**Practice-Based Social Marketing to Improve Well-being for People with Intellectual Disabilities**

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**Abstract**

Psychosocial theories that are often used to inform health promotion interventions for groups with reduced agency are not successful in bringing desirable changes. Critical social marketing provides avenues to disrupt mainstream individualistic approaches, which have been found unsuitable for vulnerable populations due to personal and systemic obstacles that prevent them to change behaviors and adopt healthier lifestyles. Adopting a critical social marketing lens, this conceptual paper explores how social practice theory can help to reimagine social marketing as a tool to reclaim agency, to improve the health and well-being of vulnerable populations, particularly people with disabilities. To demonstrate this practice-based social marketing approach, we used the example of physical activity for people with intellectual disabilities (PwID). Therefore, the paper has theoretical implications, contributing to the critical social marketing literature, and practical implications. It provides examples of how practice-based social marketing can be applied to increase physical activity and agency for PwID who reside in group homes.

Keywords: *Social Marketing, practice theory, intellectual disabilities, group homes, physical activity.*

**Statement of Contribution**: The manuscript shows the use of non-normative and non-representational theory and methods in social marketing for vulnerable populations. The manuscript highlights that current individualistic behavior change initiatives used in social marketing do not consider limited agency, vulnerable populations, and the impact this lack of agency has on the success of a health intervention. The paper outlines how a reimagined practice-based social marketing could be used to create inclusive interventions for vulnerable populations and help them to reclaim their agency.

# Introduction

Social marketing and other behavior change approaches have been criticized for placing the responsibility on the individual (Crawshaw, 2012; Gordon, 2019; Walker, 2015). While this is deeply problematic in general, it adds extra concerns when it comes to people with limited agency to make changes in their daily lives due to frailty, vulnerability, intellectual or physical disability (Klemsdal & Wittusen, 2021). This also includes people who live in group homes or other similar structures because institutional policies and processes dictate their daily routines (Bigby et al., 2017).

Downstream social marketing, which often draws from behavioral economics and similar individual-focused disciplines, takes people's capacity to change for granted. According to these individualistic approaches, people will be nudged, educated, or persuaded, and as a result, they will be "able" to change their behavior (Spotswood & Tapp, 2013). Therefore, agency is the prerequisite of downstream social marketing initiatives as it interplays with appropriate social structures that social marketers aim to create through mid and upstream social marketing initiatives (Russell-Bennett et al., 2013). This focus on the individual stems from the social norm of being able to make changes and take personal responsibility. This norm has to be challenged to 'support and value deviance' (Gappmayer, 2021, p. 102) so that social marketing can become a more inclusive approach relevant to people with reduced agency. For this to occur, reliance on individuals' intellectual and physical capacity and agency to change can be very difficult, even impossible, in certain cases, such as for people with intellectual or physical disabilities, excluding them from interventions that could improve their health and well-being. For example, Gappmayer (2019) found individualistic neoliberal values in care for people with intellectual disabilities manifested through the idea of being independent and self-determined.

Therefore, within a neoliberal narrative, the responsibility of people's health and well-being passes to the individual, instead of the government, the community, or companies, to provide, promote and support healthy lifestyles (Ayo, 2012). It is the individual's responsibility to change their habits, make healthy choices, and adopt healthy practices, leading to the idealization of independence (Weicht, 2010). Gappmayer (2019) highlights that while this approach favors autonomy, it ignores the fact that people are often incapable of making 'the right' decisions because of a lack of knowledge or lack of support. Therefore, this approach that promotes individualism while missing the wider socio-economic and political context automatically excludes those with reduced agency, making it fundamentally restrictive to people with any kind of disability and other vulnerable groups. In the same context, Williams et al. (2018) identified how everyday practices are shaped in a way that excludes people with disabilities as well as other vulnerable groups, such as older people, migrants, or single-parent households. By identifying these challenges, scholars in disability studies (e.g., Gappmayer, 2019, 2021; Schillmeier, 2007; Thibodaux, 2005; Williams et al., 2018) have argued for the relevance of a practice-related approach to support the health and well-being of people with disabilities. We draw from this to demonstrate how social marketing can evolve to better support people with disabilities.

The evolution of social marketing to overcome this narrow focus on the individual has led to other paradigms such as the midstream (Wood, 2016), upstream (Gordon, 2013), and systems-thinking social marketing (Domegan et al., 2016), which will be discussed later on in this paper. However, we argue that there is still a need for other approaches if we want to support people with disabilities; approaches that zoom out from the individual and their *ability* to change behavior and focus on (change of) practices because practices are "nonindividualist phenomena" (Schatzki, 2005, p. 480). To do so, social practice theory (SPT) can provide a novel approach to social marketing interventions. This is because SPT focuses on organized human activities, i.e. practices (Schatzki, 2005), instead of individual behaviors. According to Reckwitz (2002, 249), a practice is

a routinized type of behaviour which consists of several elements, interconnected to one another: forms of bodily activities, forms of mental activities, ‘things’ and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge

Therefore, we argue that through this focus on practices and their elements, instead of behaviors, SPT can provide new lens on how everyday life is organized, how it changes and how different groups get included or excluded from activities. To do so, this paper uses physical activity as an example to demonstrate the relevance of SPT and how SPT can be embedded into social marketing thinking and initiatives if we were to support people with intellectual disabilities (PwID) to improve their health and well-being. This is in line with literature increasingly calling for physical activity intervention approaches that focus on making physical activity more ingrained, normative, and an unreflexive part of everyday life rather than the result of participation in discrete programs or campaigns (Reis et al., 2016; Spotswood et al., 2021). In addition, the focus will be on PwID living in assisted living conditions (group homes) because their ability to change is limited and often relies on other aspects beyond their control, which will be elaborated on later in the paper. So, focusing on practices rather than people's behavior, we argue, is fundamental to identifying how physical activity for people with vulnerabilities can be increased. This paper highlights that an inclusive narrative should be around changes of practices and not behaviors.

Therefore, this paper contributes towards the emancipation of social marketing by opening up avenues for a more inclusive approach to behavior and social change to better support people's health and well-being (Gordon, 2019). Inclusivity here refers to overcoming unintended consequences that some social marketing initiatives often have and can lead to the exclusion of certain groups of people through marginalization and stigmatization (Gurrieri et al., 2013). This exclusion is very common among people with disabilities (Dell'Armo & Tassé, 2021; VanPuymbrouck et al., 2020), and social marketing needs to be reimagined to better support these groups.

The paper starts with an overview of the literature around disability and the challenges people with disabilities face to follow a healthy lifestyle, drawing from physical activity examples. It moves on to the use of social marketing to promote physical activity and then introduces how SPT in the context of health promotion/social marketing and disability have been studied so far. The discussion section builds on the previous sections and brings together SPT and social marketing to address how to support PwID's physical activity practices in group homes. Finally, the discussion section includes specific points for reimagining social marketing using a SPT lens, leading to a more inclusive social marketing approach that can be used to support healthier lifestyles for various vulnerable and marginalized groups beyond PwID.

# Health and Well-being of People with Intellectual Disabilities: challenges, agency, and services structure

Disability, as a concept, is overseen primarily by two models: the medical and the social. These models define impairment, provide insight into the attitudes and conceptions of disability, and shape policy and research (Retief & Letšosa, 2018). On the one hand, the medical model sees the problem residing in the individual, a failure of the body, with the goal of any intervention being to cure and make the person normal (Olkin, 2001). On the other hand, the social model espouses that society disables a person, and the solution lies in the society, not the individual (Barnes & Mercer, 2010; D’Alessio, 2013). This contradicts the individualistic approach of self-efficacy and independence (Pols et al., 2017), showing why neoliberal narratives create exclusions and hinder the health and well-being of people with disabilities.

To protect people with disability and their networks, the World Health Organization (WHO) produced a common global language on disabilities. It developed the International Classification of Functioning, Disability, and Health (ICF), recognizing the contribution of external forces in the physical, social, and attitudinal environments in causing or eliminating disability among people with functional impairments (WHO, 2018). It is important to note that the WHO classification of disabilities melds the medical and the social models in defining disability, thus producing a coherent view of health (WHO, 2018), and it represents the interaction between the person and their environment, and the role support networks can play in enhancing individual functioning (Schalock & Luckasson, 2013). Similalry, Schillmeier (2007) recognizes the multifaceted nature of disability and suggests that disability:

can be understood neither merely as an individual bodily impairment nor as a socially attributed disability. Rather, disability refers to complex sets of heterogeneous practice that bring to the fore how ordinary acts (re-)assemble social orderings by linking the material configurations of human (culture) and non-human (nature) relations(p.197).

Wehmeyer (2013) states that intellectual disability (ID) is also a multidimensional state of human functioning. This reimagination of disability sheds light on how people with disabilities can be better supported to enjoy a healthy and inclusive lifestyle. Maintaining good health is imperative in reducing the impairment on functioning and participation in everyday life activities for people with disabilities (Abdullah et al., 2004).

These more inclusive definitions expose the problems created by individualistic approaches that can lead to discrimination and stigma (Dell'Armo & Tassé, 2021) and still impede the health and well-being of PwIDs. In this context of individualistic approaches, it is with no surprise that PwID have high rates of obesity, low fitness levels, and lead sedentary lives (Bergström et al., 2013; Melville et al., 2015), have higher rates of comorbidities, such as diabetes and heart disease (Coppus, 2013; Tyrer et al., 2019) and die earlier than people without intellectual disabilities (O'Leary et al., 2018). In the USA, for example, only 13.5% of PwID meet the US Physical Activity Guidelines compared to 30.8% of the general population, even though various health and wellness initiatives have emerged for PwID (Stancliffe & Anderson, 2017). This happens even though these differences in health status are avoidable through preventative interventions (Bazzano et al., 2009).

Although the genetic/biological determinants of health cannot be directly targeted, lifestyle factors can be addressed for PwID to improve health and wellness outcomes (Bergström et al., 2013; Lynnes et al., 2009; Melville et al., 2015). To support healthy lifestyles for PwID, it is essential to consider the dynamics of everyday life (van Woerkum & Bouwman, 2012), which for PwID is influenced mainly by service providers and caregivers (Michalsen et al., 2020). This is because, PwID have knowledge about healthy living but have trouble translating this knowledge into behavior, and they need others to support them (Kuijken et al., 2016).

A great example of community settings to support PwIDs comes from the USA, where 13.5% of PwID live in supervised residential settings (Lulinski et al., 2018), consisting of group homes/community settings and independent living with access to 24-hour support from staff as needed. Since deinstitutionalization, group homes have been seen as one of the most critical strategies to promote social inclusion and everyday skills for PwIDs (Bigby et al., 2017). Group homes are defined as a community residential arrangement to meet the learning, physical, social, and medical needs of PwID to achieve community inclusion and participation (Friedman, 2019). They offer opportunities for PwID to learn everyday skills such as cooking and provide a social setting that they may not otherwise have had in institutions (Wiesel & Bigby, 2015).

Although group homes aim to resemble suburban homes, PwID are often treated as service users or recipients of care who live within a defined structured environment with recurring daily routines which correspond to staff routines, rosters, and priorities (Keogh, 2009). Thus, like institutional care environments, group homes maintain large power imbalances between staff and residents, and service-centered terminology is typically used to describe them (Keogh, 2009).

The structured environment of group homes for each resident is governed by their person-centered plan (PCP). A PCP is a systematic approach to the provision of support that enhances a person’s well-being (Schalock et al., 2018). The PCP is created by the resident, caseworker, agency coordinator, family, or guardian. The services offered to the resident in a group home are determined by their PCP. Leser et al. (2017) state that PwID are more likely to engage in inclusive community activities than those who live in larger congregated settings or those who live in a family home.

When it comes to physical activity as part of the daily life of PwIDs that live in group homes, intellectual limitations may make it challenging to translate theoretical information into everyday practice, to make decisions based on perceived needs, and communicate these needs to others (Douglas et al., 2015; Hellzen et al., 2018). Therefore, a resident's ability to participate in everyday decisions, as part for example of their PCP plan, is dependent on the interaction of the staff and the resident (Bigby et al., 2009), with support in decision-making for the residents being dependent on the attitudes of the staff (Bigby et al., 2009; Kåhlin et al., 2016).

Highlighting the need to remove the focus from the individual to understanding the existing practices which reflect everyday patterns of activity that govern the interaction between various stakeholders (Spotswood et al., 2021), such as group home managers, staff and residents, will provide a more inclusive environment to understand how health promotion theoretical information is translated into everyday practices. This creates challenges for the mainstream health promotion and downstream social marketing programs that focus on the individual to make personal changes and engage in a healthier lifestyle (Müller et al., 2019; Yen & Li, 2019), as is demonstrated in the next section.

# Enhancing Physical Activity and Wellness

## **Health Promotion Interventions to Increase Physical Activity**

A review of health promotion interventions to increase physical activity found that they depend on two significant factors: a person's readiness to change and a person's self-determination (Knittle et al., 2018). As we have explained above, this is deeply problematic for people with disabilities with limited agency, and Gappmayer (2019) provides a great illustration of the limitations of these approaches:

If self-determination guides a practice, it is necessary that the person deciding knows the consequences of the decision for themselves and other people. If the decision conflicts with the routine of the group home, or the caregivers think that the safety of any person or object is in danger, the decision and the occupation are restricted (p.12)

This also shows that health promotion can be complex in a group home context. It requires that the resident, staff, and management have knowledge of the long-term effects of physical activities and other health promotion matters (Bergström et al., 2013). Nevertheless, there has been an increase in health promotion interventions with a behaviour change focus to increase physical activity for PwID in group homes.

Most interventions focused on increasing health literacy and self-efficacy of the resident as a way to increase physical activity (Bazzano et al., 2009; Dunkley et al., 2018; Marks et al., 2019; Melville et al., 2015). The most prevalent type of intervention combined education with practical activities with the support of staff or a paid caregiver (Bazzano et al., 2009; Bergström et al., 2013; Marks et al., 2019; Valbuena et al., 2019). The interventions provided minimal understanding on how to tackle everyday lifestyle behaviours that co-occur in a group home. They were focused on training staff to conduct a physical activity intervention with no input from the resident (Bazzano et al., 2009; Bergström et al., 2013; Dunkley et al., 2018). Other interventions focus on increasing physical activity through rewards provided by the staff to reinforce behaviour (Valbuena et al., 2019).

No intervention provided a guide on how physical activity can be embedded in the culture of the group home through input from both the resident and the staff to be more inclusive and a pragmatic reflection of the daily routine of the staff *and* the residents, even though studies have shown that staff knowledge, time, and resources affect promoting a healthy lifestyle in a group home (Kuijken et al., 2016; Oviedo et al., 2019). The interventions reviewed did not identify the diverse components of group homes. Studies have shown that management support and deliberately chosen outcomes-focused strategies for supporting and supervising staff are necessary facilitators for the success of an intervention (Beadle-Brown et al., 2014; O'Leary et al., 2018). Another issue was that the interventions' duration were not long enough to enable the intervention to become a routine, which is a significant reason for the lack of sustainability with health promotion initiatives in group homes (Kuijken et al., 2020). Particularly, in group home settings where the support staff's daily routines are highly structured, physical activity interventions add to the staff's existing workload because it is not part of their daily schedule (Bossink et al., 2017). This, in turn, impacts the sustainability of the intervention and the PwIDs' ability to incorporate physical activity into their day. For this reason, it is imperative to design initiatives that embed physical activity in the daily routines of residents and staff.

Following on from these challenges with physical activity interventions for PwIDs, Latteck and Backhaus (2017) highlight the need for interventions that are relevant to the resident and routinely integrated into the resident’s everyday life by the caregivers. However, for PwID, the social and organizational environment plays a key role in health promotion (Marks & Sisirak, 2014; O'Leary et al., 2018; Schalock & Luckasson, 2021).

To date, the health interventions for PwID were primarily focused on the resident and staff level. They were based on behavior theories that attempted to change or understand a person's motivation to be physically active without considering their circumstances (Rhodes et al., 2019). In reality, PwID rely heavily on their immediate environment to support them and help them access facilities offering lifestyle activities (Steenbergen et al., 2017). The dynamics of everyday life are primarily overlooked when health promotion and wellness interventions for this population are implemented, and these interventions are not embedded into the daily lives of PwID (Kuijken et al., 2020; Naaldenberg et al., 2013).

## **Behavior theories in physical activity**

Successful health promotion and social marketing initiatives aiming to enhance physical activity in the general population have a theoretical underpinning (Knittle et al., 2018; Prestwich et al., 2015; Truong, 2014) which is a fundamental element of successful social marketing intervention (Rundle-Thiele et al., 2019). The behavior focus of interventions to promote physical activity for PwID relied primarily on individual and community-level approaches, which have been grounded in behavioral psychology and primarily two theories (Havercamp & Scott, 2015).

The first is social cognitive theory (SCT), which encourages learning from a goal-driven and activity-based experience at an individual level. Bandura (2004) states that SCT's core determinants are knowledge of the health risks and benefits, the perceived self-efficacy a person has over their health habits, and the expectations of doing and maintaining a healthy routine. All these require a certain degree of agency, which can be found in people without disabilities. However, for PwID, it is harder to make rational and autonomous decisions and choices about their behavior. Particularly for PwID who live in a highly structured environment, such as a group home. Nevertheless, SCT has been used in physical activity interventions conducted in assisted living or group homes (Bazzano et al., 2009; Bergström et al., 2013), yet this theory does not consider that the everyday life of PwID is influenced mainly by service providers (Ras et al., 2013).

The second theoretical framework is the Theory of Planned Behavior (TPB). The TPB (Ajzen, 1991) originates in social psychology and has been extensively applied to predicting health behaviors (Armitage & Conner, 2001). In essence, the TPB is an extension of the Theory of Reasoned Action (TRA), which proposes that people's behavior is determined by their intention to perform a behavior, as well as the person's beliefs, attitudes, and subjective norms towards this behavior (Madden et al., 1992). TRA assumes complete volitional control over behavior, while TPB supports the existence of actual or perceived constraints, adding the dimension of Perceived Behavioral Control (Ajzen, 1991). Again, perceptions, the cognitive ability, and a person's readiness to change are significant components of the TPB, yet, for a PwID, their willingness to increase their physical activity is very much influenced by the willingness of the staff who care for them to support them in that effort (Cartwright et al., 2017). Therefore, one of the barriers to the success of behavior-based interventions is the fidelity of implementation by the staff or paid/family caregiver (Bergström et al., 2013).

Psychosocial theories are limited in several ways. The focus on individual choice and responsibilization, in most instances, oversimplifies the complex set of practices that surround PwID. For well-being interventions to be truly inclusive, and by that we mean for PwID to have an active say in their everyday practices and not be affected by exclusion narratives and unintended consequences of health interventions, we need to take into account an individual's agency through an approach that is not rooted in behavioral sciences and individualistic norms. Studies have shown that an effective way to increase physical activity would be to focus on the behavior of the direct support professional (Phillips & Holland, 2011; Steenbergen et al., 2017). While the latter is a better approach than those focusing directly on changing the behavior of the PwID, it can still be problematic as it completely takes the focus away from the disabled person and, as we saw above, may not be sustainable.

There are many opportunities to explore ways to expand health directives for PwID and address health as an integral part of and a resource of everyday life (Scott & Havercamp, 2016). However, there is minimal literature on what interventions are successful for PwID who reside in group homes. Understanding the challenges of behavior change interventions for PwID, addressed above, will particularly help influence efforts to increase physical activity for PwID who live in group homes (Melville et al., 2011). We suggest that social marketing can play an important role in this direction.

## **Social Marketing Initiatives and Paradigms to Increase Physical Activity**

Social marketing focuses on finding solutions that lead to behavior and social change. It focuses on understanding and influencing behaviors by employing a systematic planning process that applies elements of commercial marketing principles and techniques to deliver a positive benefit for individuals and society (Lee & Kotler, 2019). To date, social marketing has been applied across the globe on a range of behaviors, including sexual health (Akbar et al., 2020), smoking cessation (Almestahiri et al., 2017), and promoting healthy eating habits (Carins & Rundle-Thiele, 2014). Despite its wide application to tackle various wicked problems (Lefebvre, 2012), social marketing has a limited footprint in the disability sector. Makris et al. (2021) provide a scoping review paper on the role of social marketing in decreasing health disparities for people with disabilities in primary care. In this review, they suggest there is a strong alignment between the social marketing framework and the social model of disability. By incorporating the social model of disability lens in social marketing, the focus on interventions will be less on the individual and more on the impact cultural norms have in health outcomes for people with disabilities.

Guzman et al. (2021) highlighted the importance of using social marketing in the disability field to improve quality of life. They particularly highlighted the importance of midstream social marketing approaches using a co-creation approach due to the importance of organizations and carers in the daily life of people with disabilities. Moone and Lightfoot (2009) focused on the effectiveness of using social marketing for older people with disabilities who live in centers for independent living. They suggest the use of the social marketing mix approach (product, place, price, participants, and partnering); however, as it has been described above, this approach can be challenging when it comes to PwIDs as they may not be able to express their needs.

When it comes to physical activity interventions, social marketing has been applied extensively in the general population (Goethals et al., 2020; Huhman et al., 2017; Kubacki et al., 2017), recognising the importance of supportive environments to enhance physical activity (Hennink-Kaminski et al., 2018; Luecking et al., 2017). Conceptually, increasing physical activity levels for PwID can conceivably be achieved through social marketing because of its potential to facilitate healthier lifestyles in various community settings (McKenzie-Mohr, 2000). However, its conceptual focus tends to foster downstream behavior change (Lefebvre, 2011; Spotswood et al., 2017). This downstream focus has the well-known limitations of focusing on individual agency and responsibilization (Crawshaw, 2012; Gordon, 2019; Walker, 2015) and an additional issue when it comes to closed settings, such as group homes, as it ignores the organizational shift because group homes are viewed as architectures that structure everyday life for PwID (Steenbergen et al., 2017).

Midstream social marketing solves this problem as it can work at a social settings level to reorganize and design places that better support physical activity for PwID (Wood, 2016). In addition, upstream social marketing can lead to legislation changes and a more comprehensive environment, such as the infrastructure around group homes that could provide better and safer places for physical activity (Gordon, 2013). However, for these to be effective, an in-depth understanding of how and why PwID engage with physical activity practices is vital to make mid and upstream changes. Bhat et al. (2019) reinforce this when reviewing social marketing initiatives that focus on wellness recommending an upstream approach to "avoid criticism by their target audience whose behavior is not always under their control" (p.83). While both these approaches complement downstream social marketing interventions, they face similar issues to those discussed above about the overreliance of group homes’ interventions on staff’s initiatives. In addition, the upstream approach, while focusing on policies as the site of intervention, still does not solve the problem of embedding physical activity into daily routines.

Systems social marketing is a holistic approach to behavior change, advocating for a top-down, bottom-up approach, concentrating on the ebb and flow of the structural and behavioral dynamics in the system to achieve system-wide change (Flaherty et al., 2020). Systems social marketing engages in stakeholder involvement and dynamic causality, seeking "to understand and examine the structures, functions, processes, and environments in which individuals engage" (Flaherty et al., 2020, p. 159). However, systems social marketing relies heavily on behavioral dynamics for systematic change to occur (Domegan, 2021). In addition, in the context of critical disability studies (Shildrick, 2019) that argue for disabled people to be treated as "autonomous subjects" instead of "passive objects", a systemic approach does not help towards this reimagination of the disabled person. Therefore, for PwID in assisted living conditions with limited agency and control over their environment, a systems approach can also be perceived as a neoliberal approach to solving the problem.

In addition to the previous critique, the social model of disability suggests that constructing solutions should not be directed at the individual but rather at society (Goodley & Rapley, 2002), and Schillmeier (2007) suggests that disability should be seen as a complex set of heterogeneous practices linking nature and culture. Critical (social) marketing literature (Gordon, 2019) has identified issues of social marketing’s neoliberal drive (Tadajewski, 2010), the focus on behavior change that leads to responsibilization (Crawshaw, 2012; Eckhardt & Dobscha, 2019), as well as the lack of inclusivity and the marginalization of certain groups (Gurrieri et al., 2013). To overcome the above challenges posed by the current social marketing approaches, a reimagination of social marketing is necessary if we are to support the health and well-being of people with disabilities and other vulnerable groups with similar characteristics, given the specific nature of these groups as it was described earlier in this paper.

For these purposes, a "meso-level" theory, which combines agency and structure (Warde, 2005), maybe the most relevant approach. Social practice theory (SPT) conceptualizes and analyses the social organization and performance of practices because the analytical unit is not the behavior or the system but the practice which is influenced by both agency and structure (Schatzki, 2016). Therefore, it provides a meso-level angle that the previous social marketing approaches and accompanying theories, which we described earlier in this paper, fail to do (Lefebvre, 2012). SPT has been explored in relation to public health interventions (Blue et al., 2016; Cohn, 2014), public policy (Shove, 2014), behavior change (Hargreaves, 2011), and social marketing (Beatson et al., 2020; Spotswood et al., 2017; Spotswood et al., 2021). These studies have raised the importance of SPT in (a) shifting the focus from the individualistic narratives of responsible individuals, who should have the ability to change their behaviors and adopt healthier habits, to social practices; (b) changing narratives that often blame the individuals for adopting unhealthy behaviors; (c) changing the focus of interventions by making practices the sites of interventions; and (d) restructuring the process of designing and implementing health promotion and social marketing initiatives.

All these benefits from using SPT are important for various settings and populations, and we argue that they are even more important for people with disabilities due to their lack of or reduced agency, particularly within certain settings (group homes). We build on the above observations to reimagine social marketing to become an appropriate approach for vulnerable and marginalized populations, such as for PwIDs. So, this paper adds another element towards this more inclusive critical social marketing paradigm that has the potential to better support change for people with disabilities and other vulnerable groups. In doing this, the focus is shifted from behavior to practice change, so SPT is explored and discussed further in the following sections.

# Social Practice Theory and Disability

Social Practice Theory does not refer to one theory but instead to a group of social and cultural approaches that highlight "the routinized and performative character of action" (Reckwitz, 2007, p. 1). Bourdieu (1990) suggested that all human experience is shaped by practices that stem from the interaction between people and their social world. According to Schatzki (2005), practices are the center of social life and are defined as "organized, open-ended spatial-temporal manifolds of actions" within the site of the social that it is described as "a mesh of practices and material arrangements" (Schatzki, 2005, p. 471). Individuals act as carriers of a practice (Schatzki, 1996), and in contrast to behavior theories, SPT focuses on the body and mind as elements of routines and meanings which entail that the disabled person is still there as the performer - the carrier- of the practice (Maller, 2017). In the disability context, Schillmeier (2007, p. 195) suggests that "disabilities are the effect of complex sets of heterogeneous relations that link bodies, material objects, and technologies with sensory and other practices" and so the importance of focusing on practices when studying and supporting people with disabilities is highlighted.

In this paper and in the context of studying disability through an SPT lens, we adopt Shove et al.’s (2012) conceptualization of practices. According to Shove et al. (2012), three phenomena organize practices: meanings, materials, and competencies. Materials include tools, objects, and infrastructure; meanings are about why we do things and how, based on cultural norms and shared meanings; and finally, competencies refer to bodily skills and intellectual ability. This can be understood by viewing the interactions through the three phenomena of meanings, materials, and competencies, which take into account the multilevel complexity of the 'doing' of the body and mind, which behavior theories cannot do, as it was explained in the previous sections. These interactions allow for practices maintenance, reproduction, or disruption/change (Hargreaves, 2011). This further supports our argument that social marketing can learn from SPT, which focuses on these elements, instead of the individual or the external environments and systems, to better support people with impeded agency to adopt healthier practices. Another advantage of SPT is that it overcomes the agency-structure dilemma. Nicolini (2012, p. 69) highlights that "practically intelligible, creative agency and institutionalized patterns of action are not opposed and co-exist and presuppose each other in practice." Therefore, if we want to support people with disabilities to make changes in their daily lives, we need to understand the interplay of agency and structure. We need a better understanding of how the mind and body interact with social structures and how reduced ability to use one's body or mind can be better supported by appropriate structures to ensure the performance of certain practices.

In disability studies, Thibodaux (2005) suggests that "health lifestyles of persons who experience disability are collective patterns of health-related behavior aimed at minimizing the effect of potentially disabling conditions and maximizing the capability for social participation." Thibodaux (2005, p. 509) also demonstrates that people with disabilities follow patterns of responding to life chances and using resources to create healthy lifestyles. These daily routines and practices and how PwID perform daily practices inform their disability experience. PwID are not passive recipients of a particular lifestyle; instead, they "embody their own discourse"; they control their life.

In the same line, Schillmeier (2007) suggests that a shift from *disability*, which focuses on the individual, to (*dis)abling practices* is necessary.

Dis/abling practices do not sum up as socio-structural modes of oppression or as mere individual tragedies suffering an a-normal bodily or mental condition …rather, dis/abling practices are mediated cultural/natural relations and make apparent that human affairs extend into the non-human, reconfiguring the spatialities and temporalities of societal relations (Schillmeier, 2007, p. 198).

To further illustrate Schillmeier’s (2007) dis/abling practices, people who live in group homes see institutional support as part of their social support (Clement & Bigby, 2010). The norms within this institution also mediate and reproduce power, which can reinforce or undermine power (Foucault, 2020). Svanelöv (2020) elaborates further by stating that power practices constitute and legitimize what is acceptable and desirable, where the residents are in a subordinate power position where their " participation is constructed by powerful guidelines based on normality" (p.1437). The lack of agency reinforces the substitute decision-making for PwID in group homes, rather than fostering increased agency through supported decision-making (Carney et al., 2019). The premise is based on a socially embedded cultural value attaching cognitive impairment to a lack of agency and capacity for personhood (Quinn, 2020). Finlay et al. (2008) highlighted that some staff are unsure how to promote power and thus agency because these are often seen by staff as conflicts with policies and rules of the group home. This seems to reinforce that organizations, in this instance group homes, are rule- or norm- governed by social practices (Finlay et al., 2008). However, Downey and Catterall (2007) found that homebound people who depend on a support network of caregivers but not in certain settings with predefined policies and rules, often get back their lost agency through these networks. As a result, these networks are fundamental for interventions to improve the well-being of people with disabilities. In this context, the disabled person's caregiver or personal assistant becomes an object, a material (Maller, 2017), that the disabled person can use to perform certain practices. Therefore, the caregivers' network is an essential element of the practices of the disabled person and can lead to a desirable change for the disabled person.

As noted earlier, physical activity should be more ingrained and normative and an unreflexive part of everyday life rather than a discrete program or campaign (Reis et al., 2016). Hargreaves's (2011) application of SPT to a pro-environmental behavior change program provided a more holistic and grounded perspective of the behavior change processes because SPT offers a perspective over and above individuals' attitudes or values.

Organizational level interventions have limited success because the interventions had issues with fidelity, could not be sustained by the staff and were not part of the PCP for the resident (Bergström et al., 2013; Lynnes et al., 2009; Melville et al., 2015). SPT provides the ability to view organizational routines in a novel way because it focuses on the 'doing' of these routines in practice as the core unit of analysis (Wenzel & Stjerne, 2021). Therefore, SPT shifts the focus on unpacking the production of these routines by observing how actors (re)produce organizational reality through every day contextual practicing (Gherardi, 2001; Nicolini, 2011). Finally, SPT has the potential to conceptualize the way practices configure deeply entrenched every day patterns of activity, including those that foster or work against physical activity (Blue et al., 2016; Maller, 2015; Paddock, 2017).

# Discussion: Social Practice Theory for Social Marketing Interventions

Social Marketing initiatives that rely on the individual's capacity to change, as Spotswood et al. (2017) state, fail to challenge social conventions, adding to the reproduction of inappropriate activity. In addition, overreliance on personal responsibility and behavior change can lead to marginalization and stigmatization of certain groups that do not have agency to change, such as people with disabilities. The previous review of existing interventions highlighted a need to adequately address the factors that impede or facilitate physical activity as perceived by all parties involved (Michalsen et al., 2020), which a practice-based social marketing approach can do. In addition, the application of social marketing in the disability area is still in its infancy, and current studies show a slow move beyond the mainstream social marketing approaches but still within the agentic narrative. Moone and Lightfoot (2009) adopted a marketing mix approach that draws upon down- and mid-stream social marketing paradigms, and as a result, it does not overcome their limitations when it comes to populations with reduced agency. While Guzman et al. (2021) have moved beyond the mainstream marketing mix framework, their co-creation approach is still agentic and so does not overcome the challenges of the mainstream social marketing approaches that we discussed earlier in the paper. Therefore, we build on this previous work and we recommend a reimagination of social marketing using a SPT lens. Makris et al. (2021) highlight the need to adopt more of the social model of disability for social marketing to be more inclusive for people with disabilities. This is in line with what our paper recommends. Our paper suggests three ways that SPT can lead to a social marketing reimagination, which is especially relevant for PwIDs and can be extended to other vulnerable and marginalized groups.

*Social marketing as an inclusive approach*. SPT helps social marketing initiatives to overcome any unintended consequences that lead to the exclusion of certain groups (Gurrieri et al., 2013) because the focus of analysis and intervention is on practices, their elements, and the practices’ bundles and nexuses, instead of behaviors. Using Schatzki's (2016) flat SPT ontology would require the social marketing intervention to observe one single level of social reality, not perceiving the micro and macro levels as being different. The social phenomena, commonly described as macro phenomena, are seen as a web of intermingled practices (Schatzki, 2016). This can happen by looking at the patterns of practice not as separate segments of people and behavior but as habits and routines, unraveling the relationships between the staff, residents, and the site (Spotswood et al., 2021). All of the elements of the site of the intervention, i.e., meanings, materials, and competencies, that shapes "how human lives hang together", (Schatzki, 2016, p. 19) will be seen as significant to change practices.

Using Shove et al.’s (2012) conceptualization of practices as three interconnected elements of materials, meanings, and competencies, the following aspects should be captured by social marketers aiming at designing physical activity interventions for PwIDs. In a group home, materials reflect group home infrastructure, recreational facilities, the surrounding neighborhood, organizational policies, and funding. Therefore, a practice-based social marketing approach would view the practices that impact the degree of social inclusion of the residents into the surrounding neighborhood. These facilities structure the resident's daily life, such as private bedrooms and gardens at the home, as well as the policies of the group home, including job descriptions and how they inform the power and practices of the staff. These are crucial elements that will enable an understanding of the potential barriers to changing a practice from disabling to abling. Meanings are represented through workplace culture, staff-resident relationships, group home norms, routines and conventions, self-efficacy, and stigma, exemplified in the staff's relationship with the residents. Meanings can be detected by answering the questions: Do the staff respect the resident? What level of control do the staff have over the resident’s daily practices? Are the group home routines and conventions flexible enough for the resident to exert some control (agency) to amend their daily routine? Competencies include communication skills, ambulatory level, and level of intellectual disability. Taking these elements into account will enable a social marketing initiative to become an embedded daily practice until new practices are introduced, adopted, and become the new norm. In this context, the social marketing planning process (Ong & Blaire-Stevens, 2010) will interact with old and new practices in a cyclical process of constant improvements to support the adoption and maintenance of desirable practices from vulnerable populations, such as PwID.

In addition, inclusivity here obtains another meaning as through a practice-based social marketing the identification of other practices that may influence the practice in which we are interested (Hui, 2017) is vital. This means that social marketers will create interventions that will affect bundles and nexuses of practices leading to more holistic approaches to health and well-being. According to Blue (2019), practice connections can be synergistic or antagonistic, so these connections must be identified and understood to implement appropriate social marketing interventions. Schillmeier (2007) suggests focusing on (dis)abling practices by identifying disabling practices and turning them into abling practices if we are to improve the health and well-being of people with disabilities. For example, physical activity practices for PwID in group homes can be influenced by power practices (Svanelöv, 2020), which can be disabling practices in their current state. Staff- resident dynamics, staff-management dynamics, and the overall culture of the group home that facilitates power practices can be transformed through a practice-based social marketing approach. A practice-based social marketing approach, for example, can target and change power practices through the re-configuration of policy arrangements (materials) and staff-management-resident dynamics (meanings) that will enable the adoption of desirable physical activity practices, turning them into abling practices. Therefore, the outcome will be a re-configuration of elements, relationships between elements, and interactions with other practices, as these have been identified during the scoping stage (Hargreaves, 2011). This re-configuration is expected to lead to new, desirable practices with potentially new relationships among the three elements and new interactions with other practices.

*Social marketing as a tool to reclaim agency*. Hastings (2013) suggests that social marketing can be a tool for consumers to reclaim their power from corporations. In the case of people with disabilities, power is intertwined with agency, and it is the reduced or lack of agency that leads to power imbalances for PwID. The social context of PwID is significant because of the limited ability PwID has to address changes themselves and rely on support from their social network. SPT enables the PwID to be part of the intervention and facilitates a better understanding of what practices are inclusive or exclusionary in the daily life of PwID in group homes. If we want to know how to change a social practice over time, it does not make sense to ask what motivates or constraints individuals to adopt a more active lifestyle (Blue et al., 2016), and for PwID, this may not always be possible, but this does not mean that PwID should be excluded from the decision-making process. So capturing the meanings and the competencies of the practices carriers (Maller, 2017), through formative research, provides insights that social marketing can use to design interventions that empower PwID. This is because what enables or disables agency for PwID through everyday practices can be captured, leading to reconfiguration towards abling, agentic practices (Schillmeier, 2007). These practices, for example, can foster increased agency through supported decision-making (Carney et al., 2019) that will realign meanings of power and agency within the group home as well as competencies supported by relevant materials that promote agentic practices, which in our example will embed physical activity.

For example, through formative research, we may find out that PwID like to spend (more) time in the garden (meanings), a practice that will also help them increase their physical activity. However, this may not be possible because it is not on their PCP (materials) and because when carers are around, they have to do certain scheduled activities (meanings), such as an organized outing for all the residents regardless of residents’ desire or ability to spend time in the garden. This is because there are no rules that enable the resident to make an independent choice and the PCP (materials) is the primary document the carers use to schedule the day-to-day activities of the resident, which must also align with the carers job description (materials). Social marketing can design initiatives that reconfigure these practices by looking at these three elements (materials, meanings, and competencies) and their connections. This may include the introduction of new materials and meanings, such as a new policy that allows a more frequent update of resident’s PCP based on their need to be in the garden (new meanings) and on recognition of their competencies by the staff. In addition, introducing a regular supply of warm clothes and a canopy/tent (new materials), so that residents can stay in the garden regardless of the weather conditions will further support this practice as it will allow for activities that used to take place inside to take place outside. New competencies, such as retraining staff to perform activities in a way that incorporates light physical activity that can take place outdoors, can further enable residents to walk or garden (physical activity embedded in the routine). At the same time, agency is reclaimed because the reconfigured practice is in line with the PwIDs preferences (meanings and competencies), and the staff understanding of their role, and their power, has changed (new meanings and new competencies).

Supporting abling practices helps PwIDs and other vulnerable groups to reclaim their lost agency and be treated as autonomous subjects (Shildrick, 2019). Downey and Catterall (2007) found that reclaiming agency through the configuration of certain elements, such as support networks and the meanings people assigned to these, can lead to reclaiming lost agency for people with disabilities, and we argue that this reimagined social marketing can play a vital role in this direction.

*Social marketing as a meso-level approach.* Drawing from SPT, which is a meso-level theory bringing together agency and structure (Warde, 2005), we suggest that social marketing can be reimagined as a meso-level approach. In a setting such as a group home, practices need to be analyzed in consideration of the specific surroundings and context (Schmidt, 2012). Questions such as are the daily routines of the resident a reflection of their PCP or organizational practices? Is there potential for daily practices to be co-created between the resident and the staff? Are resident capabilities fostered or not? For example, some residents may have never been taught to make a bed or do it so slowly the staff takes over this practice because they can do it faster and not delay their scheduled practices for the day. Through Shove et al.’s (2012) conceptualisation of practices as entangled meanings, materials and competencies, the residents’ ability to make their bed is not just a reflection of their competencies (or lack of them) to perform this practice. Instead, it can be seen as a disruption of meanings reflected through the staff’s wrong perception that the resident is unable of making their bed. The perception has been compounded by the staff’s strict timetables (materials), and the importance of sticking to a schedule (meanings) rather than helping the resident learn a new skill (competencies). This may indicate that the staff member does not value the resident as an adult capable of learning.The staff’s power in the group home negatively affects the agency of the resident and shows how meanings (here staff perceptions) and competencies (here PwIDs ability to make the bed) are strongly connected parts of the “making the bed” practice in group homes by PwIDs.

These insights can be helpful to inform a practice-based social marketing approach. We can use social marketing tools to exchange one habitual practice with another by addressing the elements of competencies, materials, and meanings that are causing the unhealthy practice or disrupt the desirable practice. In the bed-making example above, the power issues lie in the staff’s material and meanings, which need to be addressed at the meso-level to ensure the day-to-day competencies of the resident can be increased or better supported. Shove et al.’s (2012) elements of ‘competence’ are inextricably linked here with the *meaning* of the practice, which shifted from ‘being another domestic chore into being a highly desirable learning goal for the resident’ (Williams et al., p 13). However, as it has been discussed previously, PwIDs often lack the desirable competencies and this is where staff’s support is vital to “provide” the missing element of the practice. In addition, when practice-based SM initiatives are taking place, the value and rights of disabled people have to be at the heart of change (Williams et al., 2018).

In general, social marketing focuses on working adaptively with multiple stakeholders (Buyucek et al., 2016) and is well placed to work with the messy and iterative methods required to understand how group home culture influences the physical activity level of PwID. Mid and upstream social marketing would benefit the most from applying a SPT lens to the initiatives undertaken and use the learnings into designing appropriate and more inclusive sites (Schatzki, 2005; Williams et al., 2018) that support embedding physical activity practices into the daily lives of PwID in group homes. These are in line with the two studies that highlighted the importance of partnerships (Moone & Lightfoot, 2009) and co-creation (Guzman et al., 2021) for social marketing's effective application in the context of disability.

However, we argue that the meso-level approach supported by the SPT suggests an organization-based social marketing approach can facilitate inclusion and reclaim agency for PwID in group homes. Papakosmas et al. (2012) has started to describe this as an organization-based social marketing (OBSM) approach that ‘focused on behavior change needs of the social collective of employees’ (p.5). By using SPT, we take this idea one step further and focus on the significance of the setting of the practices and how the setting influences the way a practice is interpreted by the staff, who sees it as a place of work and the resident who sees it as their home. Practice-focused OBSM will provide insight into why people are doing what they are doing holistically and move beyond the individual’s perception and reflection of one’s own activities. Looking at the group home as a micro-organization where the organization's practices are entangled in the daily practices of management, staff, and residents would help overcome the problematic individualistic values that have been found in care for people with intellectual disabilities (Gappmayer, 2019).

# Conclusion

The paper highlights the benefits of a social practice approach instead of the positivist reductionist paradigm more commonly used in health promotion, social marketing, and behavior theories-based interventions focusing on increasing physical activity.

Practice-based social marketing introduces a novel way to enhance the effectiveness of initiatives to improve the daily lives of PwID who reside in group homes. In this process, it is hoped that social marketers can move from doing interventions to supporting voluntarily, unreflexive, normative, and embedded healthier practices into the lives of the chosen community. This can be done by considering the potentially significant role group home practices have on embedding wellness programs into the daily routines of the PwID and the staff who support them.

As demonstrated in this paper, behavior change approaches, including downstream social marketing, have been criticized for their individualistic focus that places the responsibility on the individual, promotes agentic change, and threatens inclusivity. For social marketing to become a more inclusive approach for people with reduced agency, such as people with disabilities, older people, immigrants, and single parents, we suggested shifting towards the less individualistic site ontologies that put practices at the center of social life. By doing this, the paper contributes to the emancipation of social marketing and adds to similar efforts, such as systems thinking, power, and reflexivity in social marketing (Gordon, 2019).

To support our position, we showed how physical activity for PwID who live in group homes can become a more ingrained part of everyday life and how social marketing can contribute to this effort by learning from SPT. This approach will also help overcome the power imbalances these demographics often face, particularly in closed settings, such as group homes (Finlay et al., 2008). So, we propose a social marketing narrative shift from behavior change to practice change.

Practice-informed social marketing could help shape group home physical activity by decentering individuals and bringing practices center stage. Social practice theory can guide social marketing program development and implementation by highlighting the significance of the complex relationships among bodies, material objects, structures, technologies, and meanings that form daily practices. By focusing beyond the individual's capacity to act independently (neoliberal narrative of agency) and at the same time embracing and valuing deviancy in how certain practices can be performed, vulnerable and marginalized individuals can be supported by appropriate structures to become the carrier of the desired practices, regaining their agency.

Finally, this paper uses group homes to provide a tangible example of how a reimagined, SPT-informed social marketing approach, a practice-based social marketing, could improve the health and well-being of PwID. For SPT provides an alternative, inclusive lens in social marketing that brings together agency and structure to achieve healthier lifestyles for a vulnerable and marginalized population, such as PwIDs, in any community setting.

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