitudinal research in this context is likely to involve substantial non-response because of characteristics of service users (co-occurring psychopathology, CB) and high staff turnover, we recommend taking such contextual aspects into account while making decisions on a research study design. To recruit and retain service users in future (mixed-method) case studies research, it would be advisable to offer incentives (McDonald et al., 2016). In addition, we recommend to keep questionnaires short by selecting measures that can be filled out quickly (de Leeuw & Lugtig, 2015). Short questionnaires could also be collected more frequently, thereby minimising recall bias. This is important, because for participants in general, but particularly for individuals with mild intellectual disabilities or borderline intellectual it can be difficult to think abstractly and to retrospect before answering (Hulsmans et al., 2023). For example, ecological momentary assessment could be used. In this method, experiences and behaviours of participants are frequently measured over time through short questionnaires (Hulsmans et al., 2023; Shiffman et al., 2008). In addition, we recommend collecting longitudinal qualitative data from service users. To that end,

qualitative surveys consisting of a series of open-ended questions could be used (Braun et al., 2021).

Fourth, in the studies described in Chapters 2, 4, and 6 the number of participants in some groups were limited. In the concept mapping study in Chapter 2, this related to professionals, in Chapter 4 to service users, and in Chapter 6 to external stakeholders. The small numbers are primarily a consequence of staff turnover, the presence of psychopathology in service users and postponement of data collection in response to COVID-19. In addition, the study designs of this thesis concentrated on project Pro, which concerns only three residential facilities, six residential homes, and 24 service users. In other words, the limited number of participants was to a large extent due to external, non-modifiable factors. Additional research on safety among service users and safe community participation among external stakeholders would be valuable to support and complement the findings in this thesis.

Fifth, the perspective of family members was not included in this thesis. The research questions of the studies concentrated on the operationalisation of the Pro principles. While family members are often not directly involved in the operationalisation, we did not include them as participants, even though positive family relationships have been identified as very valuable to service users (Clarke et al., 2019; Giesbers, 2020; Tournier, 2021). Meanwhile, relationships between service users and their family members may be disturbed because of service users' CB, and feelings of safety of family members might play a role in their attitude and willingness to restore relationships. To that end, gaining insight into the perspectives of family members about their and service users' sense of safety, and the role of safety aspects in their mutual relationship, would be a welcome development. Furthermore, future research could include other external stakeholders other than the police and municipality (as in Chapter 6), like the public, government, and employers.. In particular, more research among external stakeholders is warranted while the external environment affects service users' feelings of safety through the extent to which they feel accepted and can establish a normal daily life (Chapter 4). So far, aspects in the external environment have been identified as playing a role in CB of people with mild intellectual disabilities (Olivier-Pijpers, 2020), but research concentrating on the external environment of residential facilities is lacking.

Implications for policy and practice

Several implications for policy and practice can be derived from the findings in this thesis.

Creating psychological safety and a learning climate

Residential facilities that provide care and support to people with mild intellectual disabilities and severe CB should aim for an organisational climate in which professionals feel free to discuss problems or mistakes, insecurities and diminished mental well-being. Such a work climate that reflects psychological safety enhances stability in support and feelings of safety. It contributes to a learning climate, which residential facilities should also aim for (Bigby & Beadle-Brown, 2016; Newman et al., 2017). A climate with openness to outsiders and new ideas may contribute to the willingness of residential facilities to try new approaches, for example regarding CB management. In turn, this could increase their self-efficacy in dealing with service users' severe CB, thereby possibly preventing severe CB and transfers.

Professionals in leadership roles, such as board members, managing directors, managers, and team leaders, can contribute to psychological safety and a learning climate: they could contribute by positive role modelling, by being open about their own mistakes, by being non-judgmental in case of mistakes by others, and by actively creating opportunities for staff members to engage in activities to individually and socially learn from errors (e.g., joint evaluations of errors) (Buljac-Samardžic et al., 2012; Dekker, 2009; Hartman et al., 2020; Smeets et al., 2021). For example, they can enhance safe debriefings by being clear and setting the appropriate tone during meetings (Kolbe et al., 2020). Professionals in leadership roles could also clearly communicate on the importance of treating each other fairly in a team setting (Li & Bagger, 2013). Support staff members could enhance psychological safety and a learning climate by engaging in critical self-evaluation. They should be self-reflective in how they provide support and give feedback to other team members.

Furthermore, the external environment of residential facilities should become more aware of its impact on the work climate at the facilities. When stakeholders in the external environment (e.g., media, healthcare regulators, municipalities) raise questions after CB incidents about the approaches or competencies of professionals in residential facilities, support staff may be more inclined to take a controlling support style (van Baarle et al., 2022; Hartman et al., 2020; Olivier-Pijpers et al., 2019; Weenink et al., 2022). In addition, healthcare regulators who monitor and oversee quality and safety of care should adopt regulatory procedures (e.g., the forms used and questions asked) that support residential facilities to reflect and learn (Weenink et al., 2022).

Attracting and retaining support staff

Chapters 2, 4, and 5 underscored results from previous research on the importance of retaining staff for both service users and support staff, particularly in support of people with mild intellectual disabilities and severe CB. It fosters stability in support, service

users' and support staff's feelings of safety, and team climate. It should therefore remain a high priority of residential facilities, even though staff turnover complicates its realisation (Knotter et al., 2016, 2018; Neimeijer, 2021; Olivier-Pijpers, 2020; Sollied et al., 2023). To increase the chances that new staff will be willing and able to be part of the team for a longer period of time, it is important that their expectations, knowledge, attitude and competencies align with the work they are going to do (Deveau & Rickard, 2024; Hensel et al., 2015; Hermsen & Embregts, 2015; Olivier-Pijpers et al., 2018). This means that knowledge about people with mild intellectual disabilities and CB should be integrated in education for new staff, including knowledge about adverse childhood experiences, psychopathology, and the development and persistence of CB. Moreover, students should experience what the job entails and acquaint themselves with service users during their education (e.g., job shadowing) (Hermsen & Embregts, 2015).

To retain new support staff members, residential services should include a well-designed on-boarding program that consists of a comprehensive and structured introduction to the organisation, its values and its culture (Peters et al., 2024). In general, it is important for residential services to provide a supportive context with continuing training, coaching, and supervision in order to enhance support staff's competencies (e.g., self-confidence, emotion-regulation), well-being and job satisfaction (Denne et al., 2015; Peters et al., 2024; Wilson-Fall & Taylor-Cook). Perceived support may differ from received support (Eagle et al., 2019), therefore residential services should assess each staff member's support needs and monitor whether a context is being perceived as supportive. To gain insight into what type of support is valued by whom or needs improvement, it might be worthwhile to have support staff regularly evaluate how they perceive support from team leaders, managers, psychologists and other staff members in their team (Li & Bagger, 2013). In coaching support staff, it appears of added value to have a position like a team leader, who is involved in the frontline of service delivery, and can promote a positive team climate, including mutual support between staff members (Bigby et al., 2020; Buljac-Samardžic et al., 2012). In turn, support from other team members and a positive team climate can enhance team stability. When setting up a new team or in case of high staff turnover, it is therefore essential to make time and arrange activities so that staff members can get to know each other well.

In this thesis as well as in previous research, the importance of pay to retain staff was also addressed (Murray et al., 2022; Stevens et al., 2021). Murray et al. (2022) identified the relationship of support staff with service users as the most important factor. While reasons to stay in their jobs vary between support staff members, residential facilities might consider adopting more tailored approaches to retain staff, aligned to individual priorities (Murray et al., 2022).

Investing in relationships between residential facilities and external stakeholders

In line with previous research, this thesis points to the importance of residential facilities and external stakeholders (e.g., the police, municipality, employers) to further strengthen their mutual relationships (Raggi et al., 2013; Viljoen et al., 2017). To facilitate a strong collaboration, we recommend that the police explore on a national level with the appointment of special officers who are concerned with care and safety. The extra time and resources involved for these appointed police officers might be compensated by the various positive effects encountered (e.g., improved processes, more feelings of safety).

It is also recommended that residential facilities and the judiciary strengthen their relationships, as this can have positive effects on the provision of unconditionality. As reported in Chapter 5, the Pro residential facilities provide unconditionality within the boundaries of the law. When they create awareness among law enforcement officers about the importance of providing unconditionality, it seems more likely that service users with mild intellectual disabilities and severe CB will experience such unconditionality (i.e., in the law enforcement officers' approach) while staying in judicial settings. Moreover, residential facilities could share knowledge about service users with severe CB and the importance of unconditionality at the level of judges to help the legal process become therapeutic (Raggi et al., 2013). In turn, judges may be more inclined to refrain from detention under hospital order with yet another transfer when deciding upon sentencing.

Improving familiarity with people with mild intellectual disabilities and severe CB

The findings of this thesis imply that more familiarity with people with mild intellectual disabilities and severe CB should be achieved – that is, more familiarity among the public and professionals in various settings could increase the feelings of safety and quality of life of these service users. To that end, it would be useful to further integrate knowledge about mild intellectual disabilities and severe CB in education (e.g., in social care, care and welfare) (Kármán et al., 2022). People with mild intellectual disabilities and severe CB or close relatives might be involved as experts-by-experience to share their world, and make others (e.g., external stakeholders) understand their perspectives (Embregts & Frielink, 2023; Pelleboer-Gunnink et al., 2017). Involving experts-by-experience would particularly be valuable, because direct contact has shown to be an effective method in reducing negative attitudes and prejudice about people with intellectual disabilities and people with serious mental illnesses (Corrigan et al., 2012; Kármán et al., 2022).

It is also suggested that residential facilities consider an active role for experts-by-experience to increase familiarity among professionals. At *all* organisational levels,

professionals should become familiar with people with mild intellectual disabilities and severe CB, while unfamiliarity may lead to rumours and a lack of mutual support for staff working with these service users. It is likewise recommended that teams working with service users with severe CB invite other professionals to their residential home and team meetings. Sharing knowledge about service users and the role of the context in which CB is displayed, or inviting other professionals to the residential home, may also lead to more familiarity.

Conclusions

In this thesis, we aimed to gain more insight into what is important in bringing the Pro principles into practice. From the first three studies we could identify various aspects, such as being well-prepared (e.g., getting to know service and other staff members before service users arrive), a positive team climate, team safety, mutual support, a stable staff team and a strong commitment to a shared vision. In addition, the aim was to explore how the Pro principles are operationalised, while looking in more detail at safety aspects inside and outside Pro residential facilities. To this end, unconditionality and close relationships at various levels within residential facilities and with external stakeholders were highlighted. Pro residential facilities appeared to focus on many aspects that were also deemed to be important. However, because of a dynamic and challenging environment, Pro residential facilities were not able to continuously fulfil all preconditions and deliver the work they intended to. Gaining knowledge about the approach of other organisations in dealing with complexities and challenges can help build resilience in these attempts. Despite the complexities and challenges, particularly when it concerns people with mild intellectual disabilities and severe CB, towards optimal support it is recommended to deliver support unconditional, contextual and safe.

Follow-up on David

David's last transfer was five years ago, so he has now been living at the current residential facility much longer than in other places he stayed. The transfer proceeded smoothly at the time. David spent a few moments together with his support staff member before he moved. It was nice to have him as a familiar person around when he arrived at his new home, because he felt rather tense and insecure.

Although it is David's wish to live on his own, he quite likes his current home. He has many activities to do, including work activities. During the first years those activities were boring, like picking up waste or folding tea bags. However, now his job is much more fun. David does

dismantling and demolition work, together with people from other residential homes. After work, he regularly goes for a walk on his own, or does activities with other residents, like going to the gym.

David finds the continuous changes in support staff members difficult. It is hard to say goodbye over and over again to staff members whom you like and can talk to. And yet, he has no other choice but to accept it. David's relationship with his mum has improved a bit, but she still keeps him at a distance. They do call once a week, and David visits his mum every month. David hopes he can visit her more frequently in the future, when his mum notices that he keeps on showing progress. Maybe then, she can be a little bit proud of him.

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Scientific summary

Some people with mild intellectual disabilities or borderline intellectual functioning[4] who have co-occurring psychopathology and severe challenging behaviour (CB) face a vicious cycle: inadequate support leads to an escalation in their CB, which, in turn, results in repeated transfers between (forensic) healthcare services or even detention in some instances. This accumulation of profound life experiences leads to feelings of despair and makes them less confident that they will live a positive life in the future. Against this backdrop, this thesis focuses on the question of how residential services and their external stakeholders can foster a supportive context that improves the quality of life of people with mild intellectual disabilities and severe CB and, in so doing, prevents transfers.

The study was embedded within project Pro, which is a collaboration between three residential facilities for people with mild intellectual disabilities and CB (ASVZ, Pluryn, and Trajectum), two care administration offices (VGZ and Zilveren Kruis) and the Centre for Consultation and Expertise (CCE). In this project, which launched in 2017 with funding from the Dutch Ministry of Health, Welfare, and Sports, specialised housing was created for 24 people with mild intellectual disabilities and severe CB who at that time were in a situation that offered little to no hope of improvement, due to both strong restrictions upon their freedom and the inability of the healthcare provider to act.

Within the project, guiding principles were formulated with the aim of improving the quality of life of this target group. The present thesis explores, firstly, what is important in bringing the Pro principles into practice, and secondly, how residential facilities operationalise the principles. In this regard, specific attention is paid to the theme of safety, with respect to both service users and professionals in residential facilities but also society at large.

Chapter 1

The general introduction in chapter 1 describes the characteristics of people with mild intellectual disabilities and severe CB, the main difficulties in providing adequate care, and the principles of Pro.

People with mild intellectual disabilities and severe challenging behaviour

People with mild intellectual disabilities and severe CB often grow up feeling unsafe as a result of adverse childhood experiences, including abuse, neglect, violence and/or having parents with an addiction or mental illness. As a result of these adverse childhood

4 Henceforth referred to as mild intellectual disabilities.

experiences and other risk factors, many people with mild intellectual disabilities are more likely to have comorbid psychopathology, like addiction problems, impulse control disorders, personality disorders, psychoses, and post-traumatic stress disorders. In addition, prior negative experiences with healthcare and local authorities can also affect their sense of feeling safe. Their intellectual disability often goes unnoticed for a long time, which, in turn, often results in care and support that does not sufficiently align with their individual needs. This misalignment regularly leads to frequent transfers. Furthermore, they often face financial problems, debt, and have repeated encounters with the police, which frequently leads to prison sentences and criminal or civil measures upon admission.

This chapter also addresses both the meaning and emergence of (severe) CB. Behaviour can be classified as severely challenging when the individual and/or others consider externalising and/or internalising behaviour within a specific social-cultural context as being inappropriate, and when the frequency, duration, and/or the times at which the behaviour occurs is such that it leads to significant disadvantages or dangers for the person themselves, for those involved, and/or for society more broadly. Examples of externalising behaviours are verbal or physical aggression, whilst internalising behaviour can take the form of self-injurious behaviour or suicidal behaviour. CB is understood as deriving from a complex interplay of biopsychosocial, developmental, and environmental factors. Amongst other factors, adverse childhood experiences, psychopathology, and a lack of adequate support may play a role in CB.

Difficulties in providing a context that meets individuals' support needs

In the Netherlands, most people with mild intellectual disabilities and severe CB receive long-term care. Care and support are generally provided by residential facilities for people with intellectual disabilities, either within (secure) forensic or mental healthcare settings or at home through flexible assertive community treatment teams (FACT). Meeting the support needs of service users who require these types of care is difficult in a number of respects. These challenges are due, in part, to the fact that they have complex care needs, insofar as they require care that lies at the intersection of mild intellectual disabilities, severe CB, and psychiatric disorders. Consequently, the care they receive is often inadequate and characterised by incorrect diagnoses. Alongside these difficulties, it is also complex to manage CB adequately. Both organisational procedures or the negative emotions of professionals (such as fear and anger) can lead to a risk-oriented support style, which includes the use of restrictive measures. As a result, people with mild intellectual disabilities and severe CB can experience a loss of perspective over a positive future and experience a sense of despair.

There are also challenges at the organisational level. These manifest in interactions between service users and staff, in the interactions between people around service users (such as interactions between staff and family), in the organisational context (such as high staff turnover rates), and in interactions with the environment outside the organisation (such as difficulties in the collaboration with other healthcare providers, which is necessary to deal with the complex multiple problems of service users).

As such, care facilities do not always succeed in providing optimal care and support in practice. In the event that facilities consider themselves to be insufficiently capable of providing care and support, service users with mild intellectual disabilities and severe CB are often transferred to other more restricted (forensic) facilities. Some service users have experienced this process repeatedly, which results in them losing trust in professionals and hope for a better future.

Project Pro

Project Pro was initiated with the purpose of improving the quality of life of people with mild intellectual disabilities and severe CB who are repeatedly transferred. To this end, eight principles were formulated. Six are focused on service users and involve the provision of unconditionality within the support relationship, and in terms of housing, a context that meet service users' needs, a "life as ordinary as possible", and the development of (self-)confidence. The seventh principle concerns special attention to both the well-being and competency development of staff members. The last principle relates to a shared responsibility to incorporate Pro care within practice, specifically in terms of content, support and cooperation between all positions and board members.

Outline of the thesis

In order to explore both what is important in bringing the Pro principles into practice and how residential facilities operationalise these principles, five specific research questions were formulated. The studies that address these specific questions are described in chapters 2 to 6.

Chapter 2

Chapter 2 presents a concept mapping study that examines what is important when setting up a new team of support staff to work in a new residential home for people with mild intellectual disabilities, psychopathology and severe CB, with a particular focus on contextual factors. Within Pro, the perspectives were gathered from eleven services users, six support staff members, and six professionals supporting staff (five psychologists, one team leader). All of the participating professionals had been involved in Pro since the

start of the project, with one exception: a professional who had been working at Pro for more than a year. All of the participating service users had been living at a Pro home for a period of at least six months.

All three of the participant groups highlighted aspects related to relationships, including specific characteristics that support staff should have (e.g., experience, self-confidence, and the ability to regulate their emotions). However, the groups differed with respect to which relationship was the principal focus. For the service users, the focus was primarily on relationships between service users and support staff (microsystem), whilst for the support staff it was about their mutual relationships and their relationships with professionals supporting a team (mesosystem), and for the psychologists and team leader the focus was on relationships at the level of the microsystem, mesosystem, and exosystem (for example, interactions between support staff and managing directors).

Overall, four main outcomes were identified as being important. First, it was stressed that service users and support staff should get to know each other before the service user is relocated to a new home. Second, support staff place significant value upon team safety. To that end, they must be able to rely upon each other and provide support in a consistent manner, based on shared values and principles. Finally, it appeared of relevance to provide a realistic and positive view of service users with mild intellectual disabilities and severe CB within the new residential home. This is because rumours whereby CB is taken out of context can lead to the stigmatisation of service users and discourage new support staff from wanting to work at the residential home.

Chapter 3

This chapter concerns a qualitative study that sought to understand support staff members' experiences of support at work and their team climate. This involved their perceptions of the support they received from team leaders, managers, psychologists, and other staff members. Specifically, we examined, on the one hand, the association between these variables and team climate, and on the other hand, support staff members' well-being and job satisfaction. In addition, we tested two hypotheses: that more positive mutual collaboration between professionals around a team (team leaders, managers, and psychologists) leads to higher levels of perceived support (hypothesis 1), and a more positive team climate (hypothesis 2). In total, 201 staff members from 32 teams and ten residential facilities for people with intellectual disabilities completed an online questionnaire. Furthermore, 61 professionals around the teams answered questions about their mutual collaboration. Within nine teams, the position of team leader or a similar function was absent; in these cases, only managers and psychologists

who acted as professionals around teams were invited to participate. Around one-fifth of the participants were working in Pro.

On average, support staff assigned the highest ratings to the support they received from other staff members in their teams. The perceived support from other staff members and team climate were found to be higher in those teams who had a team leader compared to those without team leaders. The study therefore confirmed the positive impact of team leaders or professionals in a similar position who are working close to the frontline of service delivery.

The perceived support from team leaders, managers, psychologists, other staff members, and team climate was found to have only a small to moderate positive significant association with job satisfaction. More perceived support from team leaders, psychologists, other staff members, and team climate were also shown to be related to greater well-being. In particular, positive relations were found for support from other staff members, and team climate. The expectations that more positive mutual collaboration between professionals around a team (team leaders, managers, and psychologists) leads to higher levels of perceived support (hypothesis 1), and a more positive team climate (hypothesis 2) were not confirmed by the data. In conclusion, the results stress the importance of residential facilities investing in support for staff and fostering a positive team climate to promote staff well-being and job satisfaction.

Chapter 4

The study in chapter 4 was qualitative in nature and explored the theme of safety. Service users (N = 4) and professionals in various positions (N = 64), who were either all living or working at Pro organisations, were asked what "feeling safe" means for people with mild intellectual disabilities and severe CB living in a residential facility. In addition, factors affecting their feelings of safety were also identified. To that end, first data from ethnographic longitudinal research on Pro (based on informal interviews, non-participating observations, and document analysis) were thematically analysed. Next, these themes (factors) were validated during interviews and focus groups with four service users, forty-two support staff members from six teams, a team leader, four managers, six psychologists, two managing directors, and three board members. The interviews and focus groups also served to answer the research question what "feeling safe" means for people with mild intellectual disabilities and severe CB.

A thematic analysis of the meaning of "feeling safe" resulted in three themes: (1) a physical environment that reduces risks and temptations; (2) a reliable, predictable, and

supportive environment that service users have confidence in, and (3) an accepting environment that enables service users to establish a normal daily life. The participants primarily referred to what promotes a sense of safety rather than solely focusing on preventing risks.

The analysis of the factors affecting feelings of safety of people with mild intellectual disabilities and severe CB generated 20 themes, and 23 subthemes. These themes applied to various levels: (1) Characteristics and behaviour of service users and others within their living environment; (2) Characteristics, behaviour and knowledge of individual staff members; (3) Characteristics and behaviour of the team of support staff; (4) Perceptions, policies and practices of the organisation; and (5) Perceptions and behaviour of the external environment of residential service organisations. The results showed that factors at these levels can affect each other. Furthermore, the interrelationship between service users' sense of safety and that of support staff was also underscored.

Chapter 5

The qualitative study discussed in chapter 5 built upon the theme of safety and explored what residential facilities for people with mild intellectual disabilities and severe CB do to promote feelings of safety amongst their service users. Data were collected through ethnographic longitudinal research on Pro, which was complemented by interviews and focus groups amongst Pro professionals working within various roles (from support staff to board members) (see also chapter 4). A thematic analysis of the resulting data yielded three main themes: (1) All levels of the organisation subscribe to the vision of providing unconditional support through, for example, mutual support between professionals across all levels; (2) Providing stability to both teams and support within a dynamic environment by, for example, establishing a positive team climate; (3) Striving to give service users as normal a life as possible by, for example, providing them with a private, homely living environment.

The study showed that the negative emotions and perceptions of both support staff and other professionals within organisations can hinder the provision of unconditional support. According to the participants, these negative views often stem from fear and unfamiliarity with both Pro and its service users. Moreover, the study underscored the value of exploring the actual work that is carried out, rather than focusing on the work that should be done. Care and support for people with mild intellectual disabilities and severe CB is characterised by an ever-changing set of challenging circumstances. Therefore, it is valuable to gain insight into how residential facilities demonstrate resilience, and learn from that in future practice.

Chapter 6

Chapter 6 explores what residential facilities for people with intellectual disabilities and their external stakeholders do to promote safe community participation by people with mild intellectual disabilities and severe CB, with particular focus on the feelings of safety of both service users and their environment. Interviews and focus groups were conducted with 64 Pro professionals, ranging from support staff members to board members. In addition, four external stakeholders took part in an interview: three of these people worked at the police, and one worked at the municipality.

The first main theme generated from the thematic analysis concerned taking risks responsibly together. On the one hand, this refers to the fact that care professionals in various roles need to collaboratively identify risks, assess them, and determine which risks are acceptable. Depending on the specific residential facility, the police may also be consulted in this process. On the other hand, it is about managing risks together by, for example, adopting a step-by-step approach in which service users' activities and independence are expanded in small steps.

The second main theme pertained to changing perceptions and attitudes. For example, care professionals and stakeholders inform the public about people with mild intellectual disabilities and severe CB, which they believe leads to greater familiarity and a reduced sense of unsafety in the case of unusual behaviour. At the same time, stakeholders also aim to change the perceptions of care professionals. They stated that they believe it is important that residential facilities set limits regarding the acceptability of service users' behaviour in order to prevent serious incidents. However, they perceived reluctance amongst care professionals to press charges after CB.

Overall, the relevance of relational work was identified, namely the importance of strong cooperation between residential facilities and stakeholders and connecting with the general public.

Chapter 7

Finally, the general discussion in chapter 7 provides a summary of the key findings of this thesis, suggests avenues for future research, and presents the implications for policy and practice. The three key overarching findings are as follows:

1. The necessity of a strong commitment to the vision at all levels of the organisation

In line with extant literature, this thesis highlights the importance of unconditionality and focusing on service users' needs. However, the frequent transfers of people with mild intellectual disabilities and severe CB indicates that adhering to these principles in practice can be challenging. This thesis demonstrates that committing to the vision across all levels is essential for incorporating Pro principles within practice. Within the Pro organisations, this was realised through, amongst other things, embedding the principles within policies and procedures, and by regularly monitoring and reflecting upon its realisation. However, there were situations within Pro where full commitment was lacking (for example, amongst support staff and facility services). These situations in which the operationalisation of the principles came under pressure serve to underscore the importance of a strong commitment at all levels of the organisation.

2. Investing in relationships is key to providing feelings of safety

At various levels, investing in relationships can promote a sense of safety, both for people with mild intellectual disabilities and severe CB, and within their environment. This thesis demonstrates that investing in relationships between service users and support staff helps to increase service users' feelings of safety. In order for service users to feel safe, it is vitally important that support staff also feel safe. Team leaders, managers, and psychologists can contribute towards this by investing in relationships with support staff through both close involvement and the provision of instrumental and emotional forms of support. Furthermore, other staff members also have a pivotal role to play with respect to ensuring that support staff feel safe. Support staff value colleagues who keep to the agreed arrangements and set boundaries, and contribute towards a safe team climate. Therefore, investing in cultivating a positive team climate and team processes promotes support staff feeling safe at work. Finally, investing in relationships between residential facilities and their external stakeholders fosters a sense of safety amongst service users and within their environment. Strengthened collaboration results in improved procedures for managing risks with regard to community participation by service users with mild intellectual disabilities and severe CB.

3. Impact of negative views and a lack of familiarity with people with mild intellectual disabilities and severe challenging behaviour on their quality of life

In several studies, both negative views towards and a general lack of familiarity with Pro service users were addressed, both inside and outside of the residential facilities. This had both direct and indirect negative consequences for service users. Outside of residential facilities, it included a lack of familiarity amongst the public, which, in turn, reduces service users' sense of safety and participation within the community. Unfamiliarity was also observed within residential organisations, including amongst support staff from

other residential homes and support services, which, in turn, led them to be reluctant to either provide support in instances of CB or work at Pro residential homes.

Strengths, limitations, and suggestions for future research

A key strength of this thesis is the integrative approach that was adopted, which combines the perspectives of service users, professionals in various roles, and external stakeholders of Pro residential facilities (such as the police and municipality). Including the perspectives of people with mild intellectual disabilities and severe CB is also valuable, because they are the target group and can provide meaningful insights based on their own experiences.

The first limitation of this thesis is that all of the studies were conducted within the context of Pro, which means that their values and beliefs play a prominent role in the results. At the same time, Pro involves three different residential facilities, that operationalise the Pro principles in different ways. In future research, it would be interesting to explore both if and how these differences affect outcomes at the level of service users, professionals, and the organisation.

A second limitation pertains to the focus on the well-being and competency development (Pro principle) of staff members, which concerned almost exclusively support staff. Team leaders, managers, and psychologists also play an important role in supporting teams, and therefore, future research should explore what residential facilities can do to optimise the perceived support and competence development of these professionals.

The third limitation concerns the fact that this thesis does not include a study presenting results from a longitudinal quantitative study of Pro which would enable an assessment of the long-term outcomes of Pro and the factors (service users, support staff, others) that positively or negatively influence these outcomes. Although a longitudinal mixed-method study was conducted, it proved difficult to conduct thorough quantitative analyses due to the significant amount of missing data. Future research into the long-term results of support delivered via Pro principles would be valuable, with particular attention to the context of the research, such as service users' characteristics and staff turnover rates.

Finally, the perspectives of family members were not included in this thesis. Although they are often not directly involved in the operationalisation of the Pro principles, positive family relationships have been identified as being very valuable to service users. Whilst these relationships are often disturbed, future research into the role of safety in the relationship between service users and family members could be interesting.

Implications

Several implications can be derived from the findings of this thesis. First, it is important for residential facilities that provide care and support to people with mild intellectual disabilities and severe CB to cultivate an open and safe climate. This means that professionals should feel free to discuss their mistakes, insecurities, and vulnerabilities, insofar as this contributes towards both stability in support provision and feelings of safety. Professionals in leadership roles can promote an open and safe climate by demonstrating exemplary behaviour, such as being open about mistakes and responding in a non-judgmental manner. Support staff can also contribute towards a positive team climate by reflecting upon the way they support and provide feedback to other staff members.

Second, this thesis demonstrates the necessity for residential facilities to prioritise the retention of support staff for people with mild intellectual disabilities and severe CB. Team stability fosters stability in support and feelings of safety amongst both service users and support staff. It is therefore vitally important that support staff start their job feeling well-prepared, and that greater attention be paid to education and training in the knowledge and skills that are required for working with people with mild intellectual disabilities and severe CB. In addition, residential facilities should align their support with individual support staff members' needs and regularly monitor how they perceive the support they receive from different professionals at work.

Third, this thesis underscores the value of strengthened relationships between residential facilities and their external stakeholders, such as the police and municipality. One recommendation would be to explore this on a national level by appointing special officers who are concerned with care and safety. Moreover, the collaboration between residential facilities and the judiciary could also be enhanced, in order to maintain unconditional support within judicial settings.

Finally, the findings of this thesis suggest that it is important that both the general public and professionals within various settings familiarise themselves more with people with mild intellectual disabilities and severe CB. This could increase both feelings of safety and the quality of life of people with mild intellectual disabilities and severe CB. Indeed, people with mild intellectual disabilities and severe CB or their close relatives could be involved as experts-by-experience in order to make an active contribution towards increasing people's level of familiarity with them and sharing their unique perspectives and experiences.

Conclusions

In bringing the Pro principles into practice, amongst other things, it is important to prepare properly (for example, ensuring that there is an initial introduction between clients and support staff prior to the service user being placed there), cultivate a safe and positive team climate, engage in mutual support, ensure stability within teams, and foster a strong commitment towards a shared vision. Although providing care and support to people with mild intellectual disabilities and severe CB is complex and challenging, it nevertheless remains essential to ensure that this care and support is predicated on unconditionality, a contextual approach, and safety.

Wetenschappelijke samenvatting

Een deel van de mensen met een licht verstandelijke beperking of zwakbegaafdheid, in combinatie met psychische problematiek en ernstige gedragsproblemen (LVB+), zit in een vicieuze cirkel: ontoereikende ondersteuning leidt tot escalatie van gedragsproblemen, wat resulteert in herhaalde overplaatsingen tussen (forensische) zorginstellingen of zelfs detentie. Deze opeenstapeling van ingrijpende ervaringen veroorzaakt gevoelens van wanhoop en verlies van toekomstperspectief. Tegen deze achtergrond staat in dit proefschrift de vraag centraal hoe residentiële zorgorganisaties en hun externe stakeholders een ondersteunende context kunnen creëren die de kwaliteit van leven van mensen met LVB+ bevordert en overplaatsingen helpt voorkomen.

De studie was ingebed in het project Pro, een samenwerkingsverband tussen drie organisaties die residentiële zorg bieden aan mensen met LVB+ (ASVZ, Pluryn en Trajectum), twee zorgkantoren (VGZ en Zilveren Kruis) en het Centrum voor Consultatie en Expertise (CCE). In dit project, dat in 2017 werd gestart met steun van het ministerie van VWS, zijn 24 gespecialiseerde woonplekken gerealiseerd voor mensen met LVB+ die zich in een situatie bevinden zonder uitzicht op verbetering door sterke vrijheidsbeperkingen en handelingsverlegenheid binnen de huidige zorgomgeving.

Binnen het project zijn uitgangspunten geformuleerd die richting geven aan het verbeteren van de kwaliteit van leven van deze doelgroep. In dit proefschrift wordt onderzocht wat belangrijk is bij het realiseren van deze uitgangspunten in de praktijk, en wat zorgorganisaties doen om deze toe te passen. Daarbij is er specifieke aandacht voor het thema veiligheid – zowel voor cliënten en medewerkers binnen zorgorganisaties als de maatschappij.

Hoofdstuk 1

De algemene inleiding in Hoofdstuk 1 beschrijft kenmerken van mensen met LVB+, uitdagingen in het bieden van adequate zorg en de uitgangspunten van Pro.

Mensen met LVB+

Mensen met LVB+ groeien vaak op in een onveilige situatie door negatieve jeugdervaringen, zoals misbruik, verwaarlozing, geweld en/of ouders met een verslaving of psychische problematiek. Deze ervaringen en andere risicofactoren vergroten de kans op bijkomende psychische problematiek, zoals verslavingsproblemen, impulsstoornissen, persoonlijkheidsstoornissen, psychoses en/of posttraumatische stressstoornissen. Negatieve ervaringen met de hulpverlening en lokale autoriteiten kunnen daarnaast hun gevoel van veiligheid beïnvloeden. Vaak wordt hun verstandelijke beperking te laat herkend, waardoor de zorg en ondersteuning niet aansluit bij wat zij nodig hebben. Dit

leidt regelmatig tot herhaalde overplaatsingen. Daarnaast hebben zij vaak financiële problemen en regelmatig contact met de politie, wat kan uitlopen op gevangenisstraf of civielrechtelijke dan wel strafrechtelijke maatregelen.

Het hoofdstuk gaat ook in op de betekenis en het ontstaan van (ernstig) probleemgedrag. Van ernstig probleemgedrag is sprake wanneer internaliserend en/of externaliserend gedrag door de persoon zelf en/of de omgeving in een specifieke context als sociaal-cultureel ongewenst wordt gezien, en waarbij de frequentie, duur en/of momenten waarop het gedrag voorkomt zodanig is dat er grote nadelen of gevaar ontstaan voor de persoon zelf, voor betrokkenen en/of de samenleving. Voorbeelden van externaliserend gedrag zijn verbale of fysieke agressie. Internaliserend probleemgedrag kan zich uiten in zelfverwondend of suïcidaal gedrag. Probleemgedrag wordt beschouwd als het resultaat van een complex samenspel van bio-psychologische, ontwikkelings- en omgevingsfactoren. Onder andere negatieve jeugdervaringen, psychische problematiek en een gebrek aan adequate ondersteuning spelen hierbij een rol.

Uitdagingen in het bieden van een context die aansluit bij behoeften

In Nederland ontvangen de meeste mensen met LVB+ langdurige zorg. Begeleiding en behandeling vinden over het algemeen plaats in residentiële zorgorganisaties voor mensen met een verstandelijke beperking, in (gesloten) forensische of psychiatrische klinieken, of thuis via FACT LVB. Zorg bieden die aansluit bij de behoeften van mensen met LVB+ gaat gepaard met uitdagingen. Dat komt onder andere doordat zij een complexe zorgvraag hebben, waarbij het lastig is om adequate zorg te bieden op het snijvlak van de verstandelijke beperking, ernstige gedragsproblemen en psychische problematiek. Het gevolg is dat de zorg vaak onvoldoende aansluit en dat verkeerde diagnoses worden gesteld. Het omgaan met ernstig probleemgedrag is eveneens complex. Organisatorische procedures of negatieve emoties van professionals (zoals angst en boosheid) kunnen leiden tot een risico gestuurde begeleidingsstijl, inclusief het gebruik van onvrijwillige zorg. Dit kan ertoe leiden dat mensen met LVB+ verlies van perspectief en wanhoop ervaren.

Ook op organisatieniveau zijn er uitdagingen. Deze doen zich voor in de directe omgeving van mensen met LVB+ (zoals interacties tussen begeleiding en familie), in de organisatiecontext (zoals personeelsverloop) en buiten de organisatie (zoals de samenwerking met andere zorgaanbieders die nodig is om tegemoet te komen aan de complexe zorgvraag). In de praktijk lukt het zorgorganisaties hierdoor niet altijd om adequate zorg en ondersteuning te bieden. Wanneer zij zich daartoe onvoldoende in staat achten, worden mensen met LVB+ vaak overgeplaatst naar meer restrictieve (forensische) instellingen. Sommige mensen met LVB+ maken dit proces herhaaldelijk mee, wat leidt tot verlies van vertrouwen in de hulpverlening en in een betere toekomst.

Project Pro

Om mensen met LVB+ die herhaaldelijk overgeplaatst worden een betere kwaliteit van leven te bieden, is het project Pro ontstaan. Hiervoor zijn acht uitgangspunten opgesteld. Zes daarvan zijn gericht op cliënten en gaan over het bieden van onvoorwaardelijkheid in verblijf en ondersteuningsrelatie, een context die aansluit bij de behoeften van de cliënt, een zo gewoon mogelijk leven, en het opbouwen van (zelf)vertrouwen. Het zevende uitgangspunt betreft nadrukkelijke aandacht voor het welzijn van medewerkers en de ontwikkeling van hun competenties. Het laatste uitgangspunt betreft gedeelde verantwoordelijkheid voor de Pro-zorg op inhoud, draagvlak en samenwerking tussen alle disciplines en bestuurders.

Opbouw van het proefschrift

Om inzicht te krijgen in wat belangrijk is bij het realiseren van de Pro-uitgangspunten en hoe deze in de praktijk worden toegepast, zijn vijf specifieke onderzoeksvragen geformuleerd. De studies die deze vragen beantwoorden, worden beschreven in hoofdstuk 2 tot en met 6.

Hoofdstuk 2

Hoofdstuk 2 beschrijft een concept mapping-studie waarin de centrale vraag was wat belangrijk is bij het opstarten van een nieuw begeleidingsteam voor een woning voor mensen met LVB+ binnen een orthopedagogische behandelcontext. Binnen Pro zijn de perspectieven opgehaald van elf cliënten, zes begeleiders en zes professionals die begeleiders ondersteunen (5 behandelaren, 1 teamleider). Alle deelnemende professionals waren vanaf de start betrokken bij Pro, met uitzondering van één professional, die echter al meer dan een jaar bij Pro werkte. De deelnemende cliënten woonden minimaal zes maanden op een Pro-woning.

Alle drie de deelnemersgroepen benoemden aspecten rondom relaties, waaronder kenmerken die begeleiders moeten hebben om cliënten veiligheid en vertrouwen te bieden (zoals ervaring, zelfvertrouwen en het kunnen reguleren van emoties). Tussen de groepen was echter verschil te zien in welke relatie centraal stond. Bij cliënten ging het vooral om de relatie tussen cliënt en begeleider (microsysteem), bij begeleiders om de onderlinge samenwerking én die met ondersteunende professionals (mesosysteem), en bij behandelaren en de teamleider ging het om relaties op micro-, meso- én exosysteemniveau (bijvoorbeeld interacties tussen begeleiders en directie).

Overkoepelend kwamen vier belangrijke punten naar voren. Ten eerste werd benadrukt dat het belangrijk is dat cliënten en begeleiders elkaar al vóór de overplaatsing leren

kennen. Ten tweede hechten begeleiders veel waarde aan een veilig teamklimaat. Daarvoor moeten zij op elkaar kunnen vertrouwen en volgens een gedeelde werkwijze werken, gebaseerd op gezamenlijke waarden en uitgangspunten. Ten derde werd het belang onderstreept van ondersteuning voor begeleiders, met name vanuit teamleider, manager en behandelaar. Tot slot bleek het van belang om een realistisch en positief beeld te schetsen van de cliënten met LVB+ in de nieuwe woning. Als er geruchten circuleren waarin probleemgedrag uit context wordt gehaald, kan dat leiden tot stigmatisering van cliënten en ontmoedigen dat nieuwe begeleiders op de woning willen werken.

Hoofdstuk 3

Dit hoofdstuk betreft een kwantitatieve studie naar de steun die begeleiders van mensen met LVB+ op het werk ervaren en het teamklimaat. Daarbij ging het om ervaren steun van teamleiders, managers, behandelaren en andere collega's binnen het team. We onderzochten het verband tussen deze variabelen en het teamklimaat enerzijds, en het welbevinden en de werktevredenheid van begeleiders anderzijds. Daarnaast toetsten we twee hypothesen: dat betere samenwerking tussen ondersteunende professionals (teamleider, manager, gedragsdeskundige) leidt tot meer ervaren steun (hypothese 1) en tot een positiever teamklimaat (hypothese 2). In totaal vulden 201 begeleiders uit 32 teams van 10 zorgorganisaties voor mensen met een verstandelijke beperking een online vragenlijst in. Daarnaast beantwoordden 61 professionals die deze teams ondersteunen (teamleider, manager, gedragsdeskundige) vragen over hun onderlinge samenwerking. Bij negen teams ontbrak een teamleider of vergelijkbare functie, en zijn alleen de manager en behandelaar als ondersteunende professionals uitgenodigd voor deelname. Ongeveer een vijfde van de deelnemers was werkzaam binnen Pro.

Begeleiders beoordeelden de steun van collega's binnen het team gemiddeld het meest positief. Zowel de ervaren steun van collega's als het teamklimaat was hoger bij teams met een teamleider dan bij teams zonder. De studie bevestigt daarmee de positieve impact van een teamleider of vergelijkbare professional die dicht op de werkvloer staat.

De ervaren steun van teamleiders, managers, behandelaren, collega's en het teamklimaat vertoonden een klein tot matig positief significant verband met werktevredenheid. Meer ervaren steun van teamleiders, behandelaren, collega's en een positiever teamklimaat hingen ook samen met meer welbevinden. Deze relatie was vooral sterk bij steun van collega's en het teamklimaat. De verwachting dat betere samenwerking tussen ondersteunende professionals leidt tot meer ervaren steun (hypothese 1) en een positiever teamklimaat (hypothese 2) werd niet bevestigd door de data. Samenvattend onderstrepen de resultaten het belang voor zorgorganisaties om te investeren in goede

ondersteuning van begeleiders en een positief teamklimaat, ter bevordering van hun welbevinden en werktevredenheid.

Hoofdstuk 4

De studie in hoofdstuk 4 is kwalitatief van aard en gaat in op het thema veiligheid. Cliënten (N = 4) en professionals in verschillende functies (N = 64), allen wonend of werkend bij Pro-organisaties, is gevraagd wat 'je veilig voelen' betekent voor mensen met LVB+ in een residentiële setting. Daarnaast is in kaart gebracht welke factoren hun gevoel van veiligheid beïnvloeden. Daartoe werd eerst data uit een langlopende etnografische studie naar Pro (op basis van informele interviews, niet-participerende observaties en documentanalyse) thematisch geanalyseerd. Vervolgens vond validering van deze thema's (factoren) plaats tijdens interviews en focusgroepen met vier cliënten, 42 begeleiders van zes teams, een teamleider, vier managers, zes behandelaren, twee directeuren en drie bestuurders. De interviews en focusgroepen dienden ook om antwoord te krijgen op de vraag wat 'je veilig voelen' betekent voor mensen met LVB+.

Een thematische analyse naar de betekenis van 'je veilig voelen' resulteerde in drie thema's: (1) een fysieke omgeving die beschermt tegen risico's en verleidingen; (2) een voorspelbare, betrouwbare en ondersteunende omgeving waarin cliënten vertrouwen hebben; en (3) een accepterende omgeving waarin cliënten een gewoon dagelijks leven kunnen opbouwen. Deelnemers noemden daarbij vooral wat bijdraagt aan veiligheid, in plaats van enkel te focussen op het voorkomen van risico's.

De analyse naar factoren die een rol spelen in het gevoel van veiligheid van mensen met LVB+ leverde 20 thema's en 34 subthema's op. Deze hebben betrekking op verschillende niveaus: (1) kenmerken en gedrag van cliënten en anderen in hun leefomgeving; (2) kenmerken, gedrag en kennis van individuele begeleiders; (3) kenmerken en gedrag van het team van begeleiders; (4) opvattingen, beleid en procedures in de organisatie; en (5) opvattingen en gedrag van de externe omgeving van zorgorganisaties. De resultaten lieten zien dat factoren op deze niveaus elkaar kunnen beïnvloeden. Daarnaast kwam de relatie tussen het gevoel van veiligheid van cliënten en dat van begeleiders duidelijk naar voren.

Hoofdstuk 5

De kwalitatieve studie in hoofdstuk 5 bouwt voort op het thema veiligheid en beschrijft wat residentiële zorgorganisaties voor mensen met LVB+ doen om het gevoel van veiligheid

van hun cliënten te bevorderen. De dataverzameling vond plaats via etnografisch longitudinaal onderzoek naar Pro, aangevuld met interviews en focusgroepen onder Pro-professionals in verschillende functies (van begeleiders tot bestuurders) (zie ook hoofdstuk 4). Een thematische analyse leverde drie hoofdthema's op: (1) alle lagen van de organisatie onderschrijven de visie van onvoorwaardelijke ondersteuning, bijvoorbeeld via onderlinge steun van professionals op alle niveaus; (2) stabiliteit bieden in teams en in ondersteuning binnen een dynamische context, bijvoorbeeld door te investeren in een positief teamklimaat; (3) streven om cliënten een zo gewoon mogelijk leven te bieden, bijvoorbeeld door het creëren van een eigen, huiselijke leefomgeving.

De studie laat zien dat negatieve emoties en opvattingen van zowel begeleiders als andere professionals binnen de organisatie het bieden van onvoorwaardelijkheid kunnen belemmeren. Volgens deelnemers wordt een negatief beeld vaak veroorzaakt door angst en een gebrek aan bekendheid met de visie van Pro en de Pro-cliënten. De studie benadrukt daarnaast de meerwaarde van een focus op het werk dat feitelijk plaatsvindt, in plaats van op het werk dat wordt beoogd. In de zorg en ondersteuning voor mensen met LVB+ is sprake van een dynamische context met uitdagingen. Het is waardevol om inzicht te krijgen in hoe zorgorganisaties hiermee omgaan en daarvan te leren.

Hoofdstuk 6

Hoofdstuk 6 gaat in op wat residentiële zorgorganisaties in de verstandelijk gehandicaptensector en hun externe stakeholders doen om meedoen in de samenleving door mensen met LVB+ te bevorderen, daarbij rekening houdend met het gevoel van veiligheid van mensen met LVB+ en dat van hun omgeving. Onder 64 Pro-professionals, variërend van begeleiders tot bestuurders, zijn interviews en focusgroepen afgenomen. Daarnaast namen vier externe stakeholders van de Pro-organisaties deel aan een interview: drie daarvan werkten bij de politie, één bij de gemeente.

Het eerste hoofdthema van de thematische analyse betreft samen verantwoord risico's nemen. Dit houdt enerzijds in dat zorgprofessionals in verschillende functies gezamenlijk risico's in kaart brengen, afwegen en bepalen welke risico's acceptabel zijn. Afhankelijk van de organisatie wordt daarbij ook advies gevraagd aan de politie. Anderzijds gaat het over samen risico's managen, bijvoorbeeld door een stapsgewijze aanpak waarbij met kleine stappen wordt gewerkt aan uitbreiding van activiteiten en zelfstandigheid van cliënten.

Het tweede hoofdthema gaat over het veranderen van opvattingen en houdingen. Zorgprofessionals en stakeholders informeren bijvoorbeeld burgers over mensen

met LVB+, wat volgens hen leidt tot meer bekendheid en minder snel een gevoel van onveiligheid bij afwijkend gedrag. Tegelijkertijd proberen stakeholders ook de houding van zorgprofessionals te beïnvloeden. Zij vinden het belangrijk dat organisaties grenzen stellen aan gedrag van cliënten om ernstige incidenten te voorkomen. Stakeholders signaleren echter terughoudendheid bij professionals om aangifte te doen.

Overstijgend kwam het belang van relationeel werken naar voren: goede samenwerking tussen zorgorganisaties en externe stakeholders, en in contact treden met lokale bewoners.

Hoofdstuk 7

Tot slot biedt de algemene discussie in hoofdstuk 7 een samenvatting van de belangrijkste bevindingen van het proefschrift, met suggesties voor toekomstig onderzoek en de implicaties voor beleid en praktijk. De drie belangrijkste overkoepelende bevindingen zijn:

1. Noodzaak van een sterk commitment aan de visie op alle lagen van de organisatie
In lijn met de literatuur benadrukt dit proefschrift het belang van onvoorwaardelijkheid en het centraal stellen van de behoeften van cliënten. Herhaaldelijke overplaatsingen van mensen met LVB+ laten zien dat het vasthouden aan deze uitgangspunten uitdagend kan zijn. Dit proefschrift toont aan dat commitment aan de visie op alle lagen essentieel is om de Pro-uitgangspunten in de praktijk te brengen. Bij Pro-organisaties kreeg dit onder meer vorm door het verankeren van de uitgangspunten in beleid en procedures, en door regelmatig te monitoren en reflecteren op de uitvoering ervan. Desondanks waren er binnen Pro situaties waarbij volledige commitment ontbrak (bijvoorbeeld bij begeleiders en medewerkers van ondersteunende diensten). Deze situaties, waarin het naleven van de visie onder druk stond, benadrukken het belang van een sterk commitment op alle niveaus van de organisatie.

2. Investeren in relaties is essentieel voor het bieden van een gevoel van veiligheid
Op verschillende niveaus kan investeren in relaties het gevoel van veiligheid bevorderen, zowel voor mensen met LVB+ als hun omgeving. Dit proefschrift toont aan dat investeren in de relatie tussen cliënt en begeleider bijdraagt aan het gevoel van veiligheid bij cliënten. Voor cliënten om veiligheid te ervaren, is het belangrijk dat begeleiders zich ook veilig voelen. Teamleiders, managers en behandelaren kunnen daaraan bijdragen door te investeren in relaties met begeleiders via nauwe betrokkenheid en zowel praktische als emotionele steun. Daarnaast spelen teamleden een belangrijke rol in het gevoel van veiligheid van begeleiders. Begeleiders hechten waarde aan collega's die zich

aan afspraken houden en grenzen stellen en aan een veilig teamklimaat. Investeren in een positief teamklimaat en teamprocessen draagt daarom bij aan de veiligheid van begeleiders. Tenslotte bevordert investeren in relaties tussen zorgorganisaties en hun externe stakeholders het gevoel van veiligheid van cliënten en hun omgeving. Een betere samenwerking leidt tot betere processen voor het managen van risico's bij participatie van cliënten met LVB+ in de samenleving.

3. Impact van negatieve beeldvorming en gebrek aan bekendheid over mensen met LVB+ op hun kwaliteit van leven

In verschillende studies kwam negatieve beeldvorming over of onbekendheid met Pro-cliënten naar voren, zowel binnen als buiten zorgorganisaties. Dit had directe of indirecte nadelige gevolgen voor cliënten. Buiten zorgorganisaties was er sprake van onbekendheid in de samenleving, wat het gevoel van veiligheid van cliënten verminderde en hun participatie in de samenleving belemmerde. Ook binnen zorgorganisaties werd onbekendheid geconstateerd, bijvoorbeeld bij begeleiders van andere woningen en ondersteunende diensten, wat leidde tot terughoudendheid bij collega's om te ondersteunen bij incidenten of om op de Pro-woningen te werken.

Sterke kanten, beperkingen en toekomstig onderzoek

Een sterk punt van dit proefschrift is de integrale aanpak, waarbij de perspectieven van cliënten, professionals in diverse functies en externe stakeholders van Pro-zorgorganisaties (zoals politie en gemeente) zijn gecombineerd. Het betrekken van de perspectieven van mensen met LVB+ is waardevol, omdat zij de doelgroep zijn en vanuit hun eigen ervaringen waardevolle inzichten leveren.

Een beperking is dat alle onderzoeken in dit proefschrift zijn uitgevoerd binnen de context van Pro, waardoor hun waarden en opvattingen sterk bepalend zijn voor de uitkomsten. Tegelijkertijd gaat het bij Pro om drie zorgorganisaties die de Pro-uitgangspunten op verschillende manieren in de praktijk brengen. In toekomstig onderzoek zou het interessant zijn om te onderzoeken of en hoe deze verschillen de ervaring van cliënten, medewerkers en de organisatie beïnvloeden.

Daarnaast was er een beperking in de focus op de welzijns- en competentieontwikkeling van medewerkers (een Pro-uitgangspunt), die voornamelijk betrekking had op begeleiders. Teamleiders, managers en behandelaren spelen ook een belangrijke rol in de ondersteuning van het team. Toekomstig onderzoek zou moeten kijken naar wat organisaties kunnen doen om de ervaren steun en competentieontwikkeling van deze professionals te optimaliseren.

Een derde beperking is dat het proefschrift geen kwantitatief langlopend onderzoek naar Pro bevat om uitspraken te doen over de uitkomsten van Pro op de langere termijn en welke factoren (cliënt, begeleider, anders) deze uitkomsten positief dan wel negatief beïnvloeden. Hoewel er een langlopend mixed methods-onderzoek is uitgevoerd, bleek het door veel missende data moeilijk om gedegen kwantitatieve analyses uit te voeren. Vervolgonderzoek naar de langetermijnresultaten van de Pro-aanpak zou waardevol zijn, met bijzondere aandacht voor de context van het onderzoek, zoals de kenmerken van cliënten en het verloop onder medewerkers.

Tot slot werd het perspectief van naasten niet meegenomen in dit proefschrift. Hoewel zij geen rol spelen in de praktische uitvoering van de Pro-uitgangspunten, is bekend dat cliënten waarde hechten aan positieve familierelaties. Aangezien deze relaties vaak verstoord zijn, zou toekomstig onderzoek naar de rol van veiligheid in de relatie tussen cliënten en hun naasten interessant kunnen zijn.

Implicaties

Uit dit proefschrift volgen verschillende implicaties. Ten eerste is het voor zorgorganisaties die zorg en ondersteuning bieden aan mensen met LVB+ belangrijk om een open en veilig klimaat te creëren. Dit betekent dat medewerkers zich vrij moeten voelen om fouten, onzekerheden en kwetsbaarheden te delen, wat bijdraagt aan de stabiliteit in de zorg en het gevoel van veiligheid. Professionals met leidinggevende taken kunnen een open en veilig klimaat bevorderen door voorbeeldgedrag te tonen, zoals open te zijn over fouten en niet-oordelend te reageren. Begeleiders kunnen eveneens bijdragen aan een positief teamklimaat door te reflecteren op hoe zij anderen ondersteunen en feedback geven.

Ten tweede benadrukt dit proefschrift de noodzaak voor zorgorganisaties om hoge prioriteit te geven aan het behoud van begeleiders voor mensen met LVB+. Stabiliteit in teams draagt bij aan de stabiliteit van de zorg en het gevoel van veiligheid bij cliënten en begeleiders. Het is belangrijk dat begeleiders goed voorbereid aan hun functie beginnen en dat er in opleiding en onderwijs meer aandacht komt voor de kennis en vaardigheden die nodig zijn voor het werken met mensen met LVB+. Daarnaast moeten zorgorganisaties de ondersteuning aan begeleiders afstemmen op hun individuele behoeften en regelmatig monitoren hoe zij de steun vanuit verschillende professionals ervaren.

Ten derde wijst dit proefschrift op de meerwaarde van intensievere samenwerking tussen zorgorganisaties en hun externe stakeholders, zoals politie en gemeente. Het zou raadzaam zijn om op nationaal niveau meer ervaring op te doen met het aanstellen van specifieke wijkagenten voor zorg en veiligheid. Ook zou de samenwerking tussen

zorgorganisaties en justitie verbeterd kunnen worden, zodat onvoorwaardelijke ondersteuning ook binnen justitie kan worden voortgezet.

Ten slotte impliceert dit proefschrift dat het belangrijk is om meer bekendheid te geven aan mensen met LVB+ in de samenleving en bij professionals in verschillende sectoren. Dit kan het gevoel van veiligheid en de kwaliteit van leven van mensen met LVB+ verbeteren. Mensen met LVB+ of hun naasten kunnen als ervaringsdeskundigen een actieve bijdrage leveren aan het vergroten van de bekendheid en het delen van hun perspectieven en ervaringen.

Conclusie

Voor het in de praktijk brengen van de Pro-uitgangspunten is onder meer een goede voorbereiding (zoals een vroegtijdige kennismaking van cliënten en begeleiders voorafgaand aan de plaatsing), een veilig en positief teamklimaat, onderlinge steun, een stabiel team en een sterk commitment aan een gezamenlijke visie van belang. Als het gaat om hoe de Pro-uitgangspunten in de praktijk brengen, rekening houdend met aspecten van veiligheid, speelt investeren in relaties op verschillende niveaus een belangrijke rol. Hoewel de zorg en ondersteuning voor mensen met LVB+ complex en uitdagend is, blijft het essentieel om uit te gaan van onvoorwaardelijkheid, een contextuele aanpak en veiligheid.

Public summary/ publiekssamenvatting

Public summary

Background

This thesis is about people with mild intellectual disabilities who show severe challenging behaviour (CB), which includes being aggressive or engaging in behaviour where people get hurt. There are various causes of CB, including experiencing a difficult childhood, having psychological problems, and lacking sufficiently good care and support. When care facilities believe that they cannot provide sufficiently good care, people with mild intellectual disabilities and severe CB are often transferred elsewhere. For some of these people, this has happened over and over again. As a result, people with mild intellectual disabilities and severe CB can end up losing both trust in professionals and hope for a better future.

Project Pro

In order to both stop these routine transfers and give people with mild intellectual disabilities and severe CB a better quality of life, project Pro was created in 2017. Pro is a collaboration between six organisations: three residential care organisations for people with intellectual disabilities (ASVZ, Pluryn, Trajectum), two care administration offices (VGZ, Zilveren Kruis), and a centre with expertise in CB (Centre for Consultation and Expertise). A total of 24 people with mild intellectual disabilities and severe CB were chosen to take part in this project, with eight from each residential facility being selected.

One of the main principles of Pro is unconditionality, which means that Pro provides a space where people with mild intellectual disabilities and severe CB can live and be aided by support staff who are there for them, including in the event of CB. Pro organisations also want to meet their needs, and help them live a life that is as ordinary as possible. Alongside this, Pro is also focused on paying attention to the well-being and competencies of employees, and ensuring that all employees within the organisation take responsibility for Pro care.

The studies that the thesis is based on

In this thesis, we investigated, firstly, what is important in bringing the Pro principles into practice, and secondly, how residential facilities implement them. Special attention was paid to the theme of safety. The research included five separate studies that were based on the following research questions:

- What is important when setting up a new residential home for people with mild intellectual disabilities and severe CB with a new team of support staff?
- How do support staff feel about the support they receive from different professionals at work as well as the team climate, and is there a relationships between these outcomes and their well-being and job satisfaction?

- What does "feeling safe" mean for people with mild intellectual disabilities and severe CB, and what factors their feelings of safety?
- What do residential facilities do to promote feelings of safety among people with mild intellectual disabilities and severe CB?
- What do residential facilities, the police and municipality do to help people with mild intellectual disabilities and severe CB safely participate in the community?

We conducted the studies in a number of different ways. For example, we interviewed people, held focus groups, and created an online questionnaire. Pro service users and Pro professionals working in a variety of different roles, including support staff, psychologists, and board members, took part in the studies.

What the research found

The results of the research showed that it is important for residential facilities for people with mild intellectual disabilities and severe CB to focus on unconditionality and these individuals' needs. When it comes to people with mild intellectual disabilities and severe CB, this can sometimes be challenging. For example, sometimes the CB of people with mild intellectual disabilities can make support staff or other employees in the organisation feel afraid. Or constant changes in support staff can be challenging for residential facilities.

The research tells us what is important when trying to work in a way that follows the Pro principles. When it comes to providing support for people with mild intellectual disabilities and severe CB, it is important that support staff have self-confidence, are capable of making service users feel recognised and valued, and feel safe themselves at work. If these things are in place, then people with mild intellectual disabilities and severe CB will feel safer. For support staff, it is important that they are working in a stable team in which everybody works in the same way, and where there is a safe and positive team atmosphere, because this helps support staff to trust each other and makes them feel safer. For organisations, it is important that *all* employees work in such a way that follows the Pro principles and support each other. For example, it is important for teams of support staff to have team leaders, managers, and psychologists who are both involved and offer them support after incidents of CB. Outside organisations, it is vital that the public become more familiar with people with mild intellectual disabilities and severe CB, as this can help make people with mild intellectual disabilities and severe CB feel less unsafe and participate more in the community. Finally, the research shows that it is important to invest in relationships, specifically relationships between people with mild intellectual disabilities and severe CB and support staff members, support staff within a single team, support staff and team leaders, managers, and psychologists, and between the residential facilities and partners outside the facility.

Publiekssamenvatting

Achtergrond

Dit proefschrift gaat over mensen met een licht verstandelijke beperking (LVB) die ernstig probleemgedrag laten zien, zoals agressie of gedrag waarbij mensen zichzelf verwonden. In Nederland noemen we deze mensen ook wel mensen met LVB+. Probleemgedrag kan verschillende oorzaken hebben. Bijvoorbeeld een moeilijke jeugd, psychische problemen en een gebrek aan goede zorg en ondersteuning. Als zorgorganisaties het gevoel hebben dat zij mensen met LVB+ niet goed kunnen helpen, worden ze vaak overgeplaatst. Voor sommige mensen met LVB+ herhaalt dit proces zich keer op keer. Zij kunnen daardoor het vertrouwen in de hulpverlening en de toekomst kwijtraken.

Project Pro

Om de overplaatsingen te stoppen en mensen met LVB+ een betere kwaliteit van leven te geven, startte in 2017 het project Pro. Pro is een samenwerking tussen zes organisaties: drie zorgorganisaties voor mensen met LVB+ (ASVZ, Pluryn en Trajectum), twee zorgkantoren (VGZ, Zilveren Kruis) en een expertisecentrum rondom probleemgedrag (Centrum voor Consulatie en Expertise). Voor het project zijn 24 mensen met LVB+ geselecteerd. Bij iedere zorgorganisatie wonen acht mensen met LVB+.

Bij Pro is onvoorwaardelijkheid één van de belangrijke uitgangspunten. Dit houdt in dat Pro een plek wil bieden waar mensen met LVB+ mogen blijven wonen en waar altijd begeleiding voor hen is, ook bij probleemgedrag. Ook willen Pro-organisaties aansluiten bij de behoeften van mensen met LVB+ en hen een zo gewoon mogelijk leven bieden. Verder gaat het bij Pro over aandacht voor het welzijn en de competenties van medewerkers, en over een gezamenlijke verantwoordelijkheid voor de Pro-zorg van alle medewerkers in de organisatie.

Onderzoeken in dit proefschrift

In dit proefschrift onderzochten we wat in de praktijk belangrijk is om te kunnen werken volgens de Pro-uitgangspunten, en hoe de zorgorganisaties voor mensen met LVB+ deze uitgangspunten vormgeven. Daarbij was er in het bijzonder aandacht voor het thema veiligheid. Het onderzoek bestond uit vijf aparte onderzoeken met de volgende onderzoeksvragen:

- Wat is belangrijk bij het starten van een nieuwe woning voor mensen met LVB+ met een nieuw begeleidingsteam?
- Wat vinden begeleiders van de steun van verschillende professionals op het werk en het teamklimaat, en hangt dat samen met hun welbevinden en werktevredenheid?
- Wat betekent 'je veilig voelen' voor mensen met LVB+ en welke factoren hebben daar invloed op?

- Wat doen zorgorganisaties om het gevoel van veiligheid van mensen met LVB+ te vergroten?
- Wat doen zorgorganisaties samen met politie en gemeente om mensen met LVB+ meer te laten meedoen in de samenleving, rekening houdend met het gevoel van veiligheid van deze mensen en van de samenleving?

De onderzoeken voerden we uit op verschillende manieren. We hebben bijvoorbeeld interviews en groepsinterviews gehouden en online vragenlijsten afgenomen. De onderzoeken vonden met name plaats bij Pro-cliënten en Pro-professionals in verschillende functies, zoals begeleiders, behandelaren en bestuurders.

Uitkomsten van het onderzoek

De resultaten uit het onderzoek laten zien dat het belangrijk is dat zorgorganisaties voor mensen met LVB+ uitgaan van onvoorwaardelijkheid en de behoeften van mensen met LVB+. Als het gaat om mensen met LVB+ kan dat een uitdaging zijn. Bijvoorbeeld omdat begeleiders of andere medewerkers in de organisatie angst ervaren na probleemgedrag van mensen met LVB+. Of omdat er veel wisselingen zijn in begeleiders.

Het onderzoek laat zien wat belangrijk is om te kunnen werken volgens de Pro-uitgangspunten. Wat betreft de ondersteuning aan mensen met LVB+ is het bijvoorbeeld belangrijk dat begeleiders zelfvertrouwen hebben, ervoor zorgen dat mensen met LVB+ zich gezien en gewaardeerd voelen, en ze zichzelf veilig voelen. Hierdoor voelen mensen met LVB+ zich ook veiliger. Voor begeleiders is een vast team belangrijk, waarin iedereen werkt volgens dezelfde aanpak en er een veilig en positief teamklimaat heerst. Dat helpt begeleiders om te kunnen vertrouwen op elkaar en vergroot hun gevoel van veiligheid. Voor de organisatie is het belangrijk dat *alle* medewerkers werken volgens de Pro-uitgangspunten en elkaar ondersteunen. Zo is het voor het team bijvoorbeeld van waarde dat teamleiders, managers en behandelaren betrokken zijn en begeleiders steun bieden na incidenten met probleemgedrag. Buiten de organisatie is het van belang dat de mensen in de samenleving meer bekend raken met mensen met LVB+. Dat kan ervoor zorgen dat mensen met LVB+ zich minder snel onveilig voelen en meer kunnen meedoen in de samenleving. Tot slot laat het onderzoek zien dat aandacht voor het opbouwen van relaties belangrijk is. Daarbij gaat het om relaties tussen mensen met LVB+ en begeleiders, begeleiders in een team onderling, begeleiders en teamleiders, managers en behandelaren, en tussen de organisatie en samenwerkingspartners van buiten de zorgorganisatie.

Dankwoord (Acknowledgements)

Dankwoord (Acknowledgements)

Het idee om een promotieonderzoek te gaan doen ontstond tijdens mijn laatste jaren bij het Trimbos-instituut. Met de overstap naar de Academische Werkplaats Leven met een verstandelijke beperking in 2018 kreeg dat idee concreet invulling. In de jaren die volgden, heb ik veel steun en medewerking mogen ervaren van verschillende mensen om me heen. Die ben ik erg dankbaar en benoem ik dan ook graag op deze plek.

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Curriculum Vitae

Curriculum Vitae

Suzanne Lokman is op 21 mei 1980 geboren in Borger. Zij behaalde in 1998 haar VWO-diploma aan het Hondsrug College in Emmen. Vervolgens studeerde zij Economie met als afstudeerrichting Marketing Management aan de Rijksuniversiteit Groningen. Begin 2005 rondde zij deze studie af, waarna zij is gaan werken bij het Trimbos-instituut in Utrecht. Daar was zij betrokken bij diverse onderzoeks- en implementatieprojecten op het gebied van alcohol- en drugspreventie en depressiepreventie. Specifieke aandacht ging daarbij uit naar mensen met een lage sociaaleconomische status en beperkte gezondheidsvaardigheden, waaronder mensen met een licht verstandelijke beperking. In 2018 legde ze zich verder toe op het onderzoek door als promovenda te starten aan de Academische Werkplaats Leven met een verstandelijke beperking (Tranzo, Tilburg University). Zij voerde haar promotieonderzoek uit onder begeleiding van prof. dr. P. J. C. M. Embregts (Tilburg University Universiteit) en prof. dr. H. C. M. Didden (Radboud Universiteit). Momenteel werkt zij als senior onderzoeker en als medewerker kennisdeling bij de Academische Werkplaats Leven met een verstandelijke beperking, Tranzo, Tilburg University.

Suzanne Lokman was born on May 21 , 1980 in Borger. In 1998, she completed pre-university education at Hondsrug College in Emmen. She then pursued a degree in Economics, specialising in Marketing Management, at the University of Groningen. In early 2005, she graduated and subsequently began working at the Netherlands Institute of Mental Health and Addiction (Trimbos-institute) in Utrecht. In her role, she was involved in various research and implementation projects focused on alcohol and drug prevention, as well as depression prevention. Specific attention was given to individuals with a low socio-economic status and limited health literacy skills, including people with a mild intellectual disability. In 2018, she further focused on research by starting her PhD research at the Academic Collaborative Centre Living with an intellectual disability, Tranzo, Tilburg University. Her supervisors were prof. dr. Petri Embregts (Tilburg University) and prof. dr. Robert Didden (Radboud University). Currently, she is working as a senior researcher and knowledge sharing officer at the Collaborative Centre Living with an intellectual disability at Tranzo, Tilburg University.

Publications

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Lokman, S., van Oorsouw, W. M. W. J., Didden, R., & Embregts, P. J. C. M. (2022). Setting up a new team of support staff for people with mild intellectual disability or borderline intellectual functioning and severe challenging behaviour: A concept mapping study. *Journal of Applied Research in Intellectual Disabilities*, *35*, 1348-1359. https://doi.org/10.1111/jar.13023

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