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Quality of Life and Social Integration of Psychiatrically Disabled Citizens in Community Residences

by

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ABSTRACT

As part of a study sponsored by the Quebec government this investigation evaluated the subjective quality of life (QOL) and social integration (SI) of 70 deinstitutionalized chronic psychiatrically disabled citizens living in community residences in the Outaouais region. An extant QOL interview (Lehman 1988) was translated into French and modified to include social integration data. The revised quality of life and social integration (QOLSI) instrument was based on a conceptual model derived from subjective quality of life, person-environment (P-E) congruence, social integration, and normalization/social role valorization theoretical perspectives. Individual interviews were conducted with 37 male and 33 female residents of community housing. Data were gathered on demographics, objective quality of life indicators, global subjective quality of life measures, domain-specific subjective quality of life and personal preference indicators in ten life domains, client satisfaction with services, self-esteem, level of client activity inside and outside the residential placement, and frequency of activities with socially valued others.

Respondents were interviewed in a variety of settings, including family-care homes (n = 55), group homes (n = 10), sheltered apartments (n = 4), and an apartment hotel (n = 1). Urban residential services were located in Aylmer, Gatineau, and Hull. Rural residential services were located in the western Quebec region. Housing services were evaluated using the French-language version of PASSING--Program analysis of service systems' implementation of normalization goals (Wolfensberger, and Thomas, 1989).

The QOLSI interview data were analyzed according to the multivariate relationships in the Comprehensive conceptual (QOLSI) model. The findings indicate that the translated and modified interview replicated earlier findings with the English-language version. The

Échelle de Satisaction de Vie (ESV) was found to be as good an indicator of global subjective QOL as the Item du Bien-être Global (IBG), while offering the advantage of superior psychometric qualities. The best predictor of global subjective QOL was satisfaction in life domains. Personal preferences improved the prediction of domain-specific satisfactions in six of eight life domains. Preferences and social integration (SI) did not add significantly to the prediction of global subjective QOL. Global subjective QOL and SI were not related. Frequency of activity outside of the residential service (i.e., weak social integration) was best predicted by a combination of variable sets including: personal characteristics, OQL indicators, SQL measures, and preferences. Frequency of activities with socially valued others (i.e., strong social integration) was best predicted by age, health, and satisfaction with family contacts. Location and size of residence were negatively related to service quality as measured by PASSING. The findings generally supported the proposed QOLSI model. Preference measures and the SI scales are argued to offer guidelines for the efficient allocation of service resources toward program interventions that favour improved SQL and SI for the psychiatrically disabled residents of community residences. However, further research on these newly developed measures in relation to SQL and SI is recommended before they are adopted by program planners.

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DEDICATION

for ALEXANDRE

PREFACE

Background to the Thesis

In early 1988, the Conseil Régional de la Santé et des Services Sociaux de l'Outaouais (CRSSSO) in Hull, Quebec, received an evaluation report on the implementation of new mental health services for the Outaouais region (Pelletier, 1988). The report suggested that higher quality of service and improved quality of life were needed in community-based residential services for people with chronic psychiatric disabilities in the region. Following this report, the CRSSSO asked the supervisor of this thesis (Dr. Robert J. Flynn) to submit a research proposal for an in-depth evaluation of the quality of residential services and the quality of life in community residences within the Outaouais region of Quebec. In funding the proposal that was subsequently submitted, the CRSSSO wanted an evaluation and recommendations that would allow it to enhance the lives of residents of community homes in its region. A descriptive evaluation report was subsequently submitted to the agency (Dansereau, Duteau, Ely, and Flynn, 1990). This thesis, which presents a complete detailed analysis of the evaluation data has specific policy implications in relation to Quebec's recent mental health policy and rehabilitation goals which emphasize the importance of social integration, quality of life, and the normalization of the handicapped person's environment (Bolduc, 1989; Gouvernement du Québec, 1977, 1987, 1988).

From the outset, we (the researchers in this investigation) understood that this first evaluative survey of objective and subjective QOL and of SI would have to confront numerous problems of definitions and methods, because earlier research in this field had not yet developed widely accepted, standardized measures, particularly in French. Our goal was

to provide a conceptual framework, evaluation methodology, and initial wave of data that would inform and guide later evaluations of community residences for people with psychiatric disabilities.

Chapter one presents the background to and purpose of the thesis. It provides an overview of the research objectives and a comprehensive review of the literatures relevant to three issues: quality of life (QOL), social integration (SI), and community housing for chronic psychiatrically disabled (CPD) citizens. Chapter two presents the eight research hypotheses and the rationale underlying each one. Chapter three provides a detailed description of the research methodology, including descriptions of the sample, instruments, procedures, and data analyses. Chapter four presents the research findings. Chapter five discusses the findings, presents the strengths and limitations of the study, and suggests directions for future research. The chapter closes with some final remarks.

CHAPTER 1

INTRODUCTION

Purpose of the Thesis

The general purpose of this research was to investigate the quality of life (QOL) and social integration (SI) of deinstitutionalized chronic psychiatrically disabled citizens living in community residences in the Outaouais region of Quebec. A subsidiary goal was to establish the utility of a conceptual model and program evaluation methodology centred on subjective quality of life (QOL) and social integration (SI) measures. The intention was to demonstrate that subjective QOL and SI measures can have practical value in the evaluation of community psychiatric rehabilitation programs serving deinstitutionalized clients. To date, relatively few researchers have attempted to derive a theoretical framework or practical evaluation methodology focused on quality of service or quality of life (Hall, Nelson, and Smith Fowler, 1987; Lehman, 1989; Lehman, Possidente, and Hawker, 1986; Nelson and Smith Fowler, 1987; Pinkney, Gerber, and Lafave, 1991). Some researchers have investigated social functioning and adaptation in relation to community housing services (Kruzich and Berg, 1985; Murphy, Engelsmann, and Tcheng-Laroche, 1976; Linn, Caffey, Klett, and Hogarty, 1977), while others focused on social integration (Kruzich, 1985; Kruzich and Kruzich, 1985; Segal and Aviram, 1978; Segal, Everett-Dille, and Moyles, 1979). However, few investigations have simultaneously considered both subjective QOL and SI (Mercier, 1991; Mercier and Corton, 1989), and almost no research consideration has been given to the relationship between subjective QOL and SI as predictors of service delivery quality with this population (Kennedy, 1989). Earlier evaluations of the quality of life (QOL) of chronic

mentally disabled citizen have been restricted to comparisons with the well-being of normal populations (Cheng, 1989).

Historically, the quality of service delivery systems for chronic mentally disabled citizens has been evaluated in terms of social adjustment, employment, and/or recidivism (Dion and Anthony, 1987). However, such evaluative criteria have been argued to offer little useful predictive utility in relation to program inputs and subjective QOL (Baker and Intagliata, 1982; Lehman, Ward, and Linn, 1982). This tends to be discouraging for program managers and for clients. Numerous researchers in mental health rehabilitation have argued that it may be more practical and useful to assess the merits of community-based mental health services in terms of client satisfaction with services (Anthony, Cohen, and Vitalo, 1978; Baker and Intagliata, 1982; Cheng, 1989; Lehman et al., 1982; Nelson and Smith Fowler, 1987; Pinkney et al., 1991; Thapa and Rowland, 1989). Measures of client satisfaction are useful because poor quality of life, if subjectively defined, may be seen as a problem statement (Cheng, 1989). As such, subjective QOL measures can indicate to program planners areas where changes in service delivery are needed. For example, poor client satisfaction with leisure services may suggest the need for better planning to meet client needs. Domain-specific satisfaction measures (e.g., in the leisure domain) appear promising as needs assessment tools in that they can indicate to program planners aspects of their program needing revision. In this sense subjective QOL measures can best be combined with OQL indicators of program quality. Similarly, SI also is a need, and measures of SI can help identify the impact and efficacy of interventions in meeting SI needs.

Satisfaction measures alone, however, fail to provide program planners with indications as to which specific changes are most needed and would most influence client

satisfaction in various life domains. Another limitation of subjective QOL indicators is that they do not correlate very highly with domain-specific objective quality of life (OQL) indicators (Baker and Intagliata, 1982; Lehman, 1983b; Cheng, 1988; Diener, 1984). Because OQL measures usually pertain to program inputs, the usually weak correlations between subjective QOL and OQL measures have tempered the faith that program managers have placed in the validity and applicability of subjective QOL criteria for the assessment and refinement of their inputs into community-based programs. In light of the foregoing comments, an important element of this investigation was the formulation of a heuristic model that would guide the application of measures that could help clarify which types of program changes might best improve the subjective QOL and SI of clients. Finally, QOL and SI are two principle goals that form part of the Quebec government's general rehabilitation policy for chronically disabled citizens (Bolduc, 1991). A better understanding of how client and residence characteristics contribute to subjective QOL and SI would be directly relevant to that government's mental health policy (Bolduc, 1991).

Review of the Quality of Life Literature in the General Population

Major Studies

The first major study of the QOL experience was based on a probability sample of the American population (Gurin, Veroff, and Feld, 1960). This national survey had a mental health orientation and used measures that attempted to assess the psychological health of the respondents. Respondents completed a questionnaire that presented a checklist of "psychiatric symptoms," asked for a report of any previous "breakdown" or need for psychological

counselling, and inquired into various forms of "worry." It included only one question asking respondents to report how "happy" they were; very happy, pretty happy, or not too happy. The interrelations of the various measures were analyzed and reported along with the distribution of measures in the major segments of the population. Generally, the findings indicated that few people chose to describe themselves as "not too happy." Most of the adult population (85-90%) put themselves in one of the two higher alternatives. This tendency was greatest in younger respondents and those who lived in smaller towns and rural areas. This finding has important implications in relation to our study.

The second major study on the QOL experience also focused on mental health in the community by relying on the affective aspects of experience. In the early 1960s, Bradburn and Caplovitz (1965) of the National Opinion Research Centre initiated a program of research whose goal was to establish national norms and trend lines for mental health-related behaviour by means of periodic national surveys. Toward this end, they developed survey measures of the mental health of individuals. These instruments attempted to operationalize the notion of situational "difficulties in living" (Bradburn, 1969). Four mid-western communities were sampled on one basic measure of well-being: "Taking all things together, how would you say things are these days---would you say you are very happy, pretty happy, happy, or not too happy these days?" The respondent's position on this measure was found to be related to the "relative balance of two independent conditions: positive and negative feeling states" (Bradburn and Caplovitz, 1965). Thus, their focus on the affective aspects of problems-in-living led them to concentrate on respondents' self-reports in the areas of psychological well-being, life satisfaction, and happiness. Bradburn later expanded this concept of positive and negative affect balance into other realms such as marriage and work. His theory of

psychological well-being is based on the notion of emotional balance rather than on the differences in the type of needs an individual has (Bradburn, 1969). An unexpected finding from Bradburn's "affect balance scale" procedure was that the positive and negative affect measures were orthogonal to each other.

The third major study of the subjective QOL experience was undertaken by Cantril (1965). He was primarily concerned with comparing the concerns and satisfaction levels of citizens in 13 countries. Interviewers encouraged respondents to report their hopes and fears for the future. The free-answer comments served to identify concerns. Although the terms "happiness" and "satisfaction" were used interchangeably by Cantril, his emphasis (unlike Bradburn's) was not on affective states but rather on aspirations, needs, and satisfactions. Toward this end, Cantril developed the "self-anchoring rating scale." The technique involved asking respondents to think of "the best life" and the "worst life" imaginable and to place oneself at the point where one thought he/she presently stood on a scale ranging between these extremes. The level at which individuals placed themselves was Cantril's critical measure. At another point in his research, Cantril arrived at this measure more directly by asking respondents to localize their current satisfaction with life on a life satisfaction ladder. Cantril was the first researcher to conceptualize well-being as a cognitive experience in which the individual compares his/her perceived actual situation to a situation which he/she aspires to, expects, or feels to be deserved (Campbell, Converse, and Rodgers, 1976). The discrepancy between one's perceived life and one's aspired-to life is expressed in a measure of satisfaction-dissatisfaction. Greater satisfaction is then taken as an indicator of a sense of well-being.

The fourth and fifth major studies on the QOL experience were national surveys on the quality of life of Americans. Both studies, which are particularly relevant to this thesis, were undertaken by researchers from the Institute for Social Research at the University of Michigan during the mid 1970s and both studies were primarily concerned with the subjective experience of life; that is, the individual's perceptions of well-being rather than objective indicators. They reported extensive data on how subjective life quality relates to sociodemographic variables such as income, education, marital status, health, and so on (Andrews and Withey, 1976; Campbell et al., 1976). These investigations provided fundamental data that suggested rather weak relationships between sociodemographic variables and people's own sense of well-being. Both studies gave considerable attention to "general" or "global" measures of well-being, but also investigated satisfaction with respect to life domains or specific life concerns. Researchers working with psychiatrically disabled populations have relied on these two studies to guide their development of subjective QOL concepts and measures.

In the sixth major study on the QOL of Americans, Flanagan (1978; 1982), applied his "critical incidents" technique. He arrived at results comparable to those reported by the Michigan studies. His research was concerned with developing an empirical approach to defining the main determinants of subjective well-being in representative samples of three age groups of Americans (i.e., aged 30, 50, or 70 yrs). His survey of 3,000 subjects of various ages, races, and backgrounds focused on their needs and wants, produced 6,500 critical incidents and led him to identify 15 factors that define quality of life. These 15 life domains were grouped into five categories or dimensions that were most frequently described by both sexes as important. They included health, children, understanding oneself, work, and spouse.

However, the five dimensions that correlated most highly with subjects' reports of overall quality of life (QOL) were material comforts, work, health, learning and education, and active recreation.

Generally, the findings from these studies showed that different results may be produced by ratings of happiness (e.g., Bradburn studies), measures of feelings (e.g., Cantrill's self-anchoring scale), responses ranging from "delighted" to "terrible" (Andrews and Withey), ratings on seven-point scales from "completely satisfied" to "completely dissatisfied," or reports on the extent to which needs and wants are met on a scale going "very well met," to "not at all well met." Finally, minor changes in instructions were also shown to have the potential to create substantial changes in reports of these subjective perceptions of well-being. Those findings have direct relevance to our investigation.

Key Implications of the Michigan Studies for the Present Study

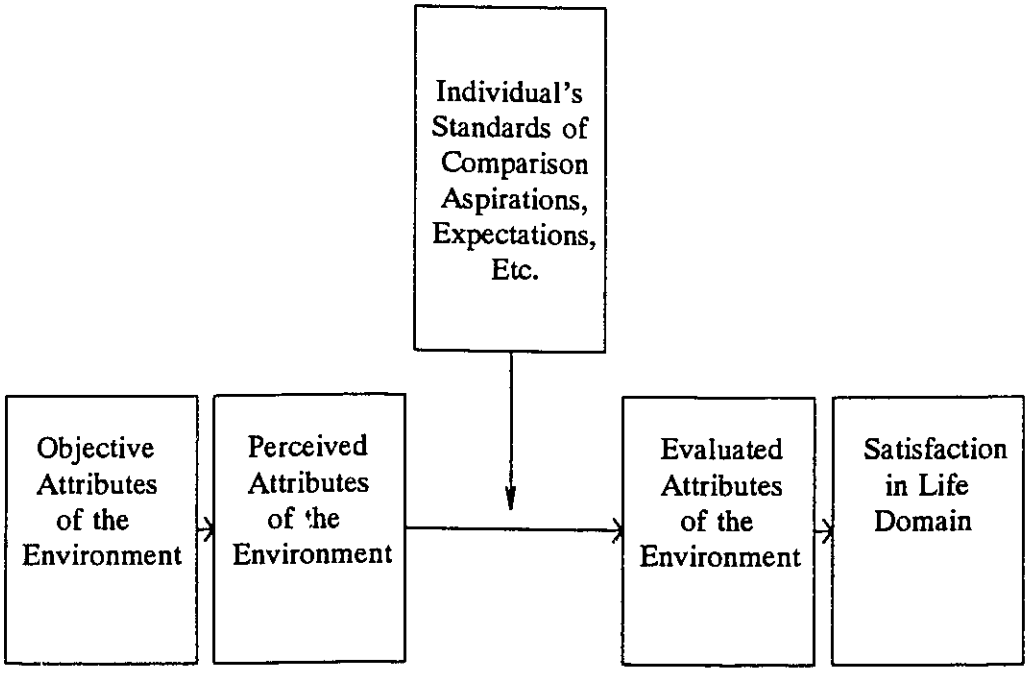
The two national surveys (Campbell et al., 1976; Andrews and Withey, 1976), which focused on subjective QOL began by exploring whether global feelings of well-being about life could accurately be seen as some composite of feelings of satisfaction or dissatisfaction with a number of the more important domains or facets of life. The goal was to understand the causal roots of such global feelings and the mechanisms producing them. Previous studies attempting to measure well-being, happiness, or general satisfaction had been based on the assumption that well-being is a pervasive quality of experience best represented by a single measure. This view underlay various studies of self-avowed happiness and was implicit in Cantril's self-anchoring scale of life satisfaction. In contrast, the national survey by Campbell and his colleagues (1976) placed the emphasis on respondent satisfactions in a variety of

specific domains of life. They argued that such a design provided more detailed information on the quality of life experience than can be derived from any single measure; it also allowed them to examine patterns of relationships between specific measures of satisfaction and the contribution of each specific measure to an overall measure of life satisfaction. The authors developed their inquiry around what they referred to as "domains of life." They selected 12 domains as the core of their inquiry and compared measures on these with measures of general satisfaction such as Cantril's self-anchoring scale and general happiness measures such as those used in the reports by Gurin, Veroff and Feld (1960), and Bradburn (1965). Campbell and his colleagues (1976) also developed a series of bi-polar descriptive adjectives in a semantic differential format; with these they asked their respondents to describe their lives (e.g., hard versus easy, empty versus full, lonely versus friendly, and so on). Later, they combined these semantic differential items to produce what they referred to as an "Index of general affect." Although none of the three aforementioned general life satisfaction measures made any direct reference to any of the 12 specific domains, each served as the basis for analyses of the relationship between general satisfaction and domain satisfaction. This analysis yielded a basic conceptual model of subjective QOL.

Figure 1 presents the basic conceptual model of subjective QOL originally proposed by Campbell and his colleagues (1976). The model is based on the relationship between objective environmental characteristics and the experienced level of satisfaction with a domain. The model assumes (following Kurt Lewin, 1935) that experience and behaviour derive from an interaction of the person and the environment; that is, people live in an objectively defined environment but perceive a subjectively defined environment. It is to this psychological life-space that they respond (Campbell et al, 1976).

Figure 1

Campbell and Colleagues Basic Subjective Quality of Life Model Showing the Relationship Between Objective Environmental Characteristics and the Experienced Level of Satisfaction with a Domain



Note: Model reconstructed from Campbell et al., (1976, p. 13).

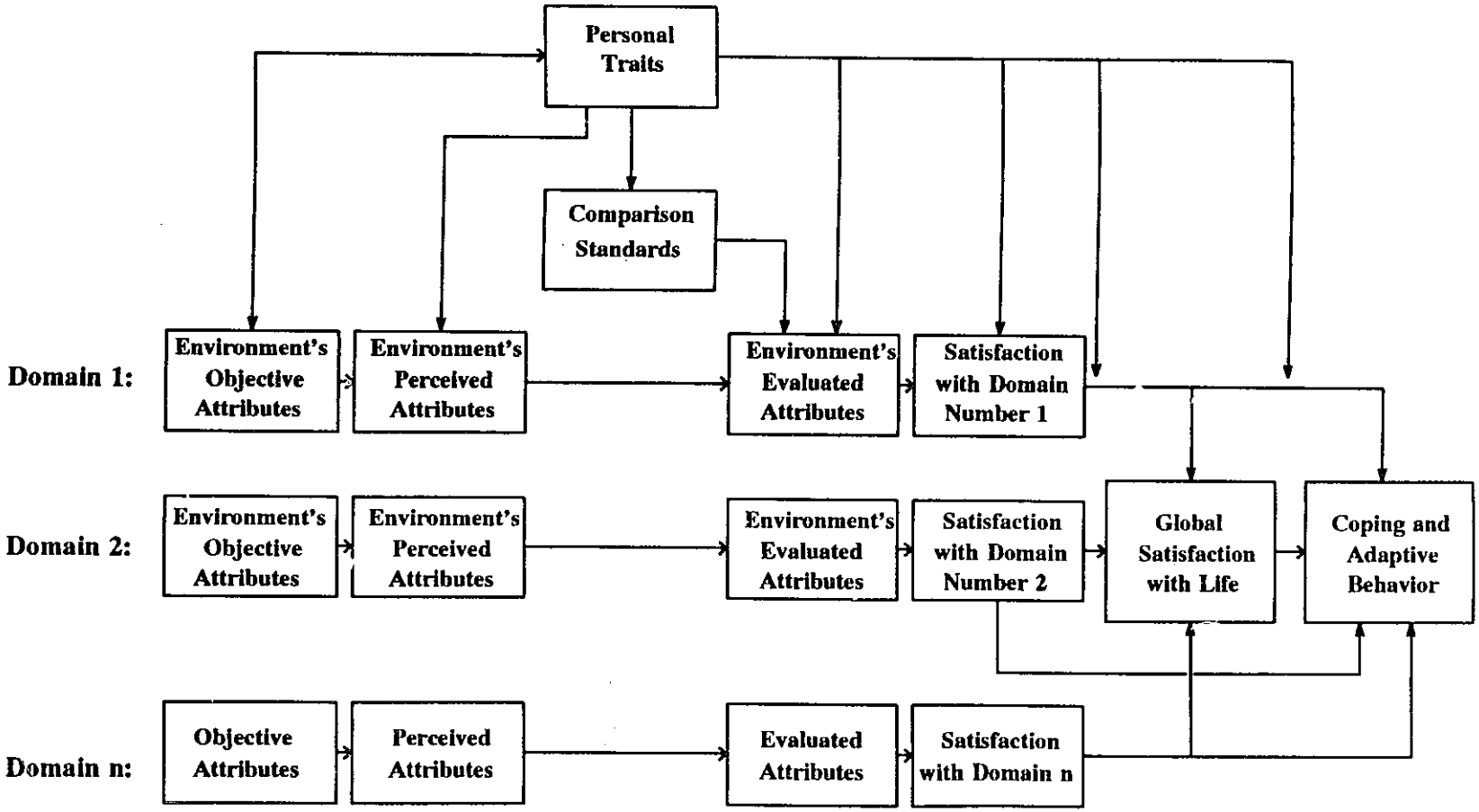
According to this model, an individual's expressed satisfaction with a domain of life is seen as dependent on his/her evaluations or assessments of various attributes of that domain. However, this model does not fully address the evaluative process. Individuals do not make domain satisfaction decisions strictly on the basis of their evaluations of perceived attributes of a domain. We believe that personal preferences mediate between those evaluations and judgments of satisfactions. The model depicted in Figure 1 presents the skeletal features of the basic conceptual model upon which Campbell and colleagues (1976) elaborated in two important directions. Figure 2 presents a reconstruction of their elaborated conceptual model of subjective QOL and shows the general path of relationships one might expect (Campbell et al., 1976, p. 16).

The first elaboration of the model involves the likely role played by the personal and demographic characteristics of the person, including the individual's social location, past experience, and other variables related to personality. The second elaboration broadens the view from factors bearing on satisfaction within any specific domain to encompass the probability that a more general sense of well-being or global subjective QOL is created from the satisfactions and dissatisfactions experienced across all the more specific domains of life. It also suggests that global levels of satisfaction have effects on various forms of coping and adaptive behaviour.

This elaborated model was to have an important influence on Lehman's work on quality of life (QOL), subjective QOL, and global subjective QOL among the chronic psychiatrically disabled (CPD). One aspect of the model that is incomplete, however, is that it does not account for how individuals arrive at their evaluations of their perceived environments.

Figure 2

Campbell and Colleagues Extended Quality of Life Model Showing the Interrelationships Among Domain Satisfaction Levels and the Relationships to General Life Satisfaction and Behavior



Note. This model was reconstructed from the original presented by Campbell and colleagues (1976, p. 16).

In order to arrive at an understanding of how individuals ultimately assess their perceived environments, it is useful, in this author's opinion, to conceptualize the model depicted in Figure 2 with the inclusion of personal preferences in relation to perceived attributes of the objective environment. Also related to the process underlying domain satisfaction is the empirical question of which person and environmental attributes are most relevant to satisfaction. The attributes of a given domain are specific to that domain. The basic model presented by Campbell and colleagues (see Figure 1) and their elaborated basic model (see Figure 2), both call for measurements of general satisfaction with each domain, as well as some explicit assessments of the component features for most domains.

According to Campbell and his colleagues (1976), the frame of reference for subjective judgments probably depends on multiple criteria at once. How a person will assess a particular attribute of a specific domain is considered to be dependent on (1) how the individual perceives the attribute and (2) the standard against which the individual judges the attribute. The individual's assessments may derive from any or all of several bases of evaluation, including aspiration levels, expectation levels, equity levels, reference group levels, personal needs levels, and personal values levels. Aspiration level refers to the situation the individual hopes to eventually attain where a given domain is concerned. Expectation level refers to the situation the individual feels likely to attain in the fairly immediate future. Equity level refers to what the individual thinks should be true of his/her situation if perfect justice prevails, given how much he/she invests in it relative to others. Reference group level refers to what the individual believes to be true of the situations of others with whom he/she identifies, such as friends and family or others of similar income, race, or occupation. Personal needs refers to the amount of a particular reward the individual may require, such

as how much savings to feel secure, how much housing to be comfortable, how much police protection to feel safe, and so on. Personal values refers to such intangibles as freedom, equality, and the like. To this list of evaluative criteria we might add personal preferences in relation to life domains.

On the basis of their national survey findings, Campbell and colleagues (1976) recommended that quality of life (QOL) researchers would be far wiser to invest time and effort in the development of summary domain-satisfaction assessments and global subjective QOL measures rather than trying to survey all possible OQL indicators of life quality. Furthermore, even a fairly limited set of domain satisfaction measures (i.e., 8-12) proved to be highly predictive of the global subjective QOL measures. They concluded that there simply was too much variation in the concrete features of people's lives to derive a finite number of OQL indicators that would predict well-being as well as do domain subjective QOL measures.

Finally, Campbell and colleagues (1976) recognized the importance of self-esteem in an individual's evaluation of personal overall well-being. Feelings of self-esteem, they argued, are fixed relatively early in life and are more likely to be causative of current satisfaction than merely produced by it, despite the possibility of reciprocal causation (Campbell et al., 1976). In so far as feelings of self-competence are related to one's overall sense of well-being, Campbell and colleagues proposed that a domain of "self" would figure as one of the most important determinants of well-being. They suggested that the concept of self-esteem may be more representative of overall well-being or global subjective QOL than its underlying components (i.e., personal competence or efficacy). They cite data from a separate national survey on the well-being of American citizens (Andrews and Withey, 1974, 1976) that indicated that satisfaction with self (i.e., self-esteem) may be as potent a predictor of global

feelings of well-being as are satisfaction measures related to any other single domain. Campbell and colleagues (1976) also presented data that support this notion. Their measure of personal competence, a construct which they argue to be no more than a major portion of self-esteem, ranked high among their diverse domain satisfaction measures in its strength of prediction of their index of well-being. Additional support for the importance of self-esteem measures as predictors of global subjective QOL comes from the fact that Campbell and colleagues found satisfaction with personal resources to be considerably more telling of overall sense of well-being than the simple measure of a person's objective resources taken alone.

Campbell and his colleagues (1976) suggested that by exploring the structure of standards of comparison and their impact on aspiration levels, researchers may arrive at a better understanding of the incidence and magnitude of discrepancies between objective conditions and subjective reactions to them. Along these lines, they cited the relevance of time-dependent effects; for example, long-term situations contribute to a process they term "accommodation" to situations, while short-term effects contribute to disproportionate surges of satisfaction or dissatisfaction. Similarly, they cite saliency or the importance of alternatives as having an impact upon satisfaction levels; for example, one component of increased education seems to act as a depressant on reports of satisfaction with most domains. The well-educated tend to be more critical of their situations than the poorly educated, once differences in the objective goodness of the situations distinguishing the two groups are taken into account. Campbell and colleagues surmised that there may be a bland form of "high satisfaction" registered by persons in situations which lack, in their minds, any very salient alternatives (i.e., ignorance is blissful). Alternatively, persons for whom many alternatives to

their current situation are familiar but unavailable, may also experience greater dissatisfaction. Since education is designed to increase awareness of alternatives, among other things, it seems plausible that such an effect might underlie some of the observed patterns associated with education (Campbell et al., 1976). The effect of such a mechanism would be to blur the goodness of fit between objective situations and subjective assessments of them. This finding has important implications for research on the subjective QOL of the chronic psychiatrically disabled (CPD), since that segment of the population is often described as having poor education, low socioeconomic status (SES), and poor social class (Brill, 1978; Lamb, 1976; Lurigio and Lewis, 1989; Pinkney, Gerber, and Lafave, 1991).

In summary, the Campbell et al. (1976) study showed the relevance of focusing on subjective perceptions of well-being rather than solely on objective indicators thereof. This finding was instrumental in shaping the social indicators movement. Both of the Michigan studies gave considerable attention to general or "global" measures of well-being. They also include measures of satisfaction with respect to domains (Campbell et al., 1976) or specific life concerns (domains and criteria as defined by Andrews and Withey, 1976). The Campbell and associates domains included marriage, family life, health, neighbourhood, friendships, housework, job, life in the U.S., the city or county, unemployment, housing, usefulness of education, standard of living, amount of education, and savings. The list of specific life concerns developed by Andrews and Withey (1976) had a similar coverage.

The second national survey on subjective QOL by the Michigan group (Andrews and Withey, 1976) also concerned itself with subjective perceptions of well-being from methodological and conceptual perspectives. Their conceptual model proposed that the perception of overall QOL can be understood as an affective response to one's "role

situations" and "evaluative criteria" or values. The potential range of domains of role situations is obviously very large, as shown by the fact that Andrews and Withey began with a list of more than 800 concerns and 30 items of affective response. Although these authors concentrated almost exclusively on experiential measures, they stated that, in evaluating overall quality of life, there is no question about society's need for both experiential and non-experiential social indicators. When contrasted with the Campbell et al. study (1976), which focused primarily on cognitive perceptions of well-being in terms of a satisfaction-dissatisfaction continuum, Andrews and Withey (1976) focused more on affective evaluations of well-being (i.e., on global measures of affective concerns). Both Michigan studies were similar in that they conceptualized well-being indicators as occurring at several levels of specificity, from the most global indicators that refer to life as a whole to those that refer to specific aspects of life concerns (i.e., domains).

Perhaps the most important finding by Andrews and Withey (1976) was that a highly replicable pattern of findings emerged from one sample to another. They found that respondents did not tend to evaluate their quality of life in terms of central versus peripheral concerns but rather in terms of how these concerns related to the self. This finding had important implications for the evaluation of subjective QOL, since it suggested that evaluative criteria were more homogeneous than evaluations of domains. In short, it suggested that for most people, general or specific concerns in life domains are subordinate to how such concerns relate to a person's self-perception (e.g., self-esteem).

Andrews and Withey (1976) showed that an adequate monitoring of perceived well-being requires it to be measured with a broad scope, with relevance to major segments of the population, with statistical and economic efficiency, with validity, and with flexibility.

Their study showed that the technology of survey research allows some of these goals to be achieved. Additionally, their study provided baseline measures for assessing future changes, knowledge of how satisfactions and dissatisfactions are distributed in society, information about the structure of perceptions of well-being, and understanding about the process of evaluation, including how feelings are combined into an overall evaluation of life quality.

The basic issues addressed by the Andrews and Withey investigation included: 1) Global evaluations of subjective QOL; 2) Concern-level evaluations (subdivided into two types: domains and criteria), and 3) Domain-by-criteria evaluations. They began by focusing on those factors which might best account for general affective evaluations of well-being with respect to the largest number of people. Andrews and Withey's (1976) primary concern was with an accurate description of those phenomena on which the population was believed to be more evenly distributed. It was this consideration which led to their development of the "delighted-terrible" scale. The latter, used for measuring affective evaluations (the building blocks of their model), was preferred for three reasons: (1) it incorporates both affective and evaluative components; (2) it attempts to differentiate people who are actively pleased from those who are merely satisfied; (3) it uses an optimal number of well defined categories (i.e., seven), as well as off-scale categories (e.g., "neutral," "does not apply to me," and "I never thought about it").

The shortcomings of the seven-point "satisfaction" scale used by Campbell and colleagues (1976) to assess people's feelings about life quality were not overlooked by Andrews and Withey (1976). They noted that the seven-point satisfaction scale often resulted in rather heavy clustering at the "satisfied" end of the scale. More specifically, for the ten concern-level aspects most central to the Campbell and colleagues (1976) investigation, the

average distribution showed two-thirds of adult Americans fell in the first two scale categories. While this may have been an accurate reflection of the proportion of people who were satisfied with their lives, Andrews and Withey argued that a different measurement method might prove able to discriminate a somewhat wider range of feelings. They proposed that the delighted-terrible (D-T) scale provided such an alternative, which, in fact, it did.

As hypothesized by Andrews and Withey, the "delighted-terrible" provided greater differentiation at the positive end of the scale than the seven-point "satisfaction scale." For the nine concerns that can closely be matched between the Andrews and Withey data and the Campbell and colleagues data, a proportionally smaller percentage of the Andrews and Withey sample (54%) was located in the top two categories of the Delighted-Terrible Scale than had been reported with the seven-point Satisfaction Scale (65%) by Campbell and colleagues (1976). Thus, the D-T scale was shown to provide more differentiation among the apparently large group of people who seemed to be "satisfied," but who were suspected of not all feeling equally positive about their lives.

A large subset of what Andrews and Withey termed domains turned out to be a taxonomy of social institutions (e.g., marriage, work, people, facilities, services, businesses, medical facilities, etc.) and agencies. Such institutions generally serve to meet people's needs and aspirations. According to Andrews and Withey (1976), all of these can be classified as domains. In contrast to life domains, a large subgroup of what Andrews and Withey (1976) termed criteria turned out to be a somewhat shared dream to be loved, liked, accepted, responsible, respected, secure and independent, comfortable, competent, successful, and to have fun. Thus, the values that one brings to bear on life are in themselves determinants of one's assessed quality of life (Andrews and Withey, 1976).

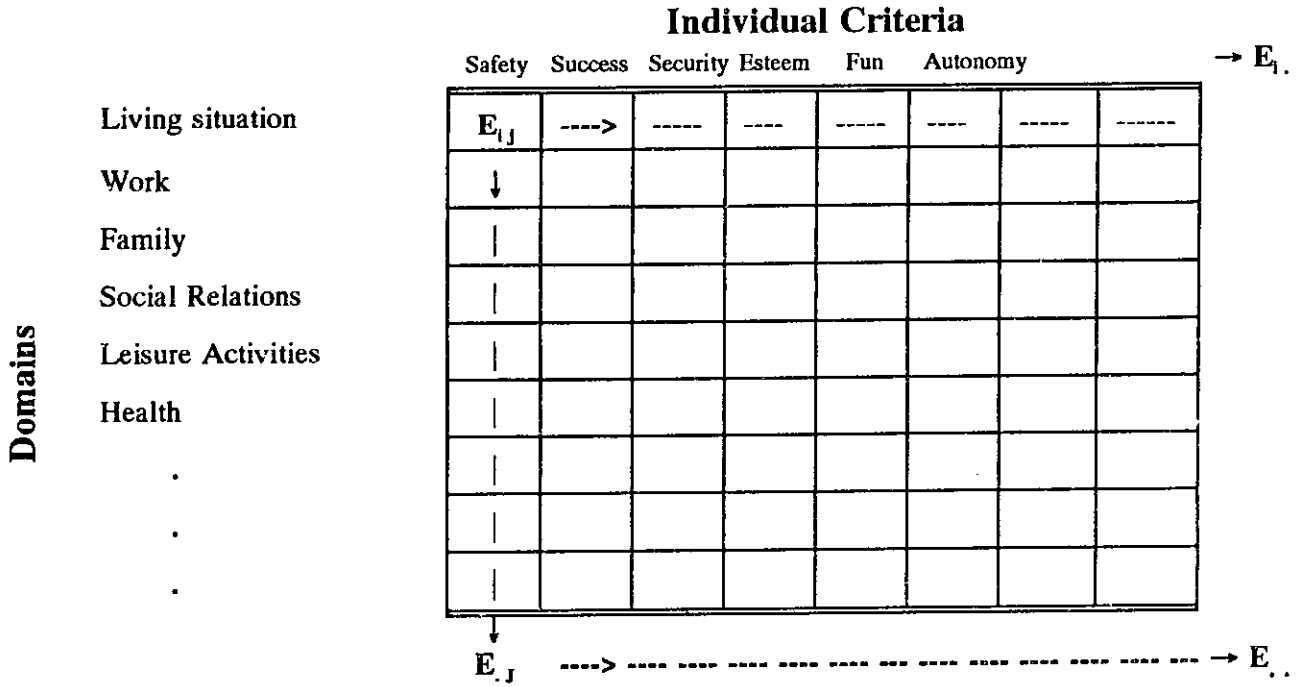
In summary, the Andrews and Withey (1976) survey on the well-being of Americans showed that subjective QOL may be best understood by studying the nature and determinants of value structures rather than by assessing the more objective conditions of living. However, the greatest gains may come from linking the objective and subjective determinants of life quality in a common framework. They argued for a conceptual relationship between the two types of concerns (i.e., domains and criteria). Figure 3 is a reconstruction of their model; a a two-dimensional matrix with examples of possible domains and criteria and with evaluations of well-being at three levels of specificity (Andrews and Withey, p. 13).

From the model we see that the three levels of specificity include (1) General affective evaluative responses to a domain (across criteria); (2) General affective evaluative responses to a criterion (across domains); and (3) General affective evaluative responses to life-as-a-whole (i.e., perceived quality of life). In Figure 3 we see that "domains" define one dimension (the rows in the Figure), and the "criteria" define the other dimension. Thus, within a given cell, one can arrive at an affective evaluative response to a particular domain with respect to a particular criterion (e.g., cell Eij in Figure 3).

Evaluations at the three levels of specificity are indicated in Figure 3 by "E", for the global level, and by "Ei" and "Ej" for the concern level. A still more specific level is represented by "Eij.S" within the cells, where "S" represents the subject. The model thus represents a person's evaluations of a specific domain with respect to a specific criterion. For example, the question, "how do you feel about the beauty and attractiveness of your house?", would involve such an evaluation (Andrews and Withey, p. 13).

Figure 3

Conceptual Model of Andrews and Withey with Examples of Possible Domains and Criteria for the Evaluation of Well-being at Three Levels of Specificity



Note. Model reconstructed from Andrews and Withey (1976, p.13).

E_{ij} = Affective evaluative response to a particular domain with respect to a specific criterion such as safety, success, security, esteem, etc.

$E_{i.}$ = General affective evaluative response to a domain (across criteria).

$E_{.j}$ = General affective evaluative response to a criterion (across domains).

$E_{..}$ = General affective evaluative response to life-as-a-whole; that is perceived global subjective quality of life.

Andrews and Withey assembled an extensive list of concerns from various sources, and prepared a 123-item questionnaire to tap these concerns. The items were administered in various overlapping subsets to three nationally representative samples of respondents, and the full set of items was administered to a more restricted group. This list of 123 items provided the broad base from which they began to explore perceptual structures.

Based on the amount of covariance observed among the concern items they derived two-dimensional and three-dimensional maps to locate the spaces which allowed inferences about how perceptions regarding life concerns are organized. Clear groupings of items into content-oriented clusters were derived. Rational transitions from one subregion to the next were also possible. Subregions could subsequently be aggregated into the following general regions: Self, Family, Other People, Economic Aspects, Job, House, Costs, Local Area, Larger Society, Religion, and Beneficence. The findings of Andrews and Withey (1976) have considerably influenced conceptual and methodological issues related to subjective QOL research with the chronic psychiatrically disabled (CPD).

In summary, the most important theoretical contributions toward our understanding of quality of life made by the Michigan group is that they succeeded in demonstrating the conceptual and empirical relevance of subjective perceptions of well-being. These contributions are of the most direct relevance to the measurement of quality of life. The research results of Andrews and Withey spoke mainly to the design of instruments for assessing the affective dimension of perceived well-being at what they termed the "global" and "concerns" levels.

If nothing else, the Michigan studies clearly illustrate that quality of life is multidimensional. As such, it may be approached from different angles. The issue really is

one of taking the approach that is best suited to the question. The Michigan group devoted considerable attention to describing the perceived (i.e., subjective) life quality of particular national subgroups, defined sociodemographically (e.g., income, education, marital status, gender, etc.), and comparing them with each other and with the larger, more general national population. Their focus on finding effective ways to measure subjective perceptions of well-being and applying those measures to broad general populations provided important baseline data for future studies. It should be noted that the measures of domain evaluation and feelings about life as a whole in the Michigan models have a large cognitive element that is to be distinguished from the affective component measured by Bradburn's (1969) affect scales. The Michigan models thus presented QOL research with an important distinction between cognitively-based judgements and affective reactions in the perception of well being. They showed that the type of question asked influenced the type of response provided. Questions that required respondents to make evaluative judgements of their life conditions tended to result in responses that were grounded in cognitively-based judgements. Questions that asked respondents to report how they felt emotionally about life conditions tended to produce affective reactions rather than cognitively-based judgements. Diener (1984) reported that the latter tend to be less reliable than the former. The manner in which the Michigan group formulated the problem of assessing QOL departed from prior conceptualizations. They argued that the central issue confronting any examination of the perceived quality of life involves the relationship between subjective and objective indicators of well being. They showed that both types of measures and especially their interaction merit monitoring, because subjective QOL measures may suffer from lack of reliability while OQL indices may suffer from lack of validity. Attempts by Campbell and his colleagues (1976) to arrive at a

systematization of the conditions under which subjective feelings of well-being diverge from what might be deduced about welfare from a knowledge of objective conditions taken alone was thus critical. Their concern with arriving at subjective indices of the experience of life rather than deriving inferences of this phenomenon from the conditions of life was apparently well founded.

We have seen that an elementary component of such a task is to determine where to find domains of agreement as to what is "objective reality"; that is, to determine when and where the subjective-objective fit is tight versus loose. The principle here is that ambiguous objects of judgment elicit less agreement about their character and a weaker subjective-objective fit. The Michigan studies also made apparent that there tends to be more agreement on descriptive fact than upon evaluations of these facts, since the latter depend on personal tastes. Thus, evaluations of more concrete and specific domains would be expected to show less variance than would evaluations of intangibles such as one's satisfaction with one's friends, marriage, and so on. Accordingly, specific concrete evaluations were found to be more stable than were global evaluations in surveys conducted by Campbell and colleagues (1976). These findings have general implications for the assessment of global and specific life quality with chronically disabled populations, and specific implications for populations with chronic psychiatric disability.

Quality of Life Among the Deinstitutionalized Psychiatrically Disabled

Major Studies

The deinstitutionalization of chronic mental patients began with the advent of modern psychoactive drugs in the 1950s and experienced continued growth into the 1980s (Brill, and Patton, 1957; Kriss, 1971; Lamb, 1979). In Canada, the number of mental hospital beds progressively diminished to less than one third of its 1960 peak (Richman and Harris, 1983).

The use of subjective QOL measures in evaluating psychiatric intervention programs has received growing attention in recent years (Baker and Intagliata, 1982; Dickey, Gudeman, Hellman, Donatelle, and Grinspoon, 1981; Lehman, 1983b; Lehman, Ward, and Linn, 1982; Lehman, 1984; Lehman, 1988; Stein and Test, 1980). However, as Cheng (1988) has pointed out, if one is comparing the subjective QOL scores of a disadvantaged and less well-adjusted group (i.e., chronic mental patients) to those of the general population, one should expect the former to have a lower level of subjective QOL than the latter. Such comparisons provide little meaningful information about the effectiveness of a program unless one evaluates program inputs in terms of clients' subjective QOL before and after program interventions. Even with a restricted focus, generic subjective QOL measures may tell us little of the dynamics of a program's effectiveness. For example, suppose the goal is to evaluate the impact of a community development program on the community. Subjective QOL measures may reflect that residents' subjective perceptions of objective aspects of their neighbourhood are enhanced, but such measures may tell us little of the impact that the objective changes have on the activities and experiences of community members (e.g., social, community, or civic activities). Moreover, as Cheng (1988) pointed out, most researchers (e.g., Baker and

Intagliata, 1982; Lehman et al, 1982) who have investigated subjective QOL issues with deinstitutionalized chronic mental patients have not yet evaluated the relationship between program inputs and the maintenance or improvement of clients' subjective QOL. The contemporary issue of interest in the mental health field is whether treatment based upon deinstitutionalized services results in a life of better quality (Lehman, 1988) and social integration (Nelson and Smith Fowler, 1987; Segal and Aviram, 1976; Segal, Silverman, and Baumohl, 1989). In this respect, the effectiveness and cost-effectiveness of treatments for the chronic mentally disabled citizen must be measured in terms of subjective QOL as well as objective QOL, while giving consideration to the social integration (SI) of clients.

We defined SI in terms of weak and strong. We defined weak social integration (WSI) in terms of a range of activities that would usually be conducted exclusively outside of the residence. We defined strong social integration (SSI) in terms of different categories of social accompaniment for activities that could be undertaken both within and outside the residence.

Our definition of social Integration (SI) modified and extended the one provided by Segal and Aviram (1975). They had conceptualized community integration as involvement in locality-relevant functions, and they distinguished between integration within the residence (internal integration) and integration outside the residence (external integration). They identified five levels of involvement: (1) presence; (2) access, (3) participation; (4) production, and (5) consumption. They expressed each level of involvement as "a necessary and sufficient condition for being integrated into the community" Segal and Aviram (1975, p. 55). Our definition of SI considered each level as a necessary but insufficient condition for community integration. We believed that each level also needs to consider the categories of social accompaniment. In terms of normalization/social role valorization theory (Wolfensberger and

Thomas, 1989), with whom the resident is seen can have an important impact on the psychiatrically disabled citizen's social image.

Ultimately, Segal and Aviram (1975) conceptualized community integration in terms of a two-by-five matrix. The vertical dimension represented the levels of involvement in locality-relevant functions, and the horizontal represented internal versus external community focus. They also identified four components of SI: (1) social support; (2) social insulation; (3) social facilitation, and (4) social-dependency-producing variables. The most important predictors of social-support were neighbours' positive response to the psychiatrically disabled, and an ideal psychiatric environment (Segal and Aviram, 1975, p. 202).

Our definition of SI adhered to these constructs but added the dimension of categories of social accompaniment. We applied normalization/social role valorization theory (Wolfensberger and Thomas, 1989) to the SI needs of this population, because it was apparent that the social image of the psychiatrically disabled had been neglected in Segal and Aviram's (1975) conceptualization. Moreover, normalization theory argues that social image can have a powerful influence on positive community responsiveness to the psychiatrically disabled.

Segal and Aviram (1975) showed that the most important predictor of social supports was a positive community response to the psychiatrically disabled. Normalization theory argues that social image can be an important determinant of community responsiveness to a devalued group. Consequently, we believed that the SI of the psychiatrically disabled should be defined in terms of not only what and where activities are conducted but also with whom.

Two principal investigations, directly related to our study, stand out in the research on the subjective QOL of the psychiatrically disabled by virtue of their adherence to the lessons provided by the Michigan group that conducted national surveys of subjective QOL

with the U.S. population. Baker and Intagliata (1982) and Lehman et al. (1984) both presented their findings on the subjective QOL of the chronic mentally disabled at roughly the same time.

Baker and Intagliata (1982) identified five reasons for using subjective QOL as an outcome measure of community-oriented programs for deinstitutionalized psychiatric populations:

1- Given the current level of medical knowledge, comfort rather than cure is a more realistic goal for services provided to citizens with a chronic psychiatric disability.

2- Community support/rehabilitation programs generally have multiple objectives. Multidimensional subjective QOL measures allow one to assess the synergistic effects of program interventions.

3- subjective QOL measures can meet consumer satisfaction and accountability concerns of program management.

4- A multidimensional subjective QOL evaluation is congruent with the holistic perspective of health care.

5- Concern for the well-being of citizens historically has been "good politics."

Baker and Intagliata (1982) interviewed 118 clients living in a variety of community settings, comparing client affect measures based on Bradburn's (1969) Affect Balance Scale (ABS) to domain satisfaction measures (15 life domains) using the Satisfaction with Life Domains Scale (SLDS) derived from Flanagan's (1978) critical incidents technique. They also looked at the relationship between mental health and well-being measures by comparing these scores with those on the Global Assessment Scale (Endicott, Spitzer, Fleiss, and Cohen,

1976). Their findings indicated that clients led restricted lives, with some being extremely socially isolated while others were dissatisfied with their family contacts. Generally, clients were observed to have few social relations and little to do during waking hours. Most clients were financially insecure, receiving barely enough money to live on from welfare sources. Life quality was found to be considerably influenced by functional limitations associated with client disorders (e.g., physical and behaviour handicaps), as well as personal preferences and interests, which also conspired to constrain the outcomes of community support programs. Domain satisfaction measures (i.e., SLDS) were found to be highly correlated with affect balance scores (i.e., ABS), suggesting that despite being somewhat different in their approach to assessments of client' subjective QOL, both tapped into common dimensions of life satisfaction. Satisfaction scores in the life domains indicated that clients' greatest proportion of neutral or unhappy feelings were in relation to finances, health, family relations, use of free time, availability of services where they lived, and their clothing. Demographic data were not correlated with clients' ratings of overall life quality. However, clients' mental health status, as measured by the Global Assessment Scale was positively and significantly related to clients' self-reported life quality on both the ABS and the SLDS. These results were consistent with the general QOL literature, including their finding of a significant relationship between health/mental health status and subjective QOL. However, also confirmed was an important limitation of the ABS in that mental health clients, like the sample in the U.S. national survey (Andrews and Withey, 1976), tended to generally recall only positive experiences. Nevertheless, the proportion of the Baker and Intagliata respondents who recalled negative experiences was twice that found in the national sample by Andrews and Withey (1976). Clients of mental health services were significantly more likely than the national

sample to report such negative experiences as "feeling very lonely or remote from other people," "bored," and "depressed or very unhappy." The authors also reported problems in relations to the faces response set they used with the SLDS. The faces response set tended to induce substantial clustering of responses at the positive end of the scale. The problem of positive response bias had also been reported by Andrews and Withey (1976) with their national sample. Typically, levels of reported satisfaction often range from 70% to 100%, regardless of the client population doing the ratings (Bartlett, 1984). The results of the Baker and Intagliata (1982) study indicated that clients felt least satisfied with their finances, use of leisure time, and their health. The authors concluded that functional limitations, associated with client disorders, and personal preferences and interests appeared to play important roles in determining the life quality of chronic mentally, while constraining the outcomes of intervention programs.

Lehman and his colleagues (1982), to which the present study is most closely related, conducted the second principal investigation of subjective QOL among the psychiatrically disabled. Like the Baker and Intagliata (1982) research, the Lehman et al. (1982) study also attended closely to the lessons drawn from the national surveys on QOL (Campbell et al., 1976; Andrews and Withey, 1976). Lehman and his colleagues developed a one-hour structured interview that was conducted with 278 chronic psychiatrically disabled residents living in 30 large board-and-care homes in Los Angeles. Demographic data were collected on resident characteristics, medical diagnoses, current medications, duration of hospitalization, previous hospital admissions, and disability status. subjective QOL data were collected in relation to eight life domains including living situation, work, finances, leisure, social relations, family relations, personal safety, and health. Client responses were gathered using

the "Delighted-terrible" (D-T) scale, the seven-point continuum that had been advocated by Andrews and Withey (1976). Additional measures included global subjective QOL indicators drawn from surveys on subjective QOL with the U.S. national samples (Campbell et al., 1976; Andrews and Withey, 1976) and the Structured and Scaled Interview to Assess Maladjustment (SSIAM), developed by Gurland, Yorkston, Stone, Frank, and Fleiss (1972).

Lehman and his colleagues (1982) reported findings indicating that their domain-specific satisfaction scales were homogeneous with construct validity that was comparable to that reported in national samples by Andrews and Withey (1976). Psychiatric clients were able to differentiate among their feelings in various life domains. More than half of the respondents reported feeling "mostly satisfied" or better in most life domains, except work, finances, and personal safety. The board-and-care home characteristic most correlated with satisfaction was privacy. In the area of family relations, frequency of contacts correlated positively and significantly with satisfaction. Satisfaction with social relations correlated with frequency of contacts within residential facilities, but not with relationships outside the residence. Among the best predictors of satisfaction with social relations was the existence of close personal friendships. Among OQL indicators, work activity correlated best with satisfaction. Satisfaction with personal safety correlated with perceived access to legal aid. Several objective indicators of health correlated with health satisfaction, including total number of illnesses reported, total use of health services, acute psychiatric services, general medical services, and perceived access to medical care. For all of these variables, correlations suggested that those with more illnesses used more services and were less satisfied with their health. Mental health (SSIAM) was found to correlate significantly with indices of global subjective QOL but not with domain-specific satisfactions. Finally, residents were significantly

less satisfied with most life domains than had been reported for the national population (Andrews and Withey, 1976). In two other studies, Lehman (1982) examined the well-being of CPD residents of single-room occupancy (SRO) hotels. Both studies found that social supports, especially social supports within the hotels, were related to residents' subjective well-being and level of functioning.

Key Implications of the Studies of subjective QOL Among the Psychiatrically Disabled

Baker and Intagliata (1982) concluded that it was difficult to discern whether the positive response bias found with their scale was due to their particular form of rating (i.e., the faces response set). This suggested that an alternative manner of reporting responses might be more suitable with this population. Lehman and his colleagues (1982) used such an alternative (i.e., the delighted-terrible scale) and concluded that subjective QOL research with the psychiatrically disabled was feasible and offered more advantages than a simple quantification of OQL indices, which do not equate with subjective life quality. They recommended more validation studies across techniques and the use of longitudinal designs to test hypothesized relationships between quality of life and various outcomes. That residents were mostly satisfied with their lives in general was interpreted as an indication that group homes provided a viable alternative to hospitalization. That residents were mostly dissatisfied with work, finances, unemployment, and personal safety was interpreted as an indication that such problems are beyond the scope of medical services and more within the realm of social services. However, social service interventions could be expected to have some impact upon these problems. The finding that social relations within the residence correlated with satisfaction and that external social relations did not was taken as evidence that relations

within and outside the home constitute separate dimensions and that efforts were needed to improve relationships within the housing service. This view had been advocated by Segal and Aviram (1978) in their study of social integration with this population. Finally, the finding that satisfaction with work correlated with employment was explained as a function of the financial and intrinsic rewards that accompany work-related activity.

Lehman and his colleagues (1982) concluded that the modest correlations between OQL and subjective QOL indicators in life domains suggest that they measure different aspects of the same construct and attest to the need for both types of measures in relation to QOL evaluations. For the most part, the psychiatrically disabled experience persistent social rather than medical problems; for example, social isolation, unsatisfying social, family, and personal relationships, economic deprivation, unemployment, and victimization by criminals. The authors recommended that if the goal is to improve the subjective QOL of residents, therapeutic programs place high value on increasing client autonomy and fostering varied and productive daytime activities, with less emphasis on traditional psychotherapy. Among those conditions predicted to directly improve clients' subjective QOL were (1) more financial assistance, (2) vocational training programs and more work opportunities, (3) better protection against crime, (4) more frequent contact with family, (5) better social relations, especially within the homes, and (6) greater privacy within the homes.

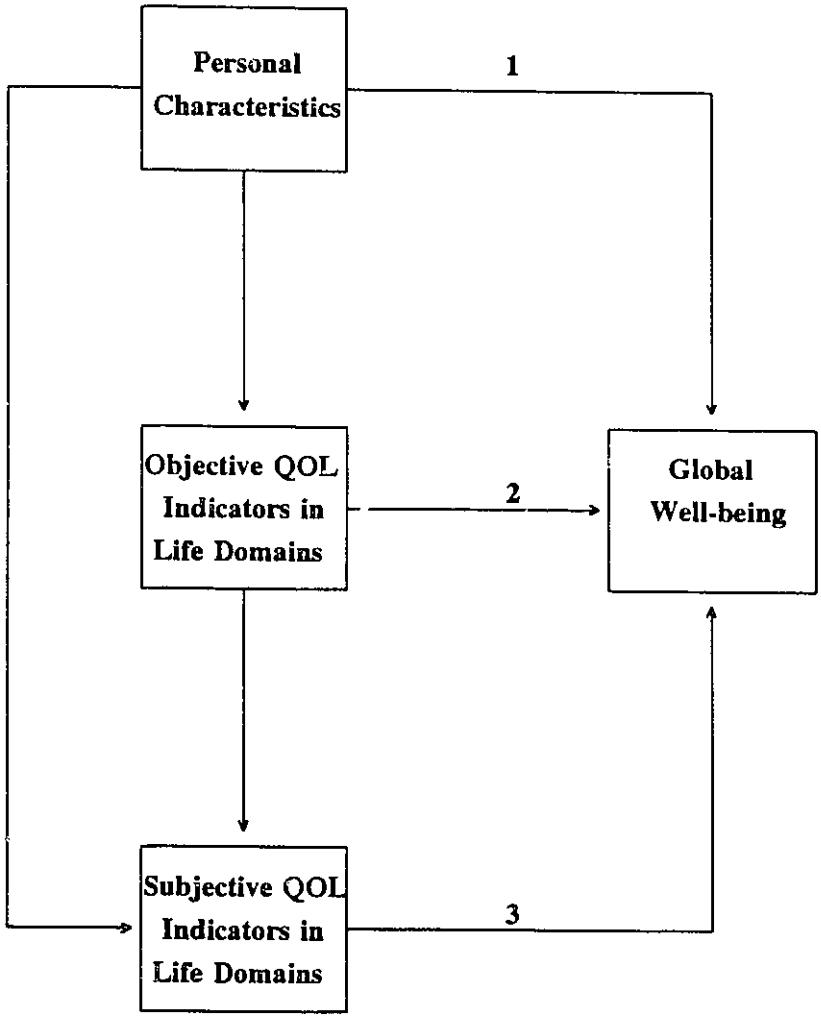
Cheng (1988) has cogently argued that poor quality of life, when subjectively defined, is essentially a problem statement; subjective QOL survey data can thus be used to assess clients' needs. In light of these arguments, the concept of subjective QOL clearly has broad applications in evaluation and program planning for the mental health field.

The theme of how QOL relates to sociodemographic variables and OQL indicators (e.g., age, gender, marital status, income, education, etc.) is of fundamental importance, and the results of QOL research continue to generate both professional and public interest. However, as with earlier investigations of general populations (i.e., Campbell et al, 1976; Andrews and Withey, 1976), more recent work on particular subgroups (e.g., deinstitutionalized psychiatric clients), tends to show significant but often quite weak relationships between sociodemographic variables and people's own sense of well-being (Andrews, 1986; Baker and Intagliata, 1982; Cheng, 1988; Coulton et al., 1984; Lehman et al., 1982; Lehman, 1983b). There is a clear need for some theoretical framework within which to account for this lack of meaningful relationship. Toward this end, Lehman (1983b; 1988) has proposed a conceptual model, that he argues, can account for the variety of current life experiences that may affect the chronic mentally disabled citizen's sense of well being. Lehman's model (1983b) derives from the models advanced by the Michigan group of researchers (see Figures 2 and 3).

Figure 4 depicts the conceptual model developed by Lehman and his colleagues (Lehman et al., 1982; Lehman, 1983b). Lehman's model argues that consideration needs to be given to the relationship between general well-being and its components. The model in Figure 4 allows comparisons of general well-being or functioning within a particular life domain, as well as assessments of the importance of various life domains to general well-being within a population. This conceptual model integrates many areas that may relate to the need for, and be affected by, the delivery of mental health and medical services.

Figure 4

Lehman's Original Quality of Life (QOL) Model



Note: QOL = Quality of Life

Figure 1: Reconstructed from Lehman's original Quality-of-Life Model (1983b, p. 369).

However, even if Lehman's model provides a satisfactory account of the meaningful relationship between the respondent's sense of general well-being or global subjective QOL and the various components contributing to this experience, it fails to provide program planners with specific directions whereby poor subjective QOL can be improved. We believed the answer to this problem required a conceptual shift related to subjective QOL measures. We believed that subjective QOL measures are needs assessments tools that can serve as indicators of person-environment (P-E) fit.

Subjective QOL Measures as Indicators of Person-environment (P-E) Fit

We agree with Cheng's (1988) contention that poor subjective QOL is essentially a problem statement. Moreover, we believe that poor subjective QOL may reflect a problem originating in a poor match or fit between the person and the person's environment, such that when personal preferences and perceived needs are not being met by the person's environment, it impacts negatively upon the person's subjective QOL. As such, subjective QOL measures may serve as indicators of P-E fit or congruence. Low subjective QOL in a given life domain would thus be indicative of poor P-E fit in that life domain. When subjective QOL is conceptualized as an index of P-E fit, one needs only to know what contributes to suitable P-E matching to develop residential programs in the community that will contribute to improved P-E fit. Better P-E fit would ultimately impact on subjective QOL in those life domains where P-E fit had improved. Moos (1984) suggested that one manner of achieving a suitable P-E match is to allow individuals to pursue their preferences in selecting environments:

> ..."Another perspective focuses on environmental preferences; this view encompasses preferences about physical design, organizational policies, the types of people in a setting, and the social climate. Conceptually, commensurate dimensions can be employed to specify the degree of congruence between individual preferences and environmental criteria. One way to achieve a suitable person-environment match is to enable individuals to follow their preferences in selecting environments (Moos, 1987, p. 233).

Moos (1987) also has argued for the role of preferences in relation to general well-being. Moos and his colleagues have elaborated considerably upon the environmental factors that account for P-E fit (Cronkite and Moos, 1978; Finney and Moos, 1984, 1986; Holahan and Moos, 1986; Lemke and Moos, 1984; Moos, 1973a, 1984, 1986a, 1987). The perspective adopted by Moos (1987) is based on the general principle that the manner in which one perceives the environment tends to influence the manner in which one will behave in that environment.

Moos (1987) has described three broad domains of social climate dimensions that characterize work, school, and health care settings. His conceptual framework also focuses on the variable influence these social climate factors have on morale and performance, depending on personal factors. His theory emphasizes the need to examine how various factors (e.g., personal resources, the impact of powerful environments, and coping strategies) influence negative and growth-producing outcomes of P-E congruence.

Figure 5 illustrates the theoretical P-E framework within which Moos has integrated his findings. The model of P-E fit proposed by Moos (1987) includes physical features, organizational structure and policies, suprapersonal factors, and social climate. The model implies that all these variables need to be addressed.

Figure 5

Moos's Conceptual Model Proposed to Account for the Links Between Personal and Environmental Factors and Individual Adaptation

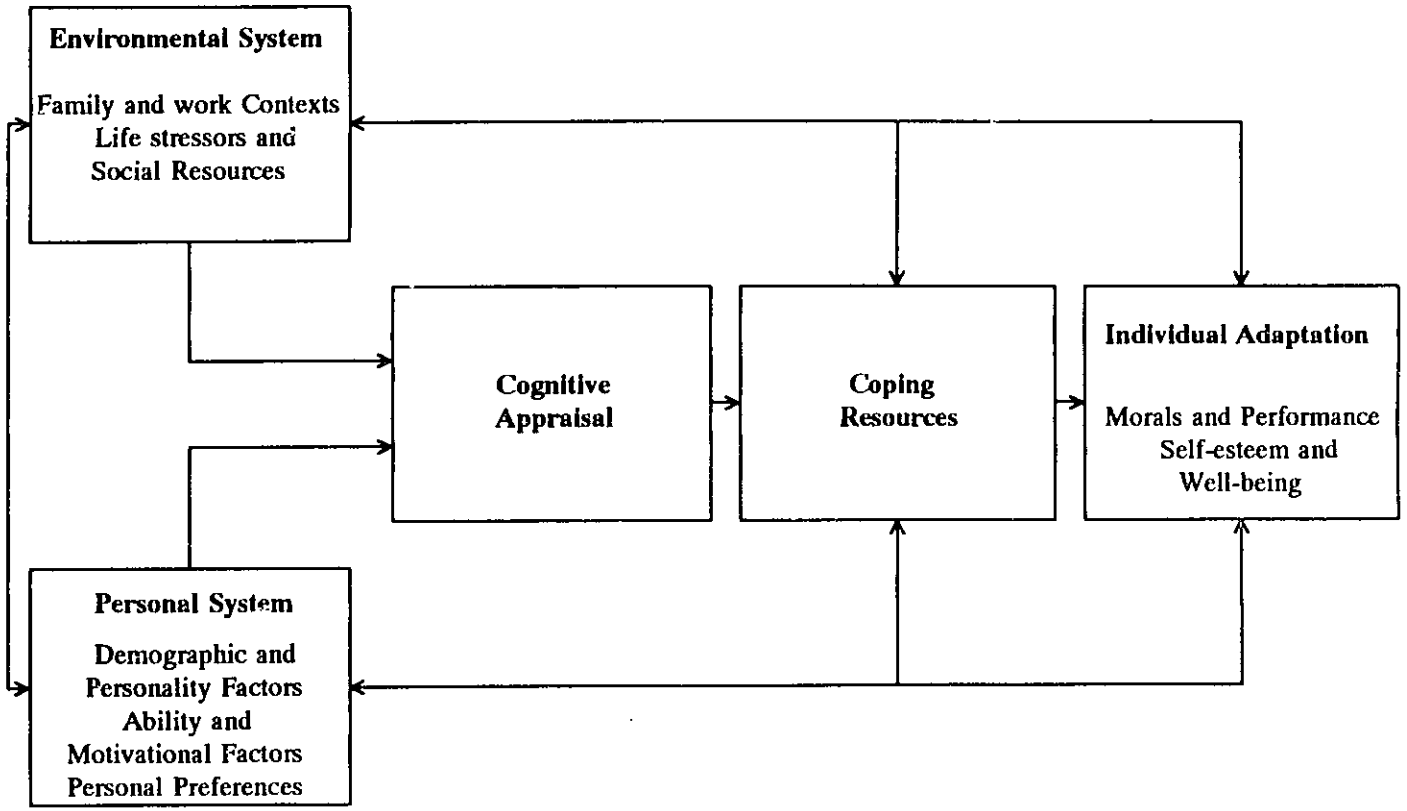


Figure reconstructed from Moos (1987, p. 232).

The model in Figure 5 emphasizes that people and environments influence each other reciprocally. It emphasizes that the relationship between a person's environmental system and individual ability to adapt is affected by reciprocal interactions between the environmental system, the personal system, cognitive appraisals, and coping responses. The model argues that these processes are transactional with reciprocal feedback occurring at each stage. The emphasis is on how individual perceptions of environments (the environmental system) tend to influence behaviours (individual adaptation). Essentially, his model argues that behaviour is organized according to domains (Flavell, 1975; Pervin, 1987).

Moos proposed that researchers need to focus on the social climate of environments, because like people, environments have unique personalities (Walsh, 1987). This view fits well with cognitive and social learning theories which emphasize that generalizations and discriminations are made by individuals in different situations. The model also dovetails with trait theory which emphasizes the relevance of traits in a range of situations (Pervin, 1987). Operationally, however, Moos's approach has focused principally upon how individual perceptions of environments tend to influence adaptive behaviour. With the main emphasis on the environmental perspective, there was some neglect of person concepts and variables (Walsh, 1987).

Specifically related to our investigation was Moos's (1984) report of how health care settings and client improvement were related. He focused on the relative influence of treatment environments such as hospital-based and community-based psychiatric programs on treatment outcome. He was able to establish a link between these factors and indices of treatment outcome.

In summary, although Moos and colleagues have developed a number of inventories to investigate the social climate concept in general, it is their focus on environmental preferences as they pertain to group housing for the CPD that was especially pertinent to the aims of this investigation. Moos' (1987) development of a variety of methods for assessing social climate preferences about physical design and program factors in group housing was less relevant to this investigation than was his principal concern of how individual perceptions of and preferences for environments (environmental systems) tend to influence adaptive behaviour and possibly subjective QOL and SI.

Role of Preferences in Predicting Subjective QOL

The previous section outlined how we came to shift our conceptualization of subjective QOL measures from problem statements and needs indicators to indicators of P-E congruence or fit. The following sections outlines how we arrived at our conceptualization of preference and preference-like measures (i.e., measures of perceived need) as predictors of subjective QOL when such subjective QOL measures are used as indicators of P-E fit.

Using the P-E fit approach, Coulton, Holland, and Fitch (1984) examined the effects of client-environment congruence on the social adjustment of psychiatrically disabled clients living in community-care facilities. Their findings suggested that more powerful prediction of success in community care facilities for the psychiatrically disabled may be arrived at by a consideration of the particular combinations of client and environmental characteristics. They argued that client adjustment and functioning within the community may be enhanced when the ***needs*** and capabilities of the client are well matched with the resources and demands of the community care home. Their focus on the congruence between the person's

needs and the environmental resources suggested to us not only that poor subjective QOL might indicate poor P-E fit in relation to community housing programs for the psychiatrically disabled, but also that placements, responsive to personal preferences, might result in improved subjective QOL and SI. However, this line of reasoning required that preferences and/or preference-line indicators (i.e., perceived need) be shown to predict subjective QOL and SI.

In a separate study, Kennedy (1989) investigated community integration and well-being with 159 psychiatrically disabled residents of New York City's supervised community residences, supported apartments, and single-room occupancy hotels. Interview data were collected on community integration using a modified version of Segal and Aviram's (1979) External Integration Scale, satisfaction with life in general, with living situation, and with social relations. The global subjective QOL measure was based on Andrews and Withey's (1976) "Life 3" scale (the single-item global well-being measure). Satisfaction with living situation and social relations was based on the domain-specific subjective QOL measures used by Lehman et al. (1982). Positive and negative affect were measured using Bradburn's (1969) affect balance scale (ABS). Social competence and social support were also measured. Correlational analyses revealed that social competence was positively related to community integration and that global well-being was significantly related to community integration.

In light of the suggestion by Moos (1987) that one way to achieve a suitable P-E match would be to enable individuals to follow their preferences in selecting environments (Moos, 1987, p. 233), the findings from the aforementioned studies suggest that subjective QOL might serve as an index of P-E fit and that measures of clients' preferences and perceived needs might serve to predict subjective QOL. Thus, if preferences and perceived

needs could be shown to be significant predictors of subjective QOL, it would follow that allowing clients to follow their preferences might be one manner of improving their P-E fit, and thereby, their subjective QOL in various life domains. Additionally, P-E fit may be related to social integration (SI), since poor P-E fit may adversely affect behaviour and personal factors that ultimately impact upon a person's SI. As such, preferences and perceived needs might also serve as predictors of SI. This conceptual shift has important implications for program evaluation and interventions because it implies that responsiveness to a person's preferences and to what a person considers important, may provide program planners with new direction as to how they could best satisfy needs that are not being met, while providing program evaluators with a method for evaluating the impact of such program interventions.

Housing for the Psychiatrically Disabled

Much of the research in this section speaks to social integration (SI) related issues rather than it does to subjective QOL issues, which was the focus of the earlier literature review. Much of the process and outcome research on community housing has direct relevance to SI. This literature has been thoughtfully reviewed by Nelson and Smith Fowler (1987) who also presented methods and a program-logic model for conceptualizing and assessing housing environments.

Both social integration (SI) and subjective QOL of the chronic mentally disabled (CPD) have received scant attention in the research literature (Kennedy, 1989). Historically, early evaluations of housing programs for the psychiatrically disabled lacked well-defined program-logic models and gauged program success on the basis of program planner

definitions of cost-effectiveness (e.g., recidivism rates and work productivity) and practioner definitions of social usefulness (e.g., employment, social adjustment, etc.). Alone, these criteria are inadequate measures of client adaptation because they do not allow for an evaluation of the quality of housing, the significance of work activity for the client, or clients' preferences for types of social involvement. As a result, clients placed in run-down board-and-care homes, asked to perform monotonous tasks in sheltered workshops, or compelled to participate in activities typically involving only other clients, could be considered as reflecting successful treatment programs. These problems originated with the criteria, which were defined for the clients by program planners and practioners, when in fact such criteria should be defined, at least in part, by the client.

More recent evaluations have used measures designed to tap the quality of clients' experiences in the community. Self-sufficiency, internal and external integration, social network support, and social adjustment are all examples of the newer measures used to tap the quality of clients' experiences in the community (Nelson and Smith Fowler, 1987). To this list one should add quality of life and quality of social accompaniment in terms of socially valued others.

The landmark study of community integration of a sheltered-care population (Segal and Aviram, 1978) reported that the major factors predicting overall community integration were the characteristics of the community, the sheltering facility, and the residents, with social supports for residents having the strongest influence on their community integration. From our review of the literature in the previous section, we saw that social support also was an important predictor of residents' well-being as well as level of functioning (Lehman, 1982).

Generally, investigations of the social integration (SI) of deinstitutionalized chronic psychiatrically disabled (CPD) citizens have distinguished between clients' social integration within and external to the housing facility (Hall et al., 1986; Kennedy, 1989; Nelson and Smith Fowler, 1987; Segal and Aviram, 1978;). However, virtually no studies have considered SI in terms of activities conducted in the company of socially valued others, which figured as an important distinction in our definition of SI.

In Canada, the number of people in institutions for the mentally ill has progressively declined over the past three decades (Hull, Keats, and Thompson, 1984). Transitional placements, established to facilitate community adjustment of the CPD, typically include board-and-care homes, group homes, family-care homes, and supervised apartment settings (Coulton, 1984; Lehman, 1983b; Nelson and Smith Fowler, 1987). When compared with other discharged clients, residents of community settings generally show lower recidivism rates and enhanced social functioning (Coulton et al., 1984). However, community placements are not always effectively utilized or successful (Anthony, Buell, Sharrah, and Althoff, 1976; Linn, Caffey, Klett, and Hogarty, 1977). Moreover, reports suggest that deinstitutionalized psychiatrically disabled citizens are seldom welcome nor well integrated into the community, and often lead isolated, lonely lives (Gomez, 1981; Lamb and Goertzel, 1977; Nelson and Smith Fowler, 1987; Segal, Baumohl, and Moyles, 1980; Segal, Silverman, and Baumohl, 1989). More than half such clients in board-and-care homes report having no goals in life and perceive their existence as meaningless (Lamb, 1979). It is not surprising that many return to the hospital periodically (Linn, Klett, and Caffey, 1982). Nevertheless, some longitudinal investigations of deinstitutionalized CPD citizens have confirmed that despite considerable heterogeneity of environments and outcomes, a general trend indicating significant

improvements or recovery for approximately half the cohort has emerged (Harding, Brooks, Takamaru, Ashikaga, Strauss, and Breier, 1987; Tsuang, Woolson, and Fleming, 1979). In particular, the Vermont longitudinal study (Harding, et al., 1987) and the "Iowa 500" longitudinal study (Tsuang et al, 1979), characterized by their methodological integrity, succeeded in showing that older concepts of predictors were not as strong as once believed (Ciompi, 1980; Strauss and Carpenter, 1977; Vaillant, 1978). Longitudinal studies, however, have yet to determine if there are better predictors of outcome, and when improvements begin during the course of mental illness (Harding et al., 1987).

Thus, despite several shortcomings with deinstitutionalization (Borus, 1981; Lamb, 1981, 1984; Uviram, 1990), there continues to exist strong support and justification for treating mental disorders in the community (Moos, 1972; Wing, 1981). However, as many authors point out, returning chronic mentally psychiatrically disabled citizens to the community without providing adequate community support networks has not proven to be the solution once expected (Aviram, 1990; Coulton, Holland, Fitch, 1984; Hobbs, 1964; Mechanic, 1989; Segal and Aviram, 1978). Attempts to prevent deinstitutionalization from becoming what Baker and Intagliata (1982) call "transinstitutionalization" have focused on efforts to develop community-oriented support systems that provide the services clients need to continue living in the community. However, the complexities of deinstitutionalization require a comprehensive community system of care and treatment that is lacking. This has led to a crisis of community care for the CPD that stems from organizational, financial, and structural factors (Aviram, 1990). However, researchers have succeeded in uncovering several factors related to SI as one criterion of successful deinstitutionalization. Some of these have been conceptualized as reflecting the geo-social environment (Hall et al., 1987), while others

have been conceptualized as reflecting housing environments (Moos, 1973; Nelson and Smith Fowler, 1987).

Geo-Social Environment of Housing Services

Recent reports estimate that approximately one third or two-fifths of the total homeless population in the United States are mentally ill (Lamb, 1984; Rossi, Wright, Fisher, and Willis, 1987). Given that those who are homeless and mentally ill may be the least likely to seek out or obtain needed mental health and support services on their own (Lamb, 1984), the needs of the less transient chronic psychiatrically disabled (CPD) and those with more stable residences are better understood and have received greater attention in the literature (Lamb, 1984; Levine and Parrish, 1986). Hall and his colleagues have referred to the characteristics of neighbourhoods which host housing programs for the chronic psychiatrically disabled (CPD) as the "geo-social environment." In this context, housing programs for CPD citizens have been studied in terms of their typical location. Generally, housing for the CPD tends to be nested in clearly demarcated inner-city enclaves (Aviram and Segal, 1973; Hall et al., 1987; Joseph and Hall, 1981; Wolch, 1979) and rural areas (Harding et al., 1987; Segal and Aviram, 1978).

Inner-city concentrations of homes for the psychiatrically disabled possibly occur for reasons of convenient proximity to needed interrelated services (Smith, 1981; White, 1979). Historically, individuals who have relocated from halfway housing have often settled nearby and continued to maintain informal supportive relationships with former and other halfway house residents and staff (Berman and Hoppe, 1976). Hall and colleagues (1987) warned that while such geographic interdependence of users and services may help promote the short-term

social integration of residents at the inner-city neighbourhood level, it may also contribute to the long-term exclusion and segregation of the residents from the larger community that is less dependent upon human services. Moreover, public attitudes and actions in relation to the location of community housing for the psychiatrically disabled has led to resistive responses by informal and formal social systems to the housing placement that may also account for the location of housing services at the inner city level (Hall et al., 1986). Consequently, the psychiatrically disabled often experience a transition of geo-social environments (Hall et al., 1987) that may be characterized as "from back wards to back alleys" (Hall et al., 1987; Lurigio and Lewis, 1989; Trotter and Kutter, 1974). Despite the long-term risks for social segregation, we can expect psychiatrically disabled citizens who migrate to urban neighbourhoods with a central location to maintain demonstrably higher levels of external integration relative to psychiatrically disabled residents of suburban and rural locations (Hull, Keats, and Thompson, 1984; Hull, and Thompson, 1981a; Segal and Aviram, 1978). Hall and his colleagues (1986) suggested that future studies need to better describe the dimensions of the social context (e.g., types of neighbourhoods and communities) that promote residents' adaptation and community integration. In contrast to urban locations, which are typically selected for their convenience, rural locations for sheltered housing have usually been selected principally on the belief that they offered quiet, benign environments, far from other sources of distress that might trigger relapses (Harding et al., 1987; Zubin, 1985).

Some authors report that community acceptance of the psychiatrically disabled tends to correlate positively with the level of personal contact community members have with the residents (Hall and Talyor, 1983; Trute and Loewen, 1978). Trute and Segal (1976) have also reported on a number of census tract variables that can serve to predict community integration

in urban settings; for example, proportionally more apartment dwellings than single family homes, a good mix of both young and elderly residents in the neighbourhood, a high proportion of households with six or more people, and a high proportion of females to males. Trute and Segal (1976) proposed that in such neighbourhoods, which tend to be middle of the road, somewhere in between socially disintegrated (back alleys), and socially cohesive neighbourhoods, the external integration of the residents may be facilitated. If Hall and his colleagues (1987) are correct in their assertion that community members' attitudes and behaviours can mediate the relationship between client integration and residential setting, then there is little in the current responses of informal social systems that promote the community integration of the psychiatrically disabled. Housing programs for the psychiatrically disabled apparently are at best tolerated or ignored only when located in neighbourhoods where residents lack the territorial conservatism so frequently found in the suburbs (Hall et al., 1987).

Generally, the greatest opposition to community homes for the psychiatrically disabled is found in stable, cohesive, residential neighbourhoods with high economic status, and comprised mostly of families with young children (Taylor, Hall, Hughes, and Dear, 1984). In contrast, Taylor and colleagues report that socially disintegrated neighbourhoods, characterized by few children, low economic status, and mixed commercial-residential land-use, were associated with accepting or neutral attitudes toward community housing programs for chronic psychiatrically disabled residents. As Hall et al. (1987) have noted, these findings extend those reported by Trute and Segal (1976), namely, that a number of census tract variables can predict residents' community integration.

Physical-Architectural Environment of Housing Services

Kruzich and colleagues (1985; Kruzich and Berg, 1985; Kruzich and Kruzich, 1985) reported from their study of several different types of residential services for the psychiatrically disabled that quality of the physical environment (e.g., lighting, maintenance, safety, etc.) did not correlate significantly with resident self-sufficiency, nor with integration into the residence or the community. Nelson and Smith-Fowler (1987) have argued that these findings are not surprising since there is little reason to assume such variables to be related. They emphasized instead the impact of the physical environment (i.e., housing) on resident levels of stress and concomitant experiences of negative feelings. In support of this hypothesis, Earls and Nelson (1988) found a positive correlation between the number of housing problems and clients' negative affect, while Goldstein and Caton (1983) have reported that poor physical environment (i.e., housing) was related to client levels of dissatisfaction with residential placement. Nelson and Earls (1986) have also reported that clients who live in their own homes, their parents' home, or group homes reported significantly fewer housing problems than did clients who lived in board-and-care homes or private apartments. The former types of residential housing services also are typically much smaller (i.e., house fewer residents) than board-and-care homes (Lehman et al., 1982; Nagy, Fisher, and Tessler, 1988). Board-and-care homes often lack adequate privacy for residents, and have poor client/staff ratios (Nagy et al., 1988). Such findings provide strong support for more detailed evaluations of the relationships between characteristics of residents and those of the housing conditions in relation to SI.

Behaviour Settings

Nelson and Smith Fowler, (1987) have emphasized the importance of the behaviour setting for psychiatrically disabled residents. Behaviour setting (Barker and Gump, 1964) refers to the interrelatedness between the physical-temporal aspects of the housing environment in relation to routine patterns of behaviour. The theory asserts that as the size of a setting increases, residents become less active and integrated, because residents experience less pressure to become involved in and take responsibility for behaviour settings. As might be expected, behaviour settings and the physical-architectural aspects of sheltered housing are interrelated.

The theory of behaviour settings may also explain why residents of smaller services tend to have lower levels of anxiety, passivity, and psychological distance from others, with concomitantly more contact with neighbours (Trute, 1986), more external integration (Kruzich, 1985), greater environmental normalization (Hull and Thompson, 1981a), higher levels of self-sufficiency (Kruzich and Berg, 1985), and more positive views of the social environment (Hellman, Greene, Morrison, and Abramowitz, 1985). Hellman and colleagues (1985) reported a deterioration in adaptive behaviours of residents when three small residences, housing six clients each, were centralized into one large facility. Nagy, Fisher, and Tessler (1988) reported from a survey of 851 mentally ill residents of 210 board-and-care homes in seven U.S. states that residents of smaller nonprofit homes engaged in more kinds of activities within the facility, made more excursions into the community, and were more likely to engage in productive activities than residents of larger for-profit homes. Moreover, the effects of size and for-profit operation were accentuated for individuals with greater impairment in social functioning. Based on an extensive review of the housing literature, Nelson and Smith Fowler

(1987) concluded that more research is needed on behaviour settings to determine the optimal size of residential services in relation to outcome and SI. Segal and Silverman (1989) arrived at a similar conclusion after interviewing 397 residents in 211 sheltered-care facilities. They concluded that interactions between the person and the environment are highly relevant to SI, such that individual characteristics may be context-specific; that is, what predicts residents' social integration in one facility may not do so in another.

Peer-induced Climates and Characteristics of Residents

An additional environmental factor related to residents' behaviours that ultimately, may impact upon levels of SI, is the influence of co-resident characteristics or peer-induced climates (Nelson and Smith Fowler, 1987). For many clients the main personal support system comprises co-residents and home operators, and they have considerable influence on the behaviour of the clients (Parks and Pilisuk, 1984). In her review of the research literature documenting the role of environments in determining outcome in residential care for the CPD, Cournos (1987) pointed to the failure of researchers to identify personal characteristics of residents that "might have more predictive value" (p. 851). Nelson and Smith Fowler (1987) have argued that characteristics of co-residents are better known than those describing operators of residential services for the psychiatrically disabled, and that the general public tends to have misconceptions regarding who they are. In fact, home operators tend to be middle-aged women who have raised a family and who see their roles as providers of shelter, food, and support for their residents (Beatty and Seely, 1980; Van Putten and Spar, 1979).

Some studies have shown that operator characteristics may be related to client levels of SI. Sherman, Frenkel, and Newman (1986) reported that operator level of activity

correlated positively with resident level of activity both with and without operator accompaniment, while Trute (1986) showed that the less home operators perceived themselves as socially alienated, the more contacts the residents, especially the female residents, had with people in their immediate neighbourhood. Operator level of perceived alienation and resident age, however, were unrelated to resident level of perceived alienation. Degree of psychopathology and gender were related to residents' perceived level of social alienation but only gender was related to resident contact with neighbours; males had fewer contacts with neighbours. Gender was unrelated to level of psychopathology and level of psychopathology was not related to resident level of contacts with neighbours. These findings speak to the general importance of both resident and operator characteristics in relation to the social integration (SI) of the CPD living in community housing.

Although few investigators have reported on co-resident characteristics in relation to client outcomes, Hull and Thompson (1981a) reported that larger disability groups of psychiatrically residents and those with proportionally more males were related to lower levels of environmental normalization. Such findings provide strong support for a balanced distribution of clients with different levels of functioning within the residential setting. Nelson and Smith Fowler (1987) have suggested that more research is needed to determine the influence of various grouping of residents and on the degree of choice residents have regarding with whom they live. To their suggestion one might equally consider studies investigating the impact of providing clients with more choice as to where they live in relation to their SI.

Organizational Structure and Culture of Community Housing

Nelson and Smith Fowler (1987) have described this dimension of community housing for the CPD as concerned with roles within an organization, communication, decision-making, and power. Some studies have shown that the emphasis of such factors in community housing programs can influence client level of functioning and SI. Kruzich and Berg (1985) have reported that self-sufficiency of clients was inversely related to management practices that emphasized rigidity of routine, block treatment of residents, depersonalization of residents, and social distance between operators/staff and residents. These same factors were also found to be inversely related to residents' social integration within the residence (Kruzich and Kruzich, 1985) and outside the residence (Kruzich, 1985). Apte (1968) has reported that halfway houses could be distinguished from hospital wards in terms of restrictive-permissive practices and responsibility-dependency expectations. Halfway houses were more permissive and encouraged responsibility more than did hospitals. Carpenter and Bourestrom (1976) have reported significantly lower rates of re-admission to hospital for psychiatrically disabled residents living in tolerant as opposed to strict housing environments. However, these authors also reported that relative to tolerant environments, strict environments produced higher levels of social participation and life satisfaction in residents. This suggests that restrictive housing services may be associated with greater social participation and life satisfaction but also that they encourage dependency, do not promote self-sufficiency, and are more often associated with re-hospitalization. These findings have important implications for SI.

Using an instrument based upon Wolfensberger and Glenn's (1975) Program Analysis of Service Systems (PASS) as their measure of environmental normalization in board-and-care facilities, Hull and Thompson (1981b) reported that level of adaptive functioning in residents

was related to several PASS-derived dimensions, including level of social protection (i.e., unnecessary rules and restrictions), opportunities for freedom and initiative, courteous resident-staff interactions, and activities that promote social integration. Such investigations emphasize the relevance of encouraging resident involvement in residence management (Nelson and Smith Fowler, 1987).

Social Climate

A significant component of human environments is the social climate (Moos, 1972, 1973). The Community-Oriented Programs Environment Scale (COPES) measures three dimensions of social climate in community programs (Moos, 1972). This approach to the assessment treatment environments is phenomenological in that it emphasizes client perceptions of a setting's social climate (Nelson and Smith Fowler, 1987). The dimensions include: personal relationships, treatment program, and systems maintenance. Factor analytic studies of the COPES by Coulton, Fitch, and Holland (1985) evaluated the social climate of 40 different housing programs for chronic psychiatrically disabled clients. They reported that settings could be classified on a continuum of two dimensions; socio-emotional support and structure. Using these dimensions, Segal and Aviram (1978) investigated a large number of housing programs for the psychiatrically disabled and found them to be positively correlated with both the internal and external social integration of residents. Moreover, resident perceptions of the support and structure dimensions have been shown to be better predictors of internal and external integration than operator perceptions (Segal, Everett-Dille, and Moyles, 1979).

Applied Behaviour Analysis

Another dimension along which the housing environment for chronic psychiatrically disabled residents may be described is in terms of applied behaviour analysis (Nelson and Smith Fowler, 1987). For example, Doniger (1970) has described the use of an incentive system in a halfway housing program whereby clients were allowed to pay less rent according to their level of participation in some meaningful activity undertaken outside the residential service, such as attendance at day programs, sheltered work or volunteer work, and so on. However, Nelson and colleagues (1987) report that their review of the housing literature revealed little additional information regarding the use of applied behaviour modification procedures in residential services for the psychiatrically disabled. The ultimate impact of similar intervention strategies upon the SI of residents has yet to be determined.

Analyses of Social Networks

Finally, analyses of the social support networks of psychiatrically disabled residents, not included in Moos's (1973) conceptualization of human environments, but considered by Nelson and Smith Fowler (1987) may have important implications for SI. Several studies have considered the relationship between social support networks in community housing and SI related variables. Holman and Shore (1978) surveyed ex-residents of a halfway house and found perceived support from both staff and co-residents to be related to fewer re-hospitalizations and to improved social adjustment. Goldstein and Canton (1983) reported that high levels of interpersonal stress and low levels of social support were related to high rates of rehospitalization. Earls and Nelson (1988) reported that the size of social networks can buffer the impact of poor housing conditions on clients' self-reported positive and negative

affect levels. Their findings support an earlier report of a similar nature by Sokolovsky, Cohen, Berger, and Geiger (1978), who found clients with impoverished networks to be at greater risk of rehospitalization than those with more extensive social support networks. In a longitudinal study of the impact that social support networks have on rehospitalization, Cohen, Sichel, and Berger (1977) described a program they initiated in a single-room occupancy (SRO) hotel to improve the social support network for clients. Clients were encouraged to participate in the program, and those who did showed a significant decrease in their frequency of rehospitalization relative to a two-year period prior to their arrival at the SRO hotel.

Nelson and Smith Fowler (1987, p. 83) concluded from their review of the literature that the ideal placement for the CPD citizen is "a home that provides the privacy, dignity, and autonomy that residents need," and which emphasizes resident responsibility for the care of co-residents and the setting. They found that small halfway houses and cooperative apartments to be settings that were most congruent with this ideal. In their review of the housing literature, Nelson and Smith Fowler (1987) emphasized the importance of evaluating the effects of housing types on outcome and client adaptation.

Effects of Housing Types on Client Adaptation

Type of housing, as a factor that may be related to SI, provides a broader dimension than does characteristics of a particular housing service. Where studies of the characteristics of a given type of housing service tend to be more descriptive and correlational in nature, studies on the different types of housing services allow experimental or quasi-experimental designs.

In a descriptive investigation of type of housing and client characteristics, Mercier (1991) reported that personal characteristics of clients and type of housing service were related and that housing type had repercussions on living conditions in general, types of activities engaged in by residents, and social integration. Clients living alone or with their spouses and children showed higher levels of functioning and had better social integration than those living in family-care homes or with their original families (e.g., parents or other relatives). Mercier also reported that type of housing was linked to expectation-related stress and the encouragement of inactivity and dependence, factors which may ultimately be related to the SI of residents.

In their general review of the research literature on community housing for the CPD, Nelson and Smith Fowler (1987) found many studies describing the characteristics of housing to be limited by their correlational nature. They cautioned that such studies do not allow causal accounts of what produces certain effects on client functioning and adaptation. They stressed that many other variables such as type of housing influence the functioning and adaptation of CPD citizens living in community residences. Type of housing placement may, however, be confounded with the fact that most clients showing the highest levels of functioning tend to receive placements having the most desirable characteristics, such as apartments and group homes (Nelson and Smith Fowler, 1987; Zubin, 1985). Such problems speak to the relevance of experimental or quasi-experimental designs that control for type of housing in relation to SI. In those cases where level of functioning was controlled, however (Segal and Aviram, 1978; Hull and Thompson, 1981b; Kruzich, 1985), housing characteristics were found to help explain variance in client levels of adaptation (Nelson and Smith Fowler, 1987). Kruzich and Kruzich (1985) have reported that a moderately rigid routine and a

moderate number of skills programming within the setting both contributed to higher levels of internal social integration. Nelson and Smith Fowler (1987) have argued that such findings illustrate the importance looking at non-linear trends in the research data. They also emphasized the importance conducting controlled or quasi-experimental research designs on the outcomes of community housing. They argued that such research would facilitate interpretations of findings indicative of successful outcomes. Some researchers have attempted experimental and quasi-experimental designs in their investigations of types of community housing for the chronic psychiatrically disabled.

Short-term family crisis care. Polak and Kirby (1976) compared the effectiveness of psychiatric inpatient settings with foster family homes offering short-term crisis care. Newly admitted clients were randomly assigned to either setting. Client ratings of services at follow-up four months later were significantly higher for foster family residents on measures of treatment effectiveness, goal attainment, and self-disclosure to significant others. These results pointed to the importance of foster family crisis care as a viable alternative to the psychiatric hospital (Nelson and Smith Fowler, 1987).

Transitional housing programs. Several reviews of more traditional housing programs (i.e., halfway houses) have suggested that despite numerous evaluations of such services, few have used control groups (Cometa, Morrison, and Ziskoven, 1979; Nelson and Smith Fowler, 1987; Rog and Rush, 1975). Nelson and Smith Fowler (1987) reported on a study by Gumruckcu (1968) which compared former residents of halfway houses with a matched control group of hospitalized clients. One year after discharge into the community, none of the former residents of the halfway house had been re-hospitalized and 67% of them were employed. In contrast to this, only 26% of the control group were employed in the

community and 20% had been re-hospitalized. In a longitudinal study with 40 psychiatrically disabled males, Samuels and Henderson (1971) reported on the effects of a transitional facility employing a token economy. Clients were randomly assigned either to a state hospital, the psychiatric ward of a municipal hospital, or the transitional program. At follow-up 18 months later, 28% of residents in the transitional facility had been re-hospitalized, compared with 50% of the state hospital group and 66% of the municipal-hospital group. Moreover, the employment records for the residents of the transitional facility were significantly better during the follow-up period than were those for the other two comparison groups (Nelson and Smith Fowler, 1987). Lamb and Goertzel (1971, 1972) reported on a longitudinal study with clients who were randomly assigned to a "high expectations" halfway house or a "low expectations" board-and-care home. They found that the high expectations group outperformed the low expectations group in rehospitalization and vocational activity at the 6, 12, 18, and 24 month follow-up evaluations. In a study involving young psychiatrically disabled adults, randomly assigned to a residential program or a control group, Velasquez and McCubbin (1980) found that relative to the control group, clients of the residential program improved significantly more at a six-month follow-up than those in the control group in terms of their social participation, self-responsibility, employment, rates of rehospitalization, and self-concept. Such findings speak to the importance of community housing programs in relation to SI related variables.

Group homes. This type of housing is similar in size to transitional housing programs, but tends to have a different orientation in as much as group home residents may remain for as long as they wish to (Nelson and Smith Fowler, 1987). Fairweather, Sanders, Maynard, and Cressler (1969) conducted a longitudinal investigation of clients on the verge

of discharge from the mental hospital. Clients were randomly assigned to either the usual outpatient care program or to a community lodge. Residents of the community lodge functioned as a family and operated a business offering janitorial services, yardwork, painting, and so on (Nelson and Smith Fowler, 1987). Upon follow-up, at intervals of six, 12, 18, 24, 30, 34, and 40 months, the two groups did not differ significantly on measures of symptomatology and community adjustment. However, lodge residents were found to spend more time in the community. In another longitudinal study, Mosher and Menn (1978) found that at two year follow-up, residents of a housing program and a group of clients who were admitted to the psychiatric ward of a hospital did not differ significantly on measures of community adjustment and symptomatology. However, residents of the housing program used significantly less medication, had significantly fewer contacts with other forms of treatment, and were significantly more likely to be living independently than was the hospital group (Nelson and Smith Fowler, 1987). In another longitudinal study, Okin, Dolnick, and Pearsall (1983) compared clients discharged to small group homes with clients who were ready for release from the state hospital but were kept in hospital because of delays in opening some homes. As little as eight months later, follow-up data indicated that the residential group exceeded the hospital group significantly in terms of subjective perceptions of social support, involvement in leisure activities, and capacity to meet basic needs.

Family-care homes. Another type of living arrangement, a variant of which is prominent in the Outaouais region of Quebec, is the foster-family care home for the chronic psychiatrically disabled citizen. With this type of service, families take clients into their homes, usually on a long-term basis (Nelson and Smith Fowler, 1987). In a longitudinal investigation of foster-family care homes, Weinman, Kleiner, Yu, and Tillson (1974)

evaluated the effects of two types of residential placements for the psychiatrically disabled. They compared live-in "enablers" who took clients into their homes to visiting "enablers" who met five times a week with clients living in groups of two or three in apartments. These two groups were compared with clients living in a socio-environmental treatment ward, and with clients living in a traditional psychiatric ward. At two years post-treatment, 16% of those in the two community housing groups had been re-hospitalized compared with 23% of those in the socio-environmental ward and 42% of those in the traditional psychiatric ward. When the two community programs were compared, 22% of those in the visiting "enabler" program had been re-hospitalized compared to only four percent of those in the live-in "enabler" program. However, clients living in apartments, either in the visiting "enabler" program or upon discharge from the socio-environmental treatment ward, had significantly higher instrumental performance than did residents of foster-family care or board-and-care homes (Nelson and Smith Fowler, 1987). Findings such as these indicate that foster-family care homes may not elicit as much instrumental performance from clients, but equally indicated is the fact that pressures which accompany independent life often result in rehospitalization for the psychiatrically disabled (Mercier, 1991).

The effects of foster-family care were compared to those of continued hospitalization by Murphy, Engelsmann, and Tcheng-Laroche (1976). Clients who met the same criteria for admission to a foster-family housing program were divided into two groups; those who were refused such placements and consequently remained in hospital and those receiving foster-care placements. Follow-up over an 18 month period revealed that the two groups differed little on a battery of measures indicative of symptomatology and social functioning.

In contrast to the findings of Murphy and colleagues (1976), Linn, Caffey, Klett, and Hogarty (1977) reported that the random assignment of a large sample of psychiatrically disabled clients to mental hospital versus foster-family placement resulted in significantly greater improvements on measures of symptomatology and social functioning for the foster-family group at a four-month follow-up. Various factors may account for the different findings between these two studies. The hospital control group in the Murphy et al. (1976) investigation was not randomly assigned to this condition, and may somehow have become aware that they had been denied or refused foster-care placement. This alone could have contributed to a persistence of their symptoms and lack of improvement in social functioning.

Cooperative apartments. In their review of community housing for the psychiatrically disabled, Nelson and colleagues (1987) reported that almost no experimental or quasi-experimental research has evaluated the effects of cooperative apartment programs. They found only one such investigation. Depp, Scarpelli, and Apostoles (1983) interviewed nine psychiatrically disabled clients just prior to placement in a cooperative apartments (in groups of four) and again after one year. The clients showed significant improvement on a measure of self-concept and some dimensions of the COPES (Nelson and Smith Fowler, 1987). Clearly more research related to the effects of cooperative apartments on the functioning and well-being of the psychiatrically disabled is needed.

Based on their review of the housing literature, Nelson and Smith Fowler (1987) concluded that while many experimental and quasi-experimental studies showed the beneficial effects of community residence for the psychiatrically disabled, most failed to present what Rutman (1980) has termed a program-logic model that clearly indicates how program activities (processes) relate to the goals for change in clients (outcomes). Thus, program

evaluators tend to investigate the effects of type of housing (e.g., family care) rather than the characteristics of housing intended to be beneficial to clients (e.g., management practices, social climate, etc.). As a result, conflicting findings (e.g., Linn et al., 1977; Murphy et al., 1976) may originate in simply looking at types of housing that are lumped together. Nelson and Smith Fowler (1987) suggested that it may be more useful to examine different dimensions of the "quality of family care." They proposed that future research on housing incorporate findings from the correlational studies on housing characteristics, which may better guide the development of more specific program-logic models. Such research may clarify not only whether community housing programs are beneficial to psychiatrically disabled clients, but also why they are beneficial (Nelson and Smith Fowler, 1987). Additionally, the suggested that poorly defined control groups such as "psychiatric inpatients," may provide less information than would a comparison of different types and characteristics of housing arrangements such as was done by Lamb and Goertzel (1971) when they compared "high expectations" with "low expectations" living environments. Finally, they proposed tnat researchers specify the goals of residential programs and develop outcome measures to assess these goals (Nelson and Smith Fowler, 1987).

Summary. The subjective quality-of-life (SQL) and SI of psychiatrically disabled citizens living in community residences have usually received separate attention in the literature. Some studies have enquired about resident satisfaction with their living situations (Budson, 1978; Chien and Cole, 1973; Linn, Caffey, Klett, et al., 1977; Marion and Grabski, 1979; Moos, 1974; Segal and Aviram, 1978) and life in general (Lamb, 1979; Stein and Test, 1977). Other studies have investigated SI related issues such as social adjustment and resident presence in the community (Nagy et al, 1988; Segal and Aviram, 1978). More recent research

has focused on the refinement of conceptual models to integrate the research findings in the literature. Examples of such models include the geo-social model of Hall and colleagues (1987), the program-logic model of Nelson and Smith Fowler (1987), and the quality of life (QOL) model presented by Lehman and his colleagues (1982).

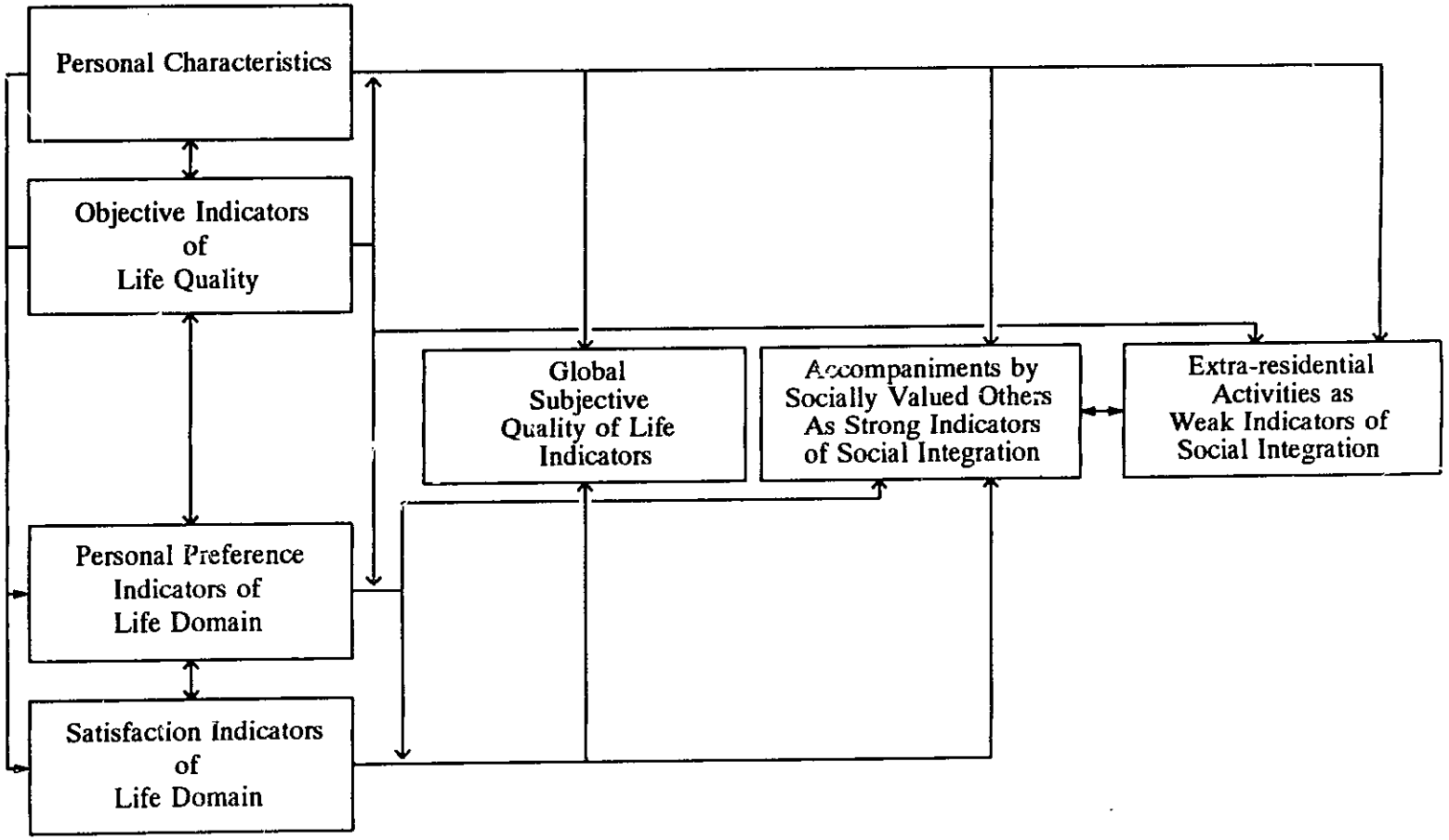
The geo-social model (Hall et al., 1987) attempts to integrate research findings related to the dimensions of the social context of housing programs. It emphasizes (1) the importance of the geo-social environment in which housing for the CPD is located; (2) the responses of informal social systems to the locations of housing, and (3) responses of the planning, policy, and service delivery systems. The program-logic model (Nelson and Smith Fowler, 1987) attempts to provide researchers with directions for conducting research on housing for the CPD. It emphasizes the key variables that are most relevant to program inputs (i.e., resources), activities (i.e., processes), and outputs (i.e., outcomes). The QOL model presented by Lehman and his colleagues (1982) makes the central point that quality of life (QOL) ultimately is a subjective matter, reflected in a sense of Global Well-being (GWB), and that this experience depends upon at least three types of variables: (a) personal characteristics, such as age and gender; (b) objective quality-of-life (OQL) in various domains of life, such as work; and (c) subjective quality-of-life (SQL) in these same life domains, such as satisfaction with work. The model proposed by Lehman et al. (1982) contrasts with traditional approaches more commonly used to assess QOL which measure only OQL conditions and from which subjective QOL may then only be inferred from such observations. Lehman later operationalized his model in a formal QOL interview (Lehman, 1988). Lehman's model (1983b) was most relevant to the aims of the present study.

Some researchers have used measures of QOL or life satisfaction in evaluations of psychiatric programs (Dickey, Gudeman, Hellman, Donatelle, and Grinspoon, 1981; Marion and Grabski, 1979). However, prior to the presentation of the Quality-of-Life Model by Lehman and his colleagues (1982), the subjective QOL concept had received little attention as a system model of evaluation in the mental health field. The QOL concept has received considerably greater systematic attention in the field of gerontology and in assessments of the impact of general medical care of clients with chronic physical illness (George and Bearon, 1980; Larson, 1978; Najman and Levine, 1981).

Lehman and his colleagues (1982) argued that the complexity of life problems facing the psychiatrically disabled demands a conceptual framework for integrating the voluminous information relevant to both the planning and evaluation of services for them. They proposed a QOL model and argued that it provided just such a conceptual framework in relation to subjective QOL (see figure 4). However, our study of the QOL and SI of chronic mentally disabled citizens living in community residences, led us to believe that although their model allowed program planners to identify client dissatisfaction in life domains, it failed to provide an adequate theoretical construct which could account for fluctuations in satisfaction, a means of systematically predicting satisfaction, and direction as to how planners could more effectively use their construct to improve service delivery. This led us to revise and adapt their model. The study presented here was partly intended to determine the utility of a revised and adapted version of their QOL model. Figure 6 presents this revision and adaptation as the QOL and SI (QOLSI) model.

Figure 6

Ely and Flynn's Quality of Life and Social Integration Model



Note: This model is an adaptation of Lehman's original model (Lehman 1983b, p.369).

A Quality of Life and Social Integration Model

The comprehensive quality of life and social integration (QOLSI) model in Figure 6 structured our investigation of the QOL and SI of psychiatrically disabled citizens living in the Outaouais. The QOLSI model attempts to clarify the issues central to the relationship between OQL indicators, preferences, and subjective QOL measures, while providing psychometrically derived measure of social integration (SI) in terms of social role valorization (SRV) theory. The model was intended more as a heuristic device than as an operational or path model. The model was derived from Lehman's (1983) original model, national survey data on QOL (Andrews and Withey, 1976; Campbell et al. 1976), P-E congruence theory (Moos, 1987), social integration theory (Segal and Aviram, 1978), and normalization/social role valorization theory (Wolfensberger, 1972, 1984, 1985).

The theoretical contributions of Moos (1987) allowed us to focus on the relationship between preferences and satisfactions, while social role valorization (SRV) theory (Wolfensberger, 1975) allowed us to focus on the relevance of accompaniments by socially valued others in relation to social integration (SI). We believed that the QOLSI model in Figure 6 provided a practical and potentially more powerful alternative as a system model of evaluation for psychiatric programs because it attempts to integrate subjective QOL and SI concepts as outcome measures in the evaluation process. When applied to psychiatric programs, a heuristic model based upon the concepts of subjective QOL and SI can provide a method of assessing the organizational effectiveness of long-term care plans that not only are cost effective but most relevant to clients. Such a conceptual model also allows for the inclusion of progressively broadening concepts of treatment outcome ranging from specific

illness-oriented indicators, such as hospital recidivism and overt psychopathology (Anthony, Buell, Sharrott, and Althoff, 1972; Erickson, 1975; Gurel, 1964), to more inclusive concepts, such as role functioning (Glazer, Aaronson, and Prusoff, 1980; Katz and Lyerly, 1963; Serban, 1978; Strauss and Carpenter, 1972;), community integration (Lamb and Goertzel, 1971; Segal and Aviram, 1978), and client satisfaction (Lehman, 1983).

Very little is known about the subjective QOL of the psychiatrically disabled, their social integration with socially valued others, and the degree to which their personal preferences might serve as predictors of their satisfaction in different life domains. We have seen that Lehman's (1988) QOL interview and model have been applied only to the study of the chronic mentally disabled (psychiatrically disabled) living in large for-profit board-and-care homes in the United States (Lehman, Ward, and Linn, 1982) and to the best of this author's knowledge, is only beginning to be studied with chronic mentally disabled citizens in Canada (Mercier, 1991; Pinkney, Gerber, and Lafave, 1991).

The literature presents compelling evidence that OQL indicators bear only weak relationships to life satisfaction in the general population and that subjective QOL evaluations are also needed to obtain a comprehensive evaluation of QOL (Andrews and Withey, 1976; Baker and Intagliata, 1982; Campbell et al. 1976; Najman and Levine, 1981; Kennedy, Northcott, and Kinzel, 1978; Rodgers, 1977; Wilkening and McGranahan, 1978). Moreover, it has been suggested that the shortcomings of OQL indicators may be even more marked among persons leading atypical lifestyles, such as the chronic mentally disabled (psychiatrically disabled) (Zautra and Goodheart, 1979). Despite the widespread acceptance of such concerns, the translation of questions about life's quality into definable and

measurable terms still remains problematic (George, 1979). A similar argument may be applied to how SI has been conceptualized and measured.

The central thesis of the Quality of life and Social Integration (QOLSI) model is consistent with the contention that QOL is ultimately a subjective matter, reflected in a sense of global well-being (GWB) (Lehman et al., 1982; Lehman, 1983b). Our model (see Figure 6) labels this experience of GWB as global subjective quality of life (QOL). The Quality of Life and Social Integration (QOLSI) model in Figure 6 differs from Lehman's (1982, 1983a) model in several important respects. It emphasizes the importance of SI, and distinguishes SI and global subjective QOL as possibly related phenomena. Moreover, it argues that both global subjective QOL and SI may depend on at least four types of variables: (a) personal attributes such as age, sex, and personality characteristics; (b) objective quality-of-life (OQL) in various domains of life, such as work and leisure activities; (c) personal preferences (PP) in these same life domains, such as preferences for work and leisure activities; and (d) subjective quality-of-life (SQL) in the same life domains, such as satisfaction with work and leisure activities.

This new conceptual framework can guide examinations of the degree to which personal preferences mediate domain-specific satisfactions and SI. As such, long-term care programs may be improved by a clearer understanding of the QOL and SI issues that are most relevant to the development of policies and programs that may most benefit individual clients.

The link that the QOLSI model makes between preferences and subjective QOL in life domains originated with the P-E fit model proposed by Moos (1984). The notion of P-E fit has allowed researchers to look at how community-based health care settings and client improvement are related. Generally, studies guided by P-E fit theory have attempted to

establish a link between P-E fit factors and environmental indices of treatment outcomes that may be related to SI. For example, supportive and cohesive programs that emphasize independence and high expectations for functioning have been shown to favourably enhance clients' social and vocational adaptation, and a moderate level of organization and structure tends to be related to positive changes in the outcome criteria, while clear, well organized, and supportive programs tend to enhance adherence to treatment regimen, and highly structured programs that restrict open interaction between participants and staff tend to correlate positively with poor environmental adjustment (Collins et al, 1985; Moos, 1984). Certain aspects of treatment settings have also been found to affect clients differentially depending on their level of functioning. High performance expectations and excessive stimulation have been argued to elicit anxiety and personal crises for clients who are not prepared to be pushed to the limits of their abilities (Moos, 1987). Such findings have implications for the well-being of clients. Ryan and Bell (1983) have suggested such clients may need more tolerance within a relatively structured setting that allows little involvement rather than social engagement and personal interaction. A reduction of environmental demands has also been shown to foster more diversity in behaviour among less able residents with no effect on more able residents within a sheltered-care setting (Lemke and Moos, 1984). Such findings are relevant to the social integration (SI) of the chronic psychiatrically disabled (CPD). Most investigations adopting a P-E fit framework have focused on environmental influences on client functioning and adaptation rather than on clients' subjective QOL. Our focus was to use the P-E fit concept in relation to clients' perceptions of subjective QOL.

Some investigators have attempted to link the congruence between individual preferences and environmental provisions to outcome criteria in community programs. Brill

(1978) investigated the implications of the conceptual level matching model for the treatment of delinquents. Brill (1978) noted that a good match between a structured residential treatment program resulted in satisfactory improvement in less mature boys, while those who were mismatched and placed in less structured programs showed less improvement. Coulton, Holland, and Fitch (1984) looked at P-E congruence and psychiatric client outcomes in community care homes. They followed chronic psychiatrically disabled clients who were discharged from state mental hospitals into community care homes. Residents were then asked to rate their personal characteristics and those of their home environment on a set of commensurate dimensions adapted from the Community Oriented Programs Environment Scale (COPES). The authors reported that when the program's emphasis on autonomy and task performance exceeded residents' capabilities, residents showed less stability in functioning over time. As well, the authors reported that when resident needs for privacy and self-understanding were not met, their level of functioning declined.

Moos (1987) has pointed to these findings in support of the notion that environmental structure is more important for developmentally less mature or competent persons. He emphasized that with more disturbed residents, high expectations for independent functioning can exacerbate symptoms and lead to a relapse. He proposed that some chronic psychiatrically disabled residents are less likely to become symptomatic in a supportive setting that allows them to remain uninvolved rather than assertively seeking changes (Finney and Moos, 1984).

Generally, these findings are consistent with previous reports by Moos on the differential effects that family settings have on discharged clients post-treatment (Moos and Moos, 1986). However, these findings also suggest the need for some measure of congruence between level of functioning and resident goals if successful adaptation and community

adjustment are to occur. Moos (1987) suggested that environmental systems tend to maintain or accentuate personal characteristics congruent with their dominant aspects. Thus, clients in treatment programs emphasizing independence tend to improve in social and vocational functioning. However, when the environmental demands either exceed the individuals preferences or capacity to manage them, one can expect some level of personal dysfunction. Moos (1987) attributed this to the power of certain environments over certain populations; he argued that powerful environments such as these offer many potential benefits to the residents, but they also carry significant risks. He suggested that any setting powerful enough to produce constructive personal change also is powerful enough to elicit concomitant stress. For example, when the deinstitutionalized chronic psychiatrically disabled are introduced into highly structured community care homes placing high expectations on personal growth and/or independent functioning, the placement may elicit greater social and vocational adaptation, but such settings also subject residents to more anxiety and stress which can erode their self-esteem and sense of well-being. Residents in the more demanding homes may be at greater risk of experiencing relapse and rehospitalization (Moos, 1987). This can impact on residents' SI. Moos suggested that researchers need to learn more about how such stress can be buffeted by other life contexts, for example, high quality relationships, which have been associated with good morale and satisfaction. We too believed that this type of impact was related to quality relationships and that such relationships were also important determinants of the SI of psychiatrically disabled residents.

We attempted to highlight the importance of quality relationships in relation to SI, by distinguishing between strong social integration (SSI) and weak social integration (WSI) in our QOLSI model. The former reflects the principle of normalization/social role valorization

addressed by Wolfensberger (1975). We believed this could be measured in terms of activities conducted in the company of socially valued persons such as family members. The concept of weak social integration (WSI) reflects the more traditional external integration, addressed by Segal and Aviram (1978), which usually is measured in terms of activity levels outside the residence, but without consideration of the relationship factor.

The present investigation aimed at clarifying the complex relationship between the preferred, perceived, and actual environments of the deinstitutionalized chronic psychiatrically disabled, and how these data relate to subjective QOL as well as social integration (SI).

Demographic variables, attribute variables, actual living conditions, and program inputs all are objective quality of life (OQL) indicators, capable of reflecting to some degree the quality of life of the psychiatrically disabled. However, only global subjective QOL and domain-specific satisfactions measures are direct indicators of the degree to which life conditions satisfy or fall short of a person's needs. We believed that to better manage the satisfaction of those needs, preference indicators might provide direction for program inputs most relevant to those needs.

For program inputs to be relevant to clients' needs they must be isomorphic with those needs. In this sense, pertinent program inputs should have measurable impact on the clients and on the residential service factors if changes are to contribute to residents' well-being and to positive outcomes. Current research has not succeeded in identifying the factors contributing to accurate predictions of successful program interventions leading to enhanced subjective QOL, integration with socially valued others, or adjustment potential in deinstitutionalized psychiatric clients. As mentioned above, most authors report significant, but not very meaningful relationships between sociodemographic variables and subjective

QOL measures (Baker and Intagliata, 1982; Coulton et al 1984; Lehman, 1983b), while very few studies have looked at the relationship between personal characteristics and SI (Cournos, 1987). Thus our research was focused on domain-specific subjective QOL and on SI as impact measures of community residences on deinstitutionalized psychiatrically disabled citizens.

We chose subjective QOL and SI as impact measures, because traditional impact measures (e.g., social adjustment) appeared unrelated to client characteristics (e.g., functioning at time of discharge) in the community (Linn et al., 1980). Although Dickey, Gudeman, Hellman, Donatelle, and Grinspoon (1981) have reported that the best predictor of current residence was age at first admission, characteristics of the home itself have been shown to have only minimal impact on client functioning (Coulton, et al., 1984). Moreover, only weak effects for a few behavioral characteristics (e.g., hyperactivity) and medication level in interaction with diagnosis have been reported to impact on social functioning (Linn et al, 1982). Data from the Linn and colleagues (1982) study suggest that clients who deteriorate in functioning are more likely to have been in larger homes, while schizophrenics appear to be somewhat more successful in homes with less supervision and less operator-initiated activity.

Predicting Quality of life and Social Integration in Psychiatric Community Residences

Magnusson (1981) has suggested that researchers need to distinguish between the main types of environmental variables. Magnusson (1981) proposed three principle types of variables that need consideration by researchers: (1) physical/geographical (i.e., physical characteristics of the environment variable); (2) people and their characteristics (e.g., attribute

variables), and (3) social/cultural variables (i.e., norms, rules, roles, etc.). To this list, Walsh (1987) has added the importance of including perceived environments and situations to the analysis. The perceived environment is defined by Walsh as an actual situation as it is perceived, interpreted, and assigned meaning in the mind of the participant; it is for each individual, the real world. In this type of analysis, environments, and situations are described and classified in terms of person variables such as needs, motives, perceptions, and reactions. However, the individual's preferred environment must also be included in the analysis. Individual preferences, as they pertain to various domains of life, present an important dimension in the analysis of P-E fit. It is the individual's preferences across various domains of life, which account for shifting motives within the environment.

No one lives life continually in the present. We are always making subjective comparisons about how this or that aspect of the environment might be more preferable. Our preferences are influenced not only by our individual standards of comparison, but also by our perception of environmental attributes that might satisfy needs that are defined by our individual standards. Reciprocally, our preferences influence our perceptions and evaluations of environmental attributes as a function of our individual standards and needs.

The comprehensive quality of life and social integration (QOLSI) model presented in Figure 6 argues that within the framework of P-E fit theory, the complex relationship between program inputs, OQL indicators, resident attribute variables, resident preferences, and resident subjective QOL measures across life domains may be clarified. More specifically, the proposed model argues that satisfaction with various domains of life is a function of the degree to which individuals experience congruency between their perceived and preferred environments for that domain of life. The model predicts that for a given domain of life, the

greater the degree of congruency between perceived and preferred environments the greater the satisfaction with that domain of life. The underlying assumption of this model is that subjective QOL instruments (i.e., domain-specific satisfaction measures) tap the degree to which the respondents' preferences, in relation to certain domain-relevant needs, are perceived as more or less met by their perceived environment. A high degree of concordance between what the respondent prefers and what is perceived in relation to domain-relevant needs results in satisfaction and concomitantly higher scores on subjective QOL measures.

In this fashion, domain-specific subjective QOL scores reflect the degree of congruency/discrepancy between a person's actual and preferred environments for different life domains. When domain-specific subjective QOL measures are seen as an index of P-E congruency their relevance as needs assessment instruments becomes apparent. When domain-specific satisfactions are high, one may assume that the degree of P-E congruency is concomitantly high. When domain-specific subjective QOL measures are low, one may assume that the degree of P-E congruency is concomitantly low.

The model also proposes that program planners can intervene more effectively by minimizing the discrepancy between what is perceived and preferred in different life domains. This approach can lead to improvements in clients' domain-specific satisfactions, the index of P-E congruency. The impact of program interventions may then be measured by pre-treatment and post-treatment subjective QOL measures.

Thus, a fundamental difference between the Lehman et al. (1982) model in Figure 4 and the QOLSI model in Figure 6, lies in our fundamental assumption that subjective QOL measures (i.e., measures of satisfaction with life domains) can only suggest to program planners that residents' needs in some life domains are not being met. The advantage of the

QOLSI model is that it provides measures of client preferences and direction as to how one could best satisfy needs that are not met in different life domains. Thus, the model predicts that a low score subjective QOL score in a given life domain (e.g., leisure) is indicative of a relatively low degree of congruence between the respondent's needs/preferences and the perceived environmental attributes that are specific to that domain of life. In essence, a low subjective QOL satisfaction score for the leisure domain would indicate that the respondent perceives that one or more domain-specific needs/preferences are not being met by the environment. The lack of congruence between the respondent's preferred and perceived environment as it relates to a given domain of life (e.g., leisure) may then be predicted on the basis of the respondent's subjective QOL scores for that domain of life. A review of the client's preferences for that domain would indicate how to most efficiently match resources with client needs/preferences. This type of evaluation procedure would allow program planners to determine whether a discrepancy between resources and outcomes can be effectively minimized through practical program interventions.

In summary, when used in conjunction with each other, subjective QOL and preference indicators can outline avenues for meeting the diverse needs of residents in different life domains. In this sense, the QOLSI model provides not only the conceptual framework, but the "nuts and bolts" procedure to more effective intervention programs.

Applying P-E fit theory to subjective QOL issues allows program planners to use domain-specific satisfaction measures as indicators of the degree to which there exists concordance or discrepancy between the respondent's preferred and perceived environment. The model argues that preferences or other indicators of person/environment congruency, such

as, for example, measures of the importance of domain-specific variables, are good predictors of domain-specific satisfactions.

It is in this regard that the QOLSI model may allow program planners to assess more accurately whether their inputs and OQL indicators are concordant or discrepant with their clients' domain-specific preferences for the program environment. For any given domain of life (e.g., health, social relations, religion, etc.), if the perceived environment is congruent with the respondent's preferences, a relatively high degree of satisfaction may be predicted.

In applied contexts, when program inputs, as reflected by OQL indicators, are congruent with the client preferences and/or perceived needs, the program might then be considered successful and no modification of the client's program would be immediately warranted. Alternatively, for any given domain of life, low satisfaction scores, used in conjunction with domain-specific preference or perceived need measures, could clarify not only areas where program inputs are not producing the desired results in terms of client satisfactions, but also provide indication as to which intervention would best meet client needs. It is in this respect that attention to clients' needs and preferences may facilitate the process-related activities that can lead to successful program outcomes. Such information could prove quite useful in the decision-making process related to funding allocations. Moreover, periodic re-assessments could help maintain a successful program at optimal levels of functioning.

In practice, when program participants perceived their actual leisure activities, for example, as concordant with their preferences for leisure, then their levels of satisfaction with the leisure domain could ostensibly be predicted as being relatively higher than for those program participants who would be experiencing a relative degree of discrepancy between

their preferred and perceived leisure activities. For the latter group, program planners would not only know where but how to better meet their clients' needs. For example, practioners could establish with the clients, a leisure activities program designed around the type and frequency of leisure activities that would be preferred by the clients.

The QOLSI model thus predicts that domain-specific subjective QOL measures reflect client needs and that domain-specific preferences or similar indicators of P-E congruency outline how to achieve better P-E fit. The model also argues that program interventions developed within such a model allow preference measures to modify process-related activities, producing measurable outcomes in terms of greater client satisfaction for the life domain for which practical interventions have been implemented as a function of clients' needs/preferences.

The advantage of applying P-E fit theory to subjective QOL issues in the evaluation of community oriented programs for the deinstitutionalized psychiatrically disabled is that it allows program developers to define client needs in terms that are most relevant to clients (i.e., their level of satisfaction with the program as it relates to various life domains). Program interventions may thus be streamlined individually for clients. This could result in more cost efficient programs, increased client self-sufficiency, lower recidivism rates, and ultimately, in greater community integration.

If a program is providing residents with interventions that are not congruent with the residents' needs for various life domains, low satisfaction scores on measures of subjective QOL for those given domains could be noted. In terms of subjective QOL, such programs might be viewed as being minimally efficient in terms of the beneficence to clients. The

consequences of inadequate interventions are now well known; re-hospitalizations, poor social relations, inactivity, low work productivity, and low community integration.

In those instances where program planners believe that their interventions are complementary with the needs of clients, but in fact are supplementary to clients' needs, the interventions will have less impact on subjective QOL than would be the case if their interventions attended to neglected needs. Typically, this results in intervention programs that have poor cost-effectiveness. For program interventions to be valid, they must be based on assessed needs. P-E matching must be based on valid communality between satisfaction and congruency measures as they pertain to needs. For example, successful program intervention should meet the degree of concordance/discrepancy between the respondent's preferred needs and his/her perceived needs in that domain of life. Thus, a respondent scoring low on satisfaction measures for the domain of social relations would be indicating a discrepancy between his perceived and preferred level of social relations. Program planners may then investigate more deeply in what ways this discrepancy may be minimized; for example, by involving the participant in social facilitation groups, theatre groups, etc., or simply by facilitating client contacts with family members. As P-E indices, domain-specific subjective QOL measures can suggest the degree to which perceived needs are not being met. It is in these respects that the QOLSI presents as a system model of evaluation for community housing programs.

In light of these arguments, our comprehensive QOLSI (see Figure 6) argues that the important task for psychologists evaluating treatment programs for deinstitutionalized chronic psychiatrically disabled citizens is to investigate the reciprocal influences between program inputs, the person, the perceived environment, the preferred environment, the actual

environment, and activities or behaviours that reflect SI. The model in figure 6 illustrates this reciprocal relationship. The model argues that each of the factors contributing to the prediction of well-being are reflected in sets of predictor variables that reflect the interaction between the person and the environment. More specifically, the influence of program inputs may be measured in terms of objective quality of life (OQL) indicators which reflect the actual environment of the person, while the influence of the person may be measured in terms of behaviour, demographic and attribute variables, personality characteristics, subjective QOL indicators, and personal preferences for environmental attributes.

In sum, our review of the literature confirmed our belief that further exploration of the quality of life and the social integration of chronic mentally disabled citizens living in small community-based residences and factors related to these phenomena was warranted. This in fact was the purpose of the thesis. However, we needed to demonstrate the replication of the findings reported by Lehman (1982, 1983a, 1983b) and the reliability of the instruments we intended to use before we could apply them in an investigation of the quality of life and social integration of the deinstitutionalized chronic psychiatrically disabled living in community housing. This was the purpose of the preliminary research goals and hypotheses.

General Summary of the Literature Review

National surveys with the U.S. population demonstrated the relevance of investigating how the general population perceives and assesses subjective QOL (Andrews and Withey, 1976; Campbell, Converse, and Rodgers, 1976; Zautra and Goodheart 1979). Lehman and his colleagues (1982) showed that when such data are combined with information on CPD

residents' personal characteristics, objective indicators of their living conditions, and domain-specific satisfactions, researchers are provided with a powerful needs assessment model (Cheng, 1988; Lehman, 1983b). We have argued that the inclusion of domain-specific preferences and level of social integration in this array might broaden the scope and refine the predictive power of such a model.

Moos's (1973, 1984, 1987) P-E fit theory provided a means whereby subjective QOL measures could be conceptualized as indicators of P-E fit. We proposed that preferences and preference-like measures (i.e., indicators of perceived need) could serve to predict subjective QOL in life domains. We argued that should the relationship between preferences and subjective QOL in life domains hold, then preferences would be shown to have practical relevance as predictors of program outcome when program outcome is measured by subjective QOL indicators.

Our general review of the literature then focused on research issues related to SOL and SI. We saw that three decades of deinstitutionalization developed into a national policy in the United States and Canada, with increasing numbers of chronic psychiatrically disabled (CPD) citizens being moved from long-stay hospitals to community-based residences. However, very little was known about the factors that contribute to their quality of life and social integration. Given such a trend, researchers demonstrated growing concern relative to the quality of life afforded to residents of these homes and their level of integration into the community (Lamb, 1979; Rog and Raush, 1975; Segal and Aviram, 1978; Scull, 1977; Van Putten and Sparr, 1979). These concerns were later substantiated by research findings indicating that from an objective standpoint, the psychiatrically disabled living in large community-based residences had low quality of life in most areas. Generally, they were

unemployed, unmarried, suffered from residual symptoms and disabilities, had limited social relations, were largely inactive, remained distant from their families, and relied on disability or welfare funds for financial support (Lamb, 1979; Lamb and Goertzel, 1977; Rog and Raush, 1977; Segal and Aviram, 1978; Talbott, 1978). Such findings led some authors to argue that residential facilities merely represented "new back wards" in the community, exposing clients to conditions that are no better and perhaps worse than those in long-stay mental hospitals (Schmidt, Reinhart, Kane, et al., 1977). Those critiques of community-based care stemmed from the realization that adversity faced by the chronic psychiatrically disabled in numerous areas of life could upset otherwise carefully planned treatment efforts (Lehman, 1983; Lehman et al., 1982; Talbott, 1978). Such findings prompted other researchers to focus attention on a number of areas in living conditions that could be related to clients' subjective QOL (Lehman et al., 1982; Lehman, 1983b) and social integration (Kruzich, 1985; Segal and Aviram, 1978).

Finally, given the many apparent needs of this population and the shrinking resources available, we argued that it would be helpful to have more information about residents' SI and perceptions of their lives in relation to their personal characteristics, their objective living conditions, their personal preferences in different life domains, and their satisfactions in these same domains of life. We proposed that more information regarding the relationship between resident and facility characteristics would also be helpful. We distinguished between strong social integration (SSI) and weak social integration (WSI) in terms that highlight the relevance of quality relationships to the normalization of activities. We concluded by suggesting that such a wide array of information may only be obtained from a comprehensive assessment of resident QOL and SI, and not merely inferred from OQL indicators. We said that subjective

QOL and SI have important policy implications in relation to the rehabilitation goals for the government of Quebec. Mental health and mental retardation policies have made subjective QOL, SI, and normalization of the client's environment central goals in that province (Bolduc, 1991). Finally, we outlined that one of the purposes of our investigation was to examine the utility of the QOL and SI concepts as a system model of evaluation for psychiatric programs. Toward this end, we developed a quality of life and social integration (QOSLI) model and established a research protocol for our investigation.

CHAPTER 2

PRELIMINARY RESEARCH GOALS AND HYPOTHESES

Research Goal 1: To determine whether Lehman's psychometric and substantive findings replicate.

Conceptual Hypothesis 1: Lehman's findings (with an American sample of chronic psychiatrically disabled citizens living in large group homes) will replicate with a French translation of his QOL interview applied to a Francophone population of chronic psychiatrically disabled citizens living in small group homes. More specifically, chronic psychiatrically disabled citizens living in small community residences will have overall subjective QOL scores similar to that reported for chronic psychiatrically disabled citizens living in large group homes and these scores will tend to be lower than that reported for the general population in national surveys.

Operational Hypothesis 1: A comparison of our findings to those reported by Lehman will show that: (a) scale reliabilities will be similar (i.e., internal consistency, and for one variable, temporal consistency); (b) mean levels of subjective QOL indices will be similar, (c) within life domains, the correlations between objective QOL indicators and subjective QOL indices will

similarly be significant but account for only modest portions of variance, and (d) the inter-correlations for the different life domain SQL scales will be significant. Our survey scores will be comparable to those reported by Lehman, and significantly lower ($p < .05$) than that reported for the general population.

Rationale Underlying Preliminary Research Goal and Hypothesis 1

The reader will recall that although previous investigations with English speaking chronic psychiatrically disabled (CPD) living in large group homes (Lehman, 1988; Lehman, 1983; Lehman et al., 1982) have partly demonstrated the feasibility of the research model and Lehman's QOL interview, we wished to determine whether his QOL model and a translation of the QOL interview would be equally applicable to a Canadian *francophone* patient population living in *small* rather than large community residences. It was assumed that the new model and the translated QOL interview would generalize to a francophone population living in smaller residential settings. It seemed reasonable to expect Lehman's findings to replicate. However, a number of factors warranted that as a preliminary step to this investigation we determine whether Lehman's psychometric and substantive findings (Lehman, 1983; Lehman et al., 1982) replicated cross-culturally and across type and location of residences. The preliminary research goal was intended to address the issue of replication, while the essential hypotheses allowed a more substantive examination of the QOLSI model.

The rationale underlying the preliminary research goal and hypothesis stemmed from a number of assumptions that needed verification given that our study involved important

differences in language (French-language translation of an English-language survey), sociocultural differences in population (French Canadian respondents rather than American anglophones), and the physical differences in residential settings (small rather than large residential services). Moreover, relative to the general population, the chronic psychiatrically disabled (CPD) are atypical. However, it was assumed that CPD citizens living in small community-based residences would be able to discriminate their impressions of their overall QOL as did the general population in national surveys (Andrews and Withey, 1976; Campbell et al., 1976). This assumption was supported by reports that CPD citizens living in large group homes were able to make such discriminatory judgments about their overall QOL (Lehman et al., 1982).

Research Goal 2: To determine whether two alternative dependent measures provide equivalent descriptions of respondents' perceptions of global QOL.

Conceptual Hypothesis 2: Given that two types of global subjective QOL measures were used in this investigation, one measure may allow for larger standard deviations while providing equal or superior psychometric properties.

Operational Hypothesis 2: Correlations of domain-specific satisfactions will be equal or greater with the Échelle de Satisfaction de Vie (ESV) and it will produce a lower mean score and a larger standard deviation than will the Item du Bien-être Global (IBG).

Rationale Underlying Preliminary Research Goal and Hypothesis 2

The Global Well-being (GWB) item was reported by Lehman (1983) as the best indicator of global subjective QOL in his survey. The GWB is a single question: "how do you feel about your life in general?" asked at the start and again at the end of the QOL interview. Despite its simplicity, other researchers have reported that it offers superior psychometric properties and accounts for as much or more valid variance as other global measures of subjective QOL, such as, for example, a composite summed score derived from domain-specific concerns (Andrews Withey, 1976). On the basis of convergent validity data, the GWB item accounts for 65% valid variance, and has a stability coefficient of .68 (Andrews and Withey, 1976). A coefficient alpha may not be computed for this measure because it is a single-item global QOL measure. However, because the measure is an index derived by combining answers to the same question asked at the start and at the end of the interview (an average time interval of less than two hours for this investigation), one may compute its test-retest reliability coefficient. For the interested reader a detailed discussion of the gains related to making such a combination may be found elsewhere (see Andrews and Withey, 1976, pp. 77-84).

A potential disadvantage of using the GWB item lies in the fact that the magnitude of the test-retest reliability coefficient tends to decrease over time (Brown, 1976). In light of the short time interval between test and retest in our investigation this potential artifact did not present as a problem. However, in longitudinal designs involving time intervals of several weeks or months between test and retest with the GWB item, it is conceivable that the

temporal reliability of this measure may diminish considerably. In fact, Diener (1984) reported that with an instrument that uses a similar metric and response set, the Delighted-Terrible Satisfaction Scale, the temporal reliability decreased from .66 to .40. after 6 months. Because the Delighted-Terrible Satisfaction Scale and the GWB item are both based upon the same response set (i.e., the Delighted-Terrible Scale in which 7 = Delighted to 1 = Terrible), it was conceivable that the temporal reliability of the GWB item (.68) might also be artificially inflated and be expected to drop over long time intervals, such as in longitudinal surveys. However, Lehman (1988) reported a one-week temporal stability coefficient of .71 for this measure, based on a sample of 45 subjects. No other longitudinal investigations have yet used the GWB item with larger samples of chronic psychiatrically disabled citizens or with longer time intervals between test and retest. The long-term temporal reliability of the GWB item did not present a problem in a cross-sectional study such as we conducted. However, future investigations may need to know which of the two global subjective QOL measures used by us is able to provide the better temporal stability.

The recently developed instrument that we wished to evaluate as a proxy for the GWB item was the Satisfaction with Life Scale (Diener, Emmons, Larsen, and Griffin, 1985). The Satisfaction with Life Scale (SWLS) is based upon an extensive review of subjective well-being measures (Diener, 1984). It is a five-item, single-factor instrument that is narrowly focused to assess global life satisfaction. It does not tap related constructs such as positive affect or loneliness. It correlates weakly with affect and strongly with personality indicators, and as such, may be useful in clinical settings (Diner et al., 1985).

For the purposes of this investigation we translated the GWB item (Andrews and Withey, 1976) into the Item du Bien-être Global (IBG) and used the French-language

translation of the Échelle de Satisfaction de Vie (Blais et al., 1989). Our application of the IBG with a francophone population, required that we translate the same question asked of the U.S. national survey sample. The time interval between test and retest in our survey was less than 2 hrs., while in the national survey by Andrews and Withey (1976), the time interval between test and retest was less than 30 minutes. It was assumed that this modification and the temporal differential would have little impact upon the validity and temporal reliability of the IBG used in our investigation.

The recent translation of the SWLS by Blais, Vallerand, Pelletier, and Brirère (1989); "l'Echelle de satisfaction de Vie" (ESV) with comparative psychometric properties as the original SWLS, obviated the need to undertake our own translation of this instrument. To the best of our knowledge, the ESV had never yet been applied in any published investigation of overall life quality with a population of chronic psychiatrically disabled citizens.

The importance of a comparative analysis of these two measures of global QOL in relation to this investigation is made all the more evident by other limitations inherent with the GWB item. More specifically, the response set (i.e., the Delighted-Terrible Scale) on which the GWB item is based tends to produce skewed results with most responses falling in the "happy" categories (Diener, 1984). Andrews and Withey (1976) provided recommendations intended to overcome such ceiling effects with the Delighted-Terrible Scale's response set. They suggested: "With respect to the Delighted-Terrible Scale, it would be desirable to alter the distribution to provide more discrimination among people at the positive end" (p. 212). More specifically, they suggested that adding more items to the "happy" categories of the Delighted-Terrible Scale might reduce ceiling effects. They also suggested the use of more than one item that taps into judgements of perceived Global Well-

being in order to determine not only the coefficient of stability for this measure but the coefficient alpha as well.

A potential advantage related to the use of the GWB item in relation to judgements of global life quality made by CPD clients was indicated in a recent report by Lehman (1983). He found that global QOL indicators and psychopathology indices were strongly correlated (.51), demonstrating that QOL was impaired among this population relative to the general population. Lehman (1983) reported that a general QOL factor and a general psychopathology factor shared 26% common variance (r^2). Domain-specific subjective QOL measures were found to be relatively more distinct from psychopathology measures. Diener and colleagues (1985) have reported similar findings with the SWLS. They found that the SWLS correlated significantly with personality indicators of well-being such as self-esteem (.54). These findings suggest that global subjective QOL indicators measure constructs more akin to personality and mental health, and that domain-specific QOL indicators may provide more discrete measures of satisfaction resulting from specific life conditions.

In summary, among the more important disadvantages of the GWB item are that it is a single item measure, that the response set induces response clustering at the positive end of the scale, and that its high test-retest reliability coefficient may be an artifact of the short time interval between testings. The fact that it correlates with other variables such as psychopathology may be considered an advantage or a disadvantage depending upon one's purposes. Despite these limitations, no clinical investigations with alternative measures of global subjective QOL have yet been shown to discriminate between as wide a range of feelings while providing superior psychometric properties. However, recent reports suggested that the SWLS and its French-language equivalent, the Échelle de Satisfaction de Vie (ESV)

could provide a viable alternative to the GWB item (Diener et al, 1985; Blais et al, 1989). When contrasted with the GWB item, the SWLS had relatively superior psychometric properties. It has been shown to account for 66% of valid variance, it correlated significantly and meaningfully (.54) with selected personality measures such as self-esteem, and had a two month test-retest reliability coefficient of .82, and a coefficient alpha of .87. Moreover, it correlated .68 and .62 with the GWB item described above (Diener et al., 1985). In light of this instrument's favourable psychometric properties and the fact that it seemed less susceptible to ceiling effects than the GWB item, we found it surprising that no other researchers had yet examined its utility in describing the subjective QOL of different populations. Moreover, a French-language translation of the scale, L'Échelle de Satisfaction de Vie (ESV) is currently available (Blais et al., 1989).

For the above reasons, it seemed reasonable to investigate the hypothesis that the ESV would provide superior psychometric properties and better discrimination over a wide range of feelings than the Item du Bien-être Global (IBG). We believed that if this should this prove to be the case, the information would provide researchers with a superior dependent measure for future investigations of QOL.

SUBSTANTIVE RESEARCH GOALS AND HYPOTHESES

Research Goal 3: To determine the role of domain-specific preferences in the prediction of domain-specific subjective QOL.

Conceptual Hypothesis 3: Domain-specific preferences make an independent contribution to the prediction of domain-specific subjective QOL over and

above that made by personal attributes and domain-specific objective QOL indicators.

Operational Hypothesis 3: In 8 separate hierarchical regression analyses, each using the pertinent domain-specific total satisfaction score as the dependent variable, domain-specific preferences will account for a statistically significant increment in the amount of variance accounted for over and above personal attributes and domain-specific objective QOL indicators summary scores. This is illustrated in the following fashion:

Step1: (age + sex + physical functioning + behavioral functioning).

Step 2: step 1 + (objective QOL indicators reflected in domain-specific summary score).

Step 3: step 1 + step 2 + (domain-specific preference score).

Rationale Underlying Substantive Research Goal and Hypothesis 3

Our review of the literature indicated that domain-specific satisfactions are closely related to global subjective QOL measures (Lehman et al., 1982, Lehman, 198). We believed that just as domain-specific satisfaction scores were shown to be better predictors of global subjective QOL, similarly, domain-specific preference scores could be shown to be better predictors of domain-specific satisfactions. From our review of the literature we hypothesized

that preferences and satisfactions were very likely related to each other. The purpose of Hypothesis 3, then, was to determine the nature of the relationship between domain-specific preferences, personal attributes, domain-specific objective QOL indicators, and domain-specific satisfactions. We believed this relationship would be explained in terms of P-E fit theory (Moos, 1987) and how it relates to one's preferences in various life domains.

Person-environment fit theory argues that a one's sense of well being is determined by the degree to which one's preferences are met by their environment (e.g. work, school). Other authors, reporting on national surveys of subjective QOL have argued that a person's experience of global subjective QOL is apparently mediated by their expectations (Andrews and Withey, 1976; Campbell et al., 1976). Moos (1987) has argued that preferences involve cognitively-based judgements and he showed that they can influence one's subjective experience of well-being. In relation to global subjective QOL theory, Campbell and colleagues (1976) have argued that expectations involve cognitively-based judgements and they showed that expectations can influence one's subjective experience of well-being. Given that both preferences and expectations have been argued to be cognitive phenomena, capable of influencing judgements of subjective QOL, we asked ourselves: "Are preferences and expectations related cognitive phenomena? We believed that one manner in which preferences and expectations could be related would involve preferences as mediating subjective judgements of well-being when such preferences were known and accommodated. Moos (1987) has argued for the role of preferences in relation to general well-being:

> ..."Another perspective focuses on environmental preferences; this view encompasses preferences about physical design, organizational policies, the types of people in a setting, and the social climate. Conceptually, commensurate dimensions can be employed to specify the degree of congruence between

> individual preferences and environmental criteria. One way to achieve a suitable person-environment match is to enable individuals to follow their preferences in selecting environments (Moos, 1987, p. 233).

We believed that preferences could mediate well-being in other life domains such that a person's preferences in relation to leisure activities, family, social relations, etc., mediated domain-specific satisfactions. Thus, just as expectations have been shown to influence a person's sense of overall well-being, preferences were believed to influence a person's domain-specific satisfactions, and ultimately, albeit indirectly, their experience of global subjective QOL (by virtue of their impact upon the person's domain-specific satisfactions). The purpose of Hypothesis 3 then was to determine how domain-specific satisfactions are mediated by a person's preferences. In order to verify Hypothesis 3, we formulated questions intended to survey respondents' preferences in specific life domains.

By clarifying the relationship between satisfaction in life domains and personal preferences in these same life domains we believed that we could also provide a superior methodology for surveying, planning, and better meeting clients' needs. Many authors have argued the importance of the QOL concept as a needs assessment tool (Baker and Intagliata, 1982; Cheng, 1989; Lehman, 1983). Given that a better understanding of residents' domain-specific satisfactions has allowed a better prediction of residents' global subjective QOL, then conceivably, a better understanding of residents' domain-specific preferences would allow a better prediction of satisfactions in life domains. By better understanding those factors that influence domain-specific satisfactions we could then further improve our understanding of residents' needs across those domains that account for so much variance in the prediction of global subjective QOL. We believed that this finding would allow program planners to better

meet clients' domain-specific needs than merely knowing whether residents were satisfied or not in these various domains of life.

A better understanding of residents' domain-specific preferences would provide the added advantage of knowing not only if a resident was satisfied with a specific domain of life, it also would provide information about the degree to which a resident preferred various elements of the domains surveyed, and how these preferences are related to the objective aspects of these same life domains. Such an approach allows functional analyses of organizational specificity in the planning and evaluation of programs fitted to optimally meet individual resident needs. Consequently, the dependent variable in Hypothesis 3 was the domain-specific satisfactions scores in each of the life domains surveyed.

An additional reason for using the domain-specific satisfaction score as the dependent variable in the regression equation stemmed from the fact that domain-specific satisfaction scores have been shown to be less sensitive to personality characteristics (e.g. self-esteem) and psychopathology than global subjective QOL scores (Lehman, 1983). Because domain-specific satisfaction scores can provide more discrete measures of satisfaction resulting from specific life conditions, variance in domain-specific satisfaction scores would tend to be more easily interpretable than variance in global subjective QOL scores. As dependent variables, domain-specific satisfactions allowed for greater clarity in the interpretation of the correlations between domain-specific satisfactions, domain-specific preferences, and domain-specific objective QOL indicators than would be possible if global subjective QOL were used as the dependent variable.

Although we surveyed 10 life domains, only eight separate regression analyses were possible. In each regression analysis, the total score in each life domain served as the

dependent measure. When data had been collected on too few subjects in a given domain (e.g., work and education) to allow the power of the test to be satisfactory, those domains were dropped from the regression analyses. More specifically, we found so few of our respondents to be actively engaged in either work or educational activity that hierarchical regression analyses were not viable in these two life domains. Consequently, only eight separate regression analyses were undertaken (one for each of the eight remaining life domains).

In summary, domain-specific satisfaction scores were the dependent measure in our hierarchical regression analyses of Hypothesis 3, because they allowed for greater clarity in the interpretation of significant predictors than would measures of global subjective QOL. Eight separate regression analyses were undertaken to test Hypothesis 3.

Research Goal 4: To identify important predictors of global subjective QOL.

Conceptual Hypothesis 4: Global subjective QOL is a function of personal characteristics, objective QOL indicators, domain-specific preferences, and domain-specific satisfactions.

Operational Hypothesis 4: Hierarchical regression analyses, described in detail in Chapter three (i.e., Method section) will be used to determine whether the additions of classes of variables produce statistically significant increments in the proportion of variance accounted for in global subjective QOL. The composite variables procedure as it will be applied in our hierarchical regression analysis is outlined below:

Step 1:	Personal attributes (demographic) class of composite variables.
Step 2:	step 1 + (self-esteem score).
step 3:	step 1 + step 2 + (domain-specific objective QOL composite score).
step 4:	step 1 + step 2 + step 3 + (domain-specific preference composite score).
step 5:	step 1 + step 2 + step 3 + step 4 + (domain-specific satisfaction composite score).

Rationale Underlying Substantive Research Goal and Hypothesis 4

Conceptual Hypothesis 4 is similar to Lehman's (1982) original hypothesis in that it tried to identify the best predictors of global subjective QOL. However, it was broader in scope than Lehman's original hypothesis, because it incorporates domain-specific preferences as a predictor of global subjective QOL.

The notion that personal preferences might be an important predictor of global subjective QOL stemmed from our review of the literature. The reader will recall that Moos (1987) demonstrated that a person's sense of well-being was significantly related to the degree of congruency between a person's actual and preferred environments. This finding that P-E congruence (i.e., the match or fit between one's actual environment and one's environmental preferences) was related to one's sense of general well-being was enlightening when we viewed it within the framework subjective QOL. We considered Moos's (1987) P-E construct within the framework of specific life domains. We believed that a person's environment could also be defined in terms of their living situation or in terms of other life domains, such as,

for example, social relations, work, leisure, family, health, and so on. Conceivably, the fit or match between a person's preferences in various life domains and a person's actual situation in these same life domains could influence that person's sense of general well-being in that life domain.

This concept is similar to that presented by several researchers investigating QOL in the general population. Andrews and Withey (1976), and Campbell and colleagues (1976) have reported that a person's expectations in relation to life domains mediate a person's domain-specific satisfactions. Andrews and Withey (1976) have also reported that domain-specific satisfactions were the best predictors of a person's experience of general well-being. In light of such findings, we believed that preferences and expectations were related cognitive phenomena and that preferences mediate a person's domain-specific satisfactions. If this were the case (an empirical question which hypothesis 3 was designed to resolve), it seemed equally conceivable that domain-specific preferences could be important predictors of domain-specific satisfactions and of global subjective QOL. However, no researchers had yet investigated the relevance of domain-specific preferences relative to domain-specific satisfactions in the prediction of global subjective QOL.

Given that domain-specific satisfactions have consistently been the most significant predictors of global subjective QOL (Andrews and Withey, 1976; Lehman et al., 1982; Lehman, 1983), we believed that our analyses would re-affirm the importance of these variables relative to domain-specific preferences in the prediction of global subjective QOL. Thus, Hypothesis 4 intends to determine which are the most significant predictors of global subjective QOL. The likelihood that domain-specific preferences and domain-specific

satisfactions overlap considerably necessitates a hierarchical regression analysis when both are used to predict global subjective QOL.

With respect to the other predictors of global subjective QOL outlined in Hypothesis 4, the literature indicated that most personal attributes, including demographic and diagnostic variables would not correlate significantly with global subjective QOL measures. Those that might correlate significantly with global well-being (e.g., marital status and sex) have been shown to do so consistently, but at low levels (Lehman, 1983). Diagnostic criteria, however, have for the most part provided poor correlations with global subjective QOL. Among the objective indicators of QOL, several variables have been reported to be significantly correlated with clients' assessments of global subjective QOL. However, the absolute values of the correlations tend to be low (i.e., ranging from .11 to .27) and objective indicators have usually accounted for 1% to 7% of the variance (r^2) in global subjective QOL (Lehman, 1983). Work variables have tended to show the highest correlations with global subjective QOL, but work variables usually apply only to a small number of residents. Most chronic psychiatrically disabled citizens living in community residences are unemployed, do not attend school, and are usually inactive. Those that do work tend to have higher global subjective QOL scores (Lehman, 1983). Ratings of satisfaction with the various domains of life tend to be more frequently and more strongly correlated with global subjective QOL than objective QOL indicators or personal attributes. Within the different life domains, the satisfaction measures that tend to correlate highest with global subjective QOL are in the areas of health (.27), social relations (.27), finances (.17) and leisure (.16).

Previous reports of hierarchical regression analyses of various global subjective QOL instruments on independent variable sets indicate that substantial improvements in the

prediction of global subjective QOL may be achieved by including marital status, education level, gender, and substance abuse from the personal attributes set of independent variables (Lehman, 1983). Including age in the regression equation does not tend to improve the power of the model, because age does not correlate significantly with this type of sample. In our investigation, the inclusion of marital status was similarly of little use, since all of our subjects were unmarried. The inclusion of a summary score related to level of functioning was believed, however, to be more helpful in our investigation. Level of functioning (impairment) has been related to productive activity (Nagy et al., 1988). Work is a form of productive activity that also requires higher levels of functioning. Given that work has been shown to correlate significantly with global subjective QOL measures (Lehman, 1983), we inferred that level of functioning and global subjective QOL might also be correlated. Since level of functioning may be physical and psychological, both dimensions were included in our hierarchical regression analyses. Personality factors have also been shown to correlate with estimates global subjective QOL (Lehman, 1988; Nagy et al., 1988). For this reason, it also seemed reasonable to include a measure of self-esteem in the regression analysis.

Research Goal 5: To determine if a relationship exists between social integration (SI) and global subjective QOL.

Conceptual Hypothesis 5: There is a significant positive relationship between global subjective QOL and SI.

Operational Hypothesis 5: The correlation between global subjective QOL and SI will be significant ($p < .05$) and positive.

Rationale Underlying Specific Research Goal and Hypothesis 5

Our review of the literature suggested that global subjective QOL and social integration (SI) could be related. Lehman (1983) reported that the Global Well-being (GWB) item correlated positively with indicators of psychopathology. Diener (1985) reported that another measure of global subjective QOL, the Satisfaction with Life Scale (SWLS) correlated positively (.54) with personality indicators such as self-esteem. These findings, taken with reports by Segal and Aviram (1978) that resident characteristics (i.e., degree of psychological disturbance and age) were significant predictors of social integration (SI) suggested to us the possibility of a relationship between global subjective QOL and SI. It seemed reasonable to assume that global subjective QOL and SI might be significantly related in a positive direction. As such, socially integrated individuals might also tend to experience better global subjective QOL. Thus, without assigning causal priority, it appeared worthy to investigate this possible relationship between global subjective QOL and SI. We believed that such information could prove useful to researchers and program planners who are interested in undertaking prospective investigations aimed at improving residents' subjective impressions of global subjective QOL by implementing socially integrating activities programs.

Research Goal 6: To determine whether the location and size of a community residence for chronic psychiatrically disabled citizens has an impact upon the social integration of its residents.

Conceptual Hypothesis 6: Among family-care homes, residents of rural and/or larger community residences will have lower SI scores than those

from urban and/or smaller community residences. In short, size and/or location of a community-based residence for chronic psychiatrically disabled citizens has an impact upon their social integration (SI).

Operational Hypothesis 6: Using hierarchical regression analysis, only size and location of facility will add significant variance accounted for in the social integration (SI) scores. More specifically, in a hierarchical regression analysis using both the strong and weak forms of SI as the dependent measure:

Step 1: Personal attributes (gender + age + level of psychological functioning).

Step 2: Step 1 + (Location of facility: 1 = urban, 0 = rural).

step 3: step 1 + step 2 + (size of facility: number of residents).

Rationale Underlying Specific Research Goal and Hypothesis 6

The reader will recall that data from a recent survey of 851 mentally ill residents of 210 board-and-care homes indicated that facility characteristics such as size, location, and for-profit operation all contributed to encourage resident activity in the community or conspired to allow resident apathy (Nagy, Fisher, and Tessler, 1988). These authors also reported that facility characteristics were accentuated for individuals with greater impairment in social

functioning and conspired to diminish their level of productive activity and presence in the community, and, ultimately, their social adjustment.

At the time of this writing, the subjective QOL of chronic psychiatrically disabled citizens living in *small* community-based facilities had, to the best of this author's knowledge, never before been investigated. Facility characteristics such as size (i.e., average number of residents) had been reported to impact significantly upon resident social adjustment (Nagy, Fisher, and Tessler, 1988). Thus, it seemed reasonable to assume that facility characteristics such as size and location were related to other dimensions of life such as resident social integration and impressions of subjective QOL. In their investigation, Nagy and colleagues found that residents of small, nonprofit homes engaged in more kinds of activities within the facility, made more excursions into the community, and were more likely to engage in productive activity than residents of larger for-profit homes. Unfortunately, their findings were based on very few services housing less than ten residents. They reported that the average facility housed 16.7 residents and that a typical resident lived with 30 housemates (Nagy et al. 1988). They also reported that the effects of size and for-profit operation were accentuated for individuals with greater impairment in social functioning. It seemed reasonable to assume that all other things being equal, residents living in smaller homes might report better QOL than residents living in large group homes. However, given the diversity in level of services available to residents of urban facilities, relative to rural facilities, location of residential service was also assumed to impact upon resident social integration.

In light of the above assumptions, it seemed noteworthy that Nagy and colleagues (1988) reported that location was found not to be significantly related to resident activity levels. However, their sample was drawn from urban and suburban settings only. The sample

in our investigation was drawn from urban, suburban, and rural settings. However, too few of our respondents were drawn from suburban settings to consider them as a separate group. Consequently, we combined our urban and suburban respondents to form an urban category. We then eliminated all of those services which were not family-care homes to better control for type of setting. Residents of family-care homes in urban areas were compared to those residents comprising the rural family-care homes category. Conceivably, the urban/rural distinction would have greater impact on social integration than the urban/suburban distinction had on activity levels of the sample surveyed by Nagy and colleagues (1988).

Given that, relative to rural areas, urban areas tend to be more heavily populated, offer a broader range of public services, and more choice and opportunities for excursions into the community, it also seemed reasonable to assume that residences located in urban areas would tend to facilitate SI to a greater degree than would residences located in rural areas. The empirical issue was determined with hierarchical regression analyses of data based on the social integration (SI) scale developed for this study.

In sum, we inferred that levels of productive activity and excursions into the community would reflect social integration and would be related to location and size of facility. Social integration and subjective impressions of general QOL as well were held to be influenced by location and size of housing service. The purpose of hypothesis 6 then was to determine the impact of service location and size on resident social integration and life quality. The order of entry of the variables in the hierarchical regression was determined on the basis of their origin in time and on the basis of their mutability. Since personal characteristics were held to precede client placement, they were entered in the first step. Location of facility was believed to be less mutable than the size of the facility (i.e., number

of residents) as operationally defined for this investigation. Consequently, the entry of location preceded the entry of size in the hierarchical regression analysis.

Research Goal 7: To determine the nature of the relationship between program quality in terms of a facility's PASSING score and objective indicators of program quality.

Conceptual Hypothesis 7: Among family-care homes, program quality, as defined in terms of normalization/social role valorization theory, will correlate negatively with rural location and size (number of residents) of facility and program quality can be predicted on the basis of location and size of a housing service.

Operational Hypothesis 7: With family-care homes as the unit of analysis, location and/or size of a facility will add significantly to the prediction of the overall PASSING score, the Environment subscale score of PASSING, and the Program subscale score of PASSING. More specifically, using hierarchical regression analysis:

Step 1: Location of facility (1 = urban; 0 = rural)

step 2: step 1 + (size of facility: number of residents).

Rationale Underlying Specific Research Goal and Hypothesis 7

PASSING evaluations tend to weight objective indicators of program quality such as location and size of facility in the formulation of an overall PASSING score. Thus, it seemed

reasonable to expect that the rural/urban distinction and the size of the facility might both contribute significantly to the overall program quality as evaluated with PASSING. We believed community-based residences located in rural areas would achieve lower PASSING scores principally because at the program level of a service, PASSING scores are a measure of SI, and because rural areas, relative to urban areas, tend to be less densely populated, and offer fewer services and opportunities for resident integration with the community (Coulton et al., 1984). Our review of the literature also indicated that residents of large community-based residences tend be less active and less present in the community than those living in small community-based residences (Nagy et al., 1988). Thus, rural facilities and those housing more residents were expected to obtain lower overall PASSING scores, reflecting lower program quality. Consequently, hypothesis 8 was intended to determine the extent of the relationship between overall program quality in terms of total PASSING score and PASSING subscale scores and the aforementioned indicators of program quality (i.e., location and/or size of facility).

Research Goal 8: To determine which of the QOLSI model's variables are the best predictors of social integration (SI).

Conceptual Hypothesis 8: Personal attributes, objective QOL indicators, domain-specific preferences, and domain-specific satisfactions may all be related to social integration.

Operational Hypothesis 8: According to the multivariate relationships in the QOLSI model (figure 6, p. 65), personal attributes, objective QOL indicators, domain-specific preferences, domain-specific

satisfactions, and GSQL are related to a respondent's social integration.

Step 1:	Personal attributes composite score
Step 2:	step 1 + (objective QOL indicators composite score + Total PASSING score).
Step 3:	step 1 + step 2 + (domain-specific preferences composite score).
Step 4:	step 1 + step 2 + step 3 + (domain-specific satisfactions composite score).
Step 5:	step 1 + step 2 + step 3 + step 4 + (global subjective QOL score).

Rationale Underlying Specific Research Goal and Hypothesis 8

Our review of the literature suggested that the social integration (SI) of chronic psychiatrically disabled citizens is a poorly understood and relatively neglected concept. Only a few authors have considered SI as it relates to this population. The most comprehensive treatment of this issue has been undertaken by Segal and Aviram (1978). Their survey interview of some 439 CPD residents in 210 facilities revealed that 3 types of factors facilitated or hindered a resident's SI: (1) community characteristics; (2) resident characteristics, and (3) sheltered-care facility characteristics. Since then, little has been undertaken with regard to this population's SI.

However, more recently, Nagy and colleagues (1988) have investigated the effects of facility characteristics on resident social adjustment. They reported that a number of facility characteristics impinge upon resident activity levels within both the residence and the community. Their findings indicate that in addition to size and location of facility, cost of care, staffing ratios, rate of resident turnover, and resident characteristics are all significantly related to activity levels. More specifically, age, gender, and level of impairment were all associated with lower levels of activity in their sample; older, more impaired females tended to be the least active in the community. However, they suggested that other factors such as diagnosis and medication may further diminish their reported effects of facility characteristics.

In light of the fact that a number of resident and facility characteristics may influence activity levels and presence in the community, it seemed reasonable to assume that resident and facility characteristics could be related not only to global subjective QOL as has been argued above, but to resident social integration as well. As such, hypothesis 8 was designed to determine whether facility and resident characteristics were related to social integration and impressions of global subjective QOL.

The research literature indicated that the type of factors that most hinder or support social integration included in order of importance: (a) community characteristics; (b); resident characteristics, and (c) facility characteristics, (Segal and Aviram, 1978). We undertook to consider each of these factors in our investigation. The community characteristics reported by Segal and Avriam (1978) to facilitate or hinder the social integration of sheltered-care residents were, in order of importance: (1) response of neighbours; (2) rural/urban location of the facility; (3) complaints from neighbours made to authorities about the facility, and (4) distance of the facility from community resources.

With respect to community characteristics, practical considerations (i.e., limited human and financial resources) prevented our investigating all of the relevant factors. Consequently, factors 1 and 3 were not dealt with in our investigation. However, we were able to consider the relevance of factors 2 and 4, as well as, previously unexplored factors which the QOLSI model (figure 6, p. 65) suggested could be relevant to social integration. According to the QOLSI model, the rural/urban location of the facility and the distance of the facility from community resources could be considered as objective QOL indicators. The instrument we used to assess these and other objective QOL indicators in relation to social integration was Program Analysis of Service Systems' Implementation of Normalization Goals (PASSING), developed by Wolf Wolfensberger and Susan Thomas (1983). PASSING was recently translated into French as "Programme d'analyse de systèmes de services" by Michel Roberge and adapted by Jacques Pelletier (1988). The instrument is presented in considerable detail in the method section and the reader is invited to refer to that section for a more comprehensive review of PASSING. It is noteworthy that social integration is the major hoped-for outcome of normalization/social role valorization, and that PASSING has been shown to predict social integration (SI) in the literature (Wolfensberger, 1985).

Our application of PASSING allowed us to assess the relevance of location (i.e., rural/urban distinction) and proximity to community resources (i.e., distance of facility from community resources) under the PASSING factor labelled as "accessibility". PASSING also allowed us to evaluate the relevance of two other factors referred to as "environment" and "program" in relation to resident social integration. According to the literature, additional factors worthy of consideration as objective QOL indicators related to social integration are

the size of facility (i.e., number of residents), frequency of intimate social contacts, and frequency of social contacts in the facility (Lehman, 1983; Nagy et al., 1988).

In contrast to reports by Nagy and colleagues (1988) that among other factors, size of the facility had the greatest impact upon resident activity in the community, Segal and Aviram (1978) have reported that facility characteristics was their least important predictor of social integration. However, in terms of the QOL model, Segal and Aviram's (1978) measure of facility characteristics may have been inadequate. They used a combined score derived from subsales of Moos' Community Oriented Programs Environment Scale (COPES) (Moos, 1974). Based on this combined score they created an index designed to consider (1) the extent to which a facility could be termed an ideal psychiatric environment and (2) the extent to which the residents as a group in the facility were isolated from the external community. Segal and Aviram (1978) have pointed out that an apparent problem with such an index lies in the fact that there is little consensus as to what constitutes an "ideal psychiatric" or "therapeutic environment" (p. 180). Clearly such an index is more abstract and subject to measurement error than are more objective indicators of facility characteristics, such as number of residents, for-profit operation, and staffing ratio. Consequently, and in accordance with the QOLSI model, we chose to consider facility characteristics in more objective terms and selected size of facility, frequency of intimate social relations, and frequency of social contacts within the facility along with the PASSING subsales of accessibility, environment, and program to comprise our objective QOL indicators in our prediction of social integration.

Among the various personal attributes which could serve as predictors of social integration with our sample, the literature suggested that the most important ones include age,

gender, behavioral functioning, and physical functioning (Nagy et al., 1988; Segal and Aviram, 1978). Consequently, we chose to consider these factors in our prediction of social integration. Behavioral functioning and physical functioning levels were based on data derived from the translation and adaptation of the Level of Care Survey (LOCS).

We used two dependent measures of social integration (SI) which we refer to as the weak form of SI and the strong form of SI. The distinction between weak social integration (WSI) and strong social integration (SSI) originated with the relevance we attribute to normalization/social role valorization theory in relation to social integration. Social role valorization theory was reviewed in the introduction and method sections and the reader is invited to refer to those sections for a more comprehensive reading. In accordance with social role valorization theory, the weak form of social integration was based upon the total number of activities outside of the residence that were undertaken by a resident over the course of the past seven days. This absolute frequency of activities outside the facility did not consider with whom the activities were undertaken. The strong form of social integration was based upon the total number of activities both inside and outside the residence that were undertaken by a resident in the company of a socially valued person, including family members and/or others who were not co-residents or residents in another service, professionals, home operators, or staff. Essentially, the strong form of social integration is closer to normalization/social role valorization theory's criterion that social integration should validate one's social role. As such, daily excursions to eat out alone in a restaurant, for example, were believed to reflect a weaker form of social integration than would eating out with or receiving a valued person (e.g., a family member) for dinner. In the former, the frequency of the activity does not reflect the normalization/social role valorization principle as strongly as does the latter.

In order to maintain a respectable subject/variable ratio in our test of hypothesis 8, five blocks of composite variables were constructed using a method originally suggested by Coleman (1975) and subsequently used by other authors (Cronkite and Moos, 1978; Flynn and Nitsch, 1981). The composite procedure was previously described in our operational definition of Hypothesis 4. It was applied similarly in our test of hypothesis 8. Five independent composite variables were formed from blocks of variables with two or more conceptually similar variables (e.g., age, gender, physical functioning, behavioral functioning, etc.). Each composite was computed as a weighted sum of the variables composing the block. In this procedure, the weights are the regression coefficients obtained when only the variables in a particular set are used to predict the criterion variable. In the present case, regression weights were obtained separately for each composite by using only the variables in the respective variable class to predict the index of social integration. Composite variables such as domain-specific preferences no longer had a natural metric (Cronkite and Moos, 1979; Flynn and Nitsch, 1981). However, individuals still ranged from high to low on such composite variables, with a "high" score referring to those combinations of domain-specific preferences that were associated with greater social integration.

CHAPTER 3

METHOD

Subjects

Data obtained from the Programme de Réhabilitation du Centre Hospitalier Pierre Janet revealed that the target universe comprised 172 residents living in 38 community-based residences. The average age of this subject sample pool was 47.3 years (*SD* = 13.2), ranging between 18 and 92 years with a median of 41.7 years. The average length of stay in these community-based facilities (though not necessarily in the same residence) was 9.5 years (*SD* = 3.7 years) and ranged between 24 days and 19.3 years, with a median of 5.7 years. Seventy-two percent of the residents in this target sample had a diagnosis of schizophrenia, paranoid schizophrenia, or major affective disorder, 14% had a diagnosis of mental deficiency, 9% had an undifferentiated diagnosis, and 5% had no diagnosis of mental illness, but were living in the community facilities due to circumstantial events.

From this pool of residents, 88 clients (51 % of sample) met the inclusionary criteria for participation in the study. Those criteria are described in the "Procedures" section of this chapter. Of the 88 residents we recruited, twelve (14%) refused and six (7%) were unable to complete the interview. The actual sample then consisted of 37 men and 33 women (80%) who were willing and able to successfully complete the QOL interview. These 70 subjects represented 41% of the total resident population. Their average age was 43.2 years (*SD* = 12.1 years), with a median of 42.5 years. The average education was 9.3 years (*SD* = 3.4) with a median of 9.0 years. None of the respondents were currently married. The majority of respondents (63% of the sample) had never married, 25 respondents (36% of the sample) were

either divorced or separated and one was a widower. All respondents were francophone. Most of the respondents had a psychotic disorder; 54 (77%) of the respondents had a diagnosis of schizophrenia, paranoid schizophrenia, or major affective disorder. Seven respondents (10%) had an undifferentiated diagnosis, two (3%) had a diagnosis of organic psychosis, one had a diagnosis of mild mental retardation, and six (9%) no longer had a psychiatric diagnosis, although they were still living in a community facility for circumstantial reasons (e.g., still in need of support or no place else to go). These diverse diagnostic groups were treated as one category because Lehman (1983a) had shown that psychopathology does not introduce bias into the overall structure of subjective QOL data. He reported that the effects of mental health ratings produced no significant change in the bivariate correlations between objective and subjective QOL indicators in life domains, nor were the partial correlations of these indicators changed in any life domains by the removal of a composite mental health score. The sample resided in 32 (84%) of the 38 services originally visited by the PASSING team. The average length of stay in their current residential setting was 3.2 years, (*SD* = 3.8 years), with a median of 1.6 years.

Facilities

The target population resided in 38 community-based residences comprising 29 family-care homes (1-9 adults residents with long-term psychiatric disabilities) five apartments (1-2 residents), three group homes (5-7 residents), and one room in a rooming house (1 resident). All of the services served an adult clientele only (18 years and older). Of these services, 23 facilities (61%) were located in urban areas and 15 (39%) were located in rural areas. The actual research sample resided in 32 of the aforementioned services, including 26 family-care

homes (1-9 adults), two apartments (1-2 residents), three group homes (5-7 residents), and one rooming house (1 resident). Nineteen facilities (60%) were located in urban areas of Hull, Aylmer, and Gatineau, and 13 (40%) were located in rural areas of Quebec's Region seven. The average service housed a mean of 5.84 citizens (*SD* = 2.20), while the median for the number of residents per service was seven.

During the site visits, the PASSING team made anecdotal note of the fact that the model for these residential services maintained important traces of the institutional model for psychiatric care; board and care were provided with much consideration, albeit without attention to essentials related to enriching work or leisure activities, which were, for the most part, absent. One explanation for this state of affairs may be found in the relationship between the scope and importance of the residents' needs, and the lack of human and service resources. The PASSING team also found that residents were crowded in most of the services they visited. There are important implications related to such physical constraints; for example, resident rights to privacy could hardly be respected. However, when the PASSING evaluators conducted their site visits and interviewed the home operators, they noticed no flagrant violations of right to privacy, but awareness of the residents' privacy needs was quite low, as was resident awareness of their rights in general. The latter was confirmed during the QOL interview with the residents.

Many of the residents we interviewed had been displaced some distance from their community of origin. Many (47%) still considered their city of birth as their "home town," and 41% of the residents were not living in their community of choice. Moreover, 65% of residents were not living in their preferred type of residence. Half the residents (n = 35) said they would prefer to live in a private setting such as an apartment or own a home. In response

to this situation, the CRSSSO had forecasted for a placement planning program which would ensure that systematic efforts to house residents in services close to their original communities would be implemented in the immediate future. In some cases, however, residents had been housed in their placement communities for over 15 years, which brings into to question the notion of "community of origin." In relation to placement setting, resident accessibility to family was found to have been given less than adequate consideration. In several instances where resident accessibility to family was facilitated by placement setting, a positive impact was noted in terms of client contacts with family and improved access to other resources due to collaborative efforts by family members who were in a position to be better apprised of the resident's needs.

Another discomforting aspect of "streamlining" services was noted in the tendency by residential care givers to over generalize when planning intervention programs for the clients. On more than one occasion, family-care home operators told us "...these people are practically all the same." This reflected a need for service operators to nurture greater awareness of each resident's individuality such that it extended beyond the scope of individually planned intervention programs. For example, in most facilities, resident birthdays passed unnoticed, and few facilities celebrated the anniversary of a resident's arrival at the service. No resident's departure from any service had ever been celebrated.

During our site visits of these services, we noted few deliberately negative aspects (e.g., restrictions on individual rights, vocabulary, interactions, etc.). Quite the contrary, we found most service operators to be genuinely concerned about the welfare of the residents. However, few resources were coherently and systematically structured so as to improve the residents' current life conditions in a dynamic and methodological fashion. In several

facilities, we found telling symbols of the residents' diminished social value. Residents' rooms were often found to be too small for shared accommodations, and too often located in the basement of the service to which resident activities were usually also limited.

Services offered to residents (housing, nursing, social, etc.) were found to be quite traditional and with a disproportionately predominant medical dimension at the expense of the psychosocial dimension. Professionals were too often relegated to crisis intervention, with relative neglect of their expertise in the areas of needs assessment, therapy, and support related to program development and implementation. Moreover, service operators often lacked important background demographic data regarding new arrivals to their service. This often limited the scope of their intervention programs. Most residential service operators appeared to consider their facility as an extension of the psychiatric hospital's treatment program, rather than as a social integration resource. Lack of information, training, or awareness often limited the potential of many home operators with a wealth of life experiences that could be brought to bear in the rehabilitation process being untapped.

In those facilities where a day program was available, important differences in the level of activity and dynamism of the residents who so participated were noticeable. In many facilities, the absence of a day program unduly expanded the mandate of the residential service such that home operators had complete charge of the residents. In such cases, residential services were perforce obliged to undertake custodial services and home operators were often unable to meet clients' needs, given their actual resources. From the residents' perspective, the absence of such day programs typically reduced them to the useless role of indolents who never experienced real vacations from their familiar and unproductive lifestyles, since to experience a vacation, one must equally experience daily activities that are

productive, significant, and valued. Several residents expressed an interest in obtaining work and a few asked us if the interview would help find them so type of productive job. However, in far more cases, prolonged unproductive years stifled any interest in seeking remunerated work.

Organized resident activities (leisure or other) were generally limited to within the home, and were too often limited to contacts with co-residents or residents of similar facilities located nearby. Few conscious, active, and intense efforts were noted on the part of home operators to encourage resident contacts with less impaired or even socially valued persons. Generally, we found the concept of residential service to be confused with the concept of treatment, which only heightened resident segregation from the community; for example, in most services, the residence constituted the only place where any activities were undertaken. In certain cases, active efforts were made to minimize resident contacts with the community by having purchases delivered to the residence and by obtaining services for the residents (e.g., haircuts, clothing purchases, etc.) directly through the institution.

It is noteworthy that these housing services, resident living situations, and lifestyles are not unique. A number of authors have provided quite similar descriptions of residential services, resident living situations, and lifestyles respective to U.S. populations of deinstitutionalized psychiatrically disabled citizens (Aviram, 1990; Lamb, 1972, 1977, 1981; Lamb and Goertzel, 1971; Rog and Raush, 1975).

Variables and Measures

Quality of Life Interview

Lehman's original quality of life (QOL) interview was developed as a means of evaluating the QOL experienced by chronic mentally disabled citizens. The 45 minute interview has the attraction of evaluating a broad variety of current life experiences that can influence one's sense of well-being. It integrates areas that can relate to the need for and be affected by the delivery of psychiatric, general medical and social services. As such, it may be applied to assist in the planning and evaluation of programs for the chronic mentally disabled.

The QOL interview is a reflection of Lehman's (1983b) conceptual model which is based upon studies of the quality of American Life (Andrews and Withey, 1976; Campbell et al., 1976). Lehman's (1983b) model views the experience of general well-being as a product of personal characteristics, objective life conditions in various life domains, and satisfaction with life conditions in these various domains. This formulation is argued to allow for comparisons across populations on any given component of the model, such as comparisons of general well-being or functioning within a particular life domain, as well as assessments of the salience of various life domains to general well-being within a population by means of regression models (Lehman, 1989). In light of new initiatives to integrate and expand psychiatric, medical, and social services for the chronic mentally disabled, a broad-based service evaluation tool such as the QOL interview appears highly relevant.

Lehman (1989, 1983a, 1983b) reports that the interview has been under development for seven years and has been used with some 500 respondents to date. The instrument has

internal consistency reliability coefficients (ranging from .74 to 86) that are adequate for survey purposes and group comparisons. The test-retest reliability correlations (ranging from .53 to 95) reveal satisfactory levels of stability for most interview items and scales (Lehman, 1989).

The French translation and adaptation of the QOL Interview was initially piloted with a sample of nine normal subjects. This allowed revisions and refinements of the original French-language version of the QOL interview. It also allowed us to determine the feasibility of completing the rather long revised and adapted version, which now incorporated not only two additional QOL scales that surveyed the domains of education and religion, but additional scales including: the self-esteem scale, the consumer satisfaction questionnaire, and the social integration scale. The pilot studies indicated that the adapted and translated interview could be completed within 1.5 hours. We estimated that our clinical sample would be able to complete the interview within 2.0 hours. The complete QOL interview can be found in Appendix A-1.

Domain-Specific Satisfactions

The French-language version of the QOL interview also surveyed the following 10 life domains: living situation, finances, work, school, leisure, health, safety, family, social relations, and religion. The items comprising the religion domain were developed by us for this investigation, since Lehman's original interview (Lehman, 1989) did not survey the religion domain. The items for the religion domain were developed by us using the same approach and sources that Lehman (1989) used. Like the other life domain scales, the religion domain was surveyed with multiple items based on previously developed QOL instruments

(Andrews and Withey, 1976; Campbell et al., 1976; Lehman et al., 1982; Lehman, 1983). All items were rated on a seven point scale ranging from "terrible" (1) to "delighted" (7).

Domain-Specific Preferences

Additionally, we developed domain-specific Preferences Scales for the aforementioned life domains. Each Preference Scale contained multiple items that were rated differently, depending upon the domain surveyed. These Preferences Scales were designed to monitor the degree to which level of concordance between respondent preferences and objective living conditions in different life domains might influence respondent satisfactions in these same life domains. The domain-specific Preference Scales were incorporated into the QOL interview and generally preceded the presentation of the domain-specific Satisfaction Scales (see Appendix A-1).

Global Subjective Quality of Life

Perceived global subjective QOL was assessed by two separate global subjective QOL scales: (1) a French-language translation of delighted-terrible question: "How do you feel about your life in general?" asked at the beginning and again at the end of the interview, and (2) a French-language translation of the Satisfaction with Life Scale (SWLS), a seven point, multiple item global subjective QOL measure (Blais, Vallerand, Pelletier, and Brière, 1989; Diener, Emmons, Larsen, and Griffin, 1985). The former, called the Global Well-being (GWB) item by several authors (Andrews and Withey, 1976; Lehman et al., 1982), is referred to as the "Item du Bien-être Global" (IBG), while the latter is referred to as the Échelle de Satisfaction de Vie" (ESV) in this text. Both instruments rate global subjective QOL along

a seven point scale. The IBGs response range is from "ravie" to "terrible," while the ESV has an item response range from "fortement en accord" to "fortement en désaccord." Both instruments also were part of the QOL interview.

Satisfaction with Life Scale

The ESV (Diener, Emmons, Larsen, and Griffin, 1985) is a unidimensional, self-report scale designed to provide an overview of the respondent's satisfaction with life in general. More specifically, the instrument is narrowly focused and does not tap into the emotional aspects of the subjective well-being construct (i.e., positive or negative affect, or loneliness), rather it provides a unidimensional overview of the cognitive-judgemental aspects of the respondent's global assessment of life quality in terms of his/her subjectively chosen criteria (Diener et al., 1985; Shin and Johnson, 1978). The scale comprises five items that are rated along a seven point continuum from strongly disagree to strongly agree.

The instrument is brief, easy to administer, is insensitive to gender effects, and has good psychometric properties. Diener and colleagues (1985) report that with a sample of undergraduate university students (n = 176) the internal consistency (Cronbach's coefficient alpha) of the scale was .87, and that the two-month test-retest correlation coefficient was .82 (n = 76). They also report that the scale correlated well with other measures of global subjective QOL and with personality measures like the Rosenberg self-esteem scale (Rosenberg, 1965). With two different samples, the authors demonstrated that the SWLS correlated .68 (n = 176) and .62 (n = 163) with the Andrews and Withey (1976) Global well-being item, and .54 (n = 163) with the Rosenberg self-esteem scale (Diener et al., 1985).

In a series of validation studies, the recently translated French-language version of the SWLS (Blais, Valerand, Pelletier, and Brière, 1989), was shown to have similarly favourable psychometric properties. With a sample of college students, l'échelle de satisfaction de vie (ESV), was shown to have an internal consistency (Cronbach's alpha) of .80 (n = 457), while in a second study (n = 374) the internal consistency was .84. In a third study (n = 60), the internal consistency of the ESV was .80 on pretest and .79 on post-test (n = 44) with a two-month test-retest correlation of .64. A fourth study with a sample of elderly citizens (n = 121) provided similar results. The internal consistency was .82 and the unidimensionality of the scale was also confirmed with factor analysis; one dimension accounted for 60% of the variance (Blais et al., 1989). In a fifth study (n = 199), the authors reported that the internal consistency was .81, while all item-total correlations were superior to .56. The authors also report that LISREL analyses confirmed the one factor solution for this scale.

Because of this scale's excellent psychometric properties and the fact that, to the best of our knowledge, it had never before been applied with a clinical population, it was integrated into the QOL interview. The addition of the French-language version of SWLS to the QOL interview allowed us to gather original normative data with this clinical population, to correlate this new instrument with a French-language translation of the Self-esteem Scale (Rosenberg, 1965), and with another well-known measure of global subjective QOL that is widely used in QOL (QOL) surveys, the delighted-terrible scale (Andrews and Withey, 1976).

Consumer Satisfaction Questionnaire

Our QOL interview also incorporated the Consumer Satisfaction Questionnaire (CSQ), developed by Larsen, Atkinson, Hargreaves, and Nguyen (1979). The CSQ is a

unidimensional instrument comprising eight items that were originally selected to tap a variety of behaviours and concerns related to consumer satisfaction in the following areas: physical surroundings, treatment staff, support staff, quality of service, quantity of service, outcome of service, general satisfaction, and procedures. Larsen et al. (1979) reduced an original pool of 45 items to eight items by empirical and statistical analyses. These eight items had an internal consistency of .93 and a high level of unidimensionality as reflected in uniformly large loadings on one principle component, which accounted for 43% of the total variance. They considered this version of the CSQ to provide a homogeneous estimate of the single dimension "general satisfaction with mental health care services".

The consumer satisfaction literature suggests a number of advantages to adopting the Consumer Satisfaction Questionnaire (CSQ) as the "standard scale." (1) The CSQ is highly reliable (Larsen et al., 1979); (2) it can provide a basis for comparison in answering many questions regarding the relative effectiveness of various treatment programs, delivery systems, and related aspects of mental health care (Lebow, 1982; Larsen et al., 1979; Weltzien, McIntyre, Ernst, Walsh, and Parker, 1986); and (3), the CSQ has been shown to be as effective as longer instruments in evaluating consumer satisfaction (Weltzien et al., 1986).

For practical reasons, we elected to integrate an abridged (3 items) version of this instrument (see Appendix A-1) into the QOL interview; time constraints and an already long interview format demanded that we limit ourselves to a realistic time frame that allowed each respondent to complete the interview in one sitting.

Self-Esteem Scale (SES)

An additional incorporation to the QOL Life Interview was the personality measure of self-esteem. Rosenberg's (1965) self-esteem scale (SES) was included in the interview principally as a control measure, because a number of authors (Lehman, 1983; Diener, 1984; Diener, Emmons, Larson and Griffin, 1985; Cheng, 1989) have reported that personality dimensions such as self-esteem may contribute significantly to the variance found in both global subjective QOL measures and domain specific satisfaction scores. After an extensive investigation of this relationship, Diener and colleagues (1985) reported data indicating that Rosenberg's 1965) Self-esteem Scale may the best known predictor of personality factors that correlate with GSQL and domain-specific satisfactions. Consequently, Rosenberg's (1965) self-esteem scale (SES) appeared as the best instrument to use as a control for personality factors that might account for variance in global subjective QOL and domain-specific satisfaction measures. The Self-Esteem Scale (Rosenberg, 1962, 1963, 1965) was thus included in our survey as a control measure for personality factors that might influence respondents' subjective QOL judgements.

Rosenberg (1962) originally developed the Self Esteem Scale (SES) as a measure of the self-acceptance aspect of self-esteem for use with adolescents. This scale may be self-administered and consists of ten items answered on a four point scale from "strongly agree" to "strongly disagree." All the items revolve around liking and/or approving of the self. A total of 5,024 high school juniors and seniors from 10 randomly selected New York schools made up the main sample originally reported by Rosenberg (1962). Since then, the scale has been used in a wide variety of samples (Rosenberg, 1963, 1965). The scale is brief and thorough in measuring the self-acceptance aspect of self-esteem. It has high reliability for

such a short scale. Silber and Tippett (1965) found a test-retest correlation over two weeks of .85 (n = 28). They also reported that the scale correlated from .56 to .83 with several similar measures and clinical assessment (n = 44).

Our French-language translation of the SES "l'Échelle d'Estime de Soi" (EES) was used without the grouping of items employed with the Guttman format. We scored the items individually such that incremental total score values indicated greater self-acceptance. Accordingly, scale items that were statements of positive self-acceptance (i.e., items 1, 2, 4, 6, and 7) were scored inversely such that the choice "strongly agree" to any of these items was scored as 4 rather than as 1. Negations of negative self-acceptance items (i.e., items 3, 5, 8, 9, and 10) retained their values such that the choice "strongly disagree" to any of the negative self-acceptance items retained its score of 4. Scoring the scale in this manner allowed us to produce single total scores with incremental values that allowed a refinement in the interpretability of the scores while providing and more accurate picture of self-esteem than would have the Guttman scoring format. The EES also was incorporated into the QOL interview (see Appendix A-1). The Social Integration Scale (SIS) was the final incorporation to the QOL interview.

Social Integration Scale

The social integration scale (SIS) was developed specifically for this investigation to measure the frequency of a respondent's activities both within and external to the residential facility, while taking into account, the fact that with whom an activity is undertaken has implications for how a person is perceived by others. This notion is central to normalization/social role valorization. We term this "social accompaniment." When the scale

takes into account a client's social accompaniment across a range of activities, it is considered a true or strong indicator of social integration; one that reflects strongly the principle of normalization/social role valorization. When the scale surveys activity levels and community presence only, without consideration for category of social accompaniment, it is considered as weak indicator of social integration; one that reflects weakly the principle of normalization/social role valorization. Both the strong social integration scale (SSIS) and the weak social integration scale (WSIS) are partly based upon the social integration scales originally developed by Segal and Aviram (1975). However, their scales have more in common with the WSIS than they do with the SSIS, because the latter attempts to incorporate the principle of normalization/social role valorization (Wolfensberger, 1975) by providing different categories of social accompaniment for the different activities surveyed.

The social integration scale (SIS) presents respondents with 35 different activities usually undertaken outside the residence and 10 activities usually undertaken within the residence (total items = 45). For each item in the scale, respondents were asked to recall approximately how often they had engaged in the activity during the course of the past 7 days. After responding to each item, respondents were then asked to tell the examiner with whom they had engaged in the activity and how often.

The instrument measures frequency of involvement for each of the 45 different activities in two ways. The first scoring procedure provides a frequency score that is expressed as one of three possible classes of frequency for each activity: 0 (not at all), 1 (once a week), 2 (three or more times a week), and 3 (daily). The total frequency score with this procedure is the sum of the frequency scores across the 45 items.

A second scoring procedure provides a frequency score that may be obtained for any given activity as the absolute frequency of the activity summed across one or more of the six different categories of accompaniment. The categories of accompaniment include: 0 (alone), 1 (another co-resident in the same facility), 2 (a resident from another facility), 3 (staff worker from the resident's facility), 4 (a professional visiting the facility), 5 (a member of the resident's family), and 6 (a valued person who is not a staff worker in the respondent's residence, nor a member of the resident's family, nor a professional visiting the resident's facility). The total frequency score here is the sum of the absolute frequencies across one or more categories of accompaniment for all activities surveyed. For example, when the scale is scored across social accompaniment categories one, two, and three, it provides a measure of accompaniment with socially devalued persons. When the scale is scored across social accompaniment categories five and six, it provides a measure of accompaniment with socially valued persons. It is this latter scoring which served as the basis for the strong social integration scale (SSIS). The instrument is presented in full in the QOL interview (see Appendix A-1).

The instrument provides different information depending on how it is scored and on which activities are grouped together to arrive at a total score. Using the first scoring procedure, which sums the classes of frequencies, one may have a total frequency score for those activities undertaken within the residence only, or a total frequency score for those activities external to the residence only, or a combined total frequency of activities score (i.e., the sum across all activities within and external to the residence).

The first scoring procedure, when applied to the 35 activities that are usually undertaken outside the residence, provides an indication of the range or scope of the

respondent's activity level within the community in terms of the total frequency score. This score provides no indication of the respondent's level of activity within the residence itself. However, such a score can be obtained if so desired. To obtain an indication of the respondent's activity level within the residence, the examiner need only apply the first scoring procedure to the 10 different activities that are usually undertaken within the residence.

It is important to note that the first scoring procedure gives no indication of normalization/social role valorization, because it does not consider with whom the activities were undertaken. As such, it is considered a weak indicator of social integration, and this only when one limits attention to the 35 activities that are usually undertaken outside the residence (i.e., it is a measure of "community presence"). The exclusion of the 10 activities that are usually undertaken within the residence is necessary when one calculates the weak social integration score. Measures of activity level within the residence are not considered indicative of social integration in this scale, but rather, indicative of integration within the residence.

To arrive at a strong indicator of social integration one must use the second scoring procedure. The second scoring procedure sums the absolute frequency of the respondent's involvement across all of the activities both within and outside the residence but only for the two most socially valued categories of accompaniment, namely, category 5 (family members) and 6 (a valued person who is not a staff worker in the respondent's residence, nor a member of the resident's family, nor a professional visiting the resident's facility).

When one wishes to derive both the strong and weak social integration scores, it is important to note that differences in the method of calculating the total scores for each can result in "total score" differences. This is to be expected since the scoring procedure for deriving the weak social integration score sums across classes of total frequency and is less

accurate than the scoring procedure for the strong social integration score, which sums across absolute frequencies.

We first noticed this anomaly when administering the SIS to our survey respondents. When the respondents were first asked about the frequency with which they engaged in different activities their responses were scored in terms of different classes of frequency (i.e, 0, 1, 2, or 3). However, when they were then asked with whom and specifically how often they engaged in these different activities, the procedure occasionally resulted in a mismatch between their first and second response. This occurred because in the one case, total frequencies were derived from the sum of the classes across the different activities, while in the other case, the absolute frequencies were derived from the sum of the accompaniment-related frequencies that were summed across the different activities.

We noticed that the sum of the absolute frequencies, which were related to category of accompaniment, tended to be greater than the classed frequencies because the former were absolute values rather than class intervals. However, we also noted that when required to think in detail about their activities in terms of with whom and how often, respondents often remembered more clearly certain activities. Apparently, the process of asking for specifics primed their memories and they more effectively recalled their level of activity than they had when simply asked whether or not they had engaged in the different activities that were being surveyed.

Generally, when using both scoring procedures, the mismatch in total frequency scores will be weighted in favour of the accompanied activities score. In our study, this did not present as a problem. We suspected our respondents would generally show very low scores in the area of accompanied activities and the bias would likely have little or no impact on the

data. The reader may also note that the SIS is skewed with more items (35) reflecting activity within the community than there are items (10) reflecting activity within the residence. The social integration scale (SIS) was deliberately skewed in favour of more activities external to the residence than that within the residence, because our review of the literature indicated this clinical population tends to show relatively low rates of community activity and integration even when intra-residence activity level and integration are high (Segal and Aviram, 1975).

Given that the ultimate goal of most rehabilitation programs is community integration rather than merely integration within a transitional facility, we believed that the social integration scale (SIS) should reflect the degree to which the residential service is facilitating this transition, and this in terms of activities external to the residence. Consequently, it was our intention that the scale provide respondents with as many opportunities to reflect greater levels of community-involvement related activities than residence-involvement related activities. For this reason, we weighted the scale in terms of respondent involvement within the community rather than weight the scale evenly or in favour of integration within the facility.

Weak Social Integration Scale. The weak form of social Integration is based on the respondents perceived frequency of activities irrespective of accompaniment. The SIS surveys 35 different activities that are usually undertaken in a setting exterior to the residence. When using the first scoring procedure, the frequency of external activities score merely reflects whether or not respondents perceived themselves to have engaged in specific activities outside of the residence and grounds. The score does not consider with whom the respondent engaged in the activities. Because of the importance we attribute to categories of accompaniment in social integration (SI) theory, and because SRV theory is not considered when computing the

frequency of external activities score, the external activities scores is treated as a weak indicator of social integration.

We believed that an instrument measuring only the frequency with which a respondent engages in different activities outside the residence is not a satisfactory indicator of the quality of the respondent's SI. Such a measure can indicate only the range of community presence. It provides no indication of the depth of this community involvement.

Strong Social Integration Scale. The stronger indicator of social integration (SI) is based upon the frequency of activities both inside and outside of the residence, summed across categories of accompaniment by socially valued others. More specifically, when computing the strong indicator of SI, the frequencies of both internal and external activities is summed across the following categories of accompaniment: (1) with one or more members of the respondent's family and (2), with any other socially valued person(s) other than the home operator or residence staff, professional visiting the residence, co-resident, or other devalued person(s).

The reader should note that when calculating the strong indicator of SI, the category of accompaniment is more relevant to normalization/social role valorization than is the setting where an activity is undertaken. Consequently, in calculating the strong form of social integration, one is summing the frequency of activities on the basis of the socially valued accompaniments. The location where the activity occurs becomes less relevant than it was when computing the frequency of activities as a weak indicator of SI. In this sense, where the activity was performed (i.e., whether inside or outside of the residence) is less critical. The central point in calculating the strong indicator of SI becomes more one of category of

accompaniment, because category of accompaniment is central to social role valorization theory (Wolfensberger, 1985).

In light of the normalization/social role valorization concept, accompaniment by professionals is less socially valued than is accompaniment by family members (category 5) and socially valued persons who are neither family members nor professionals (category 6). Such reasoning is wholly consistent with normalization/social role valorization theory. However, given the relative isolation of this segment of the population, the exclusion of the "visiting professionals" and "residence staff" accompaniment categories from the strong social integration score tends to produce an optimally strong indicator of S.I., at the expense of data indicative of any activity at all. This is primarily because of the relative rarity of the most valued forms of accompaniment for socially devalued persons such as chronic mentally disabled citizens. The exclusionary application of only the most socially valorizing categories of accompaniment may seem impractical and severely restrictive since it tends to produce very low frequencies of activity both within and outside the residence. In some instances, investigators may choose to arrive at a compromise measure that allows for perhaps a broader, less exclusive definition of socially valued categories of accompaniment that provide higher frequency scores, albeit at the expense of a valid reflection of the normalization/social role valorization concept.

For this investigation, we gave serious consideration to the different categories of accompaniment and elected to include only two categories which may be considered truly socially valued by our sample. These were family members (category 5), and other valued persons who were not residence staff, not visiting professionals, and not family members (category 6).

In sum, the social integration scale (SIS) was incorporated into the QOL interview format in order to provide information regarding the scope of our respondents' social integration (i.e, the frequency with which a range of activities were undertaken external to the residence). The scale was also designed to measure the depth of social integration (i.e., the normalization/social role valorization dimension of the different activities in terms of the category of social accompaniment across the different activities undertaken by the respondent).

PASSING

Program Analysis of Service Systems' Implementation of Normalization Goals or PASSING, is a method of evaluating the quality of human services according to the principle of normalization/social role valorization (Wolfensberger and Thomas, 1983). PASSING is a refinement and update of PASS--Program service systems: a method for the quantitative evaluation of human services (Wolfensberger and Glenn, 1975). PASSING is used to measure the degree of implementation of normalization/social role valorization in human services.

The term and principle of "normalization" were first given prominence by Nirje (1969), who used the term extensively and elaborated upon its interpretation with wide ranging implications for the mentally retarded and the services provided for them (Wolfensberger, 1984). The term and concept were further elaborated, systematized, generalized (Wolfensberger, 1972), and made relevant to other socially devalued groups (Wolfensberger, 1980a, 1980b). However, with the widespread adoption of the term, it became apparent to Wolfensberger (1984), that different meanings were being attached to normalization by different researchers and that many researchers believed that because the word was so simple and straightforward that they knew exactly what it meant without reading

the literature underlying the philosophy of normalization (Wolfensberger, 1980a, 1980b). As Wolfensberger (1984) explained, persons can be valued even when their social roles are not. The following excerpt outlines clearly that normalization really implies the promotion and defense of valued social roles for devalued persons:

> ...a man with major physical handicap will be very devalued if he is unemployed or works at a negatively-imaging occupation, but will experience a much higher quality of life and will become valued by society if that person fills the role of architect, lawyer, chairman of the board of an industry, politician, etc. (Wolfensberger, 1984, p. 24).

However, since this nuance seemed to escape many who claimed to understand normalization, Wolfensberger (1984, 1985) proposed that the terms "normalization," "normalization principle," and "principle of normalization" be replaced with the expression "social role valorization." Wolfensberger (1984) cautioned that while the term "normative" retains selected utility, users of it should be aware that it has two meanings; one is sociological and the other, statistical. Sociologically, the term refers to a "norm group," such as society and its social values. Statistically, the term refers to human characteristics and to common social phenomena. Although there is some overlap between the two meanings, they are not synonymous; what is statistically normative is not necessarily valued, and what is valued (especially highly valued), may not be statistically common (Wolfensberger, 1984). It is the sociological meaning of "normative" that is more consistent with social-role valorizing (Wolfensberger, 1984, 1985). Wolfensberger has proposed that things previously considered to be normalizing should now be seen to actually contribute to the enhancement of the social roles of individuals or groups in the eyes of others (Wolfensberger, 1984).

According to Wolfensberger (1984), the perceptions of a perceiver can be influenced both by what is done to the perceiver and by what is done to the person being perceived.

Moreover, the environment can impact upon both the perceiver and the person being perceived. In the recently published PASSING (Wolfensberger and Thomas, 1983), a tool which allows the assessment of how well human services incorporate normalization strategies, Wolfensberger and Thomas have used the term "competency enhancement" in reference to the things that one does for a person or the person's environment in order to enhance the person's image in the mind of the perceiver. PASSING covers how a service enhances the images of its clients by what it does to or about them (Wolfensberger, 1984).

The English-language version of PASSING is currently used to evaluate community group residence program, community vocational programs, and residential institutions in several countries, including Canada, the United States, the United Kingdom, and Australia. The recent French-language translation and adaptation of this instrument (Roberge and Pelletier, 1988), is currently employed in Quebec, France, Switzerland, and Belgium.

PASS was the first general purpose program evaluation tool used to measure the degree of implementation of normalization in human services. Several studies were conducted with PASS (Andrews and Berry, 1978; Fiorelli and Thurman, 1979; Flynn, 1975, 1979, Lapointe and Flynn, 1989), most of which were reviewed by Flynn (1980). Flynn and Heal (1981) drew four conclusions from a review of PASS findings:

1. Most human service programs provide only modest service quality when evaluated with total PASS scores, because elements that are central to normalization, such as social integration, intensity of relevant programming, and coherence of the service model are frequently weak.
2. PASS discriminated adequately among different types of service programs, whether the discriminations were gross (e.g., between community and

institutional programs) or fine-grained (e.g., among different types of community-based services).

3. Community-based services consistently outscored institutional programs, while community services that were integrated scored higher than segregated ones.

4. PASS assessed service dimensions that are considered desirable according to current societal values (e.g., individualization of clients, their physical and social integration etc.). Moreover, some of these dimensions were reported to have predictive validity when correlated with developmental gains in clients (Flynn and Heal, 1981).

Likes its predecessor, PASSING assesses program quality by measuring the degree to which human service programs actually implement (and not merely verbally espouse) the principle of normalization/social role valorization (Lapointe and Flynn, 1989). However, as outlined above, the principle of normalization in PASS was recently reformulated as the principle of social role valorization by Wolfensberger (1983, 1984, 1985). Social role valorization in PASSING is distinguished by its ultimate goal, which is to enhance the social role and life conditions of persons at risk of social devaluation.

PASSING rates 42 different aspects of service quality, each defined in terms of the extent to which the different aspects of a program reflect the principle goal of PASSING; that is, the implementation of the normalization/social role valorization principle. The 42 items are divided into two major sub-goals: client social image enhancement and client personal competency enhancement. Twenty-seven ratings measure program success in implementing key aspects of the first major sub-goal of social role valorization; the enhancement of clients' social image (Wolfensberger, 1985). The other 15 ratings assess the implementation of

important components of the second major sub-goal of social role valorization; the enhancement of clients' personal competencies. These two major sub-goals are further sub-divided into four sub-goals labelled as: (1) physical setting of the service; (2) service-structured groupings and interpersonal relationships; (3) service-structured activities and other uses of time, and (4) other miscellaneous service language, symbols, and images.

All 42 passing items are initially scored on a rating scale ranging from 1 to 5. A score of 1 reflects an extremely poor rating, a score of 3 reflects a mid-level rating, and a score of 5 reflects the optimal attainable rating of service quality. A total PASSING score is obtained by summing across all 42 ratings. Five sub-scale scores are also calculated from the 42 PASSING ratings: Program Relevance (1 rating), Program Intensity (6 ratings), Program Integrativeness (9 ratings), Program Image Projection (19 ratings), and Program Felicity (7 ratings).

The PASSING manual provides explicit guidelines and instructions for rating each of the 42 items. These ratings are weighted in accordance with the importance of each item, which was predetermined by the authors of PASSING, in accordance with the overall philosophy of the normalization/social role valorization principle (Wolfensberger and Thomas, 1985). An external team of trained raters (usually at least 3) uses PASSING during an on-site evaluation of the service. Individual inter-rater assessments are later conciliated by the PASSING team. A final total score, based on the conciliated weighted scores, is calculated subsequent to the conciliation process. Total PASSING scores may range from a possible low of - 1,000 to an optimal high of + 1,000. A total score of zero indicates a minimal acceptable level of service quality, indicating that the service program is neither detrimental nor enhancing for the program's clients. In our study, PASSING ratings were made consensually

in order to save time. However, it also precluded the possibility of deriving inter-rater reliabilities.

PASSING has a high total scale internal consistency (coefficient alpha) of .89, and acceptable internal consistency for the sub-scales ranging from the .60's to .80, allowing intergroup comparisons. PASSING sub-scales tend to be positively and moderately strongly correlated with each other and with the total scale (Lapointe and Flynn, 1989). These authors also report that for the total PASSING scale, inter-rater reliability is generally adequate; for example, a previous PASSING evaluation with five-member team was found to have an inter-rater reliability of .92, while a random selection of single PASSING team members were found to have inter-rater reliabilities of .70. Overall, the scale has adequate intraclass correlations, satisfactory interrater reliability, and it is internally consistent. As a general purpose program evaluation tool designed to measure the degree of implementation of normalization/social role valorization in human services, PASSING provides a level of attention to detail that is currently unrivalled.

Level of Care Survey

The Level of Care Survey (LOCS), often called Care10, is a clinical rating instrument developed by the New York State Office of Mental Health (NYSOMH) Bureau of Program Evaluation (Furman and Lund, 1979). The instrument (see Appendix A-2) is a clinical rating technique designed to assess the behavioral and medical deficits of state hospital patients. Collected data provide an overview of the psychiatric and medical conditions, and functional needs of the inpatient psychiatric population throughout the New York state hospital system (Furman and Lund, 1979). The original LCOS consisted of 146 items that were divided into

nine substantive sections. Care10 refers to the main result of the survey (Furman and Lund, 1979). The instrument yields data on individual patient's physical and psychiatric condition, current treatment, social behaviour, adjustment to the hospital environment, and medication regimen. The tool allows each patient to be classified as appropriate for one of the ten settings that would result in placing the patient in the least restrictive setting which meets his/her need for medical care, psychiatric care, and supervision (Lambert, 1982). Although the instrument presents a production-line-approach to the assessment of patient needs, it does reflect a shift from searching for patients to meet the needs of the system (Lambert, 1982). Form 103 of the LCOS contains 140 items describing the patient's medical, psychiatric, and self-care functioning along seven content areas:

I. Vision, hearing, speech, and comprehension (6 items).

II. Physical health (30 items)

III. Skilled nursing care (13 items)

IV. Diagnosis, behaviour, and dangerousness (67 items).

V. Activities of daily living (11 items).

VI. Community living predictions (6 items).

VII. Psychiatric medications (7 items).

Data on form 103 of the LOCS combines patient information such as ward location, catchment, length of stay, and other data routinely stored by the state mental health system which are then labelled and scored by computer along two types of subscales. The first are linear subscales which were developed by NSOMH using standard techniques, such as factor analysis, item reliability, and internal consistency studies, to produce subscales in which a number of items are added together in a subscale score. In addition, the NYSOMH developed

several nonlinear "process tracing" subscales which are logical statements that simulate the reasoning process clinicians are thought to use in arriving at clinical placement decisions regarding patients (Furman and Lund, 1979; Lambert, 1982). The instrument has an interview format and usually is administered by a trained nurse or a psychiatric technician who is familiar with the patient. Currently, the instrument is widely used in 17 states and three Canadian provinces (New Brunswick, British Columbia, and Quebec) to plan mental health treatment programs (Coté and Pilon, 1988).

For the purposes of our investigation of the QOL and social integration of deinstitutionalized chronic mentally disabled citizens, the LOCS was used primarily to provide us with two control measures; one for behaviour handicaps and the other for physical handicaps. These factors were believed capable of influencing our respondents' social integration, global subjective QOL assessments, and domain-specific satisfactions and domain-specific preferences. The two LOCS subscales we used are reportedly reliable. The internal consistency (Cronbach's alpha) of the Social Behaviour and Physical Health scales are .49 and .82, respectively. The interrater reliability for the former is .89, while for the latter it is .96 (Lambert, 1982).

The LOCS was recently adapted and translated into l'Inventaire du Niveau de Soins (INS) so that mental health program managers in the province of Quebec could better plan and improve service system delivery (Coté and Pilon, 1988). Like the LOCS (Bureau of Program Evaluation, New York State Office of Mental Health, 1982), the INS (Coté and Pilon, 1988) has an interview format and can be administered by trained nurses or psychiatric technicians familiar with the respondent. L'inventaire du niveau de Soins (INS) is currently in wide use by mental health services in Quebec. The French-language translation and

adaptation of the instrument (Coté and Pilon, 1988) is shorter than its English-language counterpart. The INS is a 100 item instrument that provides program planners with an overview of the global and individual, physical and mental health functions and needs of Quebec patients. The Physical Health and Social Behaviour subscales of the INS contain 50 items and 22 items, respectively.

Procedure

Quality of Life Interview Pilot Study

The study began with our translation and adaptation of Lehman's (1989) QOL Interview. Over a period of 12 weeks, the QOL interview was piloted with nine psychologically sophisticated normal adults whose cooperation and suggestions were noted and served us in formulating several improvements during the numerous revisions of the original translation of the QOL interview. Subsequent to this pilot study and the revisions which ensued, the pilot data were destroyed as per agreement with the volunteers.

PASSING Evaluation

The PASSING evaluations were undertaken within the context of a government of Quebec sponsored study designed to evaluate and improve the quality of the community mental health services offered within the catchment area of the Outaouais Regional Health and Social Service Council. The evaluative study of 38 community residences took place between June and October, 1989 (Dansereau, Duteau, Ely, and Flynn, 1990).

The PASSING evaluations were intended to provide an overview of the residential services network. The PASSING team was not required to provide an individual report on each service they visited, which is usually the case with PASSING evaluations of individual services. As a result, the PASSING team was able to visit an average of one service per day.

A typical PASSING evaluation began with an automobile drive through the neighbourhood. This was followed by a 2 to 3 hour in-depth interview with the service operator. At that time, the PASSING team would conduct a formal interview with standardized questions regarding the history of the service and its clients. This was followed by a site visit of the facility, and a 30 to 60 minute conversation with those residents who were present. At that time, residents were informed about the QOL survey that was to follow their visit and recruited to participate in that survey. The names of residents who expressed an interest in participating in the QOL survey were noted and the list was subsequently screened according to necessary selection criteria. This resulted in a "short list" that was thereafter passed on to the investigator conducting the QOL survey.

After each site visit, the PASSING team met in private to conciliate their respective evaluations as a team. Thus, each PASSING rating was made consensually rather than individually. Because most of the team members lacked experience with the instrument, initial PASSING evaluations and conciliations required 12 to 15 hours. However, as team members became better acquainted with the instrument, their efficiency with the instrument much improved until, toward the end of the investigation, a full assessment was typically completed in approximately 7 hours.

Level of Care Survey

The French-language translation and adaptation of the Level of Care Survey (LOCS), or Inventaire du Niveau de Soins (INS) was not administered by us. That survey was administered by the Outaouais Regional Health and Social Services Council of Quebec during the months of April and May of 1989. Data from that survey were made available to us in relation to our evaluation of the quality of the community mental health services offered by the sponsoring agency. We drew data from the physical and behavioral handicaps scales of the LOCS made available to us. Those two scales were used principally by us as control measures for the effects of physical and behavioral handicaps on the QOL and social integration of respondents to our QOL survey. LOCS data were available for 55 of the 70 residents who completed the QOL interview in our survey. The LOCS data were provided to us by the agency which sponsored the investigation.

Quality of Life Survey

The QOL survey was sponsored as part of a larger effort to evaluate and improve the quality of the community mental health services offered within the catchment area of the Outaouais Regional Health and Social Service Council in the province of Quebec. Like the PASSING evaluation, the QOL survey attempted to include all able and willing residents of the 38 community residences and took place between June and October, 1989.

The reader will recall that team members who comprised the PASSING team had initially visited the facilities to evaluate the objective environment. At that time, they had met with the residential service operators and most of the residents. Based on those meetings, an initial selection of residents presumed to be physically, cognitively, emotionally, and culturally

able to undertake the QOL interview had comprised a "short list." Excluded from this selection were unilingual anglophones, individuals with uncorrected visual problems, illiterates, mentally deficient individuals who did not understand the informed consent statement, and those who were too perturbed to undertake the interview during the site visit(s). The names of residents who were considered able to participate in the QOL interview were then noted and home operators were advised that these individuals would be contacted within a few days to confirm their participation in the study. Subsequent to each visit, the PASSING team provided the list of names to the two examiners conducting the QOL interviews, at which time they contacted the home operators to confirm the suitability of the residents named on the short list provided by the PASSING team and to arrange a convenient time to meet with the prospective participants.

Using the aforementioned exclusionary criteria, the examiner conducting a QOL interview always undertook a second screening of residents upon arrival at a residential service. Residents who had volunteered to participate in the survey were met individually in a private setting to ensure confidentiality. Each resident read and/or was read the informed consent form (see Appendix A-1), and then asked to relate to the examiner what he/she thought it meant. When a subject failed to demonstrate a complete understanding of the informed consent form, those points that had been misunderstood or not understood were elaborated upon by the examiner. If a subject still failed to understand the informed consent form on this first reading, the form was read again by the examiner who would explain each point in detail. If the subject then failed to demonstrate a complete understanding of the informed consent form, the subject was thanked for his/her assistance and the interview was terminated. This procedure ensured that all subjects having expressed interest at participating

in the survey were afforded the best chance of doing so, and that only those candidates who truly did not understand the informed consent form were deemed unfit to complete the interview, and consequently excused from participating in the survey. All participants who completed the survey did so in the presence of the examiner. Responses were recorded either by the respondent or by the examiner, when requested to do so. The average interview lasted approximately 1.5 hours with as many pauses as requested by the respondent. All interview candidates who appeared hesitant at undertaking the QOL interview or who became too fatigued or perturbed during the course of the interview were reassured and encouraged that they could refuse to participate and/or terminate their participation at any time without consequence. Most residents expressed their appreciation at the examiners' concern for their well-being.

Data Analyses

All data analyses were conducted on an International Business Machines's (IBM) mainframe computer using the third edition of the Statistical Package for the Social Sciences (SPSS Inc., 1989.). Initial analyses determined the integrity of the instruments. Internal consistency was determined in terms of Cronbach's coefficient alpha (Cronbach, 1951). The primary source of error with this index of reliability is non-comparability of items. As such, coefficient alpha is highly sensitive to heterogeneity of items (Cohen, 1975). Internal consistency reliabilities were thus determined for the ESV, the domain-specific Satisfactions Scales, the domain-specific Preferences Scales, the EES (i.e., French-language version of the Self-esteem Scale), the Questionnaire de Satisfaction du Client (QSC), the SSI and WSI scales, and the Level of Care Survey (LOCS) scales that measured physical and behavioral

functioning levels, the Behaviour and Physical Handicaps scales. Scales with internal consistency reliabilities (Cronbach's coefficient alpha) of .60 or greater were considered adequate for group comparisons (Cohen, 1975, p. 64). Additionally, for each of these scales, all items with negative item/total correlation coefficients or with item/total correlation coefficients less than .10 were iteratively deleted from the scales.

Subsequently, correlational analyses were conducted to answer the preliminary research questions. The purpose of the preliminary analyses was to determine whether our findings replicated those previously reported for this population (Lehman, 1988; Lehman, 1983a, 1983b; Lehman et al., 1982). Thereafter, we undertook the hierarchical regression analyses related to the substantive research hypotheses.

Data from the PASSING evaluations were scored according to psychometrically derived ratings developed by Flynn (Flynn, 1980; Flynn and Heal, 1981; Lapointe and Flynn, 1989), rather than the standard ratings described in the PASSING manual. The latter have yet to be shown to be psychometrically sound.

Internal consistency measures

Given a homogeneous scale, knowing a respondent's answer on one item allows the prediction of how a respondent would answer similar items. Consequently, analyses of internal consistency were used to determine the degree to which the different scale items were interrelated. All subsequent analyses were conducted with the refined scales. Additionally, we attempted to determine the unidimensionality (single trait characteristic) of our Social Integration Scale (SIS) using factor analyses. However, because we had too few subjects, these efforts were unrewarding. Factor analyses failed to produce an acceptable minimum

number of constructs (factors) necessary to account for the interrelations among groups of variables, and generally produced about half as many factors as there were variables. In every instance where "Varimax Rotation" (SPSSX, 1988) was used, it failed to converge in as many iterations as there were variables. We attributed this phenomenon partly to the scarcity of data on the SIS and partly to the small number of subjects in our sample.

Authors such as Lumsden (1961) and Keats (1967) have suggested that the concept of homogeneity carries the additional implication of unidimensionality, and that factor analyses may be the best method for determination of a scale's homogeneity. However, Brown (1970) has reported that there exists a general lack of agreement on the definition and appropriate index of homogeneity, with some authors considering a test homogeneous if the test items are highly intercorrelated, whereas others add the requirement that the test measure a unitary factor, with still other authors (e.g., Loevinger (1947) and Keats (1967) making even further restrictions.

Apparently, no single measure seems to be generally accepted. According to Brown (1970), homogeneity is a necessary, but not sufficient, characteristic of a test designed to measure a unitary trait, and the appropriate level of analysis depends upon the structure of the test and the purpose of the analyses (Brown, 1970, p. 83-90). Given the exploratory nature of this investigation, the small number of subjects, and the relative infrequency of their activity levels in general, the failure to successfully determine single factor scales with the SIS was not considered critical. The adoption of coefficient Alpha (Cronbach, 1951), a widely used and acceptable indicator of internal consistency, was deemed satisfactory for the purpose of this investigation. We elected to iteratively delete from the SIS all items that had negative item/total correlations and all items with item/total correlations less than .10.

One Sample Mean Test

The one-sample mean test (Perry, 1976) was used to determine whether differences between groups were significant. Standard deviations for subjective QOL measures were unavailable for the Los Angeles sample (Lehman et al., 1982) and for the U.S. national sample (Andrews and Withey, 1976). The one-sample mean test allowed a comparison of the means for the Outaouais and Los Angeles samples and the U.S. national survey sample. The procedure permits one to compare two groups on certain variables when parameters related to one group (e.g., standard deviations) are unknown (Perry, 1976, p.303-305). Because the procedure allows univariate comparisons of successive samples with no restrictions on group sizes it was best suited for our comparison of the SQL scores for the Outaouais sample with both the Los Angeles sample (Lehman et al., 1982) and the National Survey by Andrews and Withey (1976). The theoretical restrictions for the one-sample mean test include:

1. The number of distinct distributions must be equal to one.
2. The number of variables in each distribution must be equal to one.
3. The measurement level must be interval.
4. The population from which the sample was derived must have a definite mean and standard deviation.
5. The samples must be consecutive and random.

With the one sample mean test, the sampling distribution of t approximates the Student's t distribution with N-1 degrees of freedom. As N gets large, the normality assumption of the population can be relaxed. The null hypothesis (H_o) containing the μ_o) can be evaluated by t. An observed t or z_x exceeding its respective critical value provides the basis for rejecting the H_o.

Comparisons of the average subjective QOL measures for the Outaouais sample with those means from the Los Angeles (Lehman et al., 1982) and the National (Andrews and

Withey, 1976) samples, involved only univariate measures with interval scale values. Means and standard deviations for all the univariate measures drawn on the Outaouais sample were known, while only the means were available for the samples drawn from the Los Angeles survey (Lehman et al., 1982) and the National survey (Andrews and Withey, 1976).

Because of the sample size (n = 70) and the fact that the means for each univariate measure was greater than the standard deviation, the normality assumption could be violated (Perry, 1976, p.303). The sample was a non-random sample (H_o: The sample equals a random sample). When evaluating all of the theoretical restrictions, we find that in each case, all of the restrictions were met operationally except for the one being tested. The one-sample mean test thus allowed an evaluation of possibly significant differences between the Outaouais sample and the Los Angeles in relation to each other and in relation to the National samples on each univariate interval measure.

CHAPTER 4

RESULTS

Synopsis

This chapter presents the results of the statistical analyses undertaken to verify the integrity of the instruments used in this investigation and assess the study hypotheses. Few researchers have investigated the quality of life (QOL) and social integration (SI) of deinstitutionalized chronic mentally disabled citizens living in community-based facilities and even fewer appear to appear to have done so with French-speaking subjects (Mercier, 1989; Mercier and Corton, 1989; Mercier and Filion, 1987). The findings from our investigation are summarized as follows:

A. 1- Psychometric quality of the instruments pertaining to the QOL interview:

a) Domain Satisfaction Scales and Global Subjective QOL Scales.

b) Domain-specific Preferences Scales.

c) Objective QOL Indicators Scales.

d) Social Integration (strong) Scale.

e) Social Integration (weak) Scale.

f) Consumer Satisfaction Questionnaire.

g) Self-esteem Scale.

h) Écheile de Satisfaction de Vie

2- Psychometric quality of the PASSING instrument:

3- Psychometric quality of the level of care Survey (CARE10) subscales:

a) Behaviour Handicaps Scale.

b) Physical Handicaps Scale.

B. Results on the preliminary hypotheses (of a measurement nature):

a) Hypothesis 1: QOL scales: Outaouais vs Los Angeles Samples.

b) Hypothesis 2: Échelle de Satisfaction de Vie vs Item du Bien-être Global.

C. Results on the substantive research hypotheses:

a) Hypothesis 3: Domain-specific satisfactions regressed separately on predictor variables.

b) Hypothesis 4: Regression of global subjective QOL measures on composite sets of predictor variables.

c) Hypothesis 5: Correlation of global subjective QOL measures with strong social integration and weak social integration scales.

d) Hypothesis 6: Regression of strong and weak social integration measures on location and size of family-care homes.

e) Hypothesis 7: Regression of PASSING scores on location and size of family-care homes.

f) Hypothesis 8: Regression of strong and weak social integration measures on composite sets of predictor variables.

Results on Psychometric Properties of the Instruments

Domain-Specific Satisfaction and Global Subjective QOL Scales

Each of the 10 domain-specific satisfactions scales used as indicators of subjective QOL proved internally consistent as did both of the global subjective QOL scales. Table 1 summarizes these findings. The internal consistency (Cronbach's coefficient alpha) of the 10 domain-specific measures of satisfaction ranged from .67 to 89. These reliabilities are quite similar to those reported by Lehman (1983a), which ranged from .76 to .86. The Item du Bien-être Global (IBG) provided slightly lower temporal reliability (.66) than reported by Lehman (1983a) with the English-language version of this measure (coefficient alpha = .76). Of the two global subjective QOL measures we used, the five-item Échelle de Satisfaction de Vie (ESV) and the single-item IBG, the ESV provided lower mean scores with greater variance in scores than did the Item du Bien-être Global (IBG) measure (a single question scale administered at the start and again at the end of the interview). Relative to the IBG measure, the ESV appeared less susceptible to ceiling effects, provided a slight improvement in score variability, and allowed for a determination of internal consistency (see Table 1). The item/total correlations for the ESV are presented in Table C-1 of Appendix C.

The relationship between the 10 domain-specific satisfaction scales may be seen in the inter-correlation matrix presented in Table 2. Generally, the domain-specific satisfaction scales tended to inter-correlate significantly (31 out of 45 correlations were statistically significant). Correlations ranged from -.09 (work and family) to .70 (education and social relations). Many of the correlations were at least moderate in size. Although the most significant correlation was between social relations and education, leisure provided the greatest

number of significant correlations in relation with three domains, social relations, health and religion. Moreover, leisure correlated at a significant level with all other domains. Social-relations correlated significantly with all domains except work. Additional information pertaining to the item/total correlation coefficients for each of the 10 domain-specific satisfaction scales is presented in Tables C-2 to C-11 of Appendix C.

Domain-Specific Preferences Scales

Table 3 presents the internal consistency coefficients of the 10 domain-specific preferences scales, which ranged from .48 to .78. Three of the 10 preferences scales were found to be only marginally homogeneous (i.e., they fell below our a priori criterion of coefficient alpha = .60), and one scale, related to respondents' preferences for the finances domain, contained a single-item, precluding the possibility of deriving an internal consistency measure for it. Six of the 10 domain-specific preferences scales proved internally consistent (i.e., coefficient alpha = .60 or greater).

With respect to two of the four life domains for which the preferences scales proved inadequate, alternative scales that are conceptually related to preferences were used. The perceived importance (from the respondents' perspective) of service-related variables (e.g., location and stability of residential placement, food, rules, privacy, etc.), substituted for the preferences scale as an alternative indicator of person/environment fit for the "living situation" domain. The original preferences scale for this domain was marginally homogeneous and comprised only two items. The scale measuring the importance of service related variables is broader in scope (i.e., it comprises 10 items), had relatively superior internal consistency,

and provides information that is as conceptually and practically relevant to person/environment fit as does the preferences for living situation scale.

Similarly, with respect to the finances domain, respondents' perceived financial need in relation to diverse aspects of that domain substituted for preferences measure, which comprised only one item. The perceived financial needs scale comprises five items, provided satisfactory internal consistency, and appears to be as conceptually and practically relevant to person/environment fit as is the single-item preferences for finances item.

Two other scales, measuring preferences in the domains of education and safety, respectively, were found to be marginally homogeneous and no alternative scales could be substituted for these. The education scale was dropped from further analyses that tested the substantive research hypotheses. The personal safety scale, however, was kept in order to allow exploratory analyses to be undertaken with it.

Table 4 presents the inter-correlations among the 10 domain-specific preferences scales. Only about half (21 of 45 correlations) were statistically significant and even these tended to only be moderate in size. Correlations ranged from -.01 (religion and work) to .57 (education and work). Living situation and social relations each had significant correlations with six other life domains. Additional information pertaining to the item-total correlation coefficients of the domain-specific preferences scales may be found in Tables C-12 to C-21 of Appendix C. Table C-22 of Appendix C presents the correlations between the 10 domain-specific preferences with the two global subjective QOL indicators and the 10 domain-specific satisfaction scales. Table C-23 of Appendix C presents the correlations between the 10 domain-specific preferences measures and the various objective QOL indicators for these same domains.

Table 1

Psychometric Properties of Global and Life Domain Satisfaction[a] Measures from 70 Chronic Mentally Disabled Citizens Living in Community-based Residences in the Outaouais Region[b]

Domain (items)	Mean	S.D.	Median	Coefficient alpha
Living Situation (6)	4.88	1.14	5.17	.81
Family Relations (4)	4.55	1.37	4.88	.81
Social Relations (6)	4.76	1.11	5.00	.79
Leisure Activities (6)	4.64	1.17	5.00	.82
Work (5) Working[c]	4.71	0.91	4.70	.67
Education (4) Attending school[c]	5.63	0.60	6.00	.69
Finances (4)	3.64	1.59	3.38	.89
Personal Safety (5)	5.08	0.99	5.20	.73
Health (6)	4.81	1.04	5.00	.78
Religion (4)	5.14	0.99	5.25	.68
Item du Bien-être Global[d] (2)	4.43	1.54	5.00	.66[d]
Échelle de Satisfaction de Vie[e] (5)	3.93	1.67	3.90	.88

[a] Response range was from 1 = "terrible" to 7 = "Delighted."
[b] Missing data were noted for 46 respondents in the work domain (n = 24), and for 51 respondents in the education domain (n = 19). All other data are based upon n = 70.
[c] Based upon the number of respondents working and/or attending school, respectively.
[d] The score on this scale is the average of two administrations of the same item which was asked at the begining and again at the end of the interview. The coefficient for this particular measure reflects test-retest reliability.
[e] Échelle de Satisfaction de Vie (ESV) response range was from 1 = "strongly disagree" to 7 = "strongly agree." The score listed is the mean of the five items.

Table 2

Intercorrelation Matrix for Domain Satisfaction Measures of French-language Version of the Quality of Life Interview

Scale	Scale (No. of items)	Scale Numbers									
		1	2	3	4	5	6	7	8	9	10
1	Living Situation (6)	----									
2	Finances (4)	.20	----								
3	Leisure (6)	.53***	.46***	----							
4	Family (4)	.18	.05	.48***	----						
5	Social Relations (6)	.29*	.34**	.67***	.48***	----					
6	Safety (5)	.51***	.42***	.54***	.33**	.48***	----				
7	Health (6)	.50***	.41***	.62***	.46***	.61***	.56***	----			
8	Religion (4)	.36**	.36**	.66***	.40***	.45***	.61***	.56***	----		
9	Work (4)	.53**	.46*	.58**	-.09	.20	.21	.27	.10	----	
10	Education (4)	.40	.26	.45*	.03	.70***	.26	.06	.12	.51***	----

Note. Sample size for the work scale (n = 24) reflects respondents who worked. Sample size for the education scale (n = 19) reflects respondents who attended a school program. Sample sizes for all other scales = 70.

* $p < .05$ ** $p < .01$ *** $p < .001$ **** $p < .0001$

Table 3

Psychometric Properties of Domain-specific Preference Measures from 70 Chronic Mentally Disabled Citizens Living in Community-based Residences in the Outaouais Region

Life Domain (items)	Mean	S.D.	Median	Coefficient alpha
Living Situation[a] (2)	4.88	1.14	5.17	.59
Importance of service-related variables[b] (10)	3.95	0.60	4.00	.71
Family Relations[a] (3)	4.55	1.37	4.88	.78
Social Relations[a] (6)	4.76	1.11	5.00	.67
Leisure Activities[a] (5)	4.64	1.17	5.00	.70
Work[ac] (5)	4.71	0.91	4.70	.65
Education[c] (4)	5.63	0.60	6.00	.58
Finances[d] (1)	245.20	202.93	200.00	n/a
Perceived Financial need[d] (5)	3.64	1.59	3.38	.63
Personal Safety[a] (3)	5.08	0.99	5.20	.48
Health[a] (3)	4.81	1.04	5.00	.68
Religion[a] (4)	5.14	0.99	5.25	.74

[a] Response range was from 1 = "not at all" to 5 = "enormously."
[b] Response range was from 1 = "not important at all" to 5 = "very important."
[c] Based upon the number of respondents who expressed an interest in working (n = 50) and/or in attending a school program (n = 22), respectively.
[d] The response range consisted of the number of dollars respondents preferred for monthly personal expenses.
[e] The response range for each item was in additional dollars needed as perceived by respondents.

Table 4

Intercorrelation Matrix for Domain Preference Measures of French-language Version of the Quality of Life Interview

Scale	Scale (No. of items)	Scale Numbers									
		1	2	3	4	5	6	7	8	9	10
1	Living Situation (10)	----									
2	Finances (5)	.23*	----								
3	Leisure (5)	.34**	.18	----							
4	Family (3)	.01	-.15	.01	----						
5	Social Relations (6)	.07	-.27*	.37***	.13	----					
6	Safety (3)	.32**	.07	.30**	.14	.23	----				
7	Health (3)	.30**	.05	.37**	.18	.33**	.33**	----			
8	Religion (4)	.04	-.17	.13	.48****	.27*	.14	.23	----		
9	Work (5)	.32*	.11	.26	.21	.35**	.42**	.33*	-.01	----	
10	Education (4)	.53**	.27	.54**	.34	.53**	.47*	.27	.41	.57**	----

Note: Sample size for the work scale (n = 50) reflects respondents who expressed preference for work. Sample size for the education scale (n = 22) reflects respondents who expressed interest in attending a school program. Sample sizes for all other scales = 70.
* $p < .05$ ** $p < .01$ *** $p < .001$ **** $p < .0001$

Objective Quality of Life Indicators Scales

Table 5 summarizes the findings for the objective QOL indicators specific to each life domain. Scale reliabilities (internal consistencies), means, standard deviations, and medians are presented, as well as, corrected item/total correlation coefficients for the various items comprising the 10 domain-specific scales that served as objective indicators of life quality. Activity-related scales are also presented, namely, those assessing activities within the residential setting, activities external to the residential setting (which are taken as components of weak social integration), and activities carried out in the presence of a valued person whether inside or outside the residence (these are taken as measures of strong social integration). Additional information is presented regarding the two subscales derived from the level of care survey (LOCS), the physical handicaps and the behaviour handicaps scales.

Generally, composite scales comprising objective indicators of life quality for the 10 life domains were difficult to establish because of low inter-item correlations. Many of these scales had poor or marginal internal consistency, despite the fact that they were composed of objective indicators that appeared conceptually relevant to the various domains. For example, almost none of the scales related to the "living situation" domain provided acceptable levels of internal consistency. Only the placement stability/security scale provided satisfactory internal consistency (coefficient alpha = .67). The privacy scale was the next most homogeneous scale reflecting the living situation domain, and it proved only marginally homogeneous (coefficient alpha = .55). Only these two scales were retained as objective indicators of life quality for the living situation domain. It is noteworthy that several respondents revealed insecurities that are assessed by these two scales. Clients were anxious,

for example, about being displaced from their current residence and complained of having little privacy.

The frequency of contacts with family scale had marginal internal consistency (coefficient alpha = .58), but it came close enough to our a priori criterion of scale homogeneity (coefficient alpha = .60) to be considered an acceptable objective indicator of the family contacts domain. The religion scale is another objective indicator that presented a similar difficulty with homogeneity. The internal consistency of the religion scale (coefficient alpha = .53) was marginal. However, because the religion domain was previously unexplored with this population, the objective indicator was used in an exploratory fashion.

The poor internal consistency of the work scale (coefficient alpha = .46) rendered it an unsatisfactory objective indicator. Similar difficulties in grouping variables were encountered with respect to the finances domain. No set of objective indicators of the finances domain offered satisfactory scale homogeneity. Consequently, only two individual objective indicators of finances were used: total monthly income and total monthly spending money (see Table 5). Those two items are conceptually valid objective indicators of QOL in the finances domain.

The scale that served as an objective indicator of the education domain presented unsatisfactory internal consistency, probably because too few of the subjects interviewed (n = 19) participated in any type of educational program. This scale was therefore, not used in the analysis of the substantive research hypotheses. Consequently, all analyses involving the education as an objective indicator of QOL were considered exploratory only.

Two scales served as objective indicators for the health domain; the physical and behaviour handicap scales. Those two scales were derived from the level of care survey

(LOCS) data that were provided by the Conseil Régional de la Santé et des Services Sociaux de l'Outaouais (CRSSSO). However, of the total sample of 70 respondents surveyed with the QOL interview, LOCS data related to the physical and behaviour handicap scales were available for only 56 and 55 subjects, respectively. Both scales provided virtually identical and high levels of internal consistency (coefficient alpha = .86). Although concerns regarding multiple regression analyses involving these two scales and their less than satisfactory subject/variable ratios did not warrant their being rejected altogether, alternative objective indicators of respondent level of functioning, which could provided data on all 70 respondents surveyed were explored. This search lead to the 32 item "General Perceived and Needed Health Services Scale" that was part of the QOL interview and to its subscales, the Services Received Scale (16 items) and the Services Needed Scale (16 items). The services received scale (SRS) offered satisfactory internal consistency (coefficient alpha = .62) and is conceptually related to the level of functioning in so far as those clients who received the greatest number of services may be argued to be in need of those services. Clients in greater need of services were believed to be functioning at a lower level than those who were not. The availability of this alternative objective indicator for the health domain allowed multiple regression analyses that compared the prediction of health on the basis of either the physical and behaviour handicaps scales (n = 55), or the Services Received Scale N = 70). However, the reader is cautioned that the services received scale (SRS) was not intended as a proxy for the behaviour handicaps and physical handicaps scales, but rather, as an alternative, indirect predictor of client level of functioning. Because of the numerous items (45) comprising the behaviour handicaps scale, the General Perceived and Needed Health Services Scale (32 items), the Services Received Scale (16 items), and the Perceived Service Need Scale (16

items), the item/total correlations for the items comprising these scales are presented, respectively, in Tables C-24, C-25, C-26, and C-27 of Appendix C. The item/total correlations for the leisure scale (24 items), the intra-residential leisure scale (5 items), and the extra-residential leisure scale (21 items) are presented in Table C-28 to C-30 (see Appendix C). The leisure scales were constructed in order to later explore the relationship between leisure activities and subjective QOL for that domain.

Table 5 also included the activities scales as objective indicators of life quality. However, the activities scales might be argued to be representative of not only the living situation domain. They could equally represent the leisure or the social relations domains, because the majority of the items comprising the activities scales are leisure activities and/or are usually undertaken in the company of others. Moreover, the items comprising the activities scale served as the basis for both the strong and weak forms of the social integration scale (SIS) and could, therefore, be considered as representative of social integration. Consequently, the activities scales were so broad reaching, they were treated as a separate domain altogether. The item/total correlations for the activities, as well as, the intra-residential activities scales are presented in Tables C-31 and C-32 of Appendix C. Overall, this examination of the psychometric integrity of the objective indicators of life quality suggest that although objective indicators of life quality may have good test-retest reliabilities (Andrews and Withey, 1976; Cheng, 1989), composite scales constructed from objective indicators often tend to be only marginally internally consistent.

Table 5

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Living Situation					
Placement stability/Security (2)	.67		.97	.76	.50
No. of different placements.		.51	1.54	.94	1.00
No. of psychiatric admissions.		.51	.40	.81	.00
Privacy[a] (5)	.55		.39	.26	.34
Private toilet.		.15	.73	.45	1.00
Private bedroom.		.27	.40	.49	.00
Having a house key.		.41	.30	.46	.00
Privacy for telephone usage.		.38	.30	.46	.00
Reciprocal of no. of residents[b].		.59	.23	.19	.14
Autonomy (4)	.35		.31	.33	.25
No. of psychiatric admissions.		.26	.40	.81	.00
Having a house key[a].		.15	.30	.46	.00
Prepare a meal[c].		.27	.56	.91	.00
Having a paid odd job[c].		.11	.31	.69	.00
Cohesion[d] (3)	.29		3.41	.79	3.33
Conversation with co-residents.		.11	4.41	1.07	5.00
Conversation with home staff.		.20	3.49	1.25	4.00
Engaging in pre-planned activities.		.18	2.34	1.36	2.00

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Living Situation (continued)					
Independence[d] (2)	.40		1.09	.95	1.00
Writing a friend.		.30	1.43	.79	1.00
Having close friends outside residence.		.30	.74	1.51	1.00
Current Length of Stay (in months).			38.46	45.62	21.50
Number of Co-residents.			5.84	2.20	7.00
Activities[c,e] (34)	.75		.31	.13	.31
Activities within Residence[c,e] (7)	.45		.51	.19	.50
Extra-residential activities (weak indicator of Social Integration)[c,e] (27)	.73		.25	.02	.26
Activities with a valued person[c,e] (strong indicator of Social Integration)[c,e] (31)	.84		.03	.01	.00

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Social Relations[d] (9)	.62		2.28	.57	2.17
Playing card/table games with co-residents.		.35	2.33	1.35	2.00
Conversations with co-residents.		.23	4.41	1.07	5.00
Conversations with home operator.		.20	3.49	1.25	4.00
Visiting a friend outside residence.		.11	2.49	1.44	2.00
Writing a friend.		.23	1.43	.79	1.00
Engaging in pre-planned activities.		.38	2.34	.16	2.00
Spending time with a boy/girl friend.		.55	2.10	1.50	1.00
Sleep over at a friend's home.		.45	1.29	.71	1.00
Have close friends[f].		.50	.61	.06	1.00
Social Relations Within Residence[d] (4)	.41		3.14	.76	3.25
Playing cards/table games.		.27	2.33	1.35	2.00
Conversation with co-residents.		.13	4.41	1.07	5.00
Conversation with home operator.		.19	3.49	1.25	4.00
Engaging in pre-planned activities.		.31	2.34	.16	2.00

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Social Relations outside of residence[d] (8)	.50		1.67	.07	1.63
Visit a friend outside of residence.		.22	2.49	1.44	2.00
Telephone a friend.		.15	2.43	1.43	2.00
Write a friend.		.27	1.43	.79	1.00
Engage in a pre-planned activity.		.26	2.34	.16	2.00
Spend time with a boy/girl friend.		.32	2.10	1.50	1.00
Sleep over a friend's home.		.50	1.29	.71	1.00
Have close friends[f].		.36	.61	.06	1.00
Have close friends outside of residence[f].		.10	.74	1.51	1.00
Friends (2)	.32		2.46	1.44	2.46
Visit a friend outside of residence.		.22	2.49	1.44	2.00
Telephone a friend.		.15	2.43	1.43	2.00
Frequency of activity with close friend[d].			5.19	3.11	4.00
Intimacy of Social Contacts[d] (2)	.48		1.69	.95	1.00
Spend time with a boy/girl friend.		.41	2.10	1.50	1.00
Sleep over at a boy/girl friend's.		.41	1.29	.71	1.00

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Family[d] (2)	.58		3.08	1.00	3.00
Frequency of telephone contacts.		.41	3.46	.99	4.00
Frequency of meetings with family.		.41	2.70	.92	3.00
Finances					
Total monthly support. (1)	n/a		679.93	87.53	657.00
Total monthly spending money. (1)	n/a		121.31	78.22	115.00
Work					
Hourly Wage[i].		.59	1.96	3.28	.00
Hours Worked/Week[i].		.71	17.44	9.59	18.00
Current Employment Status[gh].			.36	.48	.00
Unemployment[h] (2)	.43		151.98	123.65	126.00
Months without a paying job.		.30	148.20	184.04	108.00
Months since leaving best job.		.30	155.76	118.20	134.50
Education					
Student Status - past year[fh].			.27	.45	.00
Days or evenings/week of class attendance [i].			2.20	1.44	2.00

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Religion[l] (3)	.53		2.26	.11	2.33
Frequency of attending church mass.		.43	2.24	1.26	2.00
Frequency of reading bible.		.31	1.74	1.29	1.00
Frequency of viewing religious programs on television.		.40	2.79	1.31	3.00
Legal/Safety[k] (5)	.64		1.04	.02	1.00
Arrests for shoplifting.		.51	1.07	.04	1.00
Arrests for vagrancy.		.64	1.01	.12	1.00
Arrests for other crimes.		.25	1.04	.20	1.00
Victim of violent crime(s).		.49	1.04	.27	1.00
Victim of non-violent crime(s).		.29	1.04	.27	1.00
Leisure activities[mm] (24)	.68		.31	.14	.33
Frequency of Leisure Activities Within the Residence (5)	.37		.47	.21	.40
Frequency of Leisure Activities Outside of Residence (21)	.66		.25	.14	.29

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Health[aa]					
General Perceived Health Services:					
Received and Needed[a] (32)	.76		.35	.23	.30
Total services received (16)	.62		.28	.23	.25
Total services needed (16)	.60		.41	.27	.34
Physical health services received (5)	.51		.16	.20	.20
Dental care.		.21	.40	.49	.00
In-patient psychiatric care.		.39	.16	.37	.00
Assistance for emergencies.		.37	.21	.41	.00
In-patient alcohol rehabilitation.		.32	.03	.17	.00
In-patient drug rehabilitation.		.41	.01	.12	.00
Psychological health services received (5)	.61		.13	.21	.00
Out-patient group counseling.		.38	.17	.38	.00
Out-patient individual counseling.		.32	.21	.41	.00
Out-patient family counseling.		.28	.14	.35	.00
Out-patient alcohol rehabilitation.		.38	.07	.26	.00
Out-patient drug rehabilitation.		.65	.04	.20	.00

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Domain Scales (number of items/ Item descriptors)	Internal Consistency (Cronbach's alpha)	Corrected Item-total Correlation Coefficients	Mean	S.D.	Median
Health (continued)					
Social health services received (5)	.56		.41	.56	.20
Self-care programs.		.23	.40	.49	.00
Assistance in scheduling activities.		.18	.53	.50	1.00
Assistance in finding work.		.22	.39	.49	.00
Family support programs.		.47	.41	1.53	.00
Education of civil rights.		.67	.30	1.12	.00
Frequency of Professional Contacts[o] (4)	.48		2.51	.49	2.50
Contacts with psychiatrists.		.24	2.14	.67	2.00
Contacts with nurses.		.24	3.19	1.01	3.50
Contacts with social workers.		.42	2.70	.10	3.00
Contacts with physician.		.29	2.03	.51	2.00
Physical handicap[pq] (2)	.86		1.14	.43	1.00
Self-care handicap		.82	1.11	.38	1.00
Physical disability handicaps		.82	1.19	.56	1.00
Behavioral handicap[q,r,s] (45)	.86		1.81	.42	1.78

(table continues)

Table 5 (continued)

Psychometric Properties of Objective Quality of Life Indicators for French Version of Quality of Life Interview

Note: Objective quality of life indicator items referred to past year.

[a] Items socred as 1 = "service available" or 0 = "service unavailable."

[b] Reciprocal of no. of residents refers to 1/number of co-residents.

[c] Response base was 0 = "not at all;" 1 = "at least once."

[d] Response base was 1 = "not at all;" 2 = "once a year;" 3 = "once a month;" 4 = "once a week;" 5 = "daily."

[e] Item/total correlations for the different items comprising the various dimensions of the activies scales are presented in table C-31 and C-32.

[f] Item scored as 0 = "no," and 1 = "yes."

[g] Item scored as 0 = "unemployed," and 1 = "employed."

[h] Based upon total sample (n = 70).

[i] Based upon the number of respondents involved in work of any type (n = 24).

[j] Based upon the number of respondents who attended a school program over the past year (n = 19).

[k] Response base was 1 = "not at all," 2 = "once," and 3 = "two or more times."

[l] Response base was 1 = "not at all," 2 = "less than monthly," 3 = "monthly," 4 = "weekly," and 5 = "daily."

[m] Item/total correlations for the different items comprising the various leisure scales are presented in table C-28 to C-30.

[n] Item/total correlations for the health services received and needed scales are presented in tables C-25 to C-27.

[o] Response base was 1 = "not at all," 2 = "less than once a month," 3 = "once a month," 4 = "once a week,", 5 = "daily."

[p] Number of respondents having a Physical Handicap Scale score was 56.

[q] Response base was 1 = "not at all," 2 = "slightly," 3 = "moderately," 4 = "seriously," and 5 = "very severely."

[r] Number of respondents having a Behavior Handicap Scale score was 55.

[s] Item/total correlations for the different items comprising the behavior handicap scale are presented in table C-24.

Strong Social Integration Scale

The Strong Social Integration Scale (SSIS) represents a first attempt at constructing psychometrically sound measures of the normalization/social role valorization principle in terms of a respondent's level of activity in the residence and community. The SSIS comprises all of those activities that may be undertaken with a socially valued person (i.e., with a family member or a valued person other than a family member, residence staff worker or other human service professional). Both of these categories, reflecting the most socially valued persons that might accompany the respondent during an activity, and used in this definition of strong social integration (SSI), showed approximately equivalent internal consistency (Cronbach's alpha). The internal consistency of the family accompaniment category, made up of 24 items, was .86. The internal consistency of the socially valued other persons accompaniment category, composed of 8 items, was .81. The internal consistency of the strong social integration scale (SSIS), made up of 31 items, was .84. Table 6 presents the item/total correlations for the items comprising the SSIS.

Weak Social Integration Scale

The weak social integration (WSI) scale tends to reflect only weakly the principle of normalization/social role valorization. The scale measures the frequency of a respondent's involvement across a wide range of activities usually undertaken only outside of the residence without consideration of with whom these activities are carried out. The scale thus measures the respondent's range of activities and presence in the community. The weak social integration scale (27 items) was found to be internally consistent (coefficient alpha = .73).

Table 6

Item/Total Correlations for Strong Social Integration Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Go for a walk with family	1	.47
Watch television with family.	2	.73
Go shopping with family.	4	.45
Go to a restaurant with family.	5	.55
Go to a bar with family.	6	.60
Read a book/newspaper with family.	10	.43
Listen to radio with family.	13	.67
Go for leisure car/bus ride with family.	14	.54
Prepare a meal with family.	15	.27
Go to a park with family.	19	.60
Go to Church with family.	20	.67
Go to the beach with family.	21	.11
Go to a dance with family.	25	.60
Receive a friend at family home .	27	.23
Visit family (other) with family.	28	.48
Receive family in your home/residence.	29	.19
Spend time at the plaza/mall with family.	31	.51
Go camping with family.	32	.21
Go to or have a picnic with family.	34	.21
Paid odd job with family.	35	.21
Go to the post-office with family.	37	.16
Do grocery shopping with family.	38	.19

(table continues)

Table 6 (continued)

Descriptors of Scale Items	Scale's Item Number	Corrected Item/Total Correlation Coefficient
Work around family house (outdoors).	39	.32
Haircut at a barbershop with family.	42	.49
Visit a community center with family.	43	.11
Go for a walk with a valued other.	1	.27
Go to a restaurant with a valued other.	5	.23
Leisure car/bus ride with a valued other.	14	.15
Play a sport with a valued other.	13	.11
Go to a park with a valued other.	19	.27
Do grocery shopping with a valued other.	38	.19

Note. N = 70.

[a] Cronbach's alpha for the Strong Social Integration Scale = .84 (no. of items = 31).

[b] Scale Item numbers refer to the number corresponding to each item on the scale in Appendix A.

Table 7 presents the item/total correlations for the WSI scale. The strong and weak Social Integration Scales (SIS) correlated significantly (r (68) = .28, p = 02), but not meaningfully, indicating that although both measures were related, they did not necessarily tap into identical constructs.

Tables C-37 to C-42 of Appendix C present descriptive statistics relevant to the Activities Scale and the two social integration (SI) measures. Table C-37 presents for each of the 45 activities surveyed, the average frequency of engagement by residents. Table C-38 presents the same data broken down by the seven different categories of social accompaniment. Table C-39 presents the average frequency of activities engaged in by residents for each of the seven categories of social accompaniment. Table C-40 compares the average frequencies for intra vs extra residential activities. Table C-41 presents the average frequency for intra-residential activities for each of the seven categories of social accompaniment. Table C-42 presents average frequency of extra-residential activities for each of the seven categories of social accompaniment. Generally, the descriptive statistics in these tables indicate that respondents are largely inactive and most often alone or with their co-residents.

Consumer Satisfaction Questionnaire

The three item French-language version of the Consumer Satisfaction Questionnaire (CSQ), called the "Questionnaire de Satisfaction du Client" (QSC), was found to provide lower levels of internal consistency than did the original eight item English version (CSQ). The internal consistency (coefficient alpha) of the English-language version of the eight-item CSQ reportedly was .93 (Larson et al., 1979). Although the internal consistency (Cronbach's

coefficient alpha = .66) of the abridged, three-item French-language QSC was considerably lower, it was adequate for group comparisons (Cohen, 1975, p. 64). Table 8 presents the item/total correlation coefficients for this abridged scale.

Échelle d'Estime de Soi (EES)

The French-language translation of Rosenberg's (1965) Self-Esteem Scale (SES), l'Échelle d'Estime de Soi (EES), was found to have satisfactory internal consistency (Cronbach's alpha = .83). Table 9 summarizes the item/total correlations for the EES. The EES also correlated significantly with both global subjective QOL instruments, the "Item du Bien-êt.e Globale (IBG) measure (r (68) = .52, p = .000), and the "Échelle de Satisfaction de Vie" (ESV) measure (r (68) = .52, p = 000). Table C-33 of Appendix C shows that the ESV correlated significantly with all but the work and education domain satisfaction scales. Table C-34 shows that of the 10 domain preferences scales, only the perceived financial needs scale correlated significantly with the EES. The relationship between the EES and the various objective QOL indicators for the 10 life domains is presented in Table C-35. A summary of the internal consistency (coefficient alpha) reliabilities for the client satisfaction questionnaire, domain-specific preferences, self-esteem, activities, and social integration scales is presented in Table C-36.

Table 7

Item/Total Correlations for Weak Social Integration Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Go for a walk.	1	.28
See a film at theatre.	2	.13
Go shopping.	4	.26
Go to a restaurant for meal or coffee.	5	.29
Go to a bar.	6	.30
Go for leisure car/bus ride.	10	.31
Play a sport.	13	.33
Go to a social/community meeting.	14	.18
Go to a park.	15	.24
Go to the beach.	19	.38
Go to a party.	20	.21
Go to a dance.	21	.24
Visit family at their home.	25	.42
Attend a fine arts show (e.g., concert).	27	.11
Spend time at the plaza/mall.	28	.36
Go camping.	29	.19
Work at a paid odd job.	31	.37
Sheltered work.	32	.12
Volunteer work.	34	.34
Go to a bank.	35	.40
Go to the dentist's.	37	.22
See doctor for a physical examination.	38	.16

(table continues)

Table 7 (continued)

Item/Total Correlations for Weak Social Integration Scale[a]

Descriptors of Scale Items	Item Number	Corrected Item/Total Correlation Coefficient
Shop for groceries	39	.34
Go for a bicycle ride.	42	.16
Go to barbershop/beauty salon.	43	.16
See a sports activity in person.	44	.30
Visit a community center.	45	.17

[a] Cronbach's alpha for the Weak Social Integration Scale = .73 (total n of items = 27).
[b] Scale Item numbers refer to the number corresponding to each item on the scale in Appendix A.

Table 8

Item/Total Correlations for Questionnaire de Satisfaction du Client

Descriptors of Scale Items	Scale's Item Number[b]	Corrected Item/Total Correlation Coefficients
Degree to which needs were met.	1	.53
Placement setting in general.	2	.47
Would choose services again if needed.	3	.43

Note. N = 70. The Questionnaire de Satisfaction du Client (QSC) is the French-language translation of the Consumer Satisfaction Questionnaire (Larsen et al., 1979).

[a] Cronbach's alpha for the Questionnaire de Satisfaction du Client = .66 (no. of items = 3).

[b] Scale's item number refers to item numbers for scale in Appendix A.

Table 9

Item/Total Correlations for the Echelle d'Estime de Soi[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Feels worthy as a person.	1	.61
Felt to have a number of good qualities.	2	.47
Feels like a failure.	3	.65
Is able to do things as well as others.	4	.40
Feels he/she has little to be proud of.	5	.42
Takes a positive attitude toward self.	6	.51
Is generally satisfied with self.	7	.61
Wishes for more self-respect.	8	.45
Certainly feels useless at times.	9	.53
Feels no good at times.	10	.52

Note. $N = 70$.
[a] Cronbach's alpha for the Echelle d'Estime de Soi = .83 (no. of items = 10).
[b] Scale's item number refers to item numbers for scale in Appendix A.

Échelle de Satisfaction de Vie (ESV)

The French-language version of the Satisfaction with Life Scale, l'Échelle de Satisfaction de Vie (ESV) was found to be quite homogeneous. L'Échelle de Satisfaction de Vie (ESV) by Blais and colleagues (1989) was internally consistent in our sample (Cronbach's alpha = .88). This value is similar to those reported by Blais et al. (1989) for various college-age and elderly samples, in which internal consistencies ranged between .81 and .87. Our findings also replicated the internal consistency (Cronbach's alpha = .87) reported for the SWLS by Larsen et al. (1985) with college-aged anglophones.

PASSING Instrument

Lapointe and Flynn (1989) reported on a sample of 213 PASSING evaluations from the Eastern United States, across Canada and Great Britain, involving a wide range of human service programs serving a variety of clients (mental retardation = 40%, juxtaposed deviancy conditions = 38%, and psychiatric/emotional disorders = 6%). The internal consistency (coefficient alpha), using unstandardized coefficients ranged from .60 to .80 for the subscales, and was .89 for the total score. The intraclass correlations, indicating interrater reliability, were satisfactory (.81 to .95 for the subscales and .89 to .95 for the total score).

Level of Care Subscales: Physical Handicaps and Behaviour Handicaps

The Physical Handicaps Scale comprised only two items from the Level of Care Survey (LOCS). Both items are summary evaluations of the respondent's degree of physical handicap as an impediment to normal functioning with respect to (a) self-care and (b) involvement in different activities. The internal consistency of this short scale was high

(coefficient alpha = .86). Several possible indicators of physical handicaps were explored with the Level of Care Survey (LOCS) prior to selecting this short scale as one of the two indicators of respondent level of functioning. Of all the scales that could serve as indicators of level of physical handicaps, this two-item scale provided the most satisfactory level of internal consistency (coefficient alpha). The Behaviour Handicaps Scale, the second subscale drawn from the LOCS, originally comprised 50 items. However, iterative deletions of those items with item/total correlations of less than .10 resulted in a 45-item scale with satisfactory internal consistency (coefficient alpha = .86). The item/total correlations for this scale are presented in Table C-24 (see Appendix C).

Results on Replication of Lehman's Quality of Life Interview

Hypothesis 1: Preliminary Hypothesis of a Measurement Nature

The reader will recall that operationally, Hypothesis 1 involved a comparison of our findings to those reported by Lehman and his colleagues (1982). The goal was to show that: (a) scale reliabilities would be similar (i.e., internal consistency, and for 1 variable, temporal consistency); (b) mean levels of objective and subjective QOL indices would be similar; (c) within life domains, the correlations between objective QOL indicators and subjective QOL indices would be weak; and (d) the inter-scale correlations for the different life domains would be modest. In sum, scores with the Outaouais sample were expected to be comparable to those reported by Lehman (1982, 1983a, 1983b) and significantly lower ($p < .05$) than those reported for the general population (Andrews and Withey, 1976).

Table 10 summarizes three classes of domain-specific satisfactions for the Outaouais sample, while Table 11 presents similar data for Lehman's (1982, 1983a, 1983b) Los Angeles sample. A comparison of these two tables shows that relative to Lehman's (1982) sample, a proportionally larger percentage of the Outaouais sample tended to endorse the more extreme negative ratings. In all domains allowing direct comparisons, the percentage of Outaouais respondents who rated themselves as mostly dissatisfied to terrible was greater than that reported for the Los Angeles respondents (Lehman et al., 1982). At the opposite extreme, a greater percentage of Outaouais than the Los Angeles respondents rated themselves as mostly satisfied to delighted only with respect to the Living Situation and Personal Safety domains. Despite these differences, the two samples were remarkably similar in their average subjective QOL evaluations.

Subjective QOL scale reliabilities (i.e., internal consistency or temporal consistency coefficients) for the Outaouais sample vs Lehman's (1983) sample are reported in Table 12. Here we see that the internal consistencies (Cronbach's alpha) are quite similar for both surveys and that all the subjective QOL scales provided satisfactory levels of homogeneity.

Table 13 compares the QOL findings from the sample of Outaouais residents in relation to Lehman's (1982) sample and to a U.S. national survey reported by Andrews and Withey (1976). For those domains that allowed direct comparisons, the Outaouais and Los Angeles samples presented similar satisfaction levels. These tended to be significantly lower than those reported for a U.S. national survey of the normal population (Andrews and Withey, 1976). Included in Table 13 are the results of our one-sample mean tests and those of Lehman's (1982) t-tests undertaken to verify significant differences between the group means.

Table 10

Life Domain Satisfaction Ratings[a] made by 70 Chronic Mentally Disabled Citizens Living in Community-based Residences in the Outaouais Region[b]

	Quality of Life Interview Ratings					
	Terrible-Mostly Dissatisfied		Mixed		Mostly Satisfied-Delighted	
Life Domain	n	%	n	%	n	%
Living Situation	14	20	14	20	42	60
Family Relations	20	29	15	21	35	50
Social Relations	18	26	16	23	36	51
Leisure Activities	19	27	15	22	36	51
Work						
Job (n = 24)	05	21[c]	08	33[c]	11	46[c]
Unemployed (n = 46)	n/a	n/a	n/a	n/a	n/a	n/a
School						
Attending (n = 19)	0	0	03	16[c]	16	84[c]
Not attending (n = 51)	n/a	n/a	n/a	n/a	n/a	n/a
Finances	39	56	12	17	19	27
Personal Security	11	16	13	19	46	65
Health	13	19	17	24	40	57
Religion	07	10	15	21	48	69
Life in General	25	36	9	13	36	51

[a] Ratings were grouped as follows: Terrible to Mostly dissatisfied = 1-3; Mixed = 4; Mostly Satisfied to Delighted = 5-7.

[b] Data were missing in some of the areas for some of the 70 respondents (e.g., for 46 residents in the area of work, and for 51 residents in the area of school), but all other percentages are based upon N = 70.

[c] Based upon the number of respondents with jobs and school attendance, respectively.

Table 11

Life Domain Satisfaction Ratings[a] made by 278 Chronic Mentally Disabled Citizens Living in Board and Care Homes[b] (Lehman, et al., 1982).

	Quality of Life Interview Ratings					
	Terrible-Mostly Dissatisfied		Mixed		Mostly Satisfied-Delighted	
Life Domain	N	%	N	%	N	%
Living Situation	39	14	86	31	153	55
Family Relations	61	22	55	20	158	57
Social Relations	37	13	71	26	169	61
Leisure Activities	26	9	77	28	174	63
Work						
Job (n = 42)	0		12	29[b]	30	71[b]
Unemployed (n = 226)	97	43[c]	54	24[c]	75	33[c]
School						
Attending (n/a)	n/a	n/a	n/a	n/a	n/a	n/a
Not attending (n/a)	n/a	n/a	n/a	n/a	n/a	n/a
Finances	118	42	61	22	95	34
Personal Safety	49	18	89	32	135	49
Health	35	13	64	23	178	64
Religion	n/a	n/a	n/a	n/a	n/a	n/a
Life in General	81	29	42	15	155	56

[a] Ratings were grouped as follows: Terrible to Mostly dissatisfied = 1-3; Mixed = 4; Mostly Satisfied to Delighted = 5-7.

[b] Data were missing in some of the areas for some of the 278 participants (e.g., for 4 patients in the area of family relations), but all precentages are based on N = 278.

[c] Based upon the number of participants with jobs and unemployed, respectively.

Table 12

Comparison of Internal Consistency Reliabilities[a] For Subjective Quality of Life Scales

Scales (No. of items)	Outaouais Sample (n = 70)	Lehman Sample (1983) (n = 278)
A. Global Quality of Life		
GWB Item[b] (2)	.66	.76
SWLS[c] (5)	.88	n/a
B. Domain Satisfactions[d]		
Living Situation (6)	.81	.86
Family[d] (4)[e]	.81	.85
Social Relations[d] (6)	.79	.82
Leisure[d] (6)[f]	.82	.80
Finances (4)	.89	.83
Legal/Safety (5)[g]	.73	.76
Work[d] (5)	.67	.78
Education[d] (4)	.69	n/a
Health (6)[h]	.78	.81
Religion (4)	.68	n/a

Note: The alpha coefficients listed for Lehman (1983) were derived from the initial version of his Quality of Life Interview. The Outaouais sample was administered a French translation of Lehman's second (i.e., revised) version of his interview, the subscales of which tend to be shorter. The alpha levels for his revised scales were unavailable.

[a] Cronbach's coefficient alpha (Chronbach, 1951).

[b] GWB Item = Global Well-being Item (i.e., a Global Subjective Quality of Life Item that was originally developed by Andrews and Withey (1976). It was asked at the begining and end of the Quality of Life Interview (Andrews and Withey, 1976).

[c] SWLS = Satisfaction with Life Scale (Blais et al., 1988).

[d] Alpha levels for the Outaouais sample do not reflect an optimal selection of items which could provide the best alpha levels. Rather, item selection was governed by the need to use the same items as Lehman used in the revised version of his instrument (Personal Communication, November, 1988).

[e] Lehman (1983) orignially reported 5 items for this scale. His revised scale contains only the 4 items used in our study. His alpha levels were unavailable for the 4 item scale.

[f] Lehman (1983) originally reported 9 items for this scale. His revised scale contains only the 6 items used in our study. However, his alpha levels were unavailable for the 6 item scale.

[g] Lehman (1983) orignially reported 6 items for this scale. His revised scale contains only the 5 items used in our study. However his alpha levels were unavailable for the 5 items scale.

[h] Lehman (1983) originally reported 7 items for this scale. His revised scale contains only the 6 items used in our study. However his alpha levels were unavailable for the 6 item scale.

Table 13

Mean Life Domains Satisfaction Ratings and Mean Global Life Satisfaction Ratings Made by 70 Chronic Mentally Disabled Citizens Living in Outaouais Residences Compared to a Sample of 278 Chronic Mental Patients Living in Large Board-and-Care Homes Surveyed by Lehman et al. (1982) and to a National U.S. Sample Surveyed by Andrews and Withey (1976)[a]

			Ratings of U.S. National Sample (Andrews & Withey, 1976)			
Life Domains	Ratings of Outaouais Patients (N = 70)	Ratings of Lehman's Patients (N = 278)	Total (N = 1,297)	People with Low Socioeconomic Status (N = 122)	Blacks (N = 106)	Unmarried Parents (N = 55)
Living Situation	4.9[i]	4.5	5.3[c,e]	n/a	4.5	4.7
Family Relations	4.5	4.7	5.8[b,e]	5.9[b]	6.4[e]	4.3
Social Relations	4.8	4.8	5.5[b,e]	5.5[e]	5.5[e]	5.5[g]
Leisure Activities	4.6	4.9	4.7	n/a	n/a	4.8
Work[d]	4.7	5.3[b]	5.3[b]	5.5	5.4	5.5
Education	5.6	n/a	5.0[b]	n/a	n/a	n/a
Finances	3.6	3.9	4.8[b,e]	4.4[g]	4.9[e]	4.2
Personal Safety	5.1[i]	4.1	5.2[e]	n/a	4.6[g]	4.8[g]
Health	4.8	4.9	5.3[b,e]	4.8	4.7	5.1
Religion	5.1	n/a	5.6[b]	n/a	n/a	n/a
Global Life Rating	4.4	4.4	5.4[b,e]	5.1[g]	4.8	5.0[g]

[a] Item response range: 1 = terrible, 7 = delighted.
[b] Significantly higher than mean for Outaouais patients ($p < .001$, one-sample mean test).
[c] Significantly higher than mean for Outaouais patients ($p < .01$, one-sample mean test).
[d] Applies only to those in each sample who were employed (for chronic patients, N = 24 of Outaouais sample; N = 42 of Lehman's sample).
[e] Significantly higher than mean for Lehman's patients in 1982 sample ($p < .001$, two-tailed multiple t tests), according to Lehman et al., 1982.
[f] Significantly higher than mean for Lehman's patients in 1982 sample ($p < .01$, two tailed multiple t tests), according to Lehman et al., 1982.
[g] Significantly higher than mean for Lehman's patients in 1982 sample ($p < .05$, two tailed multiple t tests), according to Lehman et al., 1982.
[h] Based on the average of personal health (4.6) and health care (5.2) from Lehman et al's. sample (1982).
[i] Significantly higher than mean for Lehman's patients in 1982 sample ($p < .01$, on-sample mean test).

Standard deviations for subjective QOL measures were unavailable to us for the Los Angeles sample (Lehman et al., 1982) and for the U.S. national survey (Andrews and Withey, 1976). However, the one-sample mean test (Perry, 1976) allowed us to determine whether our group means were significantly different from Lehman's (1982) Los Angeles sample and those reported in a U.S. national survey (Andrews and Withey, 1976). Table 13 shows that the one-sample mean test revealed Outaouais respondents were significantly more satisfied with their living situation and with personal safety than were Los Angeles respondents. The latter were significantly more satisfied than Outaouais respondents only in relation to work. Satisfactions with all other domains were not significantly different. The U.S. national survey sample, however, was significantly more satisfied than the Outaouais sample in all domains except leisure activities and personal safety.

Correlations between objective and subjective indicators of life quality for the Outaouais respondents are presented in Table 14. Table 15 presents similar correlations between the objective and subjective indicators of life quality for the Los Angeles Sample. In the Outaouais sample, the relationship between objective and subjective indicators of life quality generally tended to be non-significant. However, when Table 14 is compared to Table 15, we see that with Lehman's (1982) Los Angeles sample, significant relationships between objective and subjective indicators appeared more frequently than in the Outaouais sample, reflecting differences in sample size and statistical power. However, the magnitude of the correlations was often similar. Table 2 showed that the domain-specific satisfaction measures tended to correlate significantly as had been predicted in Hypothesis 1. Generally, these findings confirmed Hypothesis 1. Lehman's (1982, 1983a, 1983b) psychometric and substantive findings were replicated with our sample.

Table 14

Correlations Between Domain-specific Satisfactions and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais.

Satisfaction Indicator in Life Domain	Objective Indicator	*r*	*df*	Significance
	Demographics:			
	Sex	-.03	68	n.s.
	Age	.01	68	n.s.
	Education	-.16	68	n.s.
	Marital Status	-.02	68	n.s.
Living Situation	Placement stability/security	-.07	68	n.s.
	Privacy	.23	68	n.s.
	Autonomy	.03	68	n.s.
	Cohesion	.06	68	n.s.
	Independence	-.44	68	p = .000
	Number of Co-residents	-.13	68	n.s.
	Total months in resdidence	.09	68	n.s.
	Total number of different residential placements[a]	-.09	68	n.s.
	PASSING total score	.28	68	p = .02
	PASSING setting score	.30	68	p = .01
	PASSING program score	.21	68	n.s.
	PASSING beauty/comfort score	.14	68	n.s.
	PASSING accessibility score	.14	68	n.s.
	Activities	.11	68	n.s.
	Activities within residence	.17	68	n.s.
	Activities outside residence (a weak indicator of social integration)	.08	68	n.s.
	Social integration (defined in terms of accompaniment it is a strong indicator of social integration)	-.15	68	n.s.
Family	Frequency of personal and telephone contacts	.20	68	n.s.

(table continues)

Table 14 (continued)

Correlations Between Domain-specific Satisfactions and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais.

Satisfaction Indicator in Life Domain	Objective Indicator	*r*	*df*	Significance
Social Relations	Total Contacts	.17	68	n.s.
	Contacts in home	.24	68	p = .05
	Contacts outside of home	-.07	68	n.s.
	Intimacy of Contacts	.13	68	n.s.
	Friends	-.15	68	n.s.
	Activities	.27	68	p = .03
Leisure	Total no. of leisure activities	.24	68	p = .05
	Total no. of leisure activities within the residence	.27	68	p = .002
	Total no. of leisure activities outside of residence	.15	68	n.s.
Work[b]	Work Scale	.20	22	n.s.
	Current employment status	---	22	----
	Hourly wage of current job	-.04	22	n.s.
	Total hours worked per week	.25	22	n.s.
Education[c]	School Scale	.16	17	n.s.
	Student status[a]	-.15	17	n.s.
	Days or evenings per week of school attendance	.18	17	n.s.
Personal Security	Legal/safety Scale	.02	68	n.s.
	Criminal Activities Scale	-.02	68	n.s.
	Victim of Crime Scale	.05	68	n.s.
Finances	Monthly spending money	.26	68	p = .03
	Monthly income	.26	68	p = .03

(table continues)

Table 14 (continued)

Correlations Between Domain Specific Satisfactions and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais.

Satisfaction Indicator in Life Domain	Objective Indicator	*r*	*df*	Significance
Religion	Frequency of religious activity scale	.39	68	p = .001
	Frequency of attending church mass	.25	68	p = .04
	frequency of listening to religious programs	.33	68	p = .006
	Frequency of reading bible	.28	68	p = .02
Health	No. of illnesses	-.21	54	n.s.
	Behavior handicaps[d]	-.03	53	n.s.
	Pschological handicaps[e]			
	Total use of health care	-.04	68	n.s.
	Use of acute psychiatric services (i.e., number of psychiatric admissions[a])	.03	68	n.s.
	Total current dose of antipsychotics[a]	n/a	n/a	n/a
	Use of general medical services	-.06	68	n.s.
	Use of general psychiatric services	-.01	68	n.s.
	Use of general social services	-.02	68	n.s.

Note. Correlations based upon total sample (N = 70), except where so indicated.

a Pertains to past year.

[b] Work scale based on sub-sample (n = 24).

[c] Education scale based on sub-sample (n = 19).

[d] Behavior handicap scale based on sub-sample (n = 55).

[e] Physical handicaps scale based on sub-sample (n = 56).

Table 15

Correlations Between Objective and Subjective Quality of Life for Different Life Domains of 278 Chronic Mentally Disabled Citizens Living in Large Board-and-Care Homes in Los Angeles[•]

Satisfaction Domain	Objective Indicator	*r*	*df*	Significance
Living Situation	Security	-.04	275	n.s.
	Privacy	.19	276	p < .01
	Autonomy	.09	262	n.s.
Family Relations	Frequency of contacts	.22	263	p < .001
Social Relations	Total contacts	.27	274	p < .001
	Contacts in home	.22	269	p < .001
	Contacts out of home	.07	273	n.s.
	Intimacy of contacts	.27	274	p < .001
Leisure Activities	Number per week	.07	276	n.s.
Work	Total hours worked per week	.50	40	p < .001
	Total Pay per week	.57	40	p < .001
Unemployment	Currently seeking work	-.05	225	n.s.
Education	n/a	n/a	n/a	n/a
Finances	Monthly spending money total	.12	262	p < .10
Legal/Safety	Total problems[a]	-.13	271	p < .05
	Involved in criminal activity[a]	-.04	271	n.s.

(table continues)

Table 15 (continued)

Correlations Between Objective and Subjective Quality of Life for Different Life Domains of 278 Chronic Mentally Disabled Citizens Living in Large Board-and-Care Homes in Los Angeles[*]

Satisfaction Domain	Objective Indicator	*r*	*df*	Significance
Health	Number of illnesses[a]	-.17	275	$p < .01$
	Total use of health care[a]	-.22	275	$p < .001$
	In psychotherapy[a]	-.09	275	n.s.
	Use of acute psychiatric services[a]	-.19	269	$p < .01$
	Total current dose of antipsychotics[a]	.08	276	n.s.
	Use of general medical services[a]	-.19	275	$p < .01$
	Perceived access to medical care[a]	.24	276	$p < .001$

Note. Table was drawn from Los Angeles sample of Lehman et al., (1982).
[a] Pertains to experience in past year.

The data reported in Table 16 also support Hypothesis 1. Table 16 compares the Los Angeles sample to the Outaouais sample with respect to the English Global Well-being (GWB) item and its French analog, the "Item du Bien-être Global" (IBG). Fisher's *r*-to-*z* transformations and one-tailed *z*-sample tests (Jacobson, 1976, pp. 365-374) revealed that correlations between domain-specific satisfactions and the English and French versions of this single-item global subjective QOL measure differed significantly only in the family domain (1-tailed $t = 1.69$, $p < .05$). The reader should note that the one-tailed *z*-sample test was used here because it allowed for a more stringent test of our hypothesis; that the French-language version of this single-item global subjective QOL measure could provide correlations with domain-specific satisfactions that were similar to those reported for the English-language version of the measure.

Hypothesis 2 : A Comparison of Two Global Subjective QOL Instruments:

The reader will recall that the second preliminary research hypothesis was to determine whether two alternative measures provided equivalent descriptions of respondents' perceptions of global subjective QOL. The first measure of global subjective QOL was the French-language "Item du Bien-être Global" (IBG) measure, a single-item that was asked of respondents first at the start and again at the end of the interview. The second dependent measure of global subjective QOL was the "Échelle de Satisfaction de Vie" (ESV) a five-item scale that was recently translated into French by Blais and colleagues (1989).

Conceptually, preliminary Hypothesis 2 was intended to explore the utility of these two measures of global subjective QOL. It was anticipated that relative to the IBG measure, the ESV would be less subject to ceiling effects while providing equal or superior

psychometric properties. The reader will also recall that operationally, this hypothesis was tested by predicting that the Échelle de Satisfaction de la Vie (ESV) would (1) produce a lower mean score and a larger variance than would the single-item Item du Bien-être Global (IBG) measure, and (2) that the correlations of domain-specific satisfactions would be equal or greater with the Échelle de Satisfaction de la Vie (ESV).

The hypothesis was supported. On the one hand, the ESV was found to provide a lower mean score and a greater standard deviation than did the IBG measure. On the other hand, the two global subjective QOL instruments were significantly correlated. The "Item du Bien-être Global" (IBG) measure correlated .71 with the ESV ($p < .001$).

The mean of the single-item "Item du Bien-être Global" (IBG) measure was 4.43 (SD = 1.54), whereas the mean of the "Échelle de Satisfaction de la Vie" (ESV) was 3.93 (SD = 1.67). A two-tailed t-test confirmed that the mean of the ESV was significantly lower than the mean of the IBG ($t = 3.41$ $p < .001$). This significant difference indicated that the ESV was less subject to ceiling effects than was the IBG measure, and inferentially, that it could better discriminate a wider range of feelings in respondents, an argument made by those who initially developed the instrument (Diener et al., 1985). Moreover, Table 12 showed that while no indicator of internal consistency could be derived for the single-item IBG measure (temporal stability for this single-item measure was .66), the internal consistency (.88) of the ESV was excellent. In sum, Hypothesis 2 was fully supported. The ESV correlated significantly with the IBG, but had relatively superior psychometric properties and was less subject to ceiling effects.

Table 16

Correlations of Domain-Specific Subjective Quality of Life with Global Subjective Quality of Life Measures for the Outaouais and Los Angles[a] Samples

	Outaouais Sample		Lehman Sample[a]
Life Domain	Measure A[b]	Measure B[c]	Measure C[d]
Living Situation	.38**	.50****	.45***
Family	.55****	.41***	.37***
Social Relations	.61****	.68****	.58***
Leisure	.61****	.78****	.59***
Finances	.42***	.40***	.40***
Law-Safety	.54****	.57****	.42***
Work	-.06 ns	.26 ns	.17 ns
School	.16 ns	.43 ns	n/a
Health	.69****	.69****	.66***
Religion	.56****	.57****	n/a

[a] Based upon the Los Angeles Sample of Lehman and colleagues (Lehman et al, 1982).
[b] Measure A = Average of the Item du Bien-être Global (French version) asked at the beginning and end of the Quality of Life Interview with 70 chronic mentally disabled citizens living small community-based residences in the Outaouais area.
[c] Measure B = Échelled de Satisfaction de Vie (Blais et al., 1989), completed by 70 chronic mentally disabled citizens living in small community-based residences in the Outaouais area but not by the Los Angeles sample.
[d] Measure C = Average of the Global Well-being Item (English version) asked at the begining and end of the Quality of Life Interview with 278 chronic mentally disabled citizens living in large group homes in the Los Angeles area (Lehman, 1983; Lehman et al., 1982). Measure C is thus the English-language equivalent of Measure A.
* $p < .05$; ** $p < .01$; *** $p < .001$; **** $p < .000$

Data presented in Table 16 also support Hypothesis 2. Table 16 compares the correlations between the 10 domain-specific satisfactions and the two global subjective QOL measures (measures A and B in Table 16) for the Outaouais sample. Both global subjective QOL instruments provided similar correlations. Fisher's *r*-to-*z* transformations and one-tailed *z*-sample tests (Jacobson, 1976, pp. 365-374) revealed that within the Outaouais sample, the correlations between the different domain-specific satisfaction measures and the two global subjective QOL measures differed significantly only with respect to the leisure domain (1-tailed $t = 2.75$, $p < .01$). These findings support hypotheses two. The ESV performed as well as the IBG measure, and provided superior psychometric properties. Moreover, correlation patterns for both global subjective QOL measures were quite similar to that reported by Lehman and colleagues (1982) for their Global Well-being Item.

Table 17 presents the correlations between the various objective QOL indicators in relation to the two global subjective QOL measures used in the study with the Outaouais respondents. Again, the ESV and IBG appeared to correlate quite similarly with objective indicators of life quality.

The two global subjective QOL instruments were significantly correlated (r (68) = .71, $p < .001$). The IBG measure correlated .75 ($p < .001$) with the Composite Global Life Satisfaction Scale, a measure that is the average of the 10 domain-specific satisfaction scales combined, compared with .89 ($p < .001$) for the Échelle de Satisfaction de Vie (ESV). Because the work and education domains contained small sample sizes, the possibility arose that dropping the domain-specific satisfaction scores for the work ($n = 25$) and education ($n = 19$) domains from the Composite Global Life Satisfaction Scale might improve the

relationship between it and the two measures of global subjective QOL. When both the work and education domains were dropped from the composite scale and only eight domain-specific satisfaction scales were averaged to form the smaller Composite Global Life Satisfaction Scale, no appreciable improvement resulted in the correlation .76 ($p < .001$) with the IBG measure, while the correlation with the ESV actually dropped to .81, ($p < .000$). Eliminating the work and education domains from the Composite Global Life Satisfaction Scale did not appreciably improve the composite scale's relationship with either of the two global subjective QOL measures being compared in this investigation.

Finally, domain-specific preferences did not tend to correlate significantly with the two global subjective QOL indicators. However, domain-specific preferences correlated significantly, albeit not meaningfully, with five of the domain satisfaction measures. Table C-22 of Appendix C presents the results of correlation analyses of the 10 domain-specific preferences with the two global subjective QOL indicators and the 10 domain-specific satisfaction measures.

Table 17

Correlations Between Objective Quality of Life Indicators and Two Global Subjective Quality of Life Measures for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residences in the Outaouais

Life Domain	Objective Indicator	IBG[a]	ESV[b]
	Demographics:		
	Gender	.02	.17
	Age	.08	.09
	Education	-.07	-.20
	Marital status	-.04	.03
Living Situation	Placement stability/security scale	-.15	-.07
	Privacy scale	-.12	-.14
	Autonomy scale	.01	.04
	Cohesion scale	.03	.15
	Independence scale	-.16	-.21
	Privacy scale	-.06	-.07
	Number of Co-residents	.10	.02
	Total months in residence	.27*	.30**
	Total number of different residential placements[c]	-.22	-.13
	PASSING total score	-.00	-.03
	PASSING setting score	-.05	-.01
	PASSING program score	.04	-.02
	PASSING beauty/comfort score	.11	.01
	PASSING accessibility score	-.01	-.10
Family	Familial contacts scale	-.02	-.10
	Frequency of telephone contacts	-.07	-.20
	Frequency of meetings with family	.05	.03
Social Relations	Total social contacts scale	.09	.17
	Social contacts in home scale	.02	.15
	Social contacts outside of home scale	-.04	-.04
	Friends scale	-.06	-.07
	Intimacy of contacts scale	.09	.13
Finances	Monthly income	.17	.21
	Monthly spending money	.13	.05

(table continues)

Table 17 (continued)

Correlations Between Objective Quality of Life Indicators and Two Global Subjective Quality of Life Measures for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residences in the Outaouais

Life Domain	Objective Indicator	IBG[a]	ESV[b]
Leisure	Total leisure activities scale	.16	.24*
	Leisure activities within residential service scale	.32**	.39***
	Leisure activities outside of residential service scale	.07	.14
Work	Work Scale[d]	.12	.16
	Current employment status	.15	.21
	Hourly wage of current job	.13	-.04
	Total hours worked per week	.10	.21
	Unemployment Scale[e]	.14	.23
	Number of months since last paying job[e]	.12	.13
	Number of months since best paying job[e]	.11	.29*
Education	Student status[f]	.05	.10
	Days or evenings per week of school attendance[g]	-.03	.00
Personal Safety	Legal/safety Scale	-.18	-.19
	Criminal Activities Scale	-.19	-.19
	Arrests for shoplifting	-.17	-.18
	Arrests for vagrancy	-.15	-.13
	Arrests for other crimes	-.13	-.14
	Victim of Crime Scale	-.10	-.11
	Robbed	-.03	-.04
	Assaulted	-.13	-.14
Religion	Frequency of religious activity scale	.07	.18
	Frequency of attending church mass	.05	.11
	Frequency of reading bible	-.07	.07
	Frequency of listening to religious programs	.17	.21

(table continues)

Table 17 (continued)

Correlations Between Objective Quality of Life Indicators and Two Global Subjective Quality of Life Measures for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residences in the Outaouais

Life Domain	Objective Indicator	IBG[a]	ESV[b]
Health	No. of illnesses	-.08	-.01
	Behavior handicaps scale	.08	-.07
	Physical handicaps scale	-.19	-.00
	Services received and needed scale	-.14	-.12
	Services received scale	-.02	-.09
	Services needed scale	-.22	-.13
	Use of acute psychiatric services (i.e., number of psychiatric admissions[c])	-.02	.02
	Use of general medical services scale	-.13	-.04
	Use of general psychological services scale	-.12	-.04
	Use of general social services scale	.08	-.08
	Frequency of professional contacts	-.08	-.02
Activities	Frequency of activities scale	.22	.24*
	Activities within residence	.28*	.36**
	Activities outside residence (i.e., weak social integration scale)	.14	.14
	Activities with valued others (i.e., strong social integration scale)	-.04	-.03

Note. For some life domains, scales reflecting the objective indicators of life quality failed to provide satisfactory internal consistency (i.e., coefficient alpha < .60). In those instances, the scale's items were also correlated with the two GSQL measures.

[a] IBG = Item de Bien-être Global (Andrews and Withey, 1976). A global subjective quality of life item asked both at the begining and at the end of the Quality of Life Interview.

[b] ESV = Échelle de Satisfaction de Vie (Blais et al., 1989). An alternative measure of global subjective quality of life.

[c] Pertains to past year.

[d] Based upon a sub-sample (no. of respondents = 25).

[e] Based upon a sub-sample (no. of respondents = 45).

[f] Item asked of all respondents (N = 70)

[g] Item asked only of respondents having attended some school program over past year (n = 19).

* $p < .05$; ** $p < .01$; *** $p < .001$.

Results of Substantive Research Hypotheses

Substantive Hypothesis 3: Preferences as Predictors of Subjective QOL in Life Domains

The reader will recall that Hypothesis 3 was concerned with the role of domain-specific preferences in the prediction of domain-specific subjective QOL. Conceptually, domain-specific preferences were expected to make an independent contribution to the prediction of domain-specific subjective QOL over and above that made by personal attributes and domain-specific objective QOL indicators. Operationally, Hypothesis 3 was tested with eight separate hierarchical regression analyses. Each regression analysis used the pertinent domain-specific total satisfaction score as the dependent variable. It was anticipated that specific preferences would explain a statistically significant increment in the amount of variance accounted for, beyond that already accounted for by summary scores. Each of the eight separate hierarchical regression analyses involved three steps:

Step 1:	(age + gender + physical functioning + behavioural functioning).
Step 2:	step 1 + (Objective QOL indicators reflected in domain-specific summary score).
Step 3:	step 1 + step 2 + (domain-specific preference score).

Step one of each regression involved data on respondents' physical and behavioural functioning. Those data were derived from the LOCS physical handicaps and behaviour handicaps subscales. The inclusion of those two scales caused the regression analyses to be undertaken on a reduced sample (n = 55), because they were available for only 55 of the 70 respondents surveyed. Regression analyses performed on this subsample had decreased statistical power. Consequently, the eight regression analyses were undertaken twice; once with the physical handicaps and behaviour handicaps subscales of the LOCS in step one, and again a second time with an alternative indicator of respondents level of functioning, the

Services Received Scale (SRS). The SRS was drawn from the QOL interview and was available on all 70 respondents. The SRS surveys a wide range of services including, medical and nursing, psychiatric, psychological, and social. As such, the scale may be perceived as an objective indicator of client involvement with the health care system. Client involvement with the health care system could then serve as an alternative indicator of level of functioning, since the more services a client received, the more likely it was that the client needed those services. The reader should note that the SRS was not intended as a proxy for the physical and behaviour handicaps scales, but rather, as an alternative (indirect) indicator of level of functioning that allowed us to keep a control variable related to level of functioning in our regression with the full sample.

The eight separate regression analyses were run twice; first with the physical and behaviour handicaps scales as indicators of respondent level of functioning in step one (n = 55), and again with the Services Received Scale (SRS) as an indicator of respondent level of functioning in step one (N = 70). Tables 18 through 33 present the results of this test of Hypothesis 3.

Tables 18 and 19 present the results of the regression analysis for the living situation domain with the reduced (n = 55) and complete (N = 70) samples, respectively. In both instances, Hypothesis 3 was supported; the variable set to significantly improve the prediction of respondent satisfaction in the "living situation" domain was the preferences measure. The negative relationship between the perceived importance of living situation and subjective QOL in that domain indicates that as the importance of living situation increased, subjective QOL for that domain decreased. A comparison of the two regression analyses revealed that although the larger sample produced a more significant overall result, the total variance

accounted was less when the services received scale (SRS) was used as an alternative measure of client level of functioning. This suggests that the two subscales (i.e., physical and behaviour handicaps scales) drawn from the level of care survey (LOCS) were better predictors of satisfaction with living situation than was the SRS.

Tables 20 and 21 present the regression analyses for the family domain with the partial (n = 55) and full sample (N = 70), respectively. Again, Hypothesis 3 was supported: The inclusion of respondent preferences concerning the family domain significantly improved the variance accounted for in respondent satisfactions. The objective indicators of QOL in the family domain (i.e., frequency of contacts with family) also accounted for a significant increment in the variance explained, but only with the larger sample size (N = 70). The direction of the relationship indicates that the more respondents preferred to have contacts with their families, the better was their subjective QOL for the family domain. Level of functioning indicators did not significantly improve the prediction of satisfaction with family.

Tables 22 and 23 present the regression analyses for the social relations domain for both the partial and full sample, respectively. Respondent preferences did not significantly improve the prediction of satisfactions with the social relations domain.

Tables 24 and 25 present the regression analyses for the leisure domain. Hypothesis 3 was not supported for the leisure domain. Table 24 shows that with the partial sample (n = 55), no variable set significantly improved the prediction of respondent satisfactions with leisure. However, Table 25 shows that with the full sample (N = 70), objective indicators of leisure (i.e., frequency of leisure activities) significantly improved the prediction of satisfaction for this domain.

Table 18

Hierarchical Multiple Regression of Satisfaction with Living Situation on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Living Situation, and Preferences for Living Situation Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.04	.00	.00	.04
	Gender[c].	-.04	---	---	---	---
	Age.	.02	---	---	---	---
2	Handicaps.	---	.21	.04	.04	1.10
	Behavioral handicap.	-.20	---	---	---	---
	Physical handicap.	.04	---	---	---	---
3	Objective Indicators:	---	.33	.11	.06	1.67
	Privacy.	.29	---	---	---	---
	Placement stability/security	-.11	---	---	---	---
4	Importance of living situation.	-.34*	.46*	.21	.11*	6.22*

D.V. = Satisfaction with Living Situation (n = 55)

Total Equation

R^2 = .21
$F_{(7,47)}$ = 1.78 (n.s)

Mean of DV = 29.07
SD = 7.07

[a] Regression analysis undertaken with sub-sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for Gender variable were: 1 = male; 2 = female.
* $p < .05$

Table 19

Hierarchical Multiple Regression of Satisfaction with Living Situation on Demographics, Services Received, Objective Indicators of Living Situation, and Preferences for Living Situation Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.03	.00	.00	.04
	Gender[c].	-.03	---	---	---	---
	Age.	.02	---	---	---	---
2	Services Received.	-.06	.07	.00	.00	.23
3	Objective Indicators:	---	.25	.06	.06	2.02
	Privacy.	.24	---	---	---	---
	Placement stability/security	-.10	---	---	---	---
4	Importance of living situation.	-.33**	.40**	.16	.10**	7.47**

D.V. = Satisfaction with Living Situation (N = 70)

Total Equation

R^2 = .16
$F_{(6,63)}$ = 2.04 (n.s)

Mean of DV = 29.26
SD = 6.86

[a] Regression analysis undertaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for Gender variable were: 1 = male; 2 = female.
** $p < .01$

Table 20

Hierarchical Multiple Regression of Satisfaction with Family on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Family, and Family Preferences for Family Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.08	.01	.01	.17
	Gender[c].	-.04	---	---	---	---
	Age.	.09	---	---	---	---
2	Handicaps.	---	.11	.01	.00	.12
	Behavioral handicap.	-.06	---	---	---	---
	Physical handicap.	.04	---	---	---	---
3	Frequency of family contacts.	.22	.24	.06	.05	2.32
4	Preference for Family Contacts.	.35*	.43*	.19	.12*	7.83*

D.V. = Satisfaction with Family (n = 55)

Total Equation

R^2 = .19
$F_{(6,48)}$ = 1.85 (n.s)

Mean of DV = 18.29
SD = 5.35

[a] Regression analysis undertaken with partial sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .01$

Table 21

Hierarchical Multiple Regression of Satisfaction with Family on Demographics, Services Received, Objective Indicators of Family, and Family Preferences for Family Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.12	.01	.01	.47
	Gender[c].	-.08	---	---	---	---
	Age.	.12	---	---	---	---
2	Services Received.	.03	.12	.02	.00	.05
3	Frequency of family contacts.	.24*	.26*	.07	.06*	3.84*
4	Preference for Family contacts.	.35**	.43**	.19	.12**	9.20**

D.V. = Satisfaction with Family (N = 70)

Total Equation

R^2 = .19
$F_{(5,64)}$ = 2.93*

Mean of DV = 18.21
SD = 5.46

[a] Regression analysis undertaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$ ** $p < .01$

Table 22

Hiherarchical Multiple Regression of Satisfaction with Social Relations on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Social Relations and Preferences for Social Relations Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.32	.10	.10	2.90
	Gender[c].	.35	---	---	---	---
	Age.	-.18	---	---	---	---
2	Handicaps.	---	.35	.12	.02	.61
	Behavioral handicap.	-.09	---	---	---	---
	Physical handicap.	-.13	---	---	---	---
3	Frequency of social relations.	.10	.36	.13	.01	.48
4	Preferences for social relations.	.19	.40	.16	.03	1.67

D.V. = Satisfaction with Social Relations (n = 55)

Total Equation

R^2 = .16
$F_{(6,48)}$ = 1.52 (n.s)

Mean of DV = 29.26
SD = 6.04

[a] Regression analysis undertaken with sub-sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.

Table 23

Hiherarchical Multiple Regression of Satisfaction with Social Relations on Demographics, Services Received, Objective Indicators of Social Relations and Preferences for Social Relations Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.16	.03	.03	.87
	Gender[c].	.17	---	---	---	---
	Age.	-.02	---	---	---	---
2	Services Received.	-.10	.18	.03	.01	.55
3	Frequency of social relations.	.19	.26	.07	.03	2.39
4	Preferences for social relations.	.17	.30	.09	.02	1.73

D.V. = Satisfaction with Social Relations (N = 70)

Total Equation

R^2 = .09
$F_{(5,64)}$ = 1.30 (n.s)

Mean of DV = 28.59
SD = 6.66

[a] Regression undertaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.

Table 24

Hierarchical Multiple Regression of Satisfaction with Leisure on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Leisure, and Leisure Preferences for Leisure Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.20	.04	.04	1.06
	Gender[c].	.22	---	---	---	---
	Age.	-.08	---	---	---	---
2	Handicaps.	---	.27	.07	.03	.90
	Behavioral handicap.	-.18	---	---	---	---
	Physical handicap.	-.01	---	---	---	---
3	Frequency of leisure activities.	.22	.34	.11	.04	2.28
4	Preference for leisure activities.	.00	.34	.11	.00	.00

D.V. = Satisfaction with Leisure (n = 55)

Total Equation

R^2 = .11
$F_{(6,48)}$ = 1.03 (n.s)

Mean of DV = 28.46
SD = 6.77

[a] Regression analysis undertaken with partial sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.

Table 25

Hierarchical Multiple Regression of Satisfaction with Leisure on Demographics, Services Received, Objective Indicators of Leisure, and Leisure Preferences for Leisure Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.11	.01	.01	.41
	Gender[c].	.10	---	---	---	---
	Age.	.02	---	---	---	---
2	Services Received.	.06	.12	.01	.00	.18
3	Frequency of leisure activities.	.29*	.29*	.09	.07*	5.05*
4	Preference for leisure activities.	-.01	.29	.09	.00	.01

D.V. = Satisfaction with Leisure (N = 70)

Total Equation

R^2 = .09
$F_{(5,64)}$ = 1.20 (n.s)

Mean of DV = 27.81
SD = 6.99

[a] Regression analysis undertaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$

Tables 26 and 27 present the results of regression analyses on the finances domain for the partial (n = 55) and full samples (N = 70), respectively. Hypothesis 3 was supported with respect to the finances domain. Tables 26 and 27 both show that perceived financial need was an incrementally significant predictor of satisfaction with finances. Objective indicators also significantly improved the prediction of satisfaction with finances in both cases.

Table 28 and 29 present the regression analyses for the personal safety domain. Again, Hypothesis 3 was supported in regression analyses: the only predictor that accounted for a significant increase in respondent satisfaction with personal safety was respondent preferences for personal safety. The direction of this relationship was negative, indicating that the greater the preference for safety, the less satisfied were the respondents with the safety domain.

Table 30 and 31 present the results of the regression analyses for the health domain with both the partial and full samples, respectively. Hypothesis 3 was not supported with in either regression model. The regression analysis with the full sample was remarkably similar to that found with the partial sample, suggesting that the subscales of the LOCS were good predictors of satisfaction with health.

Table 32 and 33 present the results of the regression analyses for the religion domain with the partial (n = 55) and full (N = 70) samples. Hypothesis 3 was not supported with respect to the religion domain. In fact, the only predictor to significantly increase the amount of variance explained with religion was the objective indicator of the religion domain, frequency of religious activity. This finding was consistent regardless of sample size. For the work and education domains, small sample sizes precluded a test of Hypothesis 3.

Table 26

Hierarchical Multiple Regression of Satisfaction with Finances on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Finances, and Perceived Financial Need for Finances Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.20	.04	.04	1.13
	Gender[c].	.14	---	---	---	---
	Age.	-.22	---	---	---	---
2	Handicaps.	---	.24	.06	.02	.39
	Behavioral handicap.	-.04	---	---	---	---
	Physical handicap.	-.12	---	---	---	---
3	Objective Indicators:	---	.41*	.17	.11*	3.12*
	Monthly income.	.19	---	---	---	---
	Monthly spending money.	.27*	---	---	---	---
4	Amount of dollars needed.	-.47***	.61***	.37	.21***	15.25***

D.V. = Satisfaction with Finances (n = 55)

Total Equation

R^2 = .37
$F_{(7,47)}$ = 3.93**

Mean of DV = 15.00
SD = 6.43

[a] Regression analysis undertaken with partial sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$ ** $p < .01$ *** $p < .001$

Table 27

Hierarchical Multiple Regression of Satisfaction with Finances on Demographics, Services Received, Objective Indicators of Finances, and Perceived Financial Need for Finances Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.14	.02	.02	.66
	Gender[c].	.02	---	---	---	---
	Age.	-.15	---	---	---	---
2	Services Received.	-.02	.14	.02	.00	.03
3	Objective Indicators:	---	.38	.14	.12	4.54**
	Monthly income.	.26*	---	---	---	---
	Monthly spending money.	.24*	---	---	---	---
4	Amount of dollars needed.	-.45***	.58***	.33	.19***	18.17***

D.V. = Satisfaction with Finances (N = 70)

Total Equation

R^2 = .33
$F_{(6,63)}$ = 5.26***

Mean of DV = 14.56
SD = 6.35

[a] Regression analysis undertaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$ ** $p < .01$ *** $p < .001$

Table 28

Hiherarchical Multiple Regression of Satisfaction with Safety on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Safety and Preferences for Safety Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.12	.01	.01	.36
	Gender[c].	.13	---	---	---	---
	Age.	-.05	---	---	---	---
2	Handicaps.	---	.18	.03	.02	.50
	Behavioral handicap.	-.05	---	---	---	---
	Physical handicap.	-.14	---	---	---	---
3	Frequency of contact with crime.	-.11	.21	.04	.01	.54
4	Preference for safety.	-.31*	.37*	.14	.09*	5.12*

D.V. = Satisfaction with Safety (n = 55)

Total Equation

R^2 = .14
$F_{(6,48)}$ = 1.26 (n.s)

Mean of DV = 25.53
SD = 5.15

[a] Regression analysis undertaken with sub-sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$

Table 29

Hierarchical Multiple Regression of Satisfaction with Safety on Demographics, Services Received, Objective Indicators of Safety and Preferences for Safety Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.10	.01	.01	.34
	Gender[c].	.10	---	---	---	---
	Age.	-.07	---	---	---	---
2	Services Received.	.17	.18	.03	.02	1.61
3	Frequency of contact with crime.	-.04	.19	.04	.00	.10
4	Preference for safety.	-.26*	.31*	.10	.06*	4.49*

D.V. = Satisfaction with Safety (N = 70)

Total Equation

R^2 = .10
$F_{(5,64)}$ = 1.40 (n.s)

Mean of DV = 25.39
SD = 4.93

[a] Regression underaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$

Table 30

Hiherarchical Multiple Regression of Satisfaction with Health on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Health and Preferences for Health Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.15	.02	.02	.61
	Gender[c].	.14	---	---	---	---
	Age.	.03	---	---	---	---
2	Handicaps.	---	.18	.03	.01	.22
	Behavioral handicap.	-.02	---	---	---	---
	Physical handicap.	-.10	---	---	---	---
3	Frequency of health-related contacts.	-.21	.27	.07	.04	2.13
4	Preference for Health.	-.21	.34	.11	.04	2.25

D.V. = Satisfaction with Health (n = 55)

Total Equation

R^2 = .11
$F_{(6,48)}$ = 1.02 (n.s)

Mean of DV = 29.26
SD = 6.49

[a] Regression analysis undertaken with partial sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.

Table 31

Hiherarchical Multiple Regression of Satisfaction with Health on Demographics, Services Received, Objective Indicators of Health and Preferences for Health Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.10	.01	.01	.35
	Gender[c].	.06	---	---	---	---
	Age.	.07	---	---	---	---
2	Services Received.	-.00	.10	.01	.00	.00
3	Frequency of health-related contacts.	-.10	.14	.02	.01	.55
4	Preference for Health.	-.20	.24	.06	.04	2.50

D.V. = Satisfaction with Health (N = 70)

Total Equation

R^2 = .06
$F_{(5,64)}$ = .75 (n.s)

Mean of DV = 28.89
SD = 6.24

[a] Regression analysis underaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.

Table 32

Hiherarchical Multiple Regression of Satisfaction with Religion on Demographics, Behavioral and Physical Handicaps, Objective Indicators of Religion and Preferences for Religion Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.30	.09	.09	2.64
	Gender[c].	.34	---	---	---	---
	Age.	-.11	---	---	---	---
2	Handicaps.	---	.32	.10	.01	.20
	Behavioral handicap.	.08	---	---	---	---
	Physical handicap.	.04	---	---	---	---
3	Frequency of religious activity.	.44**	.51**	.26	.16**	10.80**
4	Preference for religious activity.	.09	.52*	.27	.00	.26

D.V. = Satisfaction with Religion (n = 55)

Total Equation

R^2 = .27
$F_{(6,48)}$ = 2.90*

Mean of DV = 20.71
SD = 3.93

[a] Regression analysis undertaken with partial sample (n = 55).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$ ** $p < .01$

Table 33

Hiherarchical Multiple Regression of Satisfaction with Religion on Demographics, Services Received, Objective Indicators of Religion and Preferences for Religion Domain[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Demographics:	---	.13	.02	.02	.57
	Gender[c].	.14	---	---	---	---
	Age.	-.03	---	---	---	---
2	Services Received.	-.01	.13	.02	.00	.01
3	Frequency of religious activity.	.43***	.42**	.17	.16	12.29***
4	Preference for religious activity.	.06	.42*	.18	.00	.14

D.V. = Satisfaction with Religion (N = 70)

Total Equation

R^2 = .18
$F_{(5,64)}$ = 2.72*

Mean of DV = 20.56
SD = 3.94

[a] Regression analysis undertaken with total sample (N = 70).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Value labels for gender variable were: 1 = male; 2 = female.
* $p < .05$ ** $p < .01$ *** $p < .001$

Substantive Hypothesis 4: Predicting Global Subjective QOL:

The reader will recall that the goal of Hypothesis 4 was to identify important predictors of global subjective QOL. Conceptually, the hypothesis stated that global subjective QOL is a function of attribute variables, personality characteristics, objective QOL indicators, domain-specific preferences, and domain-specific satisfactions. Operationally, Hypothesis 4 was tested with hierarchical regression analyses, with each step in the regression expected to account for a significant increment in the proportion of variance accounted for in global subjective QOL.

In order to maintain a respectable subject/variable ratio, four blocks of composite variables were constructed using a method originally suggested by Coleman (1975) and subsequently used by other authors (Cronkite and Moos, 1978; Flynn and Nitsch, 1981). The procedure involved forming composite variables from two or more conceptually similar variables. The composite was computed as a weighted sum of the variables composing the block, the weights being the raw (metric) regression coefficients obtained when only those variables in a particular set were used to predict the criterion variable (global subjective QOL). Four such composite variables were constructed: (1) personal attributes; (2) domain-specific objective QOL indicators; (3) domain-specific preferences, and (4) domain-specific satisfactions.

Composite variables such as personal attributes no longer have a natural metric (Cronkite and Moos, 1979; Flynn and Nitsch, 1981). However, individuals still may range from high to low on such composites, with a "high" score referring to those combinations of personal attributes etc., that are associated with greater global subjective QOL. The composite

variables procedure as it was applied in the regression analysis for Hypothesis 4 implicated a number of variables that are outlined below:

Step 1: Personal attributes (demographic) class of composite variables.

Step 2: step 1 + (self-esteem score).

step 3: step 1 + step 2 + (domain-specific objective QOL composite score).

step 4: step 1 + step 2 + step 3 + (domain-specific preference composite score).

step 5: step 1 + step 2 + step 3 + step 4 + (domain-specific satisfaction composite score).

The composite for the demographic data included age, gender, education, and the physical and behaviour handicaps scores. Step two involved only the raw score on the Self-Esteem Scale. For step three, an objective QOL composite score was derived for each of the eight life domains: The living situation domain composite comprised the independence, privacy, and placement stability/security measures, and the total number of months living in the current residence. The social relations domain comprised the frequency of social relations score. The leisure domain comprised the frequency of leisure activities. The family domain comprised the frequency of family contacts. The finances domain composite comprised total income and total spending money. The health domain comprised the services received scale. The personal safety domain comprised the involvement with crime scale that provided frequencies of criminal activity and frequency of being a victim of crime. The Religion domain comprised the frequency of religious activity. The domain-specific preference composite score in step four was drawn from the preference indices in the leisure, social relations, health, personal safety, religion, and family domains, and for the living situation and

finances domains, from the importance of the living situation scale, and the perceived financial need indicator (i.e., perceived financial need in terms of dollars). The domain-specific subjective QOL composite in step four was drawn from the domain-specific subjective QOL scores in each of the eight aforementioned life domains.

The hierarchical regression analysis for Hypothesis 4 was carried out with both Global Subjective QOL indices; that is, the Item du Bien-être Global (IBG) measure and the Échelle de Satisfaction de Vie (ESV), on both the sub-sample (n = 55) and the full sample (N = 70). The reader may recall that with the sub-sample, level of functioning was based upon the physical and behaviour handicaps subscales drawn from the Level of Care Survey, and that data on these subscales were available on only 55 respondents. When the hierarchical regression was conducted with the full sample (N = 70), the physical and behaviour handicaps were dropped from the demographic class of composite variables. Thus, with the full sample, the demographic class of variables composite comprised only age, gender, and education.

The findings from the regression analysis with the sub-sample (n = 55) and the full sample (N = 70) are presented in Tables 34 and 35, respectively. As can be seen in Table 34, Hypothesis 4 was generally supported. Except for demographic composite all of the composites consistently provided significant increments in the total amount of variance accounted for in the Item du Bien-être Global (IBG) measure and in the Échelle de Satisfaction de Vie (ESV). The pattern of significance varied slightly, however, depending upon which dependent measure was used. With the IBG as the dependent measure, the largest increment in global subjective QOL was accounted for by the personality variable (i.e., self-esteem), followed by the domain satisfactions composite, the preferences composite, and finally the objective indicators composite. With the ESV as the dependent measure,

personality was the most significant predictor, followed by the domain satisfactions composite, the objective indicators composite, the demographic variables composite, and finally, the preferences composite.

Table 35 presents the same regression analysis for the full sample (N = 70). With the Item du Bien-être Global (IBG) measure as the dependent variable, personality characteristics (i.e., the self-esteem score) was the most significant predictor, followed by the domain satisfactions composite, the preferences composite, and finally, the objective indicators composite. With the ESV as the dependent measure, the most significant predictor was again personality, followed by the domain satisfactions composite, the objective indicators composite, the demographics composite, and finally the preferences composite.

Overall, these findings provide support for Hypothesis 4 and the model specified therein. However, slight differences were noted in the patterns significant relationship between the various variable sets, depending upon the dependent measure used. Given the ordering of the variables that was derived from the underlying conceptual model (see Figure 6, p. 65), the Self-esteem Scale (SES) consistently emerged as the best predictor of global subjective QOL, regardless of which dependent measure was used.

Table 34

Hierarchical Multiple Regression of Global Subjective Quality of Life Indices on Demographics Composite, Self-esteem, Objective Quality of Life Composite, Domain Preferences Composite, and Domain Satisfactions Composite

		IBG measure (n = 55)					ESV (n = 55)				
Step	Variable	ß[a]	R	R^2	ΔR^2	ΔF	ß[a]	R	R^2	ΔR^2	ΔF
1	Demographics composite	.25	.25	.06	.06	3.46	.32*	.32*	.10	.10*	5.92*
2	Self-esteem score	.57****	.62****	.38	.32****	26.80****	.48****	.57****	.33	.23****	17.71****
3	OQL indicators composite	.29*	.67****	.45	.07**	6.44**	.38**	.67****	.44	.11**	10.34**
4	Preferences composite	.35**	.72****	.52	.07**	6.65**	.28*	.70****	.49	.04*	4.17*
5	Satisfactions composite	.59****	.81****	.65	.14****	19.06***	.66****	.84****	.70	.22****	36.10****
Total Equation		IBG Model R^2 = .65 $F_{(5,49)}$ = 18.24**** Mean of DV = 4.46 SD = 1.56					ESV Model R^2 = .70 $F_{(5,49)}$ = 23.25**** Mean of DV = 3.97 SD = 1.64				

Note. IBG Item refers to the averaged Item du Bien-être Global (Andrews and Withey, 1976) asked at the begining and again at the end of the Quality of Life Inteview. ESV refers to the Échelle de Satisfaction de Vie, the French translation of the Satisfaction with Life Scale (Blais et al., 1989).

[a] Beta refers to the value of the standardized partial regression coefficient (ß) after the step when the variable entered the regression model.

* $p < .05$ ** $p < .01$ *** $p < .001$ **** $p < .0001$

Table 35

Hierarchical Multiple Regression of Global Subjective Quality of Life Indices on Demographics Composite, Self-esteem, Objective Quality of Life Composite, Domain Preferences Composite, and Domain Satisfactions Composite

Step	Variable	IBG measure (n = 70) ß[a]	R	R^2	ΔR^2	ΔF	ESV (n = 70) ß[a]	R	R^2	ΔR^2	ΔF
1	Demographics composite	.09	.09	.01	.01	.57	.23*	.23*	.06	.06*	3.95*
2	Self-esteem score	.54****	.54****	.30	.29****	27.45****	.53****	.58****	.33	.28****	28.21****
3	OQL indicators composite	.30**	.61****	.37	.07**	7.71**	.39***	.68****	.47	.13***	16.18***
4	Preferences composite	.39**	.67****	.45	.08**	10.01**	.24*	.71****	.50	.03*	4.01*
5	Satisfactions composite	.68****	.81****	.65	.20****	36.17****	.68****	.86****	.74	.24****	60.10****
Total Equation		IBG Model: R^2 = .65; $F_{(5,64)}$ = 23.90****; Mean of DV = 4.43; SD = 1.54					ESV Model: R^2 = .74; $F_{(5,64)}$ = 36.53****; Mean of DV = 3.93; SD = 1.67				

Note. IBG Item refers to the averaged Item du Bien-être Global (Andrews and Withey, 1976) asked at the begining and again at the end of the Quality of Life Inteview. ESV refers to the Échelle de Satisfaction de Vie, the French translation of the Satisfaction with Life Scale (Blais et al., 1989).

[a] Beta refers to the value of the standardized partial regression coefficient (ß) after the step when the variable entered the regression model.

* p < .05 ** p < .01 *** p < .001 **** p < .0001

Substantive Hypothesis 5

The reader will recall that the research goal underlying Hypothesis 5 was to determine whether a relationship existed between social integration (SI) and global subjective QOL. Conceptually, Hypothesis 5 was intended to evaluate the possibility of a significant positive relationship between two constructs; global subjective QOL and social integration (SI). Operationally, the hypothesis was tested by verifying whether there was a significant ($p < .05$) positive correlation between the two measures of global subjective QOL, the Item du Bien-être Global and the Échelle de Satisfaction de Vie, and the two forms of social integration, the weak social integration scale (WSIS) and the strong social integration scale (SSIS).

Hypothesis 5 was not supported. The two global subjective QOL instruments (which were correlated significantly with each other, r (68) = .71, $p < .000$) did not correlate significantly with either the weak or strong social integration scales. The Item du Bien-être Global (IBG) measure was uncorrelated with the WSIS (r (68) = .14, p = .26), and was also uncorrelated with the SSIS (r (68) = -.02, p = .84). The Échelle de Satisfaction de Vie (ESV) also was uncorrelated with both the WSIS (r (68) .14, p = .77), and the SSIS (r (68) = -.03, p = .78).

Substantive Hypothesis 6: Objective Predictors of SI:

The reader will recall that the goal of the sixth research hypothesis was to determine whether the location and size of a community residence for chronic mentally disabled citizens has an impact upon the social integration of its residents. Conceptually, this hypothesis stated that among family-care homes, residents of rural housing would have lower social integration (SI) scores than those from urban housing. Similarly, residents of larger community residences

would have lower SI scores than those in smaller community residences. Operationally, this hypothesis was tested by means of hierarchical regression analyses. The hierarchical regression analyses were conducted twice, once with the Strong Social Integration Scale (SSIS) as the dependent measure and again with the Weak Social Integration Scale (WSIS) as the dependent measure. In both instances, the regression analyses were as follows:

Step 1: Personal attributes (gender + age + level of psychological functioning).

Step 2: Step 1 + (Location of facility: 1 = urban, 0 = rural).

Step 3: Step 1 + step 2 + (size of facility: number of residents).

The reader will recall that the order of entry of the variables in each step was conceptually determined a priori on the basis of the temporal origin and mutability of the variables; that is, personal attributes such as age, gender and level of behaviour functioning (behaviour handicaps score) were held to precede the other variables, while location of facility was held to be less mutable than its size as it was defined in the regression model.

Because data for these regression analyses were drawn only from respondents living in family-care homes located in urban and rural areas, the analyses were conducted with sub-samples only (n = 55). Moreover, since the personal attributes/demographics dimension in step one of the regression analysis comprised the behaviour handicaps measure, the sub-sample was further reduced; behaviour handicaps data were available for only 45 of the 55 respondents living in family-care homes. This further reduction in sample size led us to carry out the regression analyses twice; first with the behaviour handicaps included in the personal attributes/demographics step (n = 45), and again with the personal attributes/demographics data excluded (n = 55). The results of these regression analyses are presented in Tables 36 and 37.

Table 36

Hierarchical Multiple Regression of Strong and Weak Social Integration Indicators on Demographic Variables, Location of Family-Care Home, and Size of Family-Care Home

Step	Variable	Strong Social Integration (n = 45) ß[a]	R	R^2	ΔR^2	ΔF	Weak Social Integration (n = 45) ß[a]	R	R^2	ΔR^2	ΔF
1	Personal attributes/demographics:	----	.39	.15	.15	2.43	---	.39	.15	.15	2.46
	Behavior handicaps	-.14	---	---	---	---	-.34	---	---	---	---
	Gender	.30	---	---	---	---	-.00	---	---	---	---
	Age	-.38	---	---	---	---	-.25	---	---	---	---
2	Location of facility	-.01	.39	.15	.00	.01	.28	.48*	.23	.07	3.82
3	Size of facility/number of residents	.06	.39	.15	.00	.15	.04	.48	.23	.00	.06

	Strong Social Integration Model	Weak Social Integration Model
Total Equation	R^2 = .15 $F_{(5,39)}$ = 1.42 (ns)	R^2 = .23 $F_{(5,39)}$ = 2.30 (ns)
	Mean of DV = 0.80 SD = 2.37	Mean of DV = 6.24 SD = 3.74

Note. Value labels for the gender variable were (1= male, 2 = female). Value labels for the location variable were (1 = urban, 0 = rural).

[a] Beta refers to the value of the standardized partial regression coefficient (ß) subsequent to the step when the variable entered into the regression model.

Table 37

Hierarchical Multiple Regression of Strong and Weak Social Integration Indicators on Demographic Variables, Location of Family-Care Home, and Size of Family-Care Home

Step	Variable	Strong Social Integration (n = 55) ß[a]	R	R^2	ΔR^2	ΔF	Weak Social Integration (n = 55) ß[a]	R	R^2	ΔR^2	ΔF
1	Personal attributes/demographics:	----	.33*	.11	.11*	3.20*	---	.19	.04	.04	.95
	Gender	.26	---	---	---	---	-.03	---	---	---	---
	Age	-.33*	---	---	---	---	-.17	---	---	---	---
2	Location of facility	.01	.33	.11	.00	.00	.38**	.41*	.17	.13**	8.25**
3	Size of facility/number of residents	.01	.33	.11	.00	.01	-.05	.41*	.17	.00	.11

	Strong Social Integration Model	Weak Social Integration Model
Total Equation	R^2 = .11 $F_{(4,50)}$ = 1.54 (ns)	R^2 = .17 $F_{(4,50)}$ = 2.59*
	Mean of DV = 0.80 SD = 2.27	Mean of DV = 6.60 SD = 3.72

Note. Value labels for the gender variable were (1= male, 2 = female). Value labels for the location variable were (1 = urban, 0 = rural).

[a] Beta refers to the value of the standardized partial regression coefficient (ß) subsequent to the step when the variable entered into the regression model.

* $p < .05$ ** $p < .01$

In each table separate models are shown for the strong and weak social integration (SI) measures. Table 36 shows that with the partial sample of 45 family-care home residents on whom behaviour handicaps data were available, Hypothesis 6 was not confirmed; no variable sets were significant predictors of either strong or weak social integration. Table 37 shows that with the full sample of 55 respondents living in family-care homes Hypothesis 6 was only partially supported. When strong social integration was the dependent variable, the only significant predictor was personal attributes/demographics. When the weak indicator of social integration (WSIS) was regressed on the predictor variables, on the other hand, the only significant predictor of was location of the residential service. In neither case did size of facility (i.e., the number of residents) add a significant increment to the total variance explained. However, we noted that family-care homes located in rural areas tended to house more clients (M = 6.6, SD = 1.47, median = 7.0) than those in urban areas (M = 5.5, SD = 2.57, median = 4.0). On a post-hoc basis, location and size of family-care home were found to be significantly and negatively correlated (r (55) -.27, p = .04), with services located in rural areas housing 57% more residents that those located in urban areas.

Substantive Hypothesis 7: Predictors of Program Quality:

The reader will recall that the research goal of Hypothesis 7 was to determine the nature of the relationship between program quality in terms of a residential facility's PASSING score and objective indicators of program quality. Conceptually, the hypothesis stated that among family-care homes, program quality, whether defined in terms of overall PASSING score or in terms of the two PASSING subscale scores labelled "environment" and "program," would be predicted by both facility location and size (number of residents).

Operationally, the hypothesis was tested using hierarchical regression. With family-care homes as the unit of analysis, the overall PASSING percentage score, the PASSING environment subscale percentage score, and the PASSING program subscale percentage score were each regressed upon size and location of the 29 family-care homes (15 rural and 14 urban). The reader will recall that family-care homes only were included in the analysis to control for the type of residential service. The hypothesis stated that the size and location of these residential facilities would add significantly to the prediction of the aforementioned PASSING scores. Additionally, on a post-hoc basis, the regression analyses tested for the possibility of an interaction effect between facility location and facility size. The specific steps for the regression analyses were as follows:

Step 1: Location of facility (1 = urban; 0 = rural).

Step 2: step 1 + (size of facility: number of residents).

Step 3: Interaction between location and size of facility.

Hypothesis 7 was supported. Table 38 presents the results of the total PASSING percentage score regressed on the predictor variables, location and size of family-care homes. Both location and size significantly improved the prediction of the total PASSING percentage score. The interaction between location and size of family-care homes was not significant.

Table 39 presents the regression of the PASSING's Environment and Program subscale percentage scores on location and size of family-care homes. Both location and size of family-care homes significantly improved the prediction of the Environment subscale percentage score of PASSING. The interaction effect was not significant. With respect to the Program subscale percentage score, only location significantly improved the prediction equation; size of facility and the interaction between location and size were not significant.

Table 38

Hiherarchical Multiple Regression of Total PASSING Percentage Score on Location and Size of Family-care Homes[a]

Step	Variable	β[b]	R	R^2	ΔR^2	ΔF
1	Location of family care home[c]	.75****	.75****	.57	.57****	35.33****
2	Size of family-care home (number of clients served)	-.32**	.81****	.66	.10**	7.28**
3	Interaction between location and size of family-care home	-.33	.82****	.68	.02	1.39

D.V. = Total PASSING Percentage Score (n = 29)

Total Equation

R^2 = .68
$F_{(3,25)}$ = 17.65****

Mean of DV = 39.83
SD = 10.38

[a] Regression analysis undertaken on family-care homes only (n = 29).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Family-care homes were either rural (n = 15) or urban (n = 14).

* p < .05 ** p < .01 *** p < .001 **** p < .0001

Table 39

Hierarchical Multiple Regression of PASSING Percentage Scores for the Environment and Program Subscales on Location and Size of Family-care Homes[a]

Step	Variable	Environment Subscale (n = 29)					Program Subscale (n = 29)				
		ß[b]	R	R^2	ΔR^2	ΔF	ß[b]	R	R^2	ΔR^2	ΔF
1	Location of family-care home[c]	.64***	.64***	.40	.40***	18.21***	.58***	.58***	.34	.34***	13.87***
2	Size of family-care home	-.53****	.82****	.67	.26****	20.66****	-.15	.60**	.36	.02	.89
3	Interaction between location and size	-.10	.82****	.67	.00	.13	-.59	.65**	.42	.06	2.53

	Environment Percentage Score (n = 29)	Program Percentage Score (n = 29)
Total Equation	R^2 = .67 $F_{(3,25)}$ = 16.83****	R^2 = .42 $F_{(3,25)}$ = 6.03**
	Mean of DV = 50.15 SD = 12.88	Mean of DV = 31.98 SD = 10.13

[a] Regression analyses undertaken on family-care homes only (n = 29).
[b] Beta refers to the value of the standardized partial regression (β) after the step when the variable entered into the regression model.
[c] Family-care homes were grouped as either rural (n = 15) or urban (n = 14).
* $p < .05$ ** $p < .01$ *** $p < .001$ **** $p < .0001$

Substantive Hypothesis 8: Identifying Predictors of SI:

The reader will recall that the research goal of Hypothesis 8 was to determine which variable(s) of the QOLSI model predicted social integration (SI). Conceptually, Hypothesis 8 stated that personal attributes, objective QOL indicators, domain-specific preferences, and domain-specific satisfactions were all related to social integration. Operationally, the following hierarchical analyses were conducted.

Step 1: Demographics/personal attributes composite score

Step 2: Step 1 + (objective QOL indicators composite score + Total PASSING score).

Step 3: Step 1 + step 2 + (domain preferences composite score).

Step 4: Step 1 + step 2 + step 3 + (domain satisfactions composite score).

Step 5: Step 1 + step 2 + step 3 + step 4 + (Global subjective QOL score).

Composite variable sets were created using the procedure previously described (see Hypothesis 4). The composite for the demographic/personal attributes data included age, gender, education, and the physical and behaviour handicaps scores. Step two involved the total PASSING score and a composite score comprising seven domain-specific objective indicators of life quality. The living situation domain comprised the independence, autonomy, privacy, and placement stability/security measures, and the total number of months living in the current residence. The social relations domain comprised the frequency of social relations score. The family domain comprised the frequency of family contacts. The finances domain comprised total income and total spending money. The health domain comprised the services received scale. The personal safety domain comprised the involvement with crime scale that provided frequencies of criminal activity and frequency of being a victim of crime. The

religion domain comprised the frequency of religious activity. No score for the leisure domain was included in the objective QOL composite, because the indicator for the leisure domain (i.e., frequency of leisure activities) was comprised in the strong and weak SI scales. The domain-specific preference composite score in step three was drawn from the preference indices in the leisure, social relations, health, personal safety, religion, and family domains, and for the living situation and finances domains, from the importance of the living situation scale, and the perceived financial need indicator (i.e., perceived financial need in terms of dollars). The domain-specific subjective QOL composite in step four was drawn from the domain-specific subjective QOL scores in each of the eight aforementioned life domains. Step five in the hierarchical regression analysis introduced the global subjective QOL measures separately. In one regression model, the averaged Item du Bien-être Global (IBG) score was introduced in step five. In the other regression model, the score from the Échelle de Satisfaction de Vie (ESV) was introduced in step five.

The strong and weak social integration scores were regressed separately on the composite variable sets. Additional hierarchical regression analyses were conducted because the demographics/personal attributes composite score (step one in the regression analysis) included the physical and behaviour handicaps subscales from the Level of Care Survey (LOCS), on only 55 of the 70 respondents. Consequently, the analyses were undertaken twice: once with the sub-sample (n = 55) and then with the full sample (N = 70). In the multiple regression analysis with the full sample the physical handicaps and behaviour handicaps scores were deleted from the demographics/personal attributes composite. Tables 40 through 43 present the results of the hierarchical regression analyses.

Tables 40 and 42 show that with the sub-sample (n = 55), Hypothesis 8 was only partially supported. The best predictors of strong social integration were the demographic variables and domain satisfactions composites. The best predictors of weak social integration were the objective indicators and the demographic variables composites.

In contrast to these findings, Tables 41 and 43 present the results of the same multiple regression analysis with the full sample (N = 70), which generally support Hypothesis 8 and the SI portion of the QOLSI model it was intended to verify (see Figure 6 p. 65). Given our ordering of the composite variables, the best predictors of strong social integration were, in order of importance, the domain satisfactions composite, the objective indicators composite, the demographic variables composite, and the domain preferences composite. As anticipated, in no case did the global subjective QOL composite (IBG nor ESV) add a significant increment to the variance explained. The best predictors of weak social integration were the objective indicators composite and the demographics composite. Other composites of the predictor variable sets did not significantly improve the prediction equation.

Table C-43 and C-44 present the correlations between various objective predictors of social integration (SI) and the two measures of SI; the Strong Social Scale (SSIS) and the Weak Social Integration Scale (WSIS), respectively. Table C-43 shows that few objective indicators correlated significantly with the SSIS. However, frequency of activities external to the residence and frequency of school attendance both had positive significant relationships with the SSIS. Age of clients and their frequency of contacts with professional practitioners (e.g., nurses, psychiatrists, etc.) also were significantly and negatively correlated with the SSIS. The WSIS correlated significantly with several objective indicators in different life domains.

Table 40

Hierarchical Multiple Regression of Strong and Weak Social Integration on Demographic, Objective Quality of Life, Domain Preferences and Domain Satisfactions Composites and on the Item du Bien-être Global

Step	Variable	Strong Social Integration (n = 55) ß[a]	R	R^2	ΔR^2	ΔF	Weak Social Integration (n = 55) ß[a]	R	R^2	ΔR^2	ΔF
1	Demographics composite	.44***	.44***	.19	.19***	12.48***	.44***	.44***	.20	.20***	12.99***
2	Objective indicators composite	.23	.49***	.24	.05	3.27	.59****	.71****	.50	.30****	31.55****
3	Preferences composite	.23	.54***	.29	.05	3.80	-.08	.71****	.50	.00	.43
4	Satisfactions Composite	.36**	.64****	.41	.12**	10.29**	.09	.72****	.51	.01	.64
5	Item du Bien-être Global (IBG)	-.06	.65****	.42	.00	.28	-.02	.72****	.51	.00	.02

	Strong Social Integration Model	Weak Social Integration Model
Total Equation	R^2 = .42 $F_{(5,49)}$ = 6.97****	R^2 = .51 $F_{(5,49)}$ = 10.23****
	Mean of DV = .95 SD = 2.27	Mean of DV = 6.44 SD = 3.77

Note: The IBG measure is the French translation of the Global Well-being Item (Andrews and Withey, 1976), a single-item, global subjective quality of life (GSQL) measure taken at the start and again at the end of the quality of life (QOL) interview.

[a] Beta refers to the value of the standardized partial regression coefficient (ß) after the step when the variable entered into the regression model.

* p < .05 ** p < .01 *** p < .001 **** p < .0001

Table 41

Hierarchical Multiple Regression of Strong and Weak Social Integration on Demographic, Objective Quality of Life, Domain Preferences and Domain Satisfactions Composites and on the Item du Bien-être Global

Step	Variable	Strong Social Integration (n = 70) ß[a]	R	R^2	ΔR^2	ΔF	Weak Social Integration (n = 70) ß[a]	R	R^2	ΔR^2	ΔF
1	Demographics composite	.36**	.36**	.13	.13**	10.37**	.32**	.32**	.10	.10**	7.90**
2	Objective indicators composite	.35**	.50****	.25	.12**	10.72**	.64****	.66****	.44	.34****	40.43****
3	Preferences composite	.25**	.56****	.31	.06*	5.86*	-.03	.67****	.44	.00	.06
4	Satisfactions Composite	.39***	.66****	.44	.13***	14.79***	.08	.69****	.47	.03	3.34
5	Item du Bien-être Global (IBG)	-.11	.67****	.45	.01	1.31	-.07	.69****	.47	.00	.42

	Strong Social Integration Model	Weak Social Integration Model
Total Equation	R^2 = .45 $F_{(5,64)}$ = 10.54****	R^2 = .47 $F_{(5,64)}$ = 11.47****
	Mean of DV = 1.03 SD = 2.30	Mean of DV = 6.83 SD = 3.67

Note: The IBG measure is the French translation of the Global Well-being Item (Andrews and Withey, 1976), a single-item, global subjective quality of life (GSQL) measure taken at the start and again at the end of the quality of life (QOL) interview.

[a] Beta refers to the value of the standardized partial regression coefficient (ß) after the step when the variable entered into the regression model.

* $p < .05$ ** $p < .01$ *** $p < .001$ **** $p < .0001$

Table 42

Hierarchical Multiple Regression of Strong and Weak Social Integration on Demographic, Objective Quality of Life, Domain Preferences and Domain Satisfactions Composites, and on the Échelle de Satisfaction de Vie

		Strong Social Integration (n = 55)					Weak Social Integration (n = 55)				
Step	Variable	ß[a]	R	R^2	ΔR^2	ΔF	ß[a]	R	R^2	ΔR^2	ΔF
1	Demographics composite	.44***	.44***	.19	.19***	12.48***	.44***	.44***	.20	.20***	12.99***
2	Objective indicators composite	.23*	.49***	.24	.05	3.27	.59****	.71****	.50	.30****	31.55****
3	Preferences composite	.23	.54***	.29	.05	3.80	.08	.71****	.50	.00	.43
4	Satisfactions Composite	.36**	.64****	.41	.12**	10.29**	.09	.72****	.51	.01	.64
5	Échelle de Satisfaction de Vie (ESV)	-.04	.64****	.41	.00	.14	-.03	.72****	.51	.00	00

	Strong Social Integration Model	Weak Social Integration Model
Total Equation	R^2 = .41 $F_{(5,49)}$ = 6.92****	R^2 = .51 $F_{(5,49)}$ = 10.22****
	Mean of DV = .95 SD = 2.27	Mean of DV = 6.44 SD = 3.77

Note: The Échelle de Satisfaction de Vie (Blais et al., 1989) refers to the French version of this instrument administered during the interview.

[a] Beta refers to the value of the standardized partial regression coefficient (ß) after the step when the variable entered into the regression model.

* $p < .05$ ** $p < .01$ *** $p < .001$ **** $p < .0001$

Table 43

Hierarchical Multiple Regression of Strong and Weak Social Integration on Demographic, Objective Quality of Life, Domain Preferences and Domain Satisfactions Composites, and on the Échelle de Satisfaction de Vie

Step	Variable	Strong Social Integration (n = 70) ß*	R	R^2	ΔR^2	ΔF	Weak Social Integration (n = 70) ß*	R	R^2	ΔR^2	ΔF
1	Demographics composite	.36**	.36**	.13	.13**	10.37**	.32**	.32**	.10	.10**	7.90**
2	Objective indicators composite	.35***	.50****	.25	.12**	10.72**	.64****	.66****	.44	.34****	40.43****
3	Preferences composite	.25*	.56****	.31	.06*	5.86*	-.03	.67****	.44	.00	.06
4	Satisfactions Composite	.39***	.66****	.44	.13***	14.79***	.18*	.69****	.47	.03	3.34
5	Échelle de Satisfaction de Vie (ESV)	-.07	.67****	.45	.01	.52	.00	.67****	.47	.00	.00

	Strong Social Integration Model	Weak Social Integration Model
Total Equation	R^2 = .45 $F_{(5,64)}$ = 10.25****	R^2 = .47 $F_{(5,64)}$ = 11.31****
	Mean of DV = 1.03 SD = 2.30	Mean of DV = 6.83 SD = 3.67

Note: The Échelle de Satisfaction de Vie (Blais et al., 1989) refers to the French version of this instrument administered during the interview.
* Beta refers to the value of the standardized partial regression coefficient (ß) after the step when the variable entered into the regression model.
* $p < .05$ ** $p < .01$ *** $p < .001$ **** $p < .0001$

Table C-44 shows that the weak social integration scale (WSIS) correlated positively and significantly with autonomy, cohesion, social relations within and external to the residence, family contacts, leisure, work, school attendance, monthly spending money, use of health-related services, and the PASSING total score, as well as, each of the PASSING subscale scores except the beauty and comfort of residential setting. The WSIS correlated negatively and significantly with age, distance of residential setting from the nearest town, number of consecutive months in best job ever held, frequency of listening to religious programs on the media, behaviour handicaps, and frequency of contacts with professional practioners.

Tables C-45 and C-46 present the correlations of the strong and weak social integration scales with domain-specific preferences and domain-specific satisfactions, respectively. In Table C-45 we see that strong social integration (SSI) was significantly and positively correlated only with preference for leisure and education, while weak social integration (WSI) failed to correlate with any of the preference indicators. Interestingly, domain-specific subjective QOL measures generally did not tend to correlate significantly with SSI (cf. Table C-46). As might be expected, only satisfaction with family correlated with SSI (r (68) .29, p = .02), while finances (r (68) .23, p = .05) and education were the only domain-specific subjective QOL measures to correlate with WSI (r (68) .46, p = .05). It is noteworthy that frequency of contact with family, an objective QOL indicator of social integration, did not correlate with SSI, but was significantly and positively correlated with WSI (r (68) = .26, p = .03).

CHAPTER 5

DISCUSSION

Hypothesis 1: Replication of Lehman's Findings

In order to interpret our research findings with confidence, we first needed to demonstrate that the psychometric quality (internal consistency) of our instruments was satisfactory and that our findings replicated those reported by Lehman and his colleagues (1982). This latter requirement involved demonstrating that (1) the reliabilities of our subjective QOL measures were similar to those reported by Lehman et al. (1982), (2) that means on the subjective QOL measures in our sample were comparable to those reported by Lehman et al. (1982), (3) that correlations between objective QOL and subjective QOL indicators within life domains were only modest, and (4) that scale inter-correlations for the different life domain subjective QOL measures were also only modest, as had been reported by Lehman et al. (1982). We did not, on the other hand, expect the objective living conditions of the Quebec sample to be highly similar to those of the Los Angeles subjects studied by Lehman et al. (1982). Consequently, we did not anticipate that the means on our objective QOL indicators would necessarily replicate those reported by Lehman and his colleagues (1982).

Reliability:

We confirmed that both French-language global subjective QOL measures had satisfactory reliability. The Échelle de Satisfaction de Vie (ESV) had adequate internal

consistency, while the single-item Item du Bien-être Global (IBG), asked at the start and again at the end of the interview, had satisfactory temporal stability. The latter result replicated earlier reports of satisfactory temporal stability with the English-language version of this item by Lehman and his colleagues (1982). As well, each of the domain satisfaction scales had satisfactory internal consistency and the internal consistency of each scale was similar to that reported by Lehman and his colleagues (1982). In short, we were able to replicate both global subjective QOL and domain subjective QOL findings reported by Lehman et al. (1982). These findings are encouraging for program evaluators intending to use subjective QOL instruments in evaluations of housing programs for francophones with psychiatric disabilities.

Additionally, other scales used by us but not by Lehman et al. (1982), were shown to have satisfactory reliability. Specifically, domain-specific preference and preference-like indicators, the two social integration measures (i.e., the Strong and Weak Social Integration Scales), our French-language version of Rosenberg's (1965) Self-Esteem Scale (Échelle d'Estime de Soi), and the Behaviour and Physical Handicaps sub-scales drawn from the Level of Care Survey all had adequate internal consistency. The finding that inter-correlations between the various preference and preference-like indicators were only moderately significant (Table 4) suggests that these indicators have good discriminant validity. The Strong Social Integration Scale (SSIS) and the Weak Social Integration Scale (WSIS) were internally consistent and only moderately correlated with each other (r (68) = .29, p = .02), which suggests that the two scales are tapping somewhat different phenomena. The Échelle d'Estime de Soi (EES), which had satisfactory internal consistency (Table 9), was shown to be as reliable with this clinical population as has been reported for the general population (Diener, 1984). This indicates that in future studies of subjective QOL with francophone samples, the

EES would be a suitable candidate for controlling one of the reputedly more important personality factors influencing subjective QOL measures (Andrews and Withey, 1976; Diener, 1984). Finally, both the Physical and Behaviour Handicaps Scales were found to be internally consistent indicators of impairments in client level of functioning.

Average Levels of Subjective QOL:

The domain-specific subjective QOL and global subjective QOL means of the respondents to our QOL interview were significantly lower than those reported for the general population in U.S. national surveys (Andrews and Withey, 1976) but quite similar to those reported for the chronic psychiatrically disabled (CPD) respondents in Lehman's (1982) study. This finding has implications for future investigations of life quality with this clinical population; it suggests that the CPD are characteristically less satisfied with their lives than people in general, especially with their finances, family relations, leisure activities, social relations, and involvement with productive activity (i.e., work).

That the mean level of subjective QOL among ex-psychiatric patients in Western Quebec and Los Angeles is similar despite geographic, linguistic, and cultural differences, is at once both encouraging and discouraging. It suggests that this type of investigation may indeed be replicated, but also that the CPD in North America share similar patterns and levels of dissatisfaction in several life domains, namely finances, productive activity, family and social relations. These are domains that appear to need special attention in any attempt to improve the overall QOL of persons with chronic psychiatric disabilities who are living in the community. It also may suggest that improvements in these domains may require governments

to increase expenditures beyond their actual levels and that governments are responding uniformly in withholding such expenditures.

Objective and Subjective QOL Correlations:

In general, our findings supported Hypothesis 1. The findings related to the objective indicators of life quality suggest that although individual objective indicators of life quality have been shown to provide results with good test-retest reliabilities (Andrews and Withey, 1976; Cheng, 1989; Lehman et al., 1982), our efforts to construct internally consistent scales based on groupings of objective indicators generally were unsuccessful. Often such scales tended to provide only marginal internal consistency. Equally often, scales that were internally consistent were not conceptually related. One explanation for this may be that objective indicators tend to measure relatively orthogonal indices of life quality. Attempts to re-group such heterogeneous indicators under a conceptual umbrella of objective QOL apparently result in a trade-off between deriving what may be conceptually irrelevant scales or psychometrically heterogeneous ones. Future factor analytic studies with large samples might help to clarify which groupings of objective QOL indicators provide both internal consistency and preserve temporal stability. Finally, the reader is reminded that the correlational analyses between objective QOL and subjective QOL indicators reported below are to be interpreted with caution. They do not demonstrate causal relationships between the variables.

Our finding that domain-specific objective and subjective QOL indicators were not strongly correlated was expected. Lehman (1982, 1983b) had reported generally weak and often non-significant correlations between objective QOL and subjective QOL measures. That we found even fewer significant correlations between objective QOL and subjective QOL

indicators than did Lehman (1982, 1983b) was probably due to our smaller sample size. Additionally, the fact that Lehman et al. (1982) failed to report which variables comprised their composite objective QOL indicators (e.g., security, privacy, autonomy, etc.) in some life domains probably meant that our objective QOL indictors in those life domains were different from that used by Lehman et al. (1982). This may have contributed to the frequent pattern of non-significant correlations between objective QOL and subjective QOL indicators in our sample. Overall, however, we can conclude that our findings support Lehman's (1982) contention that objective QOL indices and sociodemographic variables are poor indicators of subjective QOL and that evaluation studies with this population must therefore use both subjective QOL measures and objective QOL indicators. The following paragraphs will discuss only those domain-specific objective QOL indicators that correlated significantly with the domain-specific subjective QOL indicators (see Table 14).

Living situation. Independence was the only objective QOL indicator found to be significantly correlated with living situation subjective QOL. Given our operational definition of independence and its significant negative relationship with living situation subjective QOL, this meant that clients who had maintained contacts with friends living outside of the residence tended to experience lower levels of subjective QOL with their living situation than did residents who were relatively isolated from the outside world. The finding may suggest that low satisfaction with their living situation prompted residents to engage in more frequent contact with friends outside of the residence, or else that maintaining contacts with friends outside increased their awareness of what their own living situation lacked. Both interpretations are plausible. However, the second one is more consistent with Campbell et al. (1976) who found that relative to better educated respondents, those who were less well

educated (and often part of disadvantaged ethnic groups such as inner city Blacks) tended to report a bland form of "high satisfaction" with life in general and their living situation (Campbell et al., 1976). In our sample, differences in living situation subjective QOL may be due more to awareness of the importance of alternatives in living situation than to varying levels of general education, which was fairly homogeneous. The mean level of education (grade 9) and median (also grade 9) was low for all respondents with a small standard deviation (SD = 3.38).

A third interpretation, that satisfaction with living situation subjective QOL may be influenced by individual personality characteristics that are context specific (i.e. what predicts living situation subjective QOL in one facility may not do so in another, or what predicts living situation subjective QOL in one resident of a facility may not do so in another resident of the same facility) is also plausible. Personality characteristics may conceivably have contributed to some residents perceiving their living situation as unsatisfying whereas other residents living in the same setting may have perceived their living situation as satisfying. This interpretation implies that personality characteristics possibly interact with environmental characteristics in a complex fashion. Segal et al. (1989) arrived at a variant of this interpretation in relation to social integration. Their findings suggested that the effect of personal characteristics may possibly be context specific, such that what predicts social integration in one facility may not do so in another. Further study of the relationship between living situation objective QOL and subjective QOL indicators, involving quasi-experimental designs is needed if we are to better identify the determinants of living situation subjective QOL.

Whatever the most plausible interpretation of the negative correlation between independence and living situation subjective QOL, program planners need to take note of this finding. Erroneous inferences might otherwise be based upon inflated subjective QOL measures, which may be more related to respondents' ignorance of reasonable alternatives or personality characteristics than to genuine satisfaction with their living situation. The finding also suggests that increasing residents' awareness of alternatives to their current living situation may have a negative impact on living situation subjective QOL.

Social relations. The only objective QOL indicators to correlate significantly with social relations subjective QOL were activities and contacts within the residence. These correlations, which were positive, replicate earlier results by Lehman et al. (1982) that contacts within the residence were correlated with social relations subjective QOL. However, we did not replicate their finding that total contacts and intimacy of contacts were also good predictors of social relations subjective QOL. The fact that social relations subjective QOL was not related to contacts outside the residence in the Los Angeles sample (Lehman et al., 1982) or in the Outaouais sample may be an important finding. It may suggest that fostering resident involvement in activities involving co-residents will have more impact on social relations subjective QOL than would promoting resident contact with the community at large. In line with our finding, Lehman (1982) reported that for residents of single-room occupancy hotels, support from within the service was associated with well-being. Similarly, Kennedy (1989) suggested that for some individuals with lower levels of social competence or emotional support, increased participation in programs within supervised and supportive residential services may be associated with greater subjective well-being.

The thoughtful implementation of simple, cost-effective intra-residential activities, capable of facilitating increased resident involvement with each other and in different activities, would seem limited only by the imagination of planners and practitioners. We noted one practical example of this when we observed considerable resident interest and satisfaction in cooking classes that were being provided by the daughter of a family-care home operator. The activity served to involve both male and female residents in a rewarding group activity at little cost in time and materials. However, the program was implemented on an experimental basis only and its survival appeared uncertain. In light of our findings, programs capable of involving residents with each other in rewarding activity would appear to warrant continued development and support.

Leisure. The significant positive relationship between leisure subjective QOL and both frequency of leisure activities in general and within-residence leisure activities may suggest that client satisfaction with leisure can be practically influenced by the implementation of organized leisure activities, including those within the residence. Such inputs may be accomplished at little cost yet seem capable of providing significant gains in terms of improved client satisfaction with the use of their abundant spare time. Different leisure activities could be established, such as painting, sewing, and cooking classes, music lessons, field trips, etc. The benefits of such programs would possibly include improved client participation and satisfaction in the leisure domain and perhaps, in the social relations domain as well. The merits of such programs could be evaluated periodically by the administration of subjective QOL measures.

Religion. Lehman et al. (1982) did not measure subjective QOL or objective QOL in this domain. With our sample, however, we found a significant positive relationship between

frequency of involvement in religious activity and satisfaction with religion. This presented an interesting finding in that frequency of religious activity, as operationally defined here, is an objective QOL indicator that is easily modified by clients themselves. That is, involvement in religious activities typically comes under the direct control of the resident, unless the home operator or the local parish places restrictions on such involvement. This finding may be an instance of the kind of situation which objective QOL indicators may be relatively predictive of subjective QOL. That is, in life domains where clients are given the freedom to express their preferences by their behaviours, such behaviours may correspond well to both preferences and satisfactions.

Finances. The amount of client monthly income and spending money correlated significantly and positively with subjective QOL in the finances domain. Lehman and his colleagues (1982) had reported that the association of monthly spending money only approached significance with finances subjective QOL (r (262) = .12, p = .10). We are uncertain as to why satisfaction with finances was uncorrelated with monthly spending money in the Lehman et al. (1982) study. Our findings, on the other hand, are consistent with those of several authors who have reported on the impact of financial deprivation on mental health and on objective living conditions that seem related to well-being in general.

Brill, Weinstein, and Garrat (1969) reported that 59% of a California state hospital sample (N = 517) had experienced poverty. They found social class to be inversely related to the experience of poverty but not to the feeling that it contributed to one's illness. The authors concluded that downward social mobility involves more mental suffering than does the experience of poverty just in childhood. Chronic psychiatrically disabled (CPD) clients from higher social classes tended to associate their illness with poverty more than did those

from lower social classes, while those experiencing poverty only in adult life reported that it contributed to their illness most often; that is more often than did those who had been poor all of their lives and much more often than did respondents who had been poor only in childhood. The authors concluded that the psychiatric consequences of economic deprivation may be strongest when deprivation exists in close proximity to affluence or develops after the experience of affluence. In a review of the literature on poverty and psychiatric treatment of the poor in the United States, Brill (1978) remarked that while poverty was neither necessary nor sufficient to produce mental illness, most studies revealed that the lowest classes did have the highest rates of psychoses in American society. He concluded that feelings of powerlessness accompanying poverty and chronic membership in the lower social classes can result in a higher rate of mental illness in the poor and may interfere with a general tendency in the population toward upward mobility. Pinkney et al. (1991) reported on a small sample (N = 55) of deinstitutionalized psychiatric rehabilitation clients. They found that while the majority were making satisfactory adjustments to community life, they were struggling financially on a monthly income ($600) below the poverty line. The authors concluded that the successful adjustment to community life requires that the CPD not be destined to live in poverty.

The fact that both monthly income and spending money correlated significantly and positively with subjective QOL for finances in our sample suggests that small increments in social assistance received could improve subjective QOL in the finances domain. Moreover, respondents in our study reported that an average of $245 per month would satisfy their monthly spending money needs. This is roughly double the amount they currently had available for spending money. M = $121, SD = $78). In light of earlier reports linking poverty

with mental illness and our findings linking satisfaction with finances and perceived financial need, the currently meagre income of the CPD in our sample and the small increments hoped for by our respondents suggest that it would difficult for the government to justify denying them small periodic increments in social assistance that would satisfy their modest spending money requirements.

In summary, we had expected to find in our sample, fewer significant correlations between objective and subjective indicators of life quality than that reported by Lehman (1982) with his sample. Given our smaller sample, the statistical power of our tests would not be as great. Moreover, it was anticipated that geographic and cultural differences would have some impact upon service-related demographic variables and other objective indicators of life quality. Objective QOL indicators proved to be relatively poor predictors of subjective QOL in our sample, just as they had with the Los Angeles sample (Lehman et al., 1982) and in the general population (Andrews and Withey, 1976). This pattern speaks to the need for subjective QOL indicators as well as objective QOL indicators in evaluation studies of service quality in residential housing for the CPD.

Inter-scale correlations. Lehman et al. (1982) had reported "modest" inter-correlations among the subjective QOL scales. Our finding of numerous significant inter-correlations for the different life domain subjective QOL measures suggests that many of the scales overlapped in their general orientation, as Lehman et al. (1982) had reported. However, we could not determine how closely we had replicated the intercorrelations found by Lehman (Lehman et al., 1982; Lehman, 1983a, 1983b, 1986, 1989), as he never published the intercorrelations for the domain satisfaction scales. However, we consider the intercorrelations to reflect "moderate" rather than "modest" relationships between the scales. In almost half

(21/45) of the correlations, more than 20% of the variance was shared, and in the case of many others more than 30% of the variance was shared (see Table 2). We propose that investigators either report their scale intercorrelations directly or adopt some convention for interpreting scale intercorrelations. For example, correlations ranging from 0 to .19 could be considered as low, while those from .20 to .39 could be moderately low, those ranging from .40 to .59 could be moderate, those ranging .60 to .79 could be moderately high, and those ranging from .80 to 1.00 could be high. Such a protocol would simplify replication studies.

Hypothesis 2: Comparison of Global QOL Measures

This hypothesis assessed whether two global subjective QOL (global subjective QOL) scales, the Échelle de Satisfaction de Vie (ESV) and the Item du Bien-être Global (IBG), were strongly related, whether they could therefore provide equivalent correlations with domain satisfactions measures, and whether one was psychometrically superior to the other. It was encouraging to find that the two global subjective QOL scales were highly correlated, that they provided equivalent correlations with the domain satisfaction measures, and that the ESV was psychometrically superior to the IBG. These results suggest that the "Échelle de Satisfaction de Vie" (ESV) could serve as a superior alternative to the "Item du Bien-être Global" (IBG). It would also appear to be better suited to longitudinal investigations because of its superior temporal stability (Blais et al., 1989), although this needs to be verified with clinical samples of CPD respondents, as it has been with samples of young adults and the elderly in the general population (Blais et al., 1989).

We appreciate that many investigators have come to rely on the IBG as an indicator of global subjective QOL. As well, the testing of illiterate subjects continues to present

important limitations with respect to both the ESV and the IBG. With the IBG, however, the problem of testing illiterate respondents is compounded by ceiling effects which do not appear to be a problem with the ESV. With the IBG, ceiling effects appear to be a function of the response set (i.e., the delighted-terrible scale) used with the measure (Andrews and Withey, 1976). Ceiling effects associated with the delighted-terrible scale were present in the U.S. national survey (Andrews and Withey, 1976), in the study by Lehman et al. (1982), and in our study. They restrict the utility of the IBG as an indicator of global subjective QOL. In future investigations, the effects of certain modifications to the delighted-terrible scale, specifically, modifications to its mode of presentation and range of choices, should be explored. Toward this end, we developed the Satisfaction Gradient Scale (SGS). We believe that the SGS will allow the testing of illiterate subjects, while providing respondents with a broader range of choices. Appendix D-1 presents the SGS and the instructions that accompany this proxy for the delighted-terrible scale.

Our finding that the two global subjective QOL measures tended to correlate significantly with only a few of the objective QOL indicators was expected (Table 17). Lehman et al. (1982) reported similar findings with their sample. What is interesting, however, is how similarly the ESV and the IBG related to objective QOL indicators. For the living situation domain, both the IBG and the ESV correlated positively with total months in current residence, suggesting that the longer a resident stayed in a residential service the higher was his/her global subjective QOL. For the leisure domain, only the ESV correlated positively with total leisure activities. However, both the IBG and the ESV correlated positively with leisure activities within the residence, suggesting that residents' global subjective QOL may be improved by involving them in structured leisure activities within the

housing service. Similarly, the finding that frequency of general involvement in productive activities within the residence was also positively related to both global subjective QOL indicators suggests that involving residents in productive activities in general may promote improvements in their global subjective QOL.

Hypothesis 3: The Role of Preferences in Predicting Subjective QOL

The reader will recall that Hypothesis 3 was intended to verify whether person-environment (P-E) fit, as indicated by subjective QOL measures in eight different life domains, could be predicted on the basis of preferences or preference-like indicators. This hypothesis was supported in six of eight separate hierarchical regressions.

Living situation. Perceived importance of living situation (a preference-like indicator), significantly improved the prediction of living situation subjective QOL. with respondents for whom living situation was more important tending to have lower subjective QOL scores in this domain. Alternatively, the finding may suggest that when satisfaction with living situation was low, it was perceived as more important. The former interpretation may be explained in terms of those respondents' level of awareness of alternatives to their current living situation. In their U.S. national survey, Campbell et al. (1976) reported similar findings. The better educated tended to have lower global subjective QOL scores than socially disadvantaged minorities. They explained this finding in terms of the level of awareness of alternatives that better education brings. In our sample, it is conceivable that respondents for whom living situation was more important tended to have a greater awareness of alternatives in living situation simply because it was more salient to them.

Finding that preference (or salience) were predictive is important because it suggests that the systematic use of preferences or preference-like measures could lead to more satisfying living situations for the CPD living in community residences. In applied contexts, planning committees could meet with prospective residents before they are deinstitutionalized to determine their preferences and what they consider important in living situation, allowing efforts to match clients' preferences with available living environments. Researchers, using longitudinal designs, could later apply domain-specific subjective QOL measures to monitor the impact of such interventions on clients' subjective QOL. This could serve planners by showing how and which changes in living environments may be implemented to better meet client preferences and perceived needs.

Additionally, the first hierarchical regression for Hypothesis 3 suggests that in some life domains, P-E fit, as reflected by domain-specific subjective QOL scores, may be better predicted by salience measures, which are alternatives to preference measures. In the living situation domain in particular, the perceived importance (salience) measure was the only suitable predictor of subjective QOL on psychometric grounds because the original preference scale for this domain had poor internal consistency and ultimately was reduced to a single measure.

Family. The second hierarchical regression analysis (Tables 20 and 21) also supported Hypothesis 3 in showing that satisfaction with family could be predicted by residents' preferences for contacts with their families. This finding supports reports by several authors that family relations remains an important determinant of emotional support and well-being for deinstitutionalized persons with a chronic psychiatric disability (Flanagan, 1978; Lehman et al., 1982; Mercier, 1990; Nelson and Earls, 1986).

In light of the social isolation experienced by the psychiatrically disabled (Cohen and Sokolovsky, 1978; Segal and Aviram, 1978; Lamb and Goertzel, 1971), it would seem especially important for program planners to be as responsive as possible to clients' preferences for contacts with their families. Unfortunately, many of the respondents to our interview were living quite far from their community of origin. In response to this situation, the CRSSSO has begun to study the feasibility of a placement planning program which would ensure that systematic efforts are made to house residents in services as close to their original communities as possible. In relation to placement setting, resident accessibility to family was found to have been given less than adequate consideration. In several instances where resident accessibility to family was facilitated by placement setting, however, a positive impact was noted in terms of clients' contacts with their families and improved access to other resources, due to the collaborative efforts of family members who were in a position to be better apprised of the residents' needs.

In summary, our finding indicates that if program planners wish to determine the best placement environment for institutionalized psychiatrically disabled clients, a domain-specific preference measure would appear to be useful. In such instances, a QOL interview could be conducted with clients and, based on the clients' preferences and current subjective QOL responses, an optimal placement environment could be determined and later monitored for needed changes.

Social relations. Preference measures did not significantly improve the prediction of social relations subjective QOL (see Tables 22 and 23). This may be simply because preferences do not predict social relations subjective QOL, or because of our sample size, or because of some inadequacy with our preference measure. We believe the latter explanation

to be the most likely. A measure of the importance (salience) of social relations, similar to the importance of living situation measure, might have proven to be a better predictor of subjective QOL in social relations. Alternatively, a measure of the respondents' perceived need for internal and external social relations-related activities might have been a more adequate predictor of satisfaction with social relations. Future studies could profitably investigate whether such preference-like alternatives can adequately serve as predictors of social relations subjective QOL.

Leisure. Preference for leisure did not significantly improve the prediction of satisfaction with leisure. As in the case of social relations, our preference measure may have been inadequate. On the other hand, that the objective QOL indicator (i.e., frequency of leisure activities) did significantly improve the prediction of leisure subjective QOL was unexpected. Given that client involvement in leisure activities is under the control of the client and presumably itself reflects a preference for leisure activities, easily constructed behavioral measures of involvement in leisure activities may be a viable alternative to a preference measure. On the other hand, if a client has not yet been placed, then a preference measure might be the only way to maximize future P-E fit in the leisure domain.

Finances. Perceived financial need (a preference-like measure) accounted for a significant increment in finances QOL. The majority of respondents in our study (53%) found their monthly spending money to be generally inadequate, and especially so for the purchase of clothing (57%), for transportation expenses related to displacements to and from social and leisure activities (63%), and for personal purchases such as, books, records, makeup, etc. (57%). Which may account for their perception of strong financial needs. The findings reported by Mercier (1989, 1990) suggest that deinstitutionalized CPD in Quebec generally

experience low levels of satisfaction with their finances. We believe that it is reasonable to assume that this aspect of satisfaction could be improved by attending to their perceived financial need. Another way in which clients' satisfaction with finances might be improved has been suggested by Pikney et al. (1991), who concluded that lack of employment compounds the marginal financial existence of this client population. Remunerated work-training programs may warrant consideration by program planners.

Personal safety. Preferences for personal security/safety significantly improved the prediction of satisfaction with that domain, but interpretation of this finding is made more difficult in that the preferences for personal safety/security scale had unsatisfactory internal consistency (see Table 9). Moreover, the negative relationship between preference for security and subjective QOL in that domain suggests that the more respondents preferred personal security, the less satisfied they were with personal safety/security. It is possible that personal safety/security is a variable that works somewhat like health: as long as one has it, one is relatively satisfied with it. However, once one has experienced a decline in health or personal safety/security, one becomes less satisfied with one's situation. Campbell et al. (1976) interpreted similar findings in relation to health in this manner. They found that health figured as a very important resource for all their respondents, but that for those in reasonably good health, specific information about health problems added little to prediction of variations in the sense of well-being (Campbell et al., 1976, p. 377). We found a similar pattern in relation to preferences as predictors of satisfaction with health.

Health. The hierarchical regression of preference for health on health subjective QOL did not support Hypothesis 3 (see Tables 30 and 31). The small sample (low statistical power) may have contributed to this. The low correlation between preference for health and

satisfaction with health may be attributable to moderate skewness and low variability (M = 4.39, SD = .58). This may have produced a ceiling effect. As such, preference for health would act more as a quasi-constant than as a variable. As well, most of the respondents in our study were in reasonably good physical health. Campbell et al. (1976) have spoken to the issue of good health as a personal resource that is relatively ignored until attention is drawn to it directly by its decline. However, for their survey respondents who were in poor health, reports of incapacitating health problems accounted for almost 43% of the variance in health satisfaction (Campbell et al., 1976, p 382). It is conceivable that when one is in good health, preference for health contributes no more to the prediction of health subjective QOL, than health subjective QOL does to one's sense of general well-being. Thus, in our sample, subjective QOL for health and preference for health may both have acted like quasi-constants. Future studies involving clinical samples with varying degrees of psychiatric impairment might clarify the role of preferences in relation to health. However, such studies may prove problematic, since recent investigations suggest that relative to the general population, the CPD are generally less healthy (Holmberg, 1988; Lieberman and Test, 1987), with higher incidence of unrecognized medical disorders (Karasu, Waltzman, Lindenmeyer, and Buckley, 1980; Koranyi, 1979), morbidity (Tsuang, Woolson, and Fleming, 1980), and lack opportunities to learn about health management and health-related services (Byrne, Isaacs, and Voorberg, 1991; Perry and Kirmer, 1990). Perhaps investigations with chronic physically disabled samples involving varying degrees of impairment might better clarify the relevance of preferences as predictors of such subjective transformations of objective reality which produce feelings of dissatisfaction in relation to health.

Religion. Preferences for religion did not significantly improve the prediction of religion subjective QOL, possibly because our preferences measure was inadequate. An alternative measure, such as importance (salience) of religion, might have been more adequate. That satisfaction with religion was predicted by frequency of religious activity was unexpected (see Tables 32 and 33). Once again, measuring what a person does in relation to life domains in which client behaviour reflects the exercise of individual control apparently is a better predictor of their subjective QOL in that domain than what the clients verbally espouse to be their preference. The measure of objective behaviours as indicators of personal preferences in this life domain warrants further investigation.

Our finding that preference for religion correlated positively and significantly with subjective QOL for religion suggests that for those respondents who express an interest in practising their religion, stronger efforts should be made to accommodate their preferences. In some residences, we noted that all residents were being denied access to the community church, reportedly because community pressure had been directed at home operators and the parish priest after some residents had become disruptive during services. Not all residents should be obliged to attend church services, but clearly, for those who prefer to attend church services, all reasonable efforts should be made to accommodate their preference.

The reader will recall that preferences were presented as one manner of arriving at suitable matches between residents and their environment. Preferences, however, need not be the only manner of arriving at suitable matches. In the living situation and finances domains, for example, we used, measures of the importance of living situation and measures of perceived financial need, respectively, as predictors. Our findings indicate that future research with different predictors of subjective QOL and thus of P-E congruency is warranted.

Finally, although not directly related to Hypothesis 3, the possibility that global subjective QOL and subjective QOL in life domains might be related to preferences intrigued us. Our post-hoc finding that global subjective QOL measures correlated significantly with perceived financial need and preference for religion only (Table C-22) suggests that while preferences may be good predictors of subjective QOL in life domains, they may be less satisfactory as predictors of global subjective QOL. Significant correlations between preferences and objective QOL indicators were moderate in almost all domains except religion (see Table C-23). The limitations of most objective QOL indicators in predicting subjective QOL apparently also apply to personal preferences. In most instances, preferences apparently tapped into something different from what objective QOL indicators did. Autonomy and total months in current residence, however, did correlate positively with importance of living situation. Similarly, total contacts and contacts within the housing service correlated positively and significantly with preference for social relations. The findings suggest that some objective QOL indicators may be exceptional in that they could serve as good predictors of preferences. For the social relations domain, this may be so because frequency of contacts with others is to some extent under greater control by the resident. Future investigations may show that some objective QOL indicators can serve as satisfactory predictors of preferences in those cases where the objective QOL measures reflect some degree of resident autonomy and control in the determination of the frequency of occurrence of the objective QOL variable.

Hypothesis 4: Composite Predictors of Global Subjective QOL

When global subjective QOL was regressed upon various composite variables, all of the composites provided significant increments in the variance accounted for. This supports

Hypothesis 4 and the heuristic QOLSI model we advanced (Figure 6, p. 65). As well, the IBG and the ESV performed similarly when regressed upon the predictor variables. This finding indicates that in future investigations of subjective QOL with this population, the ESV could serve as a satisfactory measure of global subjective QOL. We can only speculate that the original English-language version of the instrument, the Satisfaction with Life Scale (SWLS), would perform about as well.

Demographic variables have been argued to be poor predictors of global subjective QOL in both clinical (Lehman et al., 1982) and non-clinical samples (Andrews and Withey, 1976). Our finding that the demographic composite (step one in the hierarchical regression) significantly improved the prediction of global subjective QOL when it was measured in terms of the ESV, but not when it was measured in terms of the IBG, suggests that in earlier studies demographic data may have had limited usefulness in the prediction of global subjective QOL partly because of the global subjective QOL criterion measure used (i.e., the IBG).

One of the more remarkable findings in our assessment of Hypothesis 4 was that self-esteem (step two in the hierarchical regression) accounted for more incremental variance in global subjective QOL than any other predictor (see Tables 34 and 35). Larsen, Diener, and Emmons (1985) documented strong positive associations of global life satisfaction with the self acceptance dimension of self-esteem, while Andrews and Withey (1976) reported similar findings in relation to the self-efficacy dimension of self-esteem. We did not expect self-esteem to supplant domain satisfactions as the best predictors of global subjective QOL. However, the ordering of the variables that was derived from our underlying conceptual model (see Figure 6, p. 65) meant that self-esteem was entered early in the hierarchical regression. This helps explain why it accounted for such a large increment in global subjective QOL

variance accounted for. We believe that it was appropriate to enter self-esteem early in the hierarchical regression because enduring personality characteristics have temporal primacy over most objective QOL indicators (e.g., one's leisure activities or placement setting), over one's preferences in relation to various life domains, and over one's satisfactions in relation to life domains. Our finding argues for the importance of including measures of identity and self-concept in subjective QOL evaluations, as Cheng (1989) has advocated.

We elected to translate Rosenberg's (1965) self-esteem scale (SES) into French (EES) because Rosenberg had presented considerable convincing data on the construct validity of his unidimensional measure and because of the importance of self-esteem in general. He related positive self-esteem to many social and interpersonal consequences, including lower levels of shyness and depression, greater assertiveness, and greater extra-curricular activities. Moreover, a number of other authors (e.g., Diener, 1984; Larsen et al., 1985; Lehman, 1983; Cheng, 1989), have reported that personality dimensions such as self-esteem are capable of accounting for a significant portion of variance in measures of subjective QOL. Our findings replicated those reports and suggest that integrating a unidimensional scale such as the EES into future QOL interviews may shed some light on the complex relationship between personality dimensions (e.g., self-esteem), social activities (e.g., extra-curricular activities), QOL, and SI.

Another incidental component of our finding was that the EES correlated significantly and positively with subjective QOL indicators in all domains except work and education. A number of authors had reported that while self-esteem correlated positively and significantly with global subjective QOL measures, it tended to correlate less strongly and consistently with domain-specific satisfaction measures (Diener, 1984; Cheng, 1989; Lehman, 1983a, 1983b;

Lehman et al., 1982). Our finding that self-esteem was highly correlated with domain-specific subjective QOL indicators (Table C-33) highlights the need to use this measure as a control variable in future investigations of life quality with psychiatrically disabled populations.

Another incidental finding related to Hypothesis 4 was presented in Table C-34 and showed that self-esteem correlated significantly with two preference indicators only (i.e., preference for leisure and perceived financial need), suggesting that preference indicators overlap considerably less with personality factors than do subjective QOL indicators. In light of the high correlations between subjective QOL measures and self-esteem and the rare and moderate correlations between self-esteem and preferences, the high correlations between preferences and subjective QOL measures are all the more surprising. The finding provides additional evidence that preference measures may be useful in future subjective QOL investigations, because they seem to complement rather than duplicate personality measures such as self-esteem.

Another finding related to Hypothesis 4, that self-esteem correlated significantly with only a few objective QOL indicators was expected (Table C-35). For living situation, frequency of activities within the residence had a significant positive relationship with self-esteem, indicating that residents who, with higher self-esteem, engaged more frequently in different activities within the residential service. Residents who engaged more frequently in leisure activities within the residence also had more positive self-esteem. The only other objective QOL indicator to correlate with self-esteem was frequency of listening to religious programs (usually on television). Given that in all the services we visited the television set was always located in a common room where residents would often gather, this religiously-

oriented measure may to some degree be confounded with leisure activities and social relations.

The finding that the domain-specific objective QOL composite (step three in the hierarchical regression) significantly improved the prediction of global subjective QOL speaks to the relevance of objective QOL indicators and supports the claim by a number of authors that both objective QOL and subjective QOL indicators are necessary to arrive at an accurate prediction of global subjective QOL (Andrews and Withey, 1976; Baker and Intagliata, 1982; Lehman et al., 1982; Cheng, 1989). Relative to the findings reported by Lehman et al. (1982), few objective QOL indicators correlated significantly with global subjective QOL in our study. This difference in results was probably due to our small sample.

The domain preference composite (step four in the hierarchical regression) also significantly improved the prediction of global subjective QOL. Given that the preferences composite was entered after the demographics composite, it suggests that preferences are possibly better predictors of global subjective QOL than would be demographic data or objective QOL indicators. This provides further evidence, beyond Hypothesis 3, of the pertinence of assessing preferences in subjective QOL research.

Finally, the domain-specific subjective QOL composite (step five in the hierarchical regression) also significantly improved the prediction of global subjective QOL. This finding was expected, given earlier reports of marked correlations between domain subjective QOL and global subjective QOL (Lehman et al., 1982). However, in light of the relatively late point of entry of this composite in the regression analysis, and the rather large amount of variance accounted for by the self-esteem measure, it is surprising that domain subjective QOL still accounted for such a large increment in the amount of global subjective QOL

variance explained. This finding speaks to the robustness of the relationship between global subjective QOL and domain satisfactions.

Hypothesis 5: The Relationship Between Global Subjective QOL and SI

Global subjective QOL was not correlated with either weak social integration (WSI) or strong social integration (SSI), as the latter constructs were measured here. This finding was unexpected in light of Kennedy's (1989) report that global subjective QOL, as measured by Andrews and Withey's (1976) Global Well-being Item correlated positively and significantly with community integration, as measured with Segal and Aviram's (1978) External Integration Scale. However we did find that resident contacts with co-residents was significantly and positively related to social relations subjective QOL. This finding tends to support Kennedy's (1989) report that an increase in the amount of participation in the community was associated with subjective well-being only for individuals with higher levels of emotional support. That we could not replicate Kennedy's (1989) finding of a significant relationship between global subjective QOL and SI, may be due to a moderating influence of social competence on the relationship between well-being and community integration. In a hierarchical regression of global subjective QOL on social competence and community integration, Kennedy found a significant interaction between social competence and community integration such that among psychiatrically disabled residents with high levels of social competence, participation in the community and global well-being were related. However, level of activity in the community was not associated with global well-being among less socially competent residents. Our sample may be relatively low on social competence. Similarly, Kennedy (1989) reported that the relationship between community integration and

well-being was stronger at higher levels of emotional support than at low levels, where it was nonexistent. Our sample may have had low levels of emotional support. Thus, low levels of social competence and emotional support in our sample may account for our failure to replicate Kennedy's (1989) finding of a significant relationship between global subjective QOL and community integration.

Based on our findings and our review of those reported by Kennedy (1989), we can conclude that the link between global subjective QOL and SI may be moderated by social competence and emotional support. We consider this finding to be quite important and needing replication as it has direct implications for recent mental health policy in Quebec, which makes subjective QOL and social integration primary goals of its general rehabilitation policy (Bolduc, 1991; Gouvernement du Québec, 1987). We believe that the relationship between SI and satisfactions as well as the relationship between SI and preferences warrants further investigation to clarify how SI is related to domain-specific satisfactions and preferences.

A secondary finding of post-hoc analyses related to Hypothesis 5 found numerous significant correlations between objective QOL indicators and WSI. This tends to support our heuristic model (Figure 6, p. 65), which proposes that WSI reflects the scope of community presence in terms of frequency of involvement in activities that are usually undertaken outside the residential setting. This definition is similar to the "external integration" definition of community integration proposed by Segal and Aviram (1978), which has received wide acceptance (Kruzich, 1985; Kennedy, 1989; Hall et al., 1986; Nelson and Smith Fowler, 1986; Segal, Silverman, and Baumohl, 1989). However, when one considers SI in such terms, one is measuring merely the range, scope, or breadth of community presence, which reflects only

weakly the principle of normalization/social role valorization, since it says little about the respondent' accompaniment by socially valued others as he/she engages in the extra-residential activities.

On the basis of these auxiliary findings, we can conclude that when one measures WSI, several objective QOL indicators can serve as predictors. Future studies with clinical and non-clinical samples should establish the relative utility of these various objective QOL indicators as predictors of WSI. Our current findings suggest that fruitful objective QOL indicators to study include those related to activities conducted outside the residence and which correlated the highest with WSI (see Table C-44). These appeared related to productive and leisure activities such as school attendance, work and work-training programs, and participation in activities focused on the acquisition of self-efficacy skills.

Finally, the post-hoc correlations between domain satisfactions and the two SI measures revealed that family subjective QOL was the only domain satisfaction measure to correlate significantly with SSI and that WSI correlated significantly only with finances subjective QOL and education subjective QOL (see Table C-46). These findings point to the importance of positive family relations as a vehicle for social integration (in the strong sense), and the importance of investigating adequate income and education in relation to client presence in the community. Preferences for leisure and education both were significantly and positively correlated with SSI (see Table C-45), while no preference measure correlated with WSI. These findings need replication. However, they may have important research and policy implications, since they speak to practical rehabilitation strategies.

Hypothesis 6: Predictors of Social Integration in Family-care Homes

Hypothesis 6 was not supported with the reduced sample (n = 45) of respondents living in family-care homes (Table 36), perhaps because the small sample provided poor statistical power. With the full sample of family-care home residents (n = 55), Hypothesis 6 was partially supported in that resident characteristics significantly improved the prediction of SSI, but not WSI (Table 37). Location of residence was the only significant predictor of WSI. Size of facility did produce significant increments of variance explained in either SSI or WSI.

The finding that SSI and WSI were only moderately correlated adds an important new dimension to Segal and Aviram's (1978) original distinction between activities that reflect social integration within the residence and those that reflect social integration external to the residence. Our finding indicates that strong social integration (SSI), defined in terms of accompaniments by socially valued others warrants further study in relation to levels of activity and presence both within and external to the residence.

That Hypothesis 6 was only partially confirmed may be due to inadequacies in this first version of the social integration scale (e.g., limited range of activities measured) in combination with the fact that our sample was very sedentary. The latter factor may be more responsible for the lack of data in relation to our SI scales. Inactivity is a characteristic of the psychiatrically disabled that has been described by several investigators (Nagy et al., 1988; Lamb, 1976; Lamb and Goertzel, 1971; Segal and Aviram, 1978; Tessler et al., 1984; Trute, 1986). The extreme inactivity in our sample tends to support the aforementioned earlier reports. Thus, residents' social isolation was not limited to accompaniments by socially valued others, but also reflected by their typically sedentary lifestyle. The frequency of involvement

in most activities whether within or external to the residence, was rare (cf. Tables C-37 to C-42).

The hierarchical regression of Hypothesis 6 showed that with the full sample of family-care homes residents, only age of respondent (i.e., demographics in step one of the hierarchical regression) accounted for a significant increment in valid variance in the prediction of SSI as it was defined here. Given our definition of SSI for this study, the finding that older residents were less likely to experience social contacts with their families and socially valued others suggests the need for intervention strategies aimed at relieving the social isolation experienced to an even greater degree by older psychiatrically disabled citizens. This finding also speaks to the conclusions of Cournos (1987) who pointed to the failure of the research literature she reviewed to identify personal characteristics that "might have more powerful predictive value" (p. 851). Additionally, our finding that age was a significant predictor of SSI supports Segal and Silverman's (1989) recommendation that future research not overlook the possible interactions between characteristics of person and of the environment.

A secondary finding related to Hypothesis 6 was that frequency of contact with health-care professionals also was negatively correlated with SSI (see Table C-43). This finding supports earlier reports suggesting that extended and prolonged contacts with health-care professionals correlated positively with reduced levels of functioning and increased rehospitalization rates (Weinman et al., 1974). These authors have reported that relative to traditional hospital wards, only 16% of residents in community housing programs were rehospitalized compared to 42% of those in traditional hospital wards. The lowest rates of recidivism (4%) were from family-care homes. Lower rates of rehospitalization in family-care

homes may be related to the relatively more tolerant atmosphere in this type community housing service (Carpenter and Bourestrom, 1976). However, there are also indications that community housing can constrain social integration by discouraging self-sufficiency (Kruzich and Berg, 1985). Limited self-sufficiency has been linked to limited internal (Kruzich and Kruzich, 1985) and external social integration (Kruzich, 1985) of residents when instrumental performance is not accentuated and when staff/home operators are preoccupied with employing the same hierarchical organizational structure and practices found in mental hospitals (i.e., rigidity of routine, block treatment and depersonalization of residents, and social distance between home operators and residents). Resident satisfaction and level of social participation have shown a tendency to be greater in strict environments, but rehospitalization rates also tend to increase in such environments (Carpenter and Bourestrom, 1976), which ultimately constrains clients' level of social integration. There are indications that level of inactivity may also constrain social integration. Byrne et al. (1991) reported on the physical health needs of a sample (N = 73) of deinstitutionalized CPD and found the majority (76.6%) did not participate in any physical activity, compared to the Canadian national norm of 27% (Health and Welfare Canada, 1988). Given the high level of inactivity with this population in general, limited SI, would appear to be likely unless controlled efforts are made to foster integration.

In light of these findings, it appears that the needs and vulnerabilities of the psychiatrically disabled may be met best in family-care housing that requires resident participation in well-structured, socially integrating activities (e.g., work training, education, group activities, etc.) but tolerant of fluctuations in resident participation in most aspects of its organizational structure. Such a community housing context would appear to be able to

maintain the delicate balance between tolerance of clients' difficulties in following a structured program and the promotion of self-sufficiency in assisting clients to achieve their rehabilitation goals. On the basis of our study, we believe that family-care home operators will need considerably more assistance (financial and human) if they are to succeed in maintaining this balance.

That location only and not size of facility significantly improved the prediction of WSI was unexpected. Based on earlier reports from other researchers (Nagy et al., 1988; Segal and Aviram, 1978), we believed that size of facility would also account for a significant incremental amount of valid variance in WSI. In our sample, family-care homes located in rural areas housed 57% more residents than those in urban settings. However, none of the services we visited housed more than nine clients, reflecting a restricted range. Other studies, which suggested that facility size was an important determinant of SI, usually were conducted with samples involving services that were typically at least three times as large (Lehman et al., 1982; Segal and Aviram, 1978; Nagy et al., 1988). Moreover, with larger services, the relationship between facility size and SI is complicated by staff/client ratios, which also have been reported to influence resident level of activity and social adjustment (Nagy et al., 1988). However our sample of family-care homes all had one or two operators only. More studies of the relationship between facility size and client/staff ratios need to be conducted with smaller services in order to determine optimal residence size and client/staff ratios that best promote SI.

Hypothesis 7: Residence Location and Size as Predictors of Service Quality

With family-care homes as the unit of analysis, both location and size of facility accounted for significant increments in the variance explained in the total PASSING score (cf. Table 42). Urban location and smaller size were both associated with higher PASSING scores. This support for the hypothesis is consistent with normalization/social role valorization theory and provides evidence of the construct validity of PASSING as a measure of service quality. The non-significant interaction reported in Table 42 also suggests that a facility's location and size have an additive effect on the overall quality of service. These findings are important because ours was the first large-scale application of PASSING to residential services for the CPD. Related to our findings are those from an earlier study by Hull and Thompson (1981) who found that several PASS dimensions (e.g., level of social protection, activities promoting social integration, and opportunities for freedom and initiative) correlated with level of adaptive functioning in CPD residents.

Our finding that the general quality of housing services, as defined by the total PASSING score, may be predicted by service location and size suggests two simple strategies whereby program planners may significantly improve the general quality of service delivery: locating housing services in close proximity to larger communities, and restricting residence size. Ideally, much, even if not all, housing for the psychiatrically disabled should be located within larger population centres in order to facilitate resident presence in the community. Public services in such communities (e.g., public transportation, recreational facilities, etc.) are more abundant and available to residents than in rural areas. Easy access to larger communities and their public services will not automatically result in social integration. On the other hand, the findings do imply that the more isolated the residential service and the

larger it is, the less likely that social integration will occur. Knowing the maximum number of residents that is facilitative of more normalized and independent community living would constitute an important finding and warrants future consideration by investigators.

A related finding that has implications for program planners was that living situation subjective QOL was the only domain satisfaction score to correlate significantly with PASSING total score (r (68) = .28, p = .02), and with the Setting subscale of PASSING (r (68) = .30, p = .01). In addition to providing concurrent validity for PASSING as an indicator of the quality of service delivery, this finding suggests that PASSING may be a more valid predictor of subjective QOL in living situation than many objective QOL indicators, including demographic data.

Our finding that WSI correlated well with PASSING scores, when taken together with the findings reported by Hull and Thompson (1981) that client level of adaptive functioning in board-and-care facilities was related to several PASS dimensions, including social integration both within and external to the housing service, suggest that WSI may prove to be a good indicator of the impact of environmental normalization on individual levels of resident activity and presence in the community. However, this does not suggest that WSI could substitute for SSI as an indicator of *individual* social role valorization and social integration.

Both location and size of family-care homes also significantly improved the prediction of the Environment sub-scale of PASSING, although the prediction of the Program sub-scale of PASSING was significantly improved by location of family-care home only. This may be due to the content of the scale in combination with the restricted range of sizes in the family-care homes we visited. However, smaller family-care homes located in urban areas may be

predicted to obtain higher scores on the Environment sub-scale of PASSING than larger homes located in rural areas. This finding provides program planners with clear indications as to how they can directly improve quality of service delivery by the thoughtful selection of where family-care homes are located and by restricting their size in terms of the number of clients housed in these services.

Hypothesis 8: Composite Predictors of Strong and Weak Social Integration

The hierarchical regression of strong social integration (SSI) and weak social integration (WSI) was generally supported with the full sample (N = 70) but only partially supported with the sub-sample (n = 55). This may have occurred because the analysis with the sub-sample lacked statistical power. Since one may be justified in having more faith in the interpretation of the results involving the full sample of respondents (N = 70), only the results reported in Tables 41 and 43 will be discussed.

Personal characteristics (step one of the hierarchical regression analysis) significantly improved the prediction of both SSI and WSI. This finding highlights the relevance of demographic variables in relation to SI measures and supports conclusion drawn by Cournos (1987) that personal characteristics may have predictive value in determining outcomes in residential services.

The objective indicators composite (step two in the hierarchical regression) also accounted for a significant increment in valid variance in the prediction of both SSI and WSI, which supports earlier reports that objective QOL indicators are important predictors of outcome and external integration (Coulton, 1981; Coulton et al., 1984; Hall et al., 1986; Kruzich, 1985; Kruzich and Kruzich, 1985; Kennedy, 1989; Nelson and Smith Fowler, 1986;

Segal and Aviram, 1978; Segal, Silverman, and Baumohl, 1989). Our findings go beyond this literature in showing that objective QOL indicators may significantly hinder or facilitate the establishment of lasting meaningful relationships between CPD clients and socially valued others (SSI), who were almost exclusively families of clients in our sample. The location of residential services may be particularly relevant in this regard since many residents in our sample were placed in services located far from their families of origin.

The preferences composite (step three in the hierarchical regression) significantly improved the prediction of SSI but not WSI. This suggests that responsiveness to clients' preferences may facilitate the difficult task of establishing links between clients and socially valued others (especially members of their families). In those cases where clients no longer wish to maintain contacts with their families, responsiveness to clients' preferences could still serve to facilitate links with alternative emotionally supportive contacts that are perceived as important by clients.

The domain satisfaction composite (step four in the hierarchical regression) also significantly improved the prediction of SSI, but not WSI. This suggests that subjective satisfaction measures can serve to predict which clients will engage in activities with socially valued others. Overall, the finding supports our contention that following clients' preferences in relation to activities and social contacts may have powerful impacts upon their level of SSI, at least as defined here.

Global subjective QOL (step five in the hierarchical regression) did not significantly improve the prediction of either SSI or WSI. The fact that both global subjective QOL measures were highly correlated (i.e., redundant) with domain satisfaction measures may

account for this. Nevertheless, the finding fails to support Kennedy's (1989) report that well-being and SI were related.

Overall, social integration may be facilitated in two ways: First, one might encourage and facilitate more frequent contacts between clients and their families. Second one could promote client involvement with socially valued people other than family members through activities such as work, educational programs, and rewarding leisure activities that promote self-development, autonomy, and personal competencies. Client involvement in such activities might promote client contacts with socially valued persons other than their families. This may relieve clients' families somewhat of their burden, as they appear to be the only important medium for the SSI of clients at this time. Moreover, the implementation of such programs may prove to be good public policy.

Although age was the only demographic/personal attributes indicator to correlate significantly with SSI (Table C-43), other objective QOL indicators also correlated negatively and significantly with SSI, including frequency of contacts with health-care professionals. This may suggest a life lived excessively within the helping system (i.e., cut off from culturally valued contacts with typical valued citizens).

The SSI scale clearly indicates the relevance of measuring not only resident activity both within and outside the housing service, but also resident activity in terms of accompaniment by socially valued others as an objective indicator of resident levels social integration and of the housing program's implementation of normalization/social role valorization. Our finding that SSI was significantly and positively correlated with only two preference measures (Table C-45) and one domain satisfaction measure (Table C-46) also was surprising. The relationship between SSI and preference for leisure and educational activities

(Table C-45) may indicate that these activities are potential vehicles that can serve the development of meaningful relationships with socially valued others, which in turn can facilitate SSI.

The finding that satisfaction with family was the only domain satisfaction measure to correlate significantly with strong social integration (Table C-46) suggests that those residents who were satisfied with their family relationships were more inclined to undertake activities with family members and vice versa. This is an important finding for the rehabilitation and social integration of the psychiatrically disabled, as it indicates the need for program planners to focus on clients' social support networks. This conclusion supports by findings reported by Earls and Nelson (1986) who concluded that the size of the psychiatrically disabled client's social networks can buffer the effects of poor housing conditions on clients' self-reported positive and negative affect. Clearly the family remains the single most important determinant of the psychiatrically disabled's social isolation. Considerably greater effort needs to be directed at facilitating stronger and more rewarding client-family contacts, as well as social contacts in general, if the social integration of the psychiatrically disabled is to extend beyond their mere presence in the community.

The finding that satisfaction with finances and education (Table C-46) was significantly and positively correlated with WSI suggests that those respondents who experienced greater satisfaction with their financial situation and education also engaged more frequently in extra-residential activities. This may mean that those respondents experienced relatively greater financial independence and also were better educated. Given that financial independence and education tend to facilitate social mobility and involvement in socializing activities, this would not be surprising. In fact, the correlations between SSI and WSI in

relation to objective QOL indicators presented in Tables C-43 and C-44, are consistent with this interpretation.

Table C-43 showed that very few objective QOL indicators correlated significantly with SSI. In fact, only frequency of involvement in general activities correlated positively with SSI, suggesting that more active residents were more likely to engage in contacts with socially valued others than more sedentary residents. With a larger sample, frequency of school attendance might also have correlated positively with SSI. Age was negatively correlated with SSI, as was frequency of contacts with health-care professionals. Given our definition of SSI, the finding suggests that older, more sedentary residents and those whose general health was declining, tended to be forgotten by their families as well as the rest of society.

Table C-44 presented several objective QOL indicators that correlated significantly with WSI. However, the positive relationship between WSI and several objective QOL indicators provide little reason for encouragement, because many were at best moderate, and WSI, as defined in the QOLSI model, merely reflects level of resident activity in the community rather than true social integration as advocated in the principle of normalization/social role valorization. Among the variables significantly related to WSI, age of clients, distance of residence from the nearest town, duration of employment in best job ever, behaviour handicaps, and frequency of contacts with health-care professionals all were related to lower levels of resident activity in the community.

Conclusions

It is noteworthy that this study is limited in several ways. First it is cross-sectional rather than longitudinal. As such, we do not know whether the findings reported would be stable over time. Second, it is correlational in nature, which precludes the determination of cause-effect relationships between our measures of the predictors and dependent measures used. Third, the small sample in our study constrained many of our interpretations. Nevertheless, some general conclusions can be drawn from our findings.

Lehman's (1988) QOL interview and findings can be replicated. Subjective QOL measures, when used in conjunction with preferences may be useful to assess needs and how to best meet needs to determine suitable residential placements for the psychiatrically disabled. The findings also suggest that three decades of deinstitutionalization have done little to improve the QOL and SI of citizens with a chronic psychiatric disability. This is possibly the case because this segment of the population, with no strong lobby in its dealings with municipal, provincial, or national governments, continues to be relatively ignored by the general public. Moreover, the needs of mental health clients have often been grossly misconstrued because treatment and service programs were grounded on the viewpoints of professionals and ignored the perspective of the clients by failing to ask them what was important to them, how satisfied they were with different services, and what they preferred in terms of treatment and services. This has been especially true in relation to housing (Carling, 1990a, 1990b).

PASSING evaluations appear suitable to appraise the CPD person's living conditions and the degree to which they facilitate or impede normalization/social role valorization. In contrast to objective QOL indicators, which merely provide factual information related to the

actual living conditions of the psychiatrically disabled in community housing, PASSING structures the evaluation of such conditions against acceptable standards that are derived from normalization/social role valorization theory. It serves as the philosophical "gold standard" against which actual living conditions are evaluated. However, PASSING does not provide a direct measure of the impact that actual or changing life conditions have upon the person.

Our definition and measure of WSI appears to provide a direct appraisal of the impact living conditions have on the person's level of activity and community presence. Our definition and measure of SSI appears to provide a direct appraisal of the impact living conditions have on the person's social integration in terms of the degree to which the individual's level of activity and community presence are characterized by accompaniments with socially valued others. Thus, SSI has more in common with normalization/social role valorization theory than does WSI. However, WSI has more in common with PASSING evaluations than does SSI. PASSING evaluations typically assess a residential service in relation to the neighbourhood and larger social-community contexts. In contrast, WSI assesses the impact of the housing and community context on the individual person, while SSI assess the impact of the housing and community context upon the person's level of activity in the presence of socially valued others. Both PASSING and SI measures are deemed important for an accurate representation of SI of the deinstitutionalized psychiatrically disabled living within community residences.

Characteristically, PASSING evaluations address themselves to "inputs" and "activities." PASSING, however, does not directly assess the impact of these environments on the person's level of activity within and external to the residence, nor the person's social integration with socially valued others, their preferences, satisfactions, or QOL. Rather,

PASSING judges whether the housing, program, and social environments facilitate or impede the normalization/social role valorization of the person.

The degree to which the social milieu is conducive to normalization/social role valorization is assessed individually by each member of the PASSING team. The individual assessments are later conciliated by the PASSING team as a whole. Thus, the PASSING tool and assessments provide an evaluation of the actual living conditions of the person, gauged against a gold standard that is defined by the principle of normalization/social role valorization, and in practice, subjectively interpreted by team members. That the principle of normalization/social role valorization is somewhat subject to idiosyncratic interpretations by each member of the PASSING team is not a serious difficulty. When individual assessments are consolidated during the conciliation process, individual judgements are aligned with the principle of normalization/social role valorization. Anyone who has participated in a PASSING evaluation with experienced team members realizes that the process of consensual validation is quite effective and not as subjective as one might at first be inclined to believe. The process is, however, quite flexible and would adapt quickly and easily to significant sociocultural changes capable of influencing the philosophy of normalization/social role valorization that buttresses PASSING. In short, PASSING evaluations are structured within the framework of a well articulated and tightly woven philosophy that is responsive to current cultural standards, values, and norms. Because PASSING evaluations are conducted by team members sharing a common social and cultural heritage, PASSING evaluations can functionally assess actual conditions of community housing against a consensually validated gold standard that is mutable across time and sociocultural contexts.

On the basis of our findings, we can conclude that to a limited extent some objective QOL indicators (e.g., location and size of family-care homes), reflecting life conditions, are related to the WSI of the psychiatrically disabled. We can also presume that the living conditions of the psychiatrically disabled can either facilitate or impede their level of activity and presence in the community, and that PASSING may serve to set the optimal standard whereby this process of WSI may be achieved. In so far as WSI may be presumed to reflect the impact of actual and changing living conditions on the person's behaviour (i.e., level of activity and presence in the community), it can also serve as an indicator of the individual's involvement in a process that may be deemed facilitating in the development of meaningful relationships with socially valued others; the premise being that increments in SSI can be predicted on the basis of WSI indicators. The assumption here is that SSI flows from progressive WSI.

In short, SSI or the establishment and maintenance of meaningful and lasting relationships between socially undervalued and socially valued persons may naturally evolve from continued social experiences between socially undervalued and socially valued persons. The actualization of such experiences are apparently facilitated by involving the psychiatrically disabled (i.e., a socially devalued minority) in activities with socially valued others. The findings from our study suggest that work-related, education-related, and leisure-related activities are the most likely vehicles to facilitate such a process. The social roles concomitant with these activities may be media whereby socially devalued persons can make a shift in their social presentation from socially devalued to socially undervalued persons. More specifically, when one is presented socially as a chronic psychiatrically disabled individual, one's social image is of a socially devalued person. However, when the same

individual is presented as a student or as a person in a work-training program, the image is of a socially undervalued person. This type of categorical shift illustrates why the implementation of the aforementioned activities present as desirable functional alternatives to the social role of "mental patient." By involving the psychiatrically disabled in such productive activities they are provided a social context for sustained interactions with relatively more socially valued others (e.g., teachers, other students, employers, co-workers, leisure activities coordinators, etc.). Moreover, one of the outcomes of productive activity usually is the acquisition of personal skills and abilities that contribute to one's image of self-worth. Self-image has been shown to play an important role in the subjective QOL of the general population (Andrews and Withey, 1976 Campbell et al., 1976; Lehman, 1983a), and the relationship between productive activity and self-image may also hold for the psychiatrically disabled. For this reason, it should be of concern to program planners intent upon improving the QOL and social integration of their clients. Consequently, the planning and implementation of housing programs for the psychiatrically disabled should make productive activity (e.g., work-training, school, structured leisure activities, etc.) a priority.

Implications for Future Research

Methodological Implications

This study has produced more questions than definitive answers. The applied utility of domain satisfaction measures as indicators of program quality would seem justified. However, their role as indicators of P-E fit needs further study, especially in relation to preference and preference-like measures which served as predictors of subjective QOL in this

investigation. Longitudinal designs would seem best suited for such investigations, since they would allow program evaluators to determine the usefulness of subjective QOL measures as indicators of P-E fit on the one hand, and the usefulness of preferences as path markers directing the course of optimal intervention strategies on the other.

Objective QOL indicators offered poor internal consistency in this investigation. Researchers intending to combine groupings of objective QOL indicators (e.g., independence, autonomy, freedom, personal safety, etc.) to form scales such as those used by Lehman et al. (1982), may instead wish to apply the composite variables procedure we used in this study. It may prove to be the most suitable alternative, at least in pilot studies involving small samples, since it allows researchers to combine several conceptually similar variables into single composites, thereby allowing adequate subject/variable ratios even with small samples. The procedure would not allow interpretations of which objective QOL indicators were the best predictors of subjective QOL in life domains, but it would allow the use of numerous independent indicators with small samples.

The role of preferences in relation to health also needs more clarification. Clinical samples with varying degrees of psychiatric impairment might help in this regard. Alternatively, preferences in relation to health subjective QOL could be studied with samples having varying degrees of physical disability.

Both of the social integration scales (i.e., the SSI and the WSI) appear to offer researchers psychometrically sound outcome indicators, but they need further study. They may be conceptually more relevant to the realities of life for the psychiatrically disabled living in community residences than have been more traditional outcome measures such as re-hospitalization, employment, social adjustment, and so on. However, more research is needed

on both. Given the range of activities surveyed, the sample size, and the dearth of participation in most activities by the respondents, we were unable to conduct factor analyses with the data. Studies that showed which activities grouped under different factors would seem useful for both the SSI and WSI. The relevance of using factors such as internal activities and external activities have been shown to clarify the concept of social integration (Segal and Aviram, 1978). Perhaps the concept of SSI could be similarly elucidated by factors such as activities in the company of socially valued others (e.g. family), versus activities conducted alone, or in the company of co-residents, etc. With a larger sample, some activities may be shown to typically group under different categories of social accompaniment. Such information may be useful. However, the relevance of using more refined discriminations of factors related to SSI needs further study.

Our failure to completely replicate Kennedy's (1989) finding of a significant relationship between subjective QOL and SI suggests that the relationship may be complex, involving social competence and emotional support as moderator variables. This issue warrants further study as it may explain certain inconsistencies in the research literature. As well, a study of the concurrent validation of the WSI scale against Segal and Aviram's (1978) external integration scale would be useful.

We have argued that effects of certain modifications to the delighted-terrible, specifically, modifications to its mode of presentation and range of choices might reduce ceiling effects. This point should be explored. Toward this end, we developed the Satisfaction Gradient Scale, presented in Appendix D. We believe that the Satisfaction Gradient Scale may allow the testing of illiterate subjects, while providing respondents with a broader range of choices. This notion warrants further study.

Finally, we argued that ESV could serve as a satisfactory measure of global subjective QOL. We could only speculate that the original English-language version of the instrument, the Satisfaction with Life Scale (SWLS), would perform as well. Another study could resolve this issue.

Substantive Implications

We believe that using self-esteem scales that measure several different dimensions of self-esteem (e.g., self-competency and self-acceptance) in future QOL interviews may shed some light on the complex relationship between personality dimensions and social activities (e.g., extra-curricular activities) on the one hand, and QOL and strong social integration on the other.

We proposed that in some life domains, where client behaviours may be less controlled by others and clients have the freedom to express their preferences by their behaviours, objective measures of client behaviours may serve as better indicators of client preferences. It would be useful to know which behavioral measures best reflect such expressions of preference and in which life domains they might be best applied. As well, longitudinal studies with domain-specific subjective QOL measures may permit researchers to determine whether they perform well enough as indices of P-E fit to allow program planners to monitor the effects of changes in service delivery that have been implemented to better meet client preferences.

The strengths and limitations of using combinations of verbally expressed preference indicators in relation with behavioral expressions of preferences needs more study. Evans, Burns, Robinson, and Garret (1985) developed a QOL questionnaire that is based on an

individual's endorsement of activities in several ecological domains. Similarly, an instrument measuring preference-related activities may prove useful in this regard. The study of behaviours as indicators of personal preferences in life domains warrants more study. As well, the effects of placement protocols on preference-related behaviours could be investigated using quasi-experimental designs with pre and post placement groups. Such groups could compare residents whose placements took preferences into consideration with residents whose placements did not consider preferences. Behaviour measures of preference-related activities could serve as the outcome measure to compare the effects of placement strategies on a pre and post placement basis.

Segal and Silverman (1989) have suggested that interactions between person and environment characteristics may be powerful predictors of SI. Our findings suggest that they may also help explain why evaluations of similar objective conditions diverge for different individuals. Resource domains such as finances, health, and family appear to be particularly fertile for inquiries into the circumstances under which such evaluations diverge.

We agree with Segal and Silverman (1989) that social norms within specific environments may have considerable influence on client outcomes. They suggested that clients may be more socially integrated in the community where they can best fit into the social fabric of the environment:

> "Fit seems to depend a great deal on the extent to which community care residents have key characteristics of the dominant social group in the environment, and the willingness of that group to tolerate differences in its midst." (Segal and Silverman, 1989, p. 61).

They argued that particular environments may satisfy individual needs and wants. Our findings led us to arrive at conclusions similar to those reported by Segal and Silverman

(1989). We believed that P-E fit could be more or less achieved as a function of the degree to which the dominant social group could satisfy the needs and wants of the resident and the degree to which the resident actively engaged in contacts with key members of the dominant social group. Perhaps the relationship between our notion and the one advanced by Segal and Silverman (1989) could be studied in terms of activities conducted by the individual in the company of key members of the dominant social group. Within such a context, key behaviours that reflect the acceptable norms of the dominant social group could possibly be identified and described. As such, they could possibly be measured. We believe that these factors may account for why some residents acquire what Segal and Silverman (1989) referred to as "key characteristics" of the dominant social group and the "the willingness of that group to tolerate differences in its midst." These notions may provide fertile grounds for future studies.

Conceivably, P-E fit in a given environment and SI in a dominant social group may lie along an acceptance-rejection continuum that is partly determined by characteristics of the person, partly by characteristics of the environment, and partly by characteristics of the dominant social group. Where the individual lies along the P-E fit continuum may be a function of the interaction between individual needs and resources, environmental demands and resources, and group needs and resources. The more the factors dovetail, the better the P-E fit in the environment and the individual's SI in the dominant social group within that environment. Further studies of this notion may provide additional clarification accounting for the heterogeneity in client levels of adaptation and social integration within community settings.

Future quasi-experimental studies may wish to evaluate our findings with clients who maintain positive family ties against those who are relatively isolated from their families in relation to social integration. Type of support network and the degree to which different types of support networks satisfy the emotional needs and wants of clients may be relatively better predictors of SSI than environmental factors such as location and size of residential service. Client contacts with families and client satisfaction with family contacts may prove to be an important predictor of SSI in future studies. In our sample, preferences significantly improved the prediction of SSI but not WSI, suggesting that responsiveness to clients' preferences may be especially relevant in terms of normalization/social role valorization theory, as it speaks to the importance of helping clients establish emotionally supportive social contacts that are most relevant to clients.

Knowing the number of residents that is optimal for residents' transition to normalized and independent community living would be an important gain and warrants future consideration by investigators. Further study of personal and housing factors that contribute to the homelessness of so many deinstitutionalized CPD may also be warranted.

Final Remarks

Platt (1981) has argued that although measures of self-sufficiency, internal and external integration, social network support, and social adjustment may be useful indicators of client involvement in the community, the standard for comparison may not be relevant and therefore such assessments have limited utility as indicators of social adjustment. The

difficulty with this argument lies in that the criterion may be faulty. To consider as irrelevant clients' perspectives on the quality of their experiences and to make practioner-defined measures of social adjustment the gold standard, introduces the risk of reverting back to the historically inadequate gold standards of recidivism, work productivity, and activity level. Given the relationship between rehospitalization rates for the psychiatrically disabled and squalid housing conditions, meaningless work activity, devaluing social contacts, all of which may have been consequences of having program planners and practitioners decide for the clients the standards of a successful housing program, it would seem timely to begin allowing clients to participate in the process of operationally defining for themselves their social adjustment goals.

Program planners and practioners must not lose sight of the faci that community housing programs are intended to serve the needs of clients and that the clients' viewpoints must be considered. Nelson and Smith Fowler (1987) have outlined the need for clear specification of clients in housing programs that extend beyond descriptions of demographic characteristics (e.g., age, gender, diagnosis, hospitalization history, etc.). They also emphasized that longitudinal studies describing more than the short-term benefits of transitional facilities are needed if we are to better understand the functioning and QOL of psychiatrically disabled clients who have left transitional placements. Consideration must also be given to clients' preferences and needs for various types and characteristics of supportive residential placements (Nelson and Smith Fowler, 1987).

Rutman (1980) has argued that program evaluation may be said to be undergoing a "crisis" that stems from the fact that evaluations have generally had little impact upon program policies and activities. To this we add our own observation that a program evaluation

can be a threatening process for those who are closely involved or who have a stake in the program being scrutinized. The evaluation process can easily elicit defensive posturing and a dismissal of the findings by those whom it was initially intended to benefit. In the study we conducted, we noted that family-care home operators expressed their trepidation regarding the outcome of this evaluation study in widely different fashions (e.g, some operators made extra efforts to impress the evaluators favourably, others attempted to undermine the evaluation by discrediting the investigators, etc). Such reactions may reflect a specific consequence of our failure as evaluators to fully consider the social, organizational, and political context in which an evaluation occurs. Salasin and Davis (1979), have noted, in more general terms, that an often-cited reason explaining why evaluation results are not used in decision-making is because evaluators fail to take the aforementioned contexts into account. It has been our experience that such oversights on the part of evaluators can quickly and easily complicate the evaluation process while encouraging a dismissal of the evaluation findings. Pancer (1985) has suggested that one manner of dealing with this issue is to actively involve all those who have a stake in the outcome of the evaluation. In light of our experience, his recommendation of an inclusive invitation to policy-makers, program sponsors, program managers, service providers, and recipients to actively participate and collaborate in the evaluation research makes good sense. Moreover, it now is generally recognized that the successful implementation and application of an evaluation requires that the perspectives of these groups and individuals be given careful consideration (Leviton and Hughes, 1981; Weiss, 1983).

Most of the residents we met were severely impaired by their illness, lack of resources, and/or the social handicaps imposed by their psychiatric condition. In many cases, resident mental health needs were compounded by other equally important needs (e.g.,

intellectual deficits, social and contextual problems, substance abuse, behaviour disorders, age, etc.). For many residents, their psychiatric problems only added to the social prejudice which often limited the range and extent of services to which they were entitled.

Most residents had highly routine, predictable, and mundane existences. The average resident presented as a "patient" in the literal sense of the word: perpetually waiting, captive, and dependent. While most residents did not describe themselves as unhappy, many appeared damaged and were largely unaware of their rights, living and adapting submissively within a system which "placed" them without much consideration for their preferences or subjectively perceived needs. Most of the residents were inactive and socially isolated. Financially and intellectually deprived, many residents presented a broken social and self-image. Residents expressed few expectations related to self growth, self development, and self-valorization. In short, they did not expect to be rehabilitated. Few residents had contacts with their families, while many lived in facilities located in areas far from their original home. In many cases, residents seemed abandoned by their families who were either no longer willing or able to maintain contact with them. Compounding this, placements apparently gave little consideration to factors related to individual preferences or needs; for example, severity of illness and/or age of residents. We found a wide range of ages within residences (e.g., 21 to 67 years). Young and energetic residents placed in facilities housing for the most part older, more sedentary residents often presented a picture of premature retirement (Dansereau, Duteau, Ely, and Flynn, 1990).

In sum, our survey of extant services found that while these provide the basic necessities of life, little consideration or respect were given to resident wishes, interests, or preferences. Our findings suggest that either the system does not yet understand the dynamics

of this segment of the population, or that it is responding poorly to clients' rehabilitation needs, depending excessively upon the sensitivity and perspicacity of service providers. If we truly care about the deinstitutionalized chronic mentally disabled citizen's QOL and SI, considerably more effort, dialogue, and on-going research will be needed on the part of researchers, program planners, mental health care professionals, and service providers in order to heighten our awareness of the individual client's existential reality and improve our currently inadequate interventions for this segment of the population (Dansereau, Duteau, Ely, and Flynn, 1990). Toward this end, this investigation has attempted to provide program evaluators, program planners, and practising professionals with some conceptual, methodological, and interpretative guidelines.

POSTSCRIPT

Following the evaluative study, specific and universal recommendations were conveyed in a report provided to the CRSSSO (Dansereau et al., 1990). Specific recommendations (28) were provided in relation to location of residential services, support programs and activities, and activities of daily living. Universal recommendations (11) were aimed at the social services network in general. The report was disseminated by the CRSSSO to the programming, rehabilitation, and research divisions of the Quebec ministry of social services. The report also was made available to professional service providers and home operators in the Outaouais.

Apparently, the findings and recommendations of this study will impact on services. affecting all the stakeholders including: "Le Conseil Regional des Services Sociaux de l'Outaouais" (CRSSSO), "Le Centre des Services Sociaux de l'Outaouais" (CSSO), "Le Centre Hospitalier Pierre Janet" (CHPJ), professional service providers, the residential service operators, the residents, and the community at large.

In September of 1991, conversations with Mr. Thierry Boyer, director of the CRSSSO, a formal interview with Mr. Jean Dansereau, Coordinator of Rehabilitation Services at the CHPJ, and an informal interview with a community mental-health nurse responsible for the health care provided to residents of urban services in the Hull, Aylmer, and Gatineau provided additional information regarding the impact of the study on extant services. An analysis of the interview comments, in relation to the policy changes made by the CRSSSO, facilitated an evaluation of the impact the recommendations on service delivery.

In a copy of a letter provided to this writer by Mr. Boyer, the CRSSSO communicated to Mr. Gilles Clavel, of the Centre des Services Sociaux de l'Outaouais (CSSO), in April of 1990, that many of the recommendations had been adopted as policy, others were in the planning stages, and others still were to form part of future programs. Mr. Boyer's response to Mr. Clavel addressed each of the 28 specific recommendations and the 11 universal recommendations individually. The essence of this response to each of the recommendations was translated and is reproduced in Appendix E, which also includes a transcript of Mr. Danserau's September interview comments regarding the degree to which the recommendations resulted in improvements in service delivery. Mr. Dansereau's interview comments confirm that many of the recommendations were implemented, others were integrated into program planning, while others are intended to figure prominently in imminent policy decisions affecting the course of program development for the next five years.

Additionally, efforts were made by the CRSSSO and the CHPJ to disseminate the report findings. In June of 1990, the CRSSSO convened a general seminar in Quebec City, attended by policy makers, program planners, researchers, and service providers (n = 45). At that time, Mr. Boyer, and Mr. Dansereau, communicated the research findings, the 11 universal recommendations for the social services network in general, and the 28 specific recommendations (Danserau et al., 1990).

The CHPJ and the CRSSSO also have made plans to work together with different service providers and researchers in the Outaouais to facilitate the implementation of evaluative tools and procedures. To date, the CHPJ and the CRSSSO have convened four formal seminars in the Outaouais to inform professional service providers about the general research findings and two of these meetings involved home operators in a discussion of those

findings that were specific to their services. In addition to this, professionals and service providers from the CHPJ have repeatedly met over the past months to discuss specific themes such as activities of daily living, sexuality, and resident rights. The CRSSSO and the CHPJ, however, have not formally apprised the residents of the research findings. Mr. Dansereau commented that residents in the rehabilitation houses were informally apprised of the research findings, but he did not know whether home operators in other types of residential services had made efforts to informally apprise clients of the research findings. He suspected that nothing had been done by home operators in that regard.

The community health-care nurse was asked to reflect on any noticeable changes since the report of the evaluative study had been submitted. She commented that she had noticed few remarkable changes in extant residential services, but that recently accredited services (i.e., ones accredited after the recommendations were submitted to the CRSSSO) seemed "much better" than extant services in terms of physical surroundings, number of residents, and attitudes of home operators.

An analysis of the policy changes by the CRSSSO, in relation to the notes taken during the interview with Mr. Dansereau, revealed that many of the recommendations applicable to program planning were followed, others were still pending, and several others were still in the planning stages. However, despite numerous policy and programming changes, many recommendations were not being well implemented at the level of home care operators, possibly for lack of understanding and/or support. For example, Mr. Dansereau mentioned that three residential services had been closed for repeatedly failing to make efforts at complying with the new CRSSSO directives. In other instances, home operators were clearly trying to comply with the new guidelines. Mr. Dansereau mentioned that in one

instance, the home operator moved her family-care home to the city in order to facilitate resident access to services. In another instance, the home operators built an extension to their home so that residents could be provided with improved accommodations. In a third instance, the home operator moved resident rooms to the ground floor and established her quarters in the basement of the residence.

Whether such changes will have a significant impact on the QOL and SI of the residents will ultimately require follow-up investigations. Quality of service delivery has apparently improved and will continue to improve as the recommendations and policy changes are implemented. In that regard, the study may be viewed as having a significant impact. However, although some progress appears to have been made in responding to client preferences, little concrete progress is currently apparent in the area of enhancing community supports and the involvement of residents in socially integrating activities with persons having valued social roles.

Carling (1990a, 1990b) has argued that the focus of evaluation efforts should be on the broad process of implementing housing and community supports, and the impact of this process on the person, the person's family, on staff, on communities, and on the system. Clearly more research on where people live and spend their time is needed. As well, the allocation of resources to services and supports linked to normal housing rather than to the propagation of the residential continuum and congregate programming would likely contribute more to enhancing the QOL and SI of residents. However, this will require efforts to systematically operationalize the principle of choice in ways that will help all concerned to better understand the impact of choice on people's quality of life. Community integration

approaches need to avoid congregation and segregation and focus on building relationships between disabled and nondisabled individuals (Carling, 1990a).

In order to enhance the SI of psychiatrically disabled citizens living in the Outaouais, the social services network will need to be more responsive to a number of key ingredients that have been argued by researchers to influence community integration; for example, focus on consumer goals and preferences, an individualized and flexible rehabilitation process, and a strong emphasis on normal housing, work, and social networks (Blanch et al., 1988; Carling et al, 1987).

Policy makers, program planners, service providers, and researchers could also benefit by placing emphasis on more research in the areas of consumer preferences; successful strategies for facilitating meaningful client choices, developing housing and supports, and developing relationships with people without disabilities; documentation of the costs and benefits of housing and support initiatives; identification of clinical interventions best suited to normalized housing; and an elaboration of the role of peer support in community success (Carling, 1990a). Such studies would likely promote a needed shift from professionally-defined to consumer-defined research initiatives that focus more on the commonalities between people with and without disabilities, while defining success in terms of those aspects of QOL that are important to clients of mental health services.

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APPENDIX A-1

QUALITY OF LIFE INTERVIEW

ENTREVUE DE QUALITE DE VIE

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INTRODUCTION A LA RECHERCHE ET FORMULAIRE DE CONSENTEMENT INFORME

Quand un chercheur à l'Université d'Ottawa entreprend un projet de recherche portant sur des êtres humains, le comité universitaire de déontologie de la recherche sur des êtres humains exige que le chercheur ait le consentement écrit des participants à la recherche. Cela ne veut pas pour autant dire que la recherche implique un risque pour les participants. L'Université veut s'assurer que le participant sache exactement à quoi s'en tenir sur la recherche, ses objectifs, et ce qui sera demandé au participant.

Les chercheurs pour ce projet sont Robert Flynn, Ph.D., professeur agrégé de psychologie à l'Université d'Ottawa; Peter Ely, candidat au doctorat en psychologie clinique à l'Université d'Ottawa; Colette Duteau, agent de relations au Centre des Services sociaux de l'Outaouais (CSSO), et Jean Dansereau, coordinateur du programme de réadaptation et de réhabilitation psychiatrique au Centre Hospitalier Pierre Janet (CHPJ).

Le but de ce projet est d'évaluer la qualité de vie et la qualité des services dans des résidences communautaires dans le domaine de la santé mentale. Ces résidences se trouvent dans la région de l'Outaouais et sont supervisées par le Centre des services sociaux de l'Outaouais (CSSO). La recherche se fait sous l'autorité du Conseil régional de la Santé et des Services sociaux de l'Outaouais (CRSSSO), qui la subventionne.

Nous demandons votre participation à une entrevue qui touchera vos activités et votre satisfaction des services que vous recevez, et avec differents aspects de votre vie. L'entrevue durera à peu près une heure et demie, avec une pause après les premières 45 minutes. Nous demandons aussi votre permission pour consulter vos dossiers médicaux pour compléter nos informations sur votre histoire médicale et vos besoins de soins.

Votre identité comme participant(e) à cette étude restera complètement confidentielle. Vos réponses individuelles à l'entrevue et aussi toute information prise dans vos dossiers médicaux resteront également strictement confidentielles. Les seules personnes qui y auront accès seront les quatre membres de l'équipe de recherche mentionnés ci-dessus, Monsieur Thierry Boyer, agent de planification et d'évaluation en santé mentale au CRSSSO, et Monsieur Luc Cadieux, responsable pour les familles d'accueil au CSSO. Les responsables dans les familles d'accueil, foyers de groupe, ou appartements supervisés particuliers n'auront aucun accès à vos réponses individuelles. Dans toute communication sur l'évaluation, y compris le rapport final du projet, aucune information sur des individus ou sur une résidence en particulier ne sera présentée à personne.

Vous êtes libre de refuser de participer à cette étude ou de retirer votre participation à tout moment. Votre décision de participer ou non restera strictement confidentielle et n'aura aucun effet sur les services qui vous sont offerts.

Si vous avez des questions concernant cette étude, n'hésitez pas de vous adresser au professeur Robert Flynn (613-564-6875) ou à Monsieur Peter Ely (819-771-7761, locale 273). Si vous donnez votre consentement à participer, veuillez signer le formulaire de consentement ci-dessous.

FORMULAIRE DE CONSENTEMENT INFORME

Je donne volontairement mon consentement à participer à cette étude. Je suis libre de terminer ma participation à n'importe quel moment, sans aucun effet sur les services que je reçois actuellement ou que je pourrais recevoir à l'avenir. Il est également entendu que mes réponses aux questions demeureront complètement confidentielles et que je ne serai jamais identifiable dans la présentation des résultats de l'étude.

Nom du (de la) participant(e): _____

Signature du (de la) participant(e): _____

Signature du témoin, M. Peter Ely: _____

Date: _____

ENTREVUE DE QUALITE DE VIE

Nom de famille: _____

Prénom: _____

Initiales: _____

Résidence actuelle: _____
Codez ci-bas la catégorie de résidence

Identité de l'étude: QUALITE DE VIE SUBJECTIVE/ELY 01

Nom de l'instrument: ENTREVUE DE QUALITE DE VIE

Identité de l'instrument: ELY/FLYNN QVS 01

CATEGORIE DE RESIDENCE ACTUEL

1 = Hôpital.
2 = Foyer avec soins infirmiers 24hrs/24.
3 = Foyer intermédiaire -- soins infirmiers moins de 24hrs.
4 = Foyer de groupe supervisé (placement à long terme).
5 = Foyer de transition (e.g., de type "halfway house").
6 = Famille d'acceuil.
7 = Maison ou appartement supervisé (personnel sur les lieux).
8 = Maison ou appartement supervisé (personnel non sur les lieux).
9 = Foyer nourissier pour adultes avec un programme pour adultes.
10 = Maison de chambre et pension (repas fournis/pas de supervision).
11 = Chambre seule, sans pension (e.g., hôtel, où les repas ne sont pas fournis, mais où il peut y avoir des appareils pour faire sa propre cuisine).
12 = Maison ou appartement privé (sans supervision).
13 = Abris tel que fourni par la maison Gitami ou l'Armée du Salut.
14 = Prison.
15 = Aucune résidence, vivre sur la rue, voyager d'un endroit à l'autre.
99 = Pas d'information/refuse de répondre.

ENTREVUE DE QUALITE DE VIE

Identité de l'étude: 01

Numéro du formulaire: 01

Numéro d'Identité du (de la) participant(e): _____

Unité du (de la) participant(e): _____

Numéro de l'examinateur(trice): _____

Date du début d'administration de l'instrument: _____

Heure du début d'administration de l'instrument: _____

Date de terminaison de l'administration: _____

Heure de terminaison de l'administration: _____

Pourcentage complété: _____

Individu complètant l'instrument: _____

Référence chronologique: _____ De base = 1 Suivi = 2

Vérification du formulaire pour déterminer degré de complétion? 1 = Oui 2 = Non _____

Numéro du (de la) vérificateur(trice) _____

Utilisé pour étude de fiabilité: 1 = Oui 2 = Non _____

Enregistrement Vidéo: 1 = Oui 2 = Non _____

Enregistrement Audio: 1 = Oui 2 = Non _____

ECHELLE SUR LA QUALITE DE VIE

INTRODUCTION:

Je suis intéressé à savoir comment ça va dans votre vie, ce que vous faites de jour au jour, et comment vous vous sentez envers les choses. J'ai des questions à vous demander au sujet de divers aspects de votre vie. Il n'y a pas de bonne ou mauvaise réponse, alors, décontractez vous et prennez votre temps à répondre aux questions.

Avant de commencer avez vous des questions?

A TRAVERS L'ENTREVUE LA PERIODE DE TEMPS COUVERTE SERA INDIQUEE SOIT PAR "L'ANNEE PASSEE" POUR L'ENTREVUE DE BASE OU SOIT "DEPUIS", ET DANS CE CAS, "*" PORTERA REFERENCE AU MOMENT QUAND LA DERNIERE ENTREVUE D'EVALUATION A EU LIEU.

SECTION A: **DONNEES DEMOGRAPHIQUES**

1. SEXE 0 = Homme 1 = Femme

2. **Langue maternelle:** 1 = Français 2 = Anglais

3 = Autres _____
Spécifiez

2.1 **Préférence pour la langue parlée:** _____
Utiliser le code d'item 2

3. **Age?** _____années (99 = Inconnu)

3.1 **Ville natale:** _____

Province : _____

Pays : _____

Où avez-vous été élevé(e): _____

3.2 **Quelle ville ou village considérez-vous comme votre chez-vous?**

_____
Inscrivez ci-haut le nom de la ville ou du village répondu

4. **Quel est votre plus haute année de scolarité?**

03 ou moins/ 04 05 06 07 08/ 09 10 11 12/ 13 14 15 16/ 17 18 19 20 99 = Inconnu

Si la personne n'est pas certaine, mais elle a une idée vague, évaluez:

06 = un peu de scolarité au niveau primaire
10 = un peu de scolarité au niveau secondaire
14 = un peu de scolarité au niveau collègiale

5. **Quel est votre état civil?**

0 = Célibataire
1 = Marié(e)
2 = Séparé(e)
3 = Divorcé(e)
4 = Veuf(ve)
5 = Vivant ensemble [Accoté(e)]
6 = Ne sait pas, refuse de répondre, etc.

ECHELLE RAVI(E)-TERRIBLE

1	2	3	4	5	6	7
TERRIBLE	MALHEUREUX(EUSE)	PLUTOT INSATISFAIT(E)	PLUS OU MOINS SATISFAIT(E)	PLUTOT SATISFAIT(E)	SATISFAIT(E)	RAVI(E)

ECHELLE DE PREFERENCE

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

ECHELLE DE DEGRE D'IMPORTANCE

TRES IMPORTANT	IMPORTANT	MOYENNEMENT IMPORTANT	PAS TROP IMPORTANT	PAS IMPORTANT DU TOUT
5	4	3	2	1

SECTION B: SATISFACTION AVEC LA VIE EN GENERAL

Veuillez s'il vous plaît regarder ceci. (DONNEZ L'ECHELLERAVI-TERRIBLE AU SUJET). **Cette échelle s'appelle l'Echelle Ravi-Terrible. Pouvez-vous la lire assez bien, ou désirez-vous de l'aide?**

1	2	3	4	5	6	7
TERRIBLE	MALHEUREUX(EUSE)	PLUTOT INSATISFAIT(E)	PLUS OU MOINS SATISFAIT(E)	PLUTOT SATISFAIT(E)	SATISFAIT(E)	RAVI(E)

Au courant de l'entrevue nous utiliserons cette échelle pour vous aider à me dire comment vous vous sentez envers divers aspects de votre vie. Tout ce que vous avez à faire c'est de me dire ce qui correspond le mieux à vos sentiments sur l'échelle. Par exemple, si vous êtes une personne qui aimez la crème glacée au chocolat, vous choisirez possiblement le mot "Ravi(e)". D'autre part, si vous êtes une personne qui haissez la crème glacée au chocolat, vous choisirez possiblement le mot "Terrible". Si vous vous sentez à peu près également satisfait et insatisfait avec la crème glacée au chocolat, alors vous choisirez au milieu de l'échelle.

Avez-vous des questions au sujet de l'échelle? (REPONDEZ TOUTES QUESTIONS QUE LE SUJET PEUT AVOIR). **Alors, commençons.**

La première question est plutôt générale.

1. **Comment vous sentez-vous envers votre vie en général?**

_____

(Utilisez l'échelle Ravi-Terrible)
99 = Incapable de répondre.

SECTION C: SITUATION DE VIE

Vérifiez la plupart des items dans cette section avec les dossiers. Seulement quelques questions en caractère gras sont demandées.

1. Quelle est le lieu de vie actuel de la personne?
(Si la personne est actuellement à l'hôpital, Lieu DE VIE = Lieu DE VIE IMMEDIATEMENT AVANT SON HOSPITALISATION)

01 = Vie de groupe avec supervision (généralement de longue durée) _____ Nombre de résidents

06 = Famille d'acceuil _____ Nombre de résidents

07 = Appartement protegé (intervenant(s) sur les lieux) _____ Nombre de résidents

13 = Lieu de refuge temporaire _____ Nombre de résidents

La situation de vie est:

1 = Dans une ville; centre urbain avec une population plus de 5,000 habitants (si "oui", spécifiez le voisinage).
Voisinage de la ville:
1 = Centre ville
2 = Résidentiel dans la ville
3 = Banlieux de la ville

2 = Dans une ville rural; population de 1,000 à 5,000 habitants (spécifiez le voisinage).
Voisinage de la ville rurale:
1 = Centre ville
2 = Banlieux de la ville

3 = Dans un village rural; population moins de 1,000 habitants (spécifiez le voisinage).
Voisinage du village:
1 = Dans le village
2 = Banlieux du village

4 = **Rural, à la campagne**, à l'extérieur d'une ville ou d'un village (spécifiez le nombre le kilométrage de la ville ou le village le plus près) _____ Km.

2. Depuis quand la personne demeure-t-elle à cet endroit?
(codez en mois) _____ mois.

3. **Dans quel type de lieux (voisinage), se trouve la situation de vie que vous préférez? Dans une ville, dans une ville rurale, dans une village, ou à la campagne?**

Indiquez ci-haut la préférence de la personne et codez ci-bas

1 = Dans une ville; centre urbain avec une population plus de 5,000 habitants (si "oui", spécifiez le voisinage).
Voisinage de la ville:
1 = Centre ville
2 = Résidentiel dans la ville
3 = Banlieux de la ville

2 = Dans une ville rurale; population de 1,000 à 5,000 habitants (spécifiez le voisinage).
Voisinage de la ville rurale:
1 = Dans la ville
2 = Dans les banlieux de la ville

3 = Dans un village rurale; population moins de 1,000 habitants (spécifiez le voisinage).
Voisinage du village:
1 = Dans le village
2 = Banlieux du village

4 = **Rural**, à la campagne, à l'extérieur d'une ville ou d'un village (spécifiez le nombre le kilometrage de la ville ou le village le plus près) _____ Km.

Score de préférence

1 = Concordance (la personne vit où elle préfère)
0 = Divergence (la personne ne vit pas où elle préfère)
9 = Ne peut pas répondre/refuse de répondre, etc.

4. Dites-moi quel type de résidence préférez-vous?

Inscrivez ci-haut la réponse de la personne et encerclez ci-dessous la catégorie de son choix

1 = Hôpital.
2 = Foyer avec soins infirmiers 24hrs/24.
3 = Foyer intermédiaire -- soins infirmiers moins de 24hrs.
4 = Foyer de groupe supervisé (placement à long terme).
5 = Foyer de transition (e.g., de type "halfway house").
6 = Famille d'acceuil.
7 = Maison ou appartement supervisé (personnel sur les lieux).
8 = Maison ou appartement supervisé (personnel non sur les lieux).
9 = Foyer nourissier pour adultes avec un programme pour adultes.
10 = Maison de chambre et pension (repas fournis/pas de supervision).
11 = Chambre seule, sans pension (e.g., hôtel, où les repas ne sont pas fournis, mais où il peut y avoir des appareils pour faire sa propre cuisine).
12 = Maison ou appartement privé (sans supervision).
13 = Abris tel que fourni par la maison Gitami ou l'Armée du Salut.
14 = Prison.
15 = Aucune résidence, vivre sur la rue, voyager d'un endroit à l'autre.
99 = Pas d'information/refuse de répondre.

5. Score de préférence

1 = Concordance avec le type de résidence actuelle.
0 = Divergence avec le type de résidence actuelle.
9 = Ne sait pas/refuse de répondre, etc.

6. **Avez-vous vécu(e) dans un autre endroit (aillieurs qu'ici) pendant de l'année (depuis *)?** (INCLUANT UN HOPITAL PSYCHIATRIQUE).

0 = Non (allez à C.8)

1 = Oui (codez selon les instructions ci-dessous et allez à C.7).

9 = Ne sait pas/Pas d'information (allez à C.8)

NUMEROTEZ EN ORDRE, LES ENDROITS OU LA PERSONNE A DEMEURE (DURANT L'ANNEE/DEPUIS *), INCLUANT LES HOPITAUX PSYCHIATRIQUES. COMMENCEZ AVEC L'ENDROIT LE PLUS RECENT OU LA PERSONNE A DEMEURE (UTILISEZ LES MEMES CODES QUE DANS C.4.1 CI-HAUT). CODEZ AUSSI POUR LE TYPE DE VOISINAGE (e.g., 1 = VOSIANGE DE LA VILLE; 2 = VOISINAGE D'UNE VILLE RURALE; 3 = VOISINAGE D'UN VILLAGE; 4 = RURAL, A LA CAMPAGNE.

CODEZ POUR TYPE DE Voisinage / Résidence	DESCRIPTION
Code pour type	**DESCRIPTION**
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____
e. _____	_____
f. _____	_____
g. _____	_____
h. _____	_____

Nombre total de différentes résidences qui ne sont pas des hôpitaux (durant l'année/Depuis *)

_____

7. Laquelle de celles-ci était votre résidence habituelle (durant l'année/Depuis *)? (utilisez les codes dans C.4 ci-haut).

_____

(VERIFIEZ LES DOSSIER POUR DETERMINER SI LA PERSONNE A ETE DANS UN HOPITAL PSYCHIATRIQUE PENDANT L'ANNEE PASSEE/DEPUIS *, ET INSCRIVEZ LES PLACEMENTS CI-BAS: NOTEZ QUELLES SONT LES DATES DE SES PLACEMENT DANS UN HOPITAL PSYCHIATRIQUE PENDANT L'ANNEE (DEPUIS *). (DEBUTEZ AVEC LE PLACEMENT LE PLUS RECENT ET TRAVAILLEZ A RECULONS DANS LE TEMPS).

Plus Récente	A Date d'acceuil	B Date de départ	C Durée de temps
1	____/____ (Mois)/(Année)	____/____ (Mois)/(Année)	_____ Jours
2	____/____ (Mois)/(Année)	____/____ (Mois)/(Année)	_____ Jours
3	____/____ (Mois)/(Année)	____/____ (Mois)/(Année)	_____ Jours
4	____/____ (Mois)/(Année)	____/____ (Mois)/(Année)	_____ Jours
5	____/____ (Mois)/(Année)	____/____ (Mois)/(Année)	_____ Jours

(Nombre total de jours d'hospitalisation pendant l'année passée/Depuis *)

_____ Jours.

8. **Je vais vous demander de me dire comment vous trouvez quelques aspects des installations où vous habitez actuellement. J'aimerais que vous me disiez si l'aspect que je vais vous mentionner est disponible, et quelle importance cet aspect a pour vous.** DONNEZ UNE COPIE DES CRITERES A LA PERSONNE ET CODEZ LA RESIDENCE SELON LE CODE EN C.4.1

8.1 L'aspect est-il disponible pour votre utilisation? (Pas nécessairement pour une utilisation exclusive)

8.2 Quelle importance l'aspect a-t-il pour vous; est-il: TRES IMPORTANT (**TI**), IMPORTANT (**I**), MOYENNEMENT IMPORTANT (**MI**), PAS TROP IMPORTANT (**PTI**), PAS DU TOUT IMPORTANT (**PI**)? Si la personne ne sait pas encercler **NSP** (**Ne Sait Pas**).

		DISPONIBILITE			DEGRE D'IMPORTANCE					
		OUI	NON	NSP	TI	I	M	PTI	PI	NSP
a.	Toilette avec une porte qui se ferme et se barre	1	0	9	5	4	3	2	1	9
b.	Une chambre privée (à vous seul)?	1	0	9	5	4	3	2	1	9
c.	Une porte de chambre qui se barre?	1	0	9	5	4	3	2	1	9
d.	Une clef pour la porte de la maison?	1	0	9	5	4	3	2	1	9
f.	Un lieu privé pour parler au téléphone?	1	0	9	5	4	3	2	1	9

9. **Combien de gens préfériez-vous vivre avec?** _____
N de personnes

10. **Dans la résidence où vous demeurez actuellement, y a-t-il autres choses que vous préfériez avoir et que vous n'avez pas actuellement?**

_____

_____

(Inscrivez la réponse de la personne mot pour mot)

9. **Maintenant, j'aimerais que vous me disiez le degré d'importance personelle que vous attachez aux divers aspects de la vie que je vais mentionner? Est-ce que c'est Très Important (TI),Important (I), Moyennement Important (MI), Pas Trop Important (PTI), Pas Important du tout.** Si la personne ne sait pas, ou refuse de répondre, encercler (**NSP**).

DESCRIPTION DE L'ITEM	DEGRE D'IMPORTANCE					
	TI	I	MI	PTI	PI	NSP
Le lieu physique où vous demeurez, y compris son emplacement géographique?	5	4	3	2	1	9
La qualité de la nourriture que vous mangez?	5	4	3	2	1	9
La flexibilité des règlements la où vous habitez?	5	4	3	2	1	9
D'avoir un lieu où vous pouvez aller pour être seul(e) et privé(e)?	5	4	3	2	1	9
D'avoir la liberté de faire ce que vous voulez quand vous le voulez?	5	4	3	2	1	9
De demeurez au même endroit pour une longue période de temps (d'avoir un lieu de vie stable)?	5	4	3	2	1	9

DONNEZ L'ECHELLE DE **PREFERENCE** A LA PERSONNE ET DEMANDEZ:

10. **Dites-moi à quel point est votre préférence pour les choses suivantes:**

10.1) De la variété dans votre alimentation?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

10.2) La liberté de prendre vos propres décisions en ce qui concerne les aspects financiers de votre vie?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

10.3) L'intimité [être privé(e)]?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

11. **Maintenant, utilisez encore l'Echelle Ravi-Terrible pour répondre aux questions suivantes.** 9 = ne peut pas répondre

Comment vous sentez-vous envers:

_____ 1. Les arrangement de vie; la situation où vous demeurez?

_____ 2. La nourriture où vous demeurez?

_____ 3. Les règles où vous demeurez?

_____ 4. L'intimité (vie privée et personelle) que vous avez où vous demeurez?

_____ 5. Le montant de liberté (les occasions de faire ce que vous voulez) ou vous demeurez actuellement?

_____ 6. La possibilité de demeurer pour une longue période de temps où vous demeurez actuellement?

SECTION D: FINANCES

VERIFIEZ LES QUESTIONS AU SUJET DES RESSOURCES FINANCIERES D'APRES LES DOSSIERS.

N/A	Oui	Non	Item	Source
9	1	0	A	Travail
9	1	0	B	Régie des Rentes
9	1	0	C	Pensions pour personnes ayant un handicap
9	1	0	D	Autres genres de rentes (pensions) supplémentaires
9	1	0	E	Rentes des forces armées
9	1	0	F	Autres bénéfices sociaux tels que des rentes des gouvernements provincial et fédérale, assistance sociale, etc.
9	1	0	G	Programme de réhabilitation vocationelle tel que du travail dans un atelier protegé
9	1	0	H	Assurance chomage
9	1	0	I	Fonds de pensions, placements, Bonds du Canada, etc.
9	1	0	J	Loyer à prix modique, assistance aux locataires
9	1	0	K	Pensions alimentaires suite à une séparation ou divorce
9	1	0	L	Bonds pour achat de l'alimentation
9	1	0	M	Autre(s) source(s): Spécifiez:

_____

_____

Montant d'argent que la personne reçoit mensuellement de toutes sources: VOIR DOSSIER.

_____ $ 9999.99 = N/A.

1. A peu près combien d'argent dépensez-vous pour vous mêmes chaque mois (excluant l'argent pour votre logement et votre alimentation, et autres nécessités de base)?

_____ $ 9999.99 = Ne Sait Pas/Refuse de répondre, etc.

2. **Recevez-vous assez d'argent mensuellement pour couvrir les items suivants:**
(Cette question s'adresse à la perception de suffisance du support financier). SI LA REPONSE EST "NON", DEMANDEZ COMBIEN IL FAUT A LA PERSONNE POUR SUFFISANCE ECONOMIQUE DANS LE DOMAINE.

ITEM	OUI	NON	NSP/REFUSE	MONTANT DE PLUS EN BESOIN
.1 Manger?	1	0	9	_____ $
.2 Vêtements?	1	0	9	_____ $
.3 Loyer?	1	0	9	_____ $
.4 Transport pour aller au travail, voir le médecin, le dentiste, etc.?	1	0	9	_____ $
.5 Transport pour voir votre famille, des ami(e)s, etc?	1	0	9	_____ $
.6 Activités sociales, loisirs, ou pour aller manger aux restaurants voir des films, etc.?	1	0	9	_____ $
.7 Achats de choses personnelles telles que du tabac, des revues, du maquillage, etc.?	1	0	9	_____ $

3. **Envers quelles choses suivantes préférez-vous généralement dépenser votre argent?** (ORDONNEZ EN ORDRE DE PREFERENCE).

ITEM	ORDRE DE PREFERENCE
.1 Alimentation (manger)?	_____ $
.2 Vêtements?	_____ $
.3 Logement?	_____ $
.4 Transport pour aller au travail voir le dentiste, aller magasiner, faire des courses etc.?	_____ $
.5 Transport pour voir votre famille, des ami(e)s, etc.?	_____ $
.6 Activités sociales, loisirs, ou pour aller manger aux restaurants?	_____ $
.7 Achats de choses personnelles telles que du tabac, des livres, du maquillage, etc.?	_____ $

4. **COMBIEN D'ARGENT PREFEREZ-VOUS AVOIR PAR MOIS POUR VOS DEPENSES PERSONNELLES?**

_____ $/mois.

DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

5. Maintenant regardons encore l'échelle Ravi-Terrible et dites moi comment vous sentez-vous envers les choses suivantes:

_____ 5.1 **Le montant d'argent que vous avez?**

_____ 5.2 **Ce que vous avez à payer pour les besoins de base tels que le linge, vos produits de toilette?**

_____ 5.3 **Votre niveau de comfort et de sécurité financière?**

_____ 5.4 **Le montant d'argent que vous avez pour dépensez sur de l'agrément?**

SECTION E: TRAVAIL ET ECOLE

1. **Avez-vous un emploi actuellement?** (NOTEZ NIMPORTE QUEL TYPE D'EMPLOI).

   1 = Oui (allez au numéro E2 et suivez à E.3).
   0 = Non (allez au numéro E. 2).
   9 = Ne Sait Pas/refuse de répondre (aller au numéro E. 2).

2. **En général, préférez-vous travailler?**

   1 = Oui (demander # E 9.)
   0 = Non (aller au numéro E 12.)
   9 = Ne Sait Pas/refuse de répondre (aller au numéro E 12.)

2.1 Score de Préférence: _____

   1 = Concordance entre la préférence et la situation actuelle envers l'emploi (incluant le chomâge).
   0 = Divergence entre la préférence et la situation actuelle envers l'emploi (incluant le chomâge).
   9 = Incapable de compléter.

DEMANDEZ SEULEMENT SI LA PERSONNE A UN EMPLOI.

3. **Quel type d'emploi avez-vous actuellement?**

_____
Décrivez l'emploi ci-haut et encercler le type ci-bas

_____ 1. Emploi compétitif (emploi compétitif obtenu sur le marché du travail.
_____ 2. Emploi transitionel (emploi obtenu par l'aide d'un programme de formation ou de réhabilitation vocationelle).
_____ 3. Formation à l'emploi (préparation vocationelle--pas rémunérée.
_____ 4. Travail dans un atelier protégé (emploi à salaire, à long terme, dans un environnement de travail controllé).
_____ 5. Travail bénévolat (spécifiéz):

_____

_____ 6. Autre(s) types de travail (tel qu'un emploi avec des parents: Spécifiez):

_____

_____ 9. Ne Sait Pas/refuse de répondre, etc.

DEMANDEZ SEULEMENT SI LA PERSONNNE A UN EMPLOI.

4. **Dans quel type d'industrie ou commerce est votre emploi?**

_____

(inscrire le type d'industrie ci-haut)

5. **Combien gagnez-vous à l'heure?** _____ $/heure.

6. **Approximativement combien d'heures/semaine travaillez-vous actuellement?**

_____

Nombres d'heures/semaine

7. **Approximativement combien d'heures/semaine préférez-vous travailler?**

_____

nombre d'heures

Score de préférence: _____

1 = Concordance entre préférence pour heures de travail et la situation actuelle.
0 = Divergence entre préférence pour heures de travail et la situation actuelle.
9 = Incapable d'évaluer.

8. En vous basant sur les réponses données aux items 3 et 4, évaluez le type d'emploi de la personne (utilisez les catégories ci-dessous).

01. Exécutif(ve), propriétaire d'une grosse entreprise, professionel(le) dans une discipline majeure (e.g., avocat, juge, médecin, professeur d'université).

02. Gérant(e) d'une entrerpise importante, propriétaire d'un commerce moyennement gros, professionel(le) dans une discipline importante (e.g., psychologue, infirmière, dentiste, pharmacien, etc.).

03. Personnel administratif, propriétaire d'une petite entreprise indépendante, propriétaire d'une grosse ferme, professionel(le) dans une discipline mineure e.g., professeur d'école).

04. Travailleur(euse) dans un bureau, vendeur(euse), technicien(enne), propriétaire d'un petit commerce, propriétaire d'une ferme de moyenne grosseur.

05. Propriétaire d'une petite ferme, travailleur(euse) dans un métier (e.g., électricien, plombier, etc.).

06. Opérateur de machinerie, employé(e) avec quelques connaissances d'un métier. Fermier qui loue une ferme, et qui appartient quelques pièces d'équipement.

07. Journalier, personne ayant aucun métier spécialisé (entretien ménager), etc.

08. Employé(e) dans un atelier protégé, personne en formation, etc.

09. Personne qui reste à la maison (sans salaire).

99. Incapable de classfier.

9. Quel type d'emploi préférez-vous avoir?

_____

Décrivez l'emploi ci-haut et encercler le type ci-bas

_____ 1. Emploi compétitif (emploi compétitif obtenu sur le marché du travail).
_____ 2. Emploi transitionel (emploi obtenu par l'aide d'un programme de formation ou de réhabilitation vocationelle).
_____ 3. Formation à l'emploi (préparation vocationelle--pas rémunérée).
_____ 4. Travail dans un atelier protégé (emploi à salaire, à long terme, dans un environnement de travail controllé).
_____ 5. Travail bénévolat (spécifiez):

_____

_____ 6. Autre(s) types de travail (tel qu'un emploi avec des parents) Spécifiez:

_____

_____ 9. Ne sait pas/refuse de répondre, etc.

CODEZ LA PREFERENCE POUR LE TYPE D'EMPLOI SEULEMENT POUR LES PERSONNES QUI TRAVAILLENT ACTUELLEMENT

9.1 Score de préférence: _____
1 = Concordance entre la préférence et le type d'emploi actuel.
0 = Divergence entre la préférence et le type d'emploi actuel.
9 = Incapable de compléter.

10. Dans quel type d'industrie ou commerce se touverait le type d'emploi que vous préférez?

_____

(décrivez le type d'industrie ci-haut)

11. Votre préférence est de travailler à peu près combien d'heures/semaine?

Nombre d'heures/semaine: _____

12. En vous basant sur les réponses données aux items 9 et 10, encerclez le type d'emploi préféré de la personne (utilisez les catégories ci-dessous).

01. Exécutif(ve), propriétaire d'une grosse entreprise, professionel(le) dans une discipline majeure (e.g., avocat, juge, médecin, professeur d'université).

02. Gérant(e) d'une entrerpise importante, propriétaire d'un commerce moyennement gros, professionel(le) dans une discipline importante (e.g., psychologue, infirmière, dentiste, pharmacien, etc.).

03. Personnel administratif, propriétaire d'une petite entreprise indépendante, propriétaire d'une grosse ferme, professionel(le) dans une discipline mineure (e.g., professeur d'école).

04. Travailleur(euse) dans un bureau, vendeur(euse), technicien(enne), propriétaire d'un petit commerce, propriétaire d'une ferme de moyenne grosseur.

05. Propriétaire d'une petite ferme, travailleur(euse) dans un métier (e.g., électricien, plombier, etc.).

06. Opérateur de machinerie, employé(e) avec quelques connaissances d'un métier. Fermier qui loue une ferme, et qui appartient quelques pièces d'équipement.

07. Journalier, personne ayant aucun métier spécialisé (entretien ménager), etc.

08. Employé(e) dans un atelier protégé, personne en formation, etc.

09. Personne qui reste à la maison (sans salaire).

99. Incapable de classfier.

POUR LES PERSONNES QUI NE SONT PAS ACTUELLEMENT EMPLOYEES

12. Pourquoi n'avez-vous pas un emploi qui paie actuellement?

01. Mise-à pied temporaire
02. Physiquement incapable de travailler
03. Handicap en santé mentale/incapable de travailler
04. Handicap développemental
05. A sa retraite
06. Incapable de se trouver de l'emploi
07. Ne désire pas travailler
08. Peur de perde ses bénéfices sociaux
09. Etudiant(e) à temps plein
10. Ménager(ère) à temps plein
11. Autres (spécifiez) _____
99. Ne Sait Pas/refuse de répondre

13. Depuis combien de mois avez-vous été sans un emploi qui paie?

_____
nombre de mois 99 = Aucun emploi antérieur

14. En terme du salaire, quel était le meilleur emploi que vous avez déjà eu? (demandez seulement si la personne est actuellement sans emploi). Si la personne cite son emploi actuel, sautez au numéro 15).

_____

_____
Spécifiez ci-haut le titre de l'emploi et les responsabilités générales

15. Pendant combien de mois consécutifs avez-vous travaillé à cet emploi?

_____
Codez en mois à l'emploi

16. Depuis combien de mois avez-vous laissez cet emploi?

_____
Codez en mois depuis le départ de l'emploi

17. En vous basant sur les réponses données aux items 3 et 14, évaluer le meilleur type d'emploi que la personne avait (utiliser les catégories ci-dessous).

01. Exécutif(ve), propriétaire d'une grosse entreprise, professionel(le) dans une discipline majeure (e.g., avocat, juge, médecin, professeur d'université).

02. Gérant(e) d'une entrerpise importante, propriétaire d'un commerce moyennement gros, professionel(le) dans une discipline importante (e.g., psychologue, infirmière, dentiste, pharmacien, etc.).

03. Personnel administratif, propriétaire d'une petite entreprise indépendante, propriétaire d'une grosse ferme, professionel(le) dans une discipline mineure (e.g., professeur d'école).

04. Travailleur(euse) dans un bureau, vendeur(euse), technicien(enne), propriétaire d'un petit commerce, propriétaire d'une ferme de moyenne grosseur.

05. Propriétaire d'une petite ferme, travailleur(euse) dans un métier (e.g., électricien, plombier, etc.).

06. Opérateur de machinerie, employé(e) avec quelques connaissances d'un métier. Fermier qui loue une ferme, et qui appartient quelques pièces d'équipement.

07. Journalier, personne ayant aucun métier spécialisé (entretien ménager), etc.

08. Employé(e) dans un atelier protégé, personne en formation, etc.

09. Personne qui reste à la maison (sans salaire).

99. Incapable de classfier.

SEULEMENT POUR LES REPONDANT(E)S QUI SONT ACTUELLEMENT EMPLOYES ET POUR CEUX QUI DESIRENT AVOIR UN AUTRE TYPE D'EMPLOI: DONNEZ L'ECHELLE DE PREFERENCE ET DITES:

18. **Maintenant je vais vous demander de me dire à quel point sont vos préférences pour les choses suivantes qui touchent au fait d'avoir un emploi: Vos préférences sont-elles: ENORMEMENT,BEAUCOUP, MOYENNEMENT, UN PEU, OU PAS DU TOUT?**
DONNEZ L'ECHELLE DE PREFERENCE A LA PERSONNE:

1. AVOIR UN EMPLOI INTERESSANT?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

2. TRAVAILLER AVEC DES GENS QUI VOUS COMPRENNENT?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

3. TRAVAILLER DANS UN ENDROIT QUI EST AGREABLE?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

4. AVOIR DES HEURES DE TRAVAIL REGULIERES 5 JOURS/SEMAINE?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

5. AVOIR UN SALAIRE ADEQUAT POUR VOTRE TRAVAIL?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

19. **Maintenant nous allons encore utiliser l'échelle Ravi-Terrible et vous allez me dire comment vous vous sentez envers les choses suivantes:**

_____ **Votre emploi actuel?**

_____ **Les gens avec lesquels vous travaillez?**

_____ **Les lieux où vous travaillez (l'emplacement physique des lieux où vous travaillez)?**

_____ **Le nombre d'heures que vous travaillez?**

_____ **Le montant d'argent qu'on vous paie à votre emploi?**

20. Allez-vous à l'école de façon régulière actuellement, par exemple l'école "Alpha"?

0 = Non (ALLEZ AU NUMERO 21)
1 = Oui (ALLEZ AU NUMERO 22)
9 = Ne Sait Pas/refuse, etc. (ALLEZ AU NUMERO 21).

21. Pourquoi n'allez-vous pas à l'école de façon regulière actuellement?

_____
Inscrivez ci-haut la réponse, et encercler ci-bas la catégorie

4 = Travail
3 = Vaccances (école fermé pour période estivale, etc.).
2 = Malade
1 = Autres raison _____
(Spécifiez)
0 = Ne désire pas aller à l'école.
9 = Ne sait pas/Refuse de répondre, etc.

22. Avez-vous été un étudiant(e) (pris des cours), pendant l'année? (Notez n'importe quel type d'éducation incluant le programme d'école "ALPHA").

0 = Non (allez au numéro 24 et ensuite à 28).
1 = Oui (allez au numéro 23 et ensuite à 24 et 25).
9 = Ne Sait Pas/refuse de répondre, etc. (SECTION F).

23. Combien de jours par semaine prennez(iez)-vous des cours?

_____ Jours/semaine.
Inscrivez ci-haut le nombre de jours

24. Vouliez-vous étudier (prendre des cours) pendant l'année?

0 = Oui (divergence avec # 20 si la personne a répondu "Non"
1 = Non (concordance avec # 20 si la personne a répondu "Oui"
9 = Ne Sait Pas/refuse de répondre, etc. (SECTION F).

25. Mesure de préférence: _____

1 = Concordance entre ce que la personne fait (# 20), ou a fait (# 22), et ce que la personne voulait faire (# 24) pendant l'année scolaire.
0 = Divergence entre ce que la personne fait (# 20), ou a fait (# 22), et ce que la personne voulait faire (# 24) pendant l'année scolaire.
9 = Incapable d'évaluer la préférence.

26. **A quel niveau étudiez-vous?**

0 = Atelier scolaire (tel qu'ALPHA)
1 = Secondaire
2 = CEGEP (collège)
3 = Université
4 = Etudes supérieures
5 = Autre (spécifiez) _____
9 = Ne Sait Pas/Refuse de répondre, etc.

27. Avez(iez)-vous une pleine charge de cours?

0 = Non
1 = Oui
9 = Ne Sait Pas/Refuse de répondre, etc.

28. Planifiez-vous d'étudier (prendre des cours) l'an prochain?

1 = Oui
0 = Non
9 = Ne Sait Pas/refuse de répondre, etc.

SEULEMENT POUR LES REPONDANT(E)S QUI SONT COURAMMENT ETUDIANT(E)S. DONNEZ L'ECHELLE DE PREFERENCE ET DITES:

30. Maintenant je vais vous demander de me dire à quel point sont vos préférences pour les choses suivantes qui touchent au fait d'être un(e) étudiant(e): Vos préférences sont-elles: ENORMEMENT,BEAUCOUP, MOYENNEMENT, UN PEU, OU PAS DU TOUT?

1. Prendre des cours et étudier?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

2. Prendre des cours à l'école où vous êtes actuellement?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

3. Etudier avec des gens qui sont du même âge que vous?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

4. Avoir un choix des cours à prendre?

5	4	3	2	1	9
ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS

SEULEMENT POUR LES REPONDANT(E)S QUI SONT COURAMMENT ETUDIANT(E)S: DONNEZ DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

31. Je vais vous montrez de nouveau l'échelle Ravi(e)-Terrible. Dites-moi comment vous sentez-vous envers les choses suivantes:

_____ 1. Etre un(e) étudiant(e)?

_____ 2. Votre école?

_____ 3. Les autres étudiants à votre école?

_____ 4. Les choses que vous apprenez à l'école?

SECTION F:

ACTIVITES QUOTIDIENNES, LOISIRS, FONCTIONNEMENT ET INTEGRATION SOCIALE PERSONELLE

LISEZ LES INSTRUCTIONS A LA PERSONNE. INSCRIVEZ ENSUITE SES REPONSES EN TERMES DE FREQUENCE APPROXIMATIVE ET EVALUEZ LE NIVEAU D'INTEGRATION SOCIALE DE L'ACTIVITE EN SUIVANT LES CODES CI-DESSOUS. EN CAS DE MULTIPLES FREQUENCE AVEC DIFFERENTES PERSONNES EVALUEZ LE NIVEAU D'INTEGRATION SOCIALE DE CHAQUE FREQUENCE EN SUIVANT LE CODE SUIVANT: LE PREMIER CHIFFRE REPRESENTE TOUJOURS LA PORTION DE LA FREQUENCE TOTALE QUI DOIT ETRE MULTIPLIEZ (X) PAR LE NIVEAU D'INTEGRATION SOCIALE DE LA PERSONNE ACCOMPAGNANT LE (LA) REPONDANT(E): PAR EXEMPLE, SI LE (LA) REPONDANT(E) EST SORTIE PRENDRE UNE MARCHE 3 FOIS PENDANT LA SEMAINE DERNIERE (UNE FOIS SEUL, UNE FOIS AVEC UN(E) EDUCATEUR(TRICE), ET UNE FOIS AVEC UN(E) AUTRE RESIDENT(E) DU MEME FOYER), L'INTEGRATION SOCIALE DOIT ETRE CODEZ COMME TEL: (1 X 0; 1 X3, ET 1 X 1).

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

Maintenant nous allons parler des choses que vous avez faites avec votre temps pendant la dernière semaine (les 7 derniers jours). Je vais vous nommer des activités qu'une personne peut faire et vous allez me dire si vous avez fait ce genre d'activité. Pour chacune des activités que je vais vous nommer, dites-moi à peu près combien de fois vous avez fai cette activité, et avec qui.

01. Aller prendre une marche?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____
 # de fois

_____
 # catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

02. Aller voir un film (pas à la télévision)?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

03. Regarder la télévision?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

04. Aller magasiner?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

05. Aller au restaurant pour prendre un café ou pour manger?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

06. Aller à une taverne ou un bar?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

07. Lire le journal, une revue, ou un livre?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

08. Ecouter la radio?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

09. Jouer aux cartes ou un autre jeu de société?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

10. Aller faire un tour d'auto ou d'autobus seulement pour se balader?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

11. Préparer un repas?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

12. Travailler sur un passe-temps (hobby)?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

13. Jouer à un sport (e.g., natation, croquet, aux poches)?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
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INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

14. Aller à une réunion d'un organisme communautaire?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

15. Aller dans un parc?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

16. Aller à une bibliothèque?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

17. Aller visiter un musée?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

18. Aller à l'église?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

19. Aller à la plage?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

20. Aller à un "Party"?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

21. Aller à une danse?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

22. Aller jouer au "Bingo"?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

23. Aller visiter un(e) ami(e) chez lui (elle)?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

24. Avoir reçu(e) une visite d'un(e) ami(e) à la résidence?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

25. Aller visiter votre famille chez-elle?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

26. Avoir reçu(e) une visite de votre famille à la résidence?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

27. Aller voir un spectacle des beaux arts à l'extérieur de la résidence (pas à la télévision)?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

28. Aller au centre d'achats pour se désennuyer (plutôt que pour acheter)?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

29. Aller faire du camping?

FREQUENCE
 # de fois

_____
de fois

INTEGRATION SOCIALE
La personne valorisante

_____
catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

30. Aller à un "picnic"?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____
de fois

_____
catégorie d'intégration

31. Travailler à un emploi quelconque [accompagné(e) ou non] qui est rémunéré?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____
de fois

_____
catégorie d'intégration

32. Aller à un atelier de travail (ou de formation au travail) protégé?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____
de fois

_____
catégorie d'intégration

33. Aller à un programme scolaire (de n'importe quel type)?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____
de fois

_____
catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

34. Aller faire du travail bénévolat (pas rémunéré)?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

35. Aller à la banque?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

36. Aller au bureau de poste?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

37. Aller chez le dentiste?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

38. Aller chez le médecin (pas un psychiatre à l'hôpital)?

FREQUENCE
de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

39. Aller faire des courses (e.g., aller au marché, à l'épicerie, au dépaneur, etc.)?

FREQUENCE
de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

40. Faire du ménage autour de la maison (e.g., laver une auto, passer le balais dans l'entrée du passage, faire du jardinage, couper ou arroser la pelouse, pelleter de la neige, etc.)?

FREQUENCE
de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

41. Faire du ménage dans la maison (e.g., laver la vaisselle, balayer ou laver les planchers dans la maison, etc.)?

FREQUENCE
de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

FREQUENCE

3 = Quotidiennement
2 = 3 fois et +/semaine
1 = 1 Fois/semaine
0 = Pas du tout
9 = Ne sait pas

INTEGRATION SOCIALE

0 = Seul(e).
1 = Avec un (des) autre(s) patient(s) du même foyer.
2 = Avec un (des) autre(s) patient(s) d'un autre foyer, ou un(e) (des) autre(s) personne(s) dévalorisée.
3 = Avec le personnel du foyer du (de la) résident(e).
4= Avec un(e) professionel(le) qui visite le foyer.
5 = Avec un membre de la famille de la personne.
6 = Avec une personne valorisée (autre qu'un membre de la famille ou un(e) professionel(le) qui visite le foyer).

---

42. Aller faire un tour de bicyclette?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

43. Aller se faire couper les cheveux?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

44. Aller voir un spectacle de sports à l'extérieur de la résidence (pas à la télévision)?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

45. Aller à un centre communautaire (e.g., à l'Intersection)?

FREQUENCE
 # de fois

INTEGRATION SOCIALE
La personne valorisante

_____ # de fois

_____ # catégorie d'intégration

Préférences

Maintenant, j'aimerais savoir vos préférences pour divers aspects de votre vie quotidienne. Dites-moi à quel point sont vos préférences pour les choses suivantes:
DONNEZ L'ECHELLE DE PREFERENCE A LA PERSONNE:

1. Avoir des activités qui vous intéressent pendant votre temps libre?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

2. Avoir assez de temps pour faire les choses que vous désirez faire?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3. L'occasion d'entreprendre des choses agréables ou d'apprécier des belles choses?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

4. Avoir un certain montant d'agrément ou de plaisir?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

5. Avoir le temps qui vous suffit pour vous décontracter (pour "relaxer" vous détendre)?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

6. Ecouter la télévision ou la radio?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

7. **Quel est le degré de votre préférence pour avoir une relation d'intimité avec votre famille (pour être proche avec votre famille)?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

---

8. **Maintenant nous allons utiliser de nouveau l'échelle Ravi-Terrible. Dites-moi comment vous sentez-vous envers les choses suivantes:** DONNEZ L'ECHELLE A LA PERSONNE:

1. _____ **La façon que vous utilisez votre temps libre?**
2. _____ **Le montant (la quantité) de temps que vous avez pour faire les choses que vous voulez faire?**
3. _____ **Les occasions que vous avez pour apprécier des choses agréables ou belles?**
4. _____ **Le montant (la quantité) de plaisir et d'agrément dans votre vie?**
5. _____ **Le montant, (la quantité) de détente, décontraction ("relaxation") que vous avez dans votre vie?**
6. _____ **L'agrément que vous apporte la tétévision et/ou la radio?**

SECTION G:

ECHELLE DE SATISFACTION DE VIE

DONNEZ UNE COPIE DE L'ECHELLE DE SATISFACTION DE VIE A LA PERSONNE ET DITES:

Nous présentons ci-dessous cinq énoncés avec lesquels vous pouvez être en accord ou en désaccord. A l'aide de l'échelle de 1 à 7 ci-dessous, indiquez votre degré d'accord ou de désaccord avec chacun des énoncés en encerclant le chiffre à la droite des énoncés. Nous vous prions d'être ouvert(e) et honnête dans vos réponses. L'échelle de sept points s'interprète comme suit:

Fortement en désaccord	En désaccord	Légèrement en désaccord	Ni en désaccord ni en accord	Légèrement en accord	En accord	Fortement en accord
1	2	3	4	5	6	7

	ENCERCLER
	1 2 3 4 5 6 7
1) En général, ma vie correspond de près à mes idéaux.	1 2 3 4 5 6 7
2) Mes conditions de vie sont excellentes.	1 2 3 4 5 6 7
3) Je suis satisfait(e) de ma vie.	1 2 3 4 5 6 7
4) Jusqu'à maintenant, j'ai obtenu les choses importantes que je voulais de la vie.	1 2 3 4 5 6 7
5) Si je pouvais recommencer ma vie, je n'y changerais presque rien.	1 2 3 4 5 6 7

SECTION H: FAMILLE

1. **Combien de fois parlez-vous au téléphone avec un membre de votre famille? Diriez-vous au moins une fois par jour, une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?**

   5 = A peu près une fois par jour ou plus.

   4 = Au moins une fois par semaine, mais moins qu'une fois par jour.

   3 = Au moins une fois par mois, mais moins qu'une fois par semaine.

   2 = Moins qu'une fois par mois, mais au moins une fois par année.

   1 = Pas du tout depuis un an.

   9 = Ne s'applique pas (pas de famille), ne sait pas, refuse de répondre, etc.

2. **Combien de fois recevez-vous une lettre d'un membre de votre famille? Diriez-vous au moins une fois par jour, une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?**

   5 = A peu près une fois par jour ou plus.

   4 = Au moins une fois par semaine, mais moins qu'une fois par jour.

   3 = Au moins une fois par mois, mais moins qu'une fois par semaine.

   2 = Moins qu'une fois par mois, mais au moins une fois par année.

   1 = Pas du tout depuis un an.

   9 = Ne s'applique pas (pas de famille), ne sait pas, refuse de répondre, etc.

3. **Combien de fois écrivez-vous une lettre à un membre de votre famille? Diriez-vous au moins une fois par jour, une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?**

   5 = A peu près une fois par jour ou plus.

   4 = Au moins une fois par semaine, mais moins qu'une fois par jour.

   3 = Au moins une fois par mois, mais moins qu'une fois par semaine.

   2 = Moins qu'une fois par mois, mais au moins une fois par année.

   1 = Pas du tout depuis un an.

   9 = Ne s'applique pas (pas de famille), ne sait pas, refuse de répondre, etc.

4. **Combien de fois vous réunissez-vous avec un membre de votre famille? Diriez-vous au moins une fois par jour, une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?**

   5 = A peu près une fois par jour ou plus.

   4 = Au moins une fois par semaine, mais moins qu'une fois par jour.

   3 = Au moins une fois par mois, mais moins qu'une fois par semaine.

   2 = Moins qu'une fois par mois, mais au moins une fois par année.

   1 = Pas du tout depuis un an.

   9 = Ne s'applique pas (pas de famille), ne sait pas, refuse de répondre, etc.

5. **Combien de fois préférez-vous vous réunir avec un membre de votre famille? Au moins une fois par jour, une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?**

   5 = A peu près une fois par jour ou plus.

   4 = Au moins une fois par semaine, mais moins qu'une fois par jour.

   3 = Au moins une fois par mois, mais moins qu'une fois par semaine.

   2 = Moins qu'une fois par mois, mais au moins une fois par année.

   1 = Pas du tout.

   9 = Ne s'applique pas (pas de famille), ne sait pas, refuse de répondre, etc.

6. **A quel point est-il important pour vous de vous réunir avec un membre de votre famille. Diriez-vous que c'est Très Important, Important, Moyennement Important, Pas trop important, ou Pas Important du tout?**

   5 = Très Important

   4 = Important

   3 = Moyennement Important

   2 = Pas Trop Important

   1 = Pas Important du tout

   9 = Ne s'applique pas (personne n'a pas de famille, ne sait pas/refuse de répondre, etc.).

7. **A quel point préféréz-vous les choses suivantes:**

7.1 **Vous réunir avec un ou plusieurs membre de votre famille chez eux (e.g., pour la journée, fin-de-semaine, etc.)?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

7.2 **Avoir des contacts avec les membres de votre famille par téléphone et/ou par lettre?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

7.3 **Entretenir un rapport (des liens) intime avec les membres de votre famille?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

8. **Regardez encore l'échelle Ravi(e)-Terribel et dites-mois comment vous sentez-vous envers les choses suivantes?**

_____ 1. **Votre famille en général?**

_____ 2. **La fréquence des contacts que vous avez avec votre famille tel que par téléphone et/ou par lettre?**

_____ 3. **Les comportements entre votre famille et vous?**

_____ 4. **La relation que vous avez avec votre famille en générale?**

SECTION I: RELATIONS SOCIALES

Maintenant j'aimerais que nous parlions des autres personnes dans votre vie qui ne sont pas des membres de votre famille. Je vais vous nommer des choses qu'une personne peut faire avec d'autres personnes, et dites-moi à peu près combien de fois vous les faites. Dites-moi si vous les faites au moins une fois par jour, à peu près une fois par semaine, à peu près une fois par mois, moins qu'une fois par mois, ou jamais:

1.1 Jouer aux cartes ou autres jeux de société avec les autres résidents où vous demeurez?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.2 Essayer d'entretenir une conversation avec les autres résidents où vous demeurez?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.3 S'assoir et entretenir une conversation avec le(la) propriétaire ou le personnel du foyer où vous demeurez?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.4 Faire une visite chez quelqu'un qui ne demeure pas avec vous?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.5 Téléphoner à quelqu'un qui ne demeure pas avec vous?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.6 Ecrire une lettre à quelqu'un?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.7 Participer à une activité que vous avez planifiée et préparée avec quelqu'un?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.8 Passer du temps avec une personne que vous considerez être plus qu'un(e) ami(e)?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

1.9 Rester à coucher pour la nuit chez un(e) bon(ne) ami(e)?

A CHAQUE JOUR	1 FOIS/SEMAINE	1 FOIS/MOIS	MOINS QU'UNE FOIS/MOIS	JAMAIS	NE SAIT PAS
5	4	3	2	1	9

2. Avez-vous des ami(e)s intimes? _____
Inscrivez la relation ci-haut

1 = Oui (allez au numéro 2.1)
0 = Non (allez au numéro 3)
9 = Ne Sait Pas/refuse de répondre, etc. (allez au numéro 3)

2.1 Parmi ces ami(e)s, en avez-vous qui demeurent à l'extérieur de la résidence (du foyer)?

1 = Oui (allez au numéro 2.2)
0 = Non
9 = Ne s'applique pas/refuse de répondre/ne sait pas, etc.

2.2 A peu près combien de fois faites-vous une ou plusieurs activités avec un(e) de vos ami(e)s intime(s)? Au moins à chaque jour, à peu près une fois par semaine, à peu près une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?

_____
Inscrivez la réponse de la personne ci-haut

5 = A peu près quotidiennement
4 = Hebdomadairement
3 = Mensuellement
2 = Moins que mensuellement mais au moins une fois par an
1 = Pas du tout depuis un an
9 = Ne sait pas, refuse de répondre, etc.

2.3 Combien de fois préférez-vous faire une activité avec un(e) de vos ami(e)s intimes? Au moins une fois par jour, à peu près une fois par semaine, à peu près une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout?

Inscrivez la réponse de la personne ci-haut

5 = A peu près quotidiennement
4 = Hebdomadairement
3 = Mensuellement
2 = Moins que mensuellement mais au moins une fois par année
1 = Pas du tout
9 = Ne Sait Pas/ne s'applique pas/refuse de répondre, etc.

3. A quel point préféréz-vous les choses suivantes:

3.1 Faire des activités avec d'autres personnes (pas nécessairement des ami(e)s?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3.2 Passer du temps avec d'autres personnes?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3.3 Rencontrer une variété de personnes à des occasions sociales?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3.4 Vous accorder avec les gens en général?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3.5 **Voir des gens avec lesquels vous vous sentez à l'aise et comfortable?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3.6 **Avoir des ami(e)s dans votre vie?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

4. **Maintenant, nous allons encore utiliser l'échelle Ravi-Terrible, et dites-moi comment vous sentez-vous envers les choses suivantes:**

1. _____ **Les choses (activités) que vous faites avec d'autres personnes?**

2. _____ **Le montant de temps que vous passez avec d'autres personnes?**

3. _____ **Les gens que vous côtoyez socialement?**

4. _____ **La façon dont vous vous accordez avec les gens en général?**

5. _____ **Les occasions que vous avez pour connaître des personnes avec lesquelles vous vous sentez vraiment à l'aise et comfortable?**

6. _____ **Le montant d'amitié dans votre vie?**

SECTION J: DROITS ET POINTS LEGAUX

1. Pendant l'année passée, avez-vous été arrêté(e) par la police pour n'importe quel des délits suivants?

TYPES DE DELITS	PAS DU TOUT	UNE FOIS	2 FOIS OU PLUS	NE SAIT PAS/REFUSE
Toxicomanie (drogue, alcohol, etc.)	1	2	3	9
Vol à l'étalage	1	2	3	9
Vagabondage	1	2	3	9
Autres crimes (spécifiez)	1	2	3	9

_____

_____

2. Avez-vous été une victime d'un crime au courant de l'année passée?

1 = Oui (allez au numéro 2.1) 0 = Non 9 = Ne Sait Pas/refuse de répondre, etc.

2.1 TYPE DE CRIME	PAS DU TOUT	UNE FOIS	2 FOIS OU PLUS	NE SAIT PAS
Crime(s) violent(s) (e.g., voie de faits, viol, vol avec assault, etc.)	1	2	3	9
Crime(s) non-violent(s) (e.g,. cambriolage, fraude, etc.)	1	2	3	9

DONNEZ L'ECHELLE DE **PREFERENCE** A LA PERSONNE ET DITES:

3. Nous allons utiliser l'échelle de PREFERENCE de nouveau. Dites-moi à quel point sont vos préférences pour les choses suivantes?

1. **Avoir aucune inquiétude pour votre protection contre des crimes?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

2. **Demeurer dans un voisinage qui est en sûreté?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3. **Etre à l'abris contre le vol ou contre des attaques envers vous?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

---

4. Maintenant nous allons utiliser l'échelle Ravi-Terrible encore, et vous allez me dire comment vous sentez-vous envers les choses suivantes:

1. _____ **Votre sûreté (sécurité) personnelle?**

2. _____ **Votre sûreté sur les rues de votre voisinage?**

3. _____ **Votre sûreté là où vous demeurez?**

4. _____ **La protection que vous avez contre le vol ou d'être attaqué(e)?**

5. _____ **Vos chances de trouver un policier si vous en avez besoin d'un?**

SECTION K: SERVICES ET CONTINUITE DES SOINS

1. **A présent j'aimerais vous demander des questions au sujet des services que vous avez possiblement reçus pendant l'année passée. Pour chaque service que je vais décrire, j'aimerais savoir les choses suivantes:**

   A. Croyez-vous avoir reçu le service?
   B. Croyez-vous avoir eu besoin du service?
   C. Croyez-vous avoir eu un ou des problèmes à recevoir le service?

ENCERCLER UN CODE POUR CHAQUE SERVICE

1 = OUI 0 = NON 9 = NE SAIT PAS (NSP)/REFUSE DEREPONDRE, ETC.

NOTER: SI LA PERSONNE INDIQUE QU'ELLE A EU UN PROBLEME A RECEVOIR UN SERVICE, SPECIFIEZ LA NATURE DU PROBLEME.

	RECU			BESOIN			PROBLEME A RECEVOIR		
	OUI	NON	NSP	OUI	NON	NSP	OUI	NON	NSP
SERVICE									
01 Une évaluation de vos besoins de services?	1	0	9	1	0	9	1	0	9
02 De l'assistance pour obtenir de l'aide sociale, du linge, ou des biens personnels?	1	0	9	1	0	9	1	0	9
03 Des soins médicaux (pour un problème de santé physique)?	1	0	9	1	0	9	1	0	9
04 Des soins dentaires?	1	0	9	1	0	9	1	0	9

SERVICE	RECU			BESOIN			PROBLEME A RECEVOIR		
	OUI	NON	NSP	OUI	NON	NSP	OUI	NON	NSP
05 Des soins psychiatrique à l'internat (à l'hôpital)?	1	0	9	1	0	9	1	0	9
06 De la thérapie/ "Counseling" de groupe à l'externat?	1	0	9	1	0	9	1	0	9
07 De la thérapie/ "Counseling" individuelle à l'externat?	1	0	9	1	0	9	1	0	9
08 De la thérapie/ "Counseling" familliale à l'externat?	1	0	9	1	0	9	1	0	9
09 Hôpital de jour/ (traitement de jour)?	1	0	9	1	0	9	1	0	9
10 Des médicaments pour des problèmes emotionnels?	1	0	9	1	0	9	1	0	9
11 De l'assistance pour des situations urgentes (de crises), telles qu'une visite à l'urgence, de l'assistance téléphonique pour situation de crises, etc.?	1	0	9	1	0	9	1	0	9

SERVICE	RECU			BESOIN			PROBLEME A RECEVOIR		
	OUI	NON	NSP	OUI	NON	NSP	OUI	NON	NSP
12 Programme d'apprentissage pour vous assister à prendre soin de vous même, tel que la gérance de vos médicaments, hygiène personnelle, votre alimentation, comment aller magasiner, comment utiliser le transport publique, etc.?	1	0	9	1	0	9	1	0	9
13 De l'assistance dans la planification de vos activités de temps libre; comment planifier des activités sociales et récréatives, etc.?	1	0	9	1	0	9	1	0	9
14 De l'assistance avec l'emploi (tel qu'une formation vocationelle, des occasions pour travailler dans un atelier,protégé, etc.?	1	0	9	1	0	9	1	0	9
15 Un programme de service d'hébergement (e.g., un appartement supervisé)?	1	0	9	1	0	9	1	0	9
16 Du support pour votre famille, vos ami(e)s, votre employeur, etc., tel qu'un groupe de support familial?	1	0	9	1	0	9	1	0	9
17 Des méthodes pour vous informer de vos droits, et pour protéger vos droits?	1	0	9	1	0	9	1	0	9

	RECU			BESOIN			PROBLEME A RECEVOIR		
	OUI	NON	NSP	OUI	NON	NSP	OUI	NON	NSP
SERVICE									
18 Un programme à l'externat pour soigner la dépendence sur l'acohol?	1	0	9	1	0	9	1	0	9
19 Un programme à l'internat pour soigner la dépendence sur l'acohol?	1	0	9	1	0	9	1	0	9
20 Un programme à l'externat pour soigner la dépendence sur la drogue?	1	0	9	1	0	9	1	0	9
21 Un programme à l'internat ou un programme résidentiel pour soigner la dépendence sur la drogue?	1	0	9	1	0	9	1	0	9

2. PENDANT L'ANNEE QUI VIENT DE PASSER COMBIEN DE FOIS AVEZ-VOUS RECU DES SERVICES DES PERSONNES SUIVANTES?

	1/JOUR	1/SEMAINE	1/MOIS	-1/MOIS	PAS DU TOUT	NE SAIT PAS
PROFESSIONELS						
Psychologue	5	4	3	2	1	9
Psychiatre	5	4	3	2	1	9
Infirmier(ère)	5	4	3	2	1	9
Travailleur(euse) Sociale?	5	4	3	2	1	9
Educateur(trice)	5	4	3	2	1	9
Médecin	5	4	3	2	1	9
Dentiste	5	4	3	2	1	9
Autre(s) Professionel(s) (spécifiez)	5	4	3	2	1	9

A NOTER: SI LA PERSONNE A RECU AUCUN SERVICE DES PROFESSIONELS MENTIONNES CI-HAUT, EVALUEZ CHACUN COMME ETANT "1" (PAS DU TOUT).

DONNEZ L'ECHELLE DE PREFERENCE A LA PERSONNE ET DEMANDEZ:

3. A quel point sont vos préférences pour les choses suivantes?

1. Avoir une bonne santé physique?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

2. Avoir une bonne santé mentale?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3. Avoir accès à des services médicaux?

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

4. **Avoir accès à un(e) conseiller(ère) ou à un(e) thérapeute personnelle?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

4. **Maintenant nous allons de nouveau utiliser l'échelle Ravi-Terrible. Dites-moi comment vous sentez-vous envers les choses suivantes:**

_____ 1. **Votre santé en général?**

_____ 2. **Les soins médicaux qui vous sont disponibles si vous en avez besoin?**

_____ 3. **La fréquence avec laquelle vous voyez un médecin?**

_____ 4. **L'occasion que vous avez de parler avec un(e) thérapeute?**

_____ 5. **Votre état de santé physique?**

_____ 6. **Votre bien-être émotionnel?**

SECTION L: SATISFACTION GLOBALE AVEC LES SERVICES

FORME ABREGEE DU QUESTIONNAIRE DE SATISFACTION DES PARTICIPANTS

DONNEZ UNE COPIE DE L'ECHELLE DE SATISFACTION GLOBALE AVEC LES SERVICES A LA PERSONNE ET DITES:

Ce questionnaire est fait pour nous aider à améliorer les services que vous recevez. Nous aimerions les réponses les plus franches possibles, qu'elles soient positives ou négatives. Vous pourrez aussi rajouter vos commentaires.

1. A quel point le programme résidentiel correspond à vos besoins?

Presque tous mes besoins furent rencontrés	La plupart de mes besoins furent recontrés	Quelques-uns seulement de mes besoins furent rencontrés	Aucun de mes besoins ne furent rencontrés
4	3	2	1

2. Dans l'ensemble êtes-vous satisfait(e) du service que vous recevez?

Très Satisfait(e)	Plutôt Satisfait(e)	Indifférent(e) ou légèrement insatisfait(e)	Insatisfait(e)
4	3	2	1

3. Si vous vous retrouviez avec les mêmes besoins d'aide, feriez-vous le même choix de venir dans ce programme résidentiel?

Définitivement Pas	Je crois que non	Je crois que oui	Définitivement oui
1	2	3	4

_____

_____

SECTION M: RELIGION

Maintenant je vais vous demander quelques questions au sujet de la religion et son importance dans votre vie:

1. **Avez-vous une religion?** _____
Spécifiez la dénomination ci-haut

1 = Oui (spécifiez la dénomination et allez au numéro 2).
0 = Non (allez à la section L).
9 = Ne Sait Pas/Refuse, etc., (allez à la section L).

2. **Quelle importance diriez-vous que la religion a dans votre vie? Diriez-vous que dans votre vie la religion est TRES IMPORTANTE, IMPORTANTE, MOYENNEMENT IMPORTANTE, PAS TROP IMPORTANTE, ou PAS IMPORTANTE DU TOUT?**

TRES IMPORTANTE	IMPORTANTE	MOYENNEMENT IMPORTANTE	PAS TROP IMPORTANTE	PAS DU TOUT IMPORTANTE	NE SAIT PAS/ REFUSE
5	4	3	2	1	9

3. **A peu près combien de fois allez-vous à la messe, à l'église? Diriez-vous au moins à tous les jours, à peu près une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?**

5 = A CHAQUE JOUR
4 = UNE FOIS PAR SEMAINE
3 = UNE FOIS PAR MOIS
2 = MOINS QU'UNE FOIS PAR MOIS MAIS AU MOINS UNE FOIS PAR ANNEE
1 = PAS DU TOUT DEPUIS UN AN
9 = NE SAIT PAS/REFUSE DE REPONDRE ETC.

4. **Combien de fois lisez-vous la bible? Diriez-vous au moins à chaque jour, une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?**

5 = A CHAQUE JOUR
4 = UNE FOIS PAR SEMAINE
3 = UNE FOIS PAR MOIS
2 = MOINS QU'UNE FOIS PAR MOIS MAIS AU MOINS UNE FOIS PAR ANNEE
1 = PAS DU TOUT DEPUIS UN AN
9 = NE SAIT PAS/REFUSE DE REPONDRE ETC.

5. Combien de fois écoutez-vous une émission religieuse à la télévision ou à la radio? Diriez-vous au moins une fois par jour, à peu près une fois par semaine, une fois par mois, moins qu'une fois par mois mais au moins une fois par année, ou pas du tout depuis un an?

5 = A CHAQUE JOUR
4 = UNE FOIS PAR SEMAINE
3 = UNE FOIS PAR MOIS
2 = MOINS QU'UNE FOIS PAR MOIS MAIS AU MOINS UNE FOIS PAR ANNEE
1 = PAS DU TOUT DEPUIS UN AN
9 = NE SAIT PAS/REFUSE DE REPONDRE ETC.

6. Dites-moi à quel point préférez-vous les choses suivantes:

1. **Rencontrer des gens avec qui vous pouvez partager votre foi (vos convictions religieuses)?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

2. **Aller à la messe, à l'église de façon régulière?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

3. **Ecouter des émissions religieuses diffusées à la télévision ou à la radio?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

4. **Lire la bible ou des revues religieuses?**

ENORMEMENT	BEAUCOUP	MOYENNEMENT	UN PEU	PAS DU TOUT	NE SAIT PAS
5	4	3	2	1	9

DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

7. **Maintenant nous allons encore utiliser l'échelle Ravi-Terrible. Dites-moi comment vous sentez-vous envers les choses suivantes:**

_____ 1. **La religion dans votre vie?**

_____ 2. **Les occasions que vous avez pour aller à l'église (e.g, à la messe)?**

_____ 3. **Votre engagement et votre participation avec votre église?**

_____ 4. **Le nombre d'émissions religieuses que vous pouvez écouter à la télévision ou à la radio?**

SECTION N: ESTIME DE SOI

ECHELLE D'ESTIME DE SOI DE ROSENBERG

DONNEZ UNE COPIE DE L'ECHELLE D'ESTIME DE SOI A LA PERSONNE ET DITES:

Maintenant je vais vous lire des façons qu'une personne peut se sentir envers elle-même. Pour chacun des énoncés suivants, dites-moi si vous êtes FORTEMENT EN ACCORD, EN ACCORD, EN DESACCORD, ou FORTEMENT EN DESACCORD.

1. **J'ai le sentiment d'être une personne de valeur (de mérite), au moins égale aux autres.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

2. **J'ai le sentiment d'avoir un certain nombre de bonnes qualités.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

3. **Dans l'ensemble, je suis porté(e) à me sentir comme une personne ratée (manquée).**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

4. **Je suis capable de faire des choses aussi bien que la plupart des gens.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

5. **J'ai le sentiment que j'ai peu de quoi à me sentir fier(ère).**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

6. **Je prends une attitude positive envers moi-même.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

7. **Dans l'ensemble, je suis satisfait(e) de moi-même.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

8. **Je souhaiterais avoir plus de respect envers moi-même.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

9. **A l'occasion, je me sens certainement inutile.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

10. **A l'occasion, je crois que je suis bon(nne) à rien.**

FORTEMENT EN ACCORD	EN ACCORD	EN DESACCORD	FORTEMENT EN DESACCORD
1	2	3	4

SECTION O: EVALUATION GLOBALE DU BIEN-ETRE

DONNEZ L'ECHELLE RAVI(E)-TERRIBLE A LA PERSONNE ET DITES:

1. **J'ai une autre question générale à vous demander. Nous allons encore utiliser l'échelle Ravi-Terrible. Dites-moi comment vous sentez-vous envers votre vie en général?**

_____

Indiquez ci-haut la réponse de la personne

SECTION P: EVALUATION DE L'EVALUATEUR(TRICE)

Evaluer les items suivants à la fin de l'entrevue:

1. Le temps total de l'entrevue: _____

Inscrivez ci-haut le temps

2. La fiabilité des réponses de la personne. Décrivez par des commentaires votre évaluation de la fiabilité, ci-bas.

4 = Très fiable

3 = Généralement fiable

2 = Généralement peu fiable

1 = Très peut fiable

9 = Entrevue Incomplète (fiabilité minime)

DECRIVEZ CI-BAS LA FIABILITE:

_____

_____

_____

---- FIN ----

APPENDIX A-2

FORMULA FOR TRANSFORMING WEIGHTED PASSING SCORES INTO A PERCENTAGE OF MAXIMUM POSSIBLE WEIGHTED SCORES

Formules pour la transformation des scores pondérés PASSING en pourcentage du score maximal pondéré possible

Pour l'échelle PASSING totale:

$$\text{le pourcentage du score maximal pondéré possible} = \left(\frac{1000.5 + \text{le score PASSING total pondéré}}{2001}\right) * 100$$

Pour la sous-échelle Environnement:

$$\text{le pourcentage du score maximal pondéré possible} = \left(\frac{251.5 + \text{le score Environnement pondéré}}{503}\right) * 100$$

Pour la sous-échelle Programme:

$$\text{le pourcentage du score maximal pondéré possible} = \left(\frac{465.5 + \text{le score Programme pondéré}}{931}\right) * 100$$

Pour la sous-échelle Beauté-Confort:

$$\text{le pourcentage du score maximal pondéré possible} = \left(\frac{76.5 + \text{le score Beauté/Confort pondéré}}{153}\right) * 100$$

Pour la sous-échelle Accessibilité:

$$\text{le pourcentage du score maximal pondéré possible} = \left(\frac{80.5 + \text{le score Accessibilité pondéré}}{161}\right) * 100$$

Note. Toutes ces formules assurent qu'un score pondéré de zéro correspond exactement à 50% du score maximal pondéré possible.

APPENDIX A-3

FRENCH-LANGUAGE TRANSLATION AND ADAPTATION OF THE LEVEL OF CARE SURVEY

Ministère des Affaires sociales

INVENTAIRE DU NIVEAU DE SOINS

Identification

ODE DE ÉTABLISSEMENT (8) | N° DE L'UNITÉ | Nom de l'unité | TYPE DE RÉSIDENCE (actuellement) (16)

UMÉRO DU NÉFICIAIRE (24) | SEXE M F | DATE DE NAISSANCE an mois jour | STATUT LÉGAL A B C | STATUT CIVIL (36)

TE DE LA RNIÈRE ADMISSION an mois jour | CODE DU NOMBRE DE JOURS EN INSTITUTION (43)

Vue, ouie, parole et compréhension *(Cocher la case correspondante)*

	Normale sans correctif 1	Normale avec correctif 2	Partielle sans correctif 3	Partielle avec correctif 4	Incapacité complète 5	Pas d'information 9
1. VUE	☐	☐	☐	☐	☐	☐
2. OUIE	☐	☐	☐	☐	☐	☐

3. LANGUE D'USAGE — Français 1 ☐ Anglais 2 ☐ Autre 3 ☐ Inconnue 9 ☐ (46)

	INCAPACITÉ PARTIELLE				INCAPACITÉ TOTALE	
	Sans incapacité 1	Problème physique 2	Barrière de langue 3	Articulation 4	Refus de parler 5	Incapable de parler 6
4. PAROLE	☐	☐	☐	☐	☐	☐

5. CAPACITÉ DE COMMUNIQUER PENSÉES ET BESOINS AUX AUTRES

Sans difficulté 1	Légère difficulté 2	Difficulté modérée 3	Grande difficulté 4	Pas de communication 5
☐	☐	☐	☐	☐

6. COMPRÉHENSION

Comprend tout 1	Légère difficulté 2	Difficulté modérée 3	Grande difficulté 4	Ne comprend rien 5	Ne peut être déterminé 9
☐	☐	☐	☐	☐	☐ (49)

Santé physique

7. COCHER "OUI" POUR CHAQUE DÉSORDRE PHYSIQUE INSCRIT AU DOSSIER MÉDICAL COMME PROBLÈME ACTUEL OU CONTINU. SI CETTE MALADIE EST ABSENTE OU N'A PAS ENCORE ÉTÉ DIAGNOSTIQUÉE POSITIVEMENT, COCHER "NON".

		NON 1	OUI 2
a	Maladie cardiaque artériosclérotique	☐	☐
b	Hypertension	☐	☐
c	Artériosclérose cérébrale	☐	☐
d	Autre trouble cardiaque ou circulatoire	☐	☐
e	Trouble de l'appareil respiratoire	☐	☐
f	Trouble du système digestif	☐	☐
g	Obésité	☐	☐
h	Trouble du rein	☐	☐
i	Autre trouble de l'appareil génito-urinaire	☐	☐
j	Fracture	☐	☐
k	Arthrite	☐	☐
l	Autre trouble de l'appareil musculaire et osseux	☐	☐
m	Diabète	☐	☐
n	Autre trouble métabolique	☐	☐
o	Maladie de l'oeil	☐	☐
p	Trouble dermatologique (peau)	☐	☐
q	Cancer	☐	☐
r	Paralysie	☐	☐
s	Maladie de Parkinson	☐	☐
t	Trouble épileptique	☐	☐
u	Autre trouble neuro-musculaire	☐	☐
v	Autre (préciser) _____	☐	☐ (71)

8. TEL QU'INDIQUÉ CI-DESSUS, COCHER "OUI" POUR CHAQUE TYPE D'EFFETS SECONDAIRES QUE PRÉSENTE CETTE PERSONNE POUR TOUTE MÉDICATION QU'ELLE PREND. SI ABSENTS, COCHER "NON".

		NON 1	OUI 2
a	Symptômes pyramidaux type parkinsoniens	☐	☐
b	Dyskinésie tardive	☐	☐
c	Autres effets secondaires neurologiques	☐	☐
d	Prédisposition à une allergie	☐	☐
e	Autres effets secondaires (préciser) _____	☐	☐ (76)

9. GLOBALEMENT, JUSQU'À QUEL POINT LES PROBLÈMES PHYSIQUES DE CETTE PERSONNE ENTRAVENT-ILS SA CAPACITÉ À

		Pas du tout 1	Légèrement 2	Modérément 3	Sérieusement 4	Très sérieusement 5
a	Se baigner, s'habiller et s'alimenter elle-même:	☐	☐	☐	☐	☐
b	Participer aux activités régulières de son unité:	☐	☐	☐	☐	☐

10. COMMENT ÉVALUEZ-VOUS LE NIVEAU GÉNÉRAL DE SANTÉ PHYSIQUE DE CETTE PERSONNE PAR COMPARAISON AVEC LES ADULTES EN GÉNÉRAL?

Excellent 1	Très bon 2	Bon 3	Passable 4	Mauvais 5	Très mauvais 6
☐	☐	☐	☐	☐	☐ (79)

III- Procédés de soins

11 VEUILLEZ PRECISER LESQUELLES PARMI LES TECHNIQUES SUIVANTES FONT PARTIE DU PLAN DE SOINS ACTUEL DU BENEFICIAIRE EN SPECIFIANT QUI LES ADMINISTRE. SI LA TECHNIQUE N'EST PAS EMLOYEE, VEUILLEZ COCHER "NON".

		NON 1	OUI ADMINISTREE PAR Bénéficiaire 2	Autre 3
a	Injection d'insuline	☐	☐	☐
b	Injection d'une autre médication non psychiatrique	☐	☐	☐
c	Inhalothérapie/oxygène	☐	☐	☐
d	Perfusion	☐	☐	☐
e	Succion	☐	☐	☐
f	Pansement aseptique	☐	☐	☐
g	Irrigation de lésion	☐	☐	☐
h	Sonde urétrale	☐	☐	☐
i	Drainage pour colostomie	☐	☐	☐
j	Signes vitaux quotidiens	☐	☐	☐
k	Soins de plaies de lit	☐	☐	☐
l	Physiothérapie	☐	☐	☐
m	Autre (préciser)_____			
	_____	☐	☐	☐ (92)

IV- Santé mentale et comportement

13. NIVEAU D'INTELLIGENCE APPARENT

1 ☐ au dessus de la moyenne
2 ☐ moyen
3 ☐ sous la moyenne
4 ☐ frontière
5. ☐ retard léger
6. ☐ retard modéré
7. ☐ retard sévère
8. ☐ retard profond (93)

COMPORTEMENT: *Veuillez évaluer, pour chaque item, le comportement OBSERVÉ chez cette personne pendant LES TROIS DERNIERS JOURS; indiquez votre réponse en cochant la case appropriée pour chaque énoncé.*

		Jamais 1	Parfois 2	Souvent 3	Habituellement 4	Toujours 5
14.	Tenue négligée	☐	☐	☐	☐	☐
15.	Est impatient	☐	☐	☐	☐	☐
16.	Pleure	☐	☐	☐	☐	☐
17.	S'intéresse aux activités autour de lui	☐	☐	☐	☐	☐
18.	Demeure assis s'il n'est pas dirigé vers une activité	☐	☐	☐	☐	☐
19.	Se fâche ou est contrarié facilement	☐	☐	☐	☐	☐
20.	Entend des choses qui n'existent pas	☐	☐	☐	☐	☐
21.	Maintient ses vêtements propres	☐	☐	☐	☐	☐
22.	Cherche à fraterniser avec les autres	☐	☐	☐	☐	☐
23.	Facilement bouleversé si quelque chose ne lui convient pas	☐	☐	☐	☐	☐
24.	Refuse de faire les choses simples que l'on attend de lui	☐	☐	☐	☐	☐
25.	Irritable et grognon	☐	☐	☐	☐	☐
26.	A de la difficulté à se souvenir	☐	☐	☐	☐	☐
27.	Refuse de parler	☐	☐	☐	☐	☐
28.	Rit et sourit à des blagues ou événements drôles	☐	☐	☐	☐	☐
29.	Malpropre lorsqu'il mange	☐	☐	☐	☐	☐
30.	Engage la conversation avec les autres	☐	☐	☐	☐	☐
31.	Dit se sentir déprimé	☐	☐	☐	☐	☐
32.	Parle des choses qui l'intéressent	☐	☐	☐	☐	☐
33.	Voit des choses qui n'existent pas	☐	☐	☐	☐	☐
34.	Il faut lui rappeler quoi faire	☐	☐	☐	☐	☐
35.	Dort, à moins d'être dirigé vers une activité	☐	☐	☐	☐	☐
36.	Dit qu'il ne vaut rien	☐	☐	☐	☐	☐
37.	Il faut lui dire de suivre les règlements de l'hôpital	☐	☐	☐	☐	☐
38.	A de la difficulté à compléter des tâches simples par lui-même	☐	☐	☐	☐	☐
39.	Se parle, marmonne	☐	☐	☐	☐	☐
40.	Dit se sentir inutile, rejeté, sans espoir	☐	☐	☐	☐	☐
41.	Glousse et rit sans raison apparente	☐	☐	☐	☐	☐
42.	Sort facilement de ses gonds	☐	☐	☐	☐	☐
43.	Se garde propre	☐	☐	☐	☐	☐
44.	S'oriente sans aide	☐	☐	☐	☐	☐
45.	Est insupportable	☐	☐	☐	☐	☐
46.	A des idées et des propos étranges	☐	☐	☐	☐	☐
47.	S'approprie les choses qui ne lui appartiennent pas	☐	☐	☐	☐	☐
48.	Devient confus	☐	☐	☐	☐	☐
49.	Conscient de son environnement	☐	☐	☐	☐	☐
50.	Ne tient pas en place	☐	☐	☐	☐	☐
51.	Négligent lorsqu'il fume	☐	☐	☐	☐	☐
52.	Répond à son nom	☐	☐	☐	☐	☐
53.	Pince, pousse, touche ou tape les autres	☐	☐	☐	☐	☐
54.	S'entend avec les autres	☐	☐	☐	☐	☐
55.	S'exhibe ou se masturbe en public	☐	☐	☐	☐	☐
56.	Injurie les autres	☐	☐	☐	☐	☐
57.	Présente des comportements ou des rituels bizarres	☐	☐	☐	☐	☐
58.	Défèque et urine de façon antisociale	☐	☐	☐	☐	☐
59.	Parle de se tuer, souhaite être mort	☐	☐	☐	☐	☐
60.	Semble prendre plaisir à ce qu'il fait	☐	☐	☐	☐	☐
61.	Accumule les objets hétéroclites	☐	☐	☐	☐	☐
62.	Pertubateur	☐	☐	☐	☐	☐
63.	Connaît le nom du personnel et des autres bénéficiaires	☐	☐	☐	☐	☐

(143)

QUESTIONS 64 à 71: *Pour chaque énoncé suivant, indiquer seulement LA PLUS RÉCENTE manifestation:*

		Jamais 1	Oui au cours du dernier mois 2	Oui au cours des 3 derniers mois 3	Oui il y a plus de 3 mois 4
64.	A tenté de se suicider	☐	☐	☐	☐
65.	S'est infligé une blessure volontairement	☐	☐	☐	☐
66.	Assaut physique sur quelqu'un	☐	☐	☐	☐
68.	A tenté de tuer quelqu'un	☐	☐	☐	☐
69.	A mis le feu	☐	☐	☐	☐
70.	Bris d'ameublement ou de biens	☐	☐	☐	☐
71.	Violent ou dangereux	☐	☐	☐	☐

72. **SOINS PSYCHIATRIQUES:** *Cette personne a-t-elle au cours des TRENTE derniers jours*

a. Reçu d'urgence une médication (Stat ou PRN) pour contrôler un comportement dangereux
b. Été mise sous gilet, isolée, ou soumise à toute autre forme de contention physique pour contrôler un comportement dangereux
c. Fait l'objet d'une surveillance personnelle sur l'unité en raison d'un comportement dangereux pour elle-même ou autrui

73. Cette personne est-elle actuellement considérée dangereuse pour elle-même ou pour les autres
74. Cette personne est-elle autorisée à quitter son unité et à y revenir sans surveillance

	Pas du tout 1	Léger 2	Modéré 3	Sévère 4	Très sévère 5
75. Jusqu'à quel point l'abus d'alcool est-il un problème pour cette personne?	☐	☐	☐	☐	☐
76. Jusqu'à quel point l'abus de drogue est-il un problème pour cette personne?	☐	☐	☐	☐	☐
77. Jusqu'à quel point les problèmes mentaux empêchent-ils cette personne de participer aux activités régulières?	☐	☐	☐	☐	☐

(159)

78. LEQUEL DES ÉNONCÉS SUIVANTS S'APPLIQUE-T-IL LE MIEUX À CE BÉNÉFICIAIRE? *(Cocher un seul énoncé):*

1. ☐ Est tellement dangereux pour les autres qu'il devrait être confiné à un milieu psychiatrique à circulation contrôlée
2. ☐ Manifeste actuellement des symptômes psychiatriques sévères et doit recevoir des services psychiatriques intensifs
3. ☐ Ses symptômes psychiatriques peuvent avoir été stabilisés, mais il nécessite en tout temps une surveillance de son comportement. Il ne convient pas pour un placement en communauté.
4. ☐ Ses symptômes psychiatriques sont maintenant stabilisés et il pourrait maintenant vivre dans la communauté aussi longtemps que des services de suivi et de support lui sont dispensés.
5. ☐ Peut présenter parfois des problèmes psychiatriques mais il devrait maintenant vivre dans la communauté avec l'aide des services de support réguliers
6. ☐ Semble ne présenter aucun problème psychiatrique, n'a pas besoin d'une surveillance de son comportement et devrait être libéré
7. ☐ Aucun problème psychiatrique mais demande une surveillance à cause du comportement
8. ☐ Ne s'applique pas (160)

V. Activités de la vie quotidienne

Cocher pour chaque énoncé qui suit, l'expression qui décrit le mieux l'état ACTUEL du bénéficiaire. Choisir l'expression qui a la valeur supérieure si plus d'une expression s'applique.

79. MOBILITÉ

1. ☐ Marche de façon autonome
2. ☐ Marche sans aide avec difficulté
3. ☐ Marche avec une canne ou son équivalent
4. ☐ Marche seulement avec aide
5. ☐ Utilise une chaise roulante ou une marchette de façon autonome
6. ☐ Doit être poussé en chaise roulante
7. ☐ Confiné à une chaise
8. ☐ Confiné à son lit (161)

80. BAIN/DOUCHE

1. ☐ Autonomie complète
2. ☐ A besoin de rappels
3. ☐ A besoin de surveillance
4. ☐ Besoin de surveillance personnelle
5. ☐ Besoin d'aide physique
6. ☐ Doit être lavé

81. SOINS PERSONNELS (se raser, se peigner, se maquiller, etc.)

1. ☐ Autonomie complète
2. ☐ A besoin de rappels
3. ☐ A besoin de surveillance
4. ☐ Besoin de surveillance personnelle
5. ☐ Besoin d'aide physique
6. ☐ A besoin des soins complets

82. HABILLEMENT

1. ☐ Autonomie complète
2. ☐ A besoin de rappels
3. ☐ A besoin de surveillance
4. ☐ Besoin d'un peu d'aide physique
5. ☐ Besoin d'une aide physique modérée
6. ☐ Doit être habillé (164)

83. ALIMENTATION

1. ☐ Autonomie complète
2. ☐ Autonomie mais malpropre
3. ☐ A besoin de surveillance
4. ☐ A besoin d'aide physique
5. ☐ Doit être nourri
6. ☐ Nourri par tubes
7. ☐ Nourri par solution intra-veineuse

84. UTILISATION DE LA TOILETTE

1. ☐ Autonomie complète
2. ☐ Besoin de suggestions, de cajoleries
3. ☐ Besoin d'aide physique
4. ☐ N'utilise pas la toilette
5. ☐ Utilise la bassine
6. ☐ A un cathéter
7. ☐ A une colostomie

85. INCONTINENCE URINAIRE

1. ☐ Jamais
2. ☐ Moins d'une fois par semaine
3. ☐ La nuit seulement
4. ☐ Moins d'une fois par jour
5. ☐ Une fois par jour
6. ☐ Plusieurs fois par jour
7. ☐ A un cathéter

86. INCONTINENCE DES SELLES

1. ☐ Jamais
2. ☐ Moins d'une fois par semaine
3. ☐ Moins d'une fois par jour
4. ☐ Une fois par jour
5. ☐ A une colostomie

(168)

87. ACTIVITÉ DE TRAVAIL: *Indiquer le niveau de travail le plus élevé dans lequel le bénéficiaire EST ACTUELLEMENT ENGAGÉ.*

1. ☐ Aucune
2. ☐ A soin de son espace
3. ☐ Thérapie d'occupation
4. ☐ S.A.T.H.
5. ☐ Formation professionnelle
6. ☐ Plateau de travail, stage, C.T.A.
7. ☐ Emploi compétitif

88. POTENTIEL DE TRAVAIL: *Indiquer quel est le niveau de travail le plus élevé dont le bénéficiaire EST ACTUELLEMENT CAPABLE DE S'ACQUITTER?*

1. ☐ Aucun
2. ☐ A soin de son espace
3. ☐ Thérapie d'occupation
4. ☐ Atelier protégé
5. ☐ S.A.T.H.
6. ☐ Formation professionnelle
7. ☐ Plateau de travail, stage, C.T.A.
8. ☐ Emploi compétitif

89. QUEL ÉNONCÉ, PARMI LES SUIVANTS, DÉCRIT LE MIEUX LE BÉNÉFICIAIRE?

1. ☐ La santé de cette personne est généralement bonne. Ce bénéficiaire n'a pas besoin de surveillance ou d'aide pour prendre un bain, s'habiller ou s'alimenter.
2. ☐ La santé de cette personne est généralement bonne, mais ce bénéficiaire demande de la surveillance ou un peu d'aide pour le bain, l'habillement ou l'alimentation.
3. ☐ Cette personne présente certains problèmes de santé qui requièrent des soins de nursing occasionnels (ex. une injection d'insuline) ou elle demande beaucoup de surveillance ou d'aide physique pour prendre un bain, s'habiller ou s'alimenter. (Les soins de santé requis par ce type de bénéficiaire sont typiques de ceux qui sont dispensés dans un établissement de santé).
4. ☐ Ce bénéficiaire demande régulièrement beaucoup d'aide physique sinon une prise en charge complète pour son bain, son habillement et son alimentation; ou il est tellement physiquement malade ou infirme qu'il requiert des services de nursing tels que dispensés dans un établissement de soins physiques spécialisés. (171)

VI- Vie communautaire

90. SI CE BENEFICIAIRE ETAIT MAINTENANT INTEGRE A LA COMMUNAUTE.

	Definitivement oui 1	Probablement oui 2	Peut être 3	Probablement non 4	Definitivement non 5
a Prendrait sa medication de maniere autonome	☐	☐	☐	☐	☐
b Respecterait ses rendez-vous a la clinique externe ou a d'autres ressources en sante	☐	☐	☐	☐	☐
c Utiliserait correctement ses ressources financieres afin de pourvoir à ses besoins	☐	☐	☐	☐	☐
d Conserverait un emploi remunerateur s'il en avait l'occasion	☐	☐	☐	☐	☐
e S'acquitterait des tâches necessaires a l'entretien d'un logement	☐	☐	☐	☐	☐

(176)

91. COCHER LE TYPE DE RESIDENCE LE PLUS APPROPRIÉ POUR CETTE PERSONNE.

Completement autonome Domicile 1	Avec un certain support Appartement supervise 2	Avec une certaine supervision Pavillon Famille d accueil 3	Avec supervison de 24 heures CAH CAR Foyer de groupe 4	Avec supervision medicale 24 heures CHLD physique 5	Traitement psychiatrique CHCD 6
☐	☐	☐	☐	☐	☐

(177)

VII- Médication psychiatrique: *Cette section est facultative. Si vous désirez la compléter, elle doit être remplie par un(e) représentant(e) du nursing.*

1. *Référer au dossier médical afin d'identifier les médicaments présentement prescrits à ce bénéficiaire.*
2. *Localiser le code correspondant à chaque médicament dans la liste à cet effet. Si un médicament n'apparaît pas dans cette liste, ne pas l'enregistrer ici.*
3. *Ne pas codifier les prescriptions STAT ou PRN à moins qu'elles n'aient été administrées aujourd'hui.*

	Nom du medicament	Code
92.		
93.		
94.		
95.		
96.		
97.		
98.		

(219

VIII- Pour usage exclusif de l'établissement

A B	C D	E F	G H	I J
K L	M N	O P	Q R	S T

(20

IX- Le diagnostic psychiatrique

Répondre seulement si le bénéficiaire a été diagnostiqué - utiliser le CIM-9

Primaire ☐☐☐☐ Associé ☐☐☐☐ Indéterminé ☐ (31)

Commentaires _____

Signature de l'évaluateur _____ Titre _____ Date an mois jour ☐☐☐☐☐☐ (37

100. PROFESSION DE L'EVALUATEUR

1☐ infirmier 3☐ éducateur 5☐ travailleur social
2☐ psychiatre 4☐ psychologue 6☐ travailleur santé mentale 7☐ autre _____ (38

Adapté et traduit des formulaires 103 (1983 et 1984) du bureau de la Santé mentale, New York, par Jacques Côté, PhD. et par Wilfrid Pilon, PhD, novembre 1984.

Module de recherche
Psycho-sociale
2601 de la Canardière
Beauport, Québec
G1J 2G3

APPENDIX B

AUTHORIZATION TO USE THE DATA COLLECTED IN THE STUDY

Conseil régional
de la santé et
des services sociaux
de l'Outaouais

Le 28 novembre 1989

Monsieur Peter Ely
Pavillon Lamoureux
Pièce 348
Ecole de psychologie
Université d'Ottawa
145, Jean-Jacques Lussier
Ottawa (Ontario)
K1N 6N5

Monsieur,

Par la présente, il vous est autorisé d'utiliser les données concernant l'étude sur l'évaluation de la qualité de vie et la qualité des services dans les programmes résidentiels et communautaires en santé mentale pour votre thèse de doctorat.

Nous vous demandons expressément de vous assurer de la plus stricte confidentialité de ces données et de vous assurer que par déduction, dans le cadre d'analyses ou d'éléments, on ne puisse identifier quelque personne que ce soit, autant des personnes qui donnent des services que des personnes recevant des services.

Espérant le tout conforme, je vous prie de recevoir, Monsieur, l'expression de mes sentiments distingués.

Thierry Boyer,
Conseiller à la Programmation

TB/rb

c.c. Monsieur Robert Flynn, Directeur de thèse, Université d'Ottawa

APPENDIX C

SUPPLEMENTARY TABLES

Appendix C
Table C-1

Item/Total Correlations for Satisfaction with Life Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Life is close to ideal.	1	.73
Life conditions are excellent.	2	.74
Satisfied with my life.	3	.85
Have satisfied important wants.	4	.65
Would change almost nothing.	5	.57

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Life Scale = .88 (no. of items = 5).
[b] Item number refers to item numbers for Satisfaction with Life Scale scale in Appendix A.

Appendix C
Table C-2

Item/Total Correlations for Satisfaction with Living Situation Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Living arrangements in residence.	1	.54
Food in residence..	2	.55
Rules in residence.	3	.59
Privacy available in residence.	4	.70
Freedom allowed in residence.	5	.67
Stability of placement.	6	.48

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Living Situation Scale = .81 (no. of items = 6).
[b] Item number refers to item numbers for Satisfaction with Living Situation Scale in Appendix A.

Appendix C
Table C-3

Item/Total Correlations for Satisfaction with Family Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Family in general.	1	.63
Frequency of contacts by phone or mail.	2	.38
Interpersonal behaviors within family	3	.81
Family relations.	4	.72

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Family Scale = .81 (no. of items = 4).
[b] Item number refers to item numbers for Satisfaction with Family Scale in Appendix A.

Appendix C
Table C-4

Item/Total Correlations for Satisfaction with Social Relations Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Things done with other people.	1	.62
Time spent with other people.	2	.54
People you meet socially.	3	.56
The way you get along with others.	4	.28
Opportunities you have to meet people.	5	.67
Ammount of friendship in your life.	6	.63

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Social Relations Scale = .79 (no. of items = 6).
[b] Item number refers to item numbers for Satisfaction with Social Relations Scale in Appendix A.

Appendix C
Table C-5

Item/Total Correlations for Satisfaction with Leisure Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
The way you use your free time.	1	.70
The ammount of free time you have.	2	.55
Opportunities to enjoy activities.	3	.69
Ammount of pleasure in your life.	4	.67
Ammount of relaxation in your life.	5	.61
Pleasure derived from TV and radio.	6	.26

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Leisure Scale = .82 (no. of items = 6).
[b] Item number refers to item numbers for Satisfaction with Leisure Scale in Appendix A.

Appendix C
Table C-6

Item/Total Correlations for Satisfaction with Finances Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Total income.	1	.81
Price of basic necessities.	2	.66
Financial security.	3	.72
Money available for amusement.	4	.82

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Finances Scale = .89 (no. of items = 4).
[b] Item number refers to item numbers for Satisfaction with Finances Scale in Appendix A.

Appendix C
Table C-7

Item/Total Correlations for Satisfaction with Security Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Personal safety in general.	1	.53
Security in neighborhood streets.	2	.48
Personal security in residence.	3	.59
Protection from crime.	4	.47
Chances of finding a police officer.	5	.43

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Security Scale = .73 (no. of items = 5).
[b] Item number refers to item numbers for Satisfaction with Security Scale in Appendix A.

Appendix C
Table C-8

Item/Total Correlations for Satisfaction with Health Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Health in general.	1	.66
Medical services available.	2	.49
Frequency of contacts with physician.	3	.41
Opportunity to talk with therapist.	4	.39
Physical health.	5	.61
Emotional well-being.	6	.65

Note. $N = 70$.
[a] Cronbach's alpha for the Satisfaction with Health Scale = .78 (no. of items = 6).
[b] Item number refers to item numbers for Satisfaction with Health Scale in Appendix A.

Appendix C
Table C-9

Item/Total Correlations for Satisfaction with Religion Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Religion in your life.	1	.42
Opportunities to attend church.	2	.43
Personal involvement with your Church.	3	.69
Number of religious programs in media.	4	.36

Note. $N = 70$

[a] Cronbach's alpha for the Satisfaction with Religion Scale = .68 (no. of items = 4).

[b] Item number refers to item numbers for Satisfaction with Religion Scale in Appendix A.

Appendix C
Table C-10

Item/Total Correlations for Satisfaction with Work Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Job in general.	1	.31
Co-workers.	2	.58
Work environment.	3	.65
Number of hours worked.	4	.38
Salary.	5	.28

Note. $n = 24$.
[a] Cronbach's alpha for the Satisfaction with Work Scale = .67 (no. of items = 5).
[b] Item number refers to item numbers for Satisfaction with Work Scale in Appendix A.

Appendix C
Table C-11

Item/Total Correlations for Satisfaction with Education Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Being a student in general.	1	.56
School setting.	2	.42
Other students at school.	3	.30
Things you learn at school	4	.76

Note. $n = 19$.
[a] Cronbach's alpha for the Satisfaction with Education Scale = .69 (no. of items = 4).
[b] Item number refers to item numbers for Satisfaction with Education Scale in Appendix A.

Appendix C
Table C-12

Item/Total Correlations for Importance of Living Situation Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Having a private room.	1	.45
Having a locking bedroom door.	2	.34
Having a house key.	3	.53
Privacy for use of telephone in residence.	4	.45
Location of residential placement.	5	.37
Variety in food served in residence.	6	.23
Strictness of residence rules.	7	.38
Privacy in general in residence.	8	.37
Amount of freedom in residence.	9	.41
Stability of residential placement.	10	.15

Note. $N = 70$.
[a] Cronbach's alpha for the Importance of Living Situation Scale = .71 (no. of items = 10).
[b] Item number refers to item numbers for Importance of Living Situation Scale in Appendix A.

Appendix C
Table C-13

Item/Total Correlations for Family Preferences Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Reunions with family at their home.	1	.71
Telephone/mail contacts with family.	2	.63
Maintain close family ties.	3	.52

Note. $N = 70$.
[a] Cronbach's alpha for the Family Preferences Scale = .78 (no. of items = 4).
[b] Item number refers to item numbers for Family Preferences Scale in Appendix A.

Appendix C
Table C-14

Item/Total Correlations for Preferences with Social Relations Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Do things with others.	1	.30
Spend time with others.	2	.62
See different people socially.	3	.47
Get along with others in general.	4	.48
See friends.	5	.36
Having friends in general.	6	.23

Note. $N = 70$.
[a] Cronbach's alpha for the Preferences with Social Relations Scale = .67 (no. of items = 6).
[b] Item number refers to item numbers for Preferences with Social Relations Scale in Appendix A.

Appendix C
Table C-15

Item/Total Correlations for Preferences with Leisure Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Interesting activities during free time.	1	.41
Time for doing things that interest you.	2	.48
Occasions for undertaking activities.	3	.57
Having enjoyment in activities.	4	.56
Having time to relax.	5	.36

Note. $N = 70$.
[a] Cronbach's alpha for the Preferences with Leisure Scale = .70 (no. of items = 5).
[b] Item number refers to item numbers for Preferences with Leisure Scale in Appendix A.

Appendix C
Table C-16

Item/Total Correlations for Perceived Financial Need Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Amount for clothing.	2	.37
Amount for work transportation.	4	.64
Amount for social transportation.	5	.40
Amount for social activities.	6	.58
Amount for personal purchases.	7	.46

Note. $N = 70$.
[a] Cronbach's alpha for the Perceived Financial Need Scale = .63 (no. of items = 5).
[b] Item number refers to item numbers for Perceived Financial Need Scale in Appendix A.

Appendix C
Table C-17

Item/Total Correlations for Security Preferences Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Having no worries about crime.	1	.22
Living in a safe neighborhood.	2	.36
Being sheltered from crime.	3	.33

Note. $N = 70$.
[a] Cronbach's alpha for the Preferences with Security Scale = .48 (no. of items = 3).
[b] Item number refers to item numbers for Preferences with Security Scale in Appendix A.

Appendix C
Table C-18

Item/Total Correlations for Health Preferences Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Having good physical health.	1	.54
Having good mental health.	2	.59
Access to medical services when needed.	3	.36

Note. $N = 70$.
[a] Cronbach's alpha for the Preferences with Health Scale = .68 (no. of items = 3).
[b] Item number refers to item numbers for Preferences with Health Scale in Appendix A.

Appendix C
Table C-19

Item/Total Correlations for Preferences with Religion Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Meeting with other members of Church.	1	.42
Attending mass at Church.	2	.43
Listening to religious programs on media.	3	.69
Reading the bible.	4	.36

Note. $N = 70$.
[a] Cronbach's alpha for the Preferences with Religion Scale = .74 (no. of items = 4).
[b] Item number refers to item numbers for Satisfaction with Religion Scale in Appendix A.

Appendix C
Table C-20

Item/Total Correlations for Work Preferences Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Having an interesting job.	1	.55
Pleasant co-workers.	2	.27
Pleasant work environment.	3	.48
Regular work schedule.	4	.41
Adequate salary.	5	.40

Note. n = 50. Scale was completed by all respondents who expressed an interest in working.
[a] Cronbach's alpha for the Work Preferences Scale = .65 (no. of items = 5).
[b] Item number refers to item numbers for Work Preferences Scale in Appendix A.

Appendix C
Table C-21

Item/Total Correlations for Education Preferences Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Taking courses in general.	1	.54
School setting.	2	.26
Age of cohorts.	3	.31
Choosing own courses.	4	.47

Note. N = 26. Scale was completed by all respondents who expressed an interest in schooling.
[a] Cronbach's alpha for the Education Preferences Scale = .58 (no. of items = 4).
[b] Item number refers to item numbers for Education Preferences Scale in Appendix A.

Appendix C
Table C-22

Correlations of Domain-Specific Preferences with Global Subjective Quality of Life Measures and Domain Satisfactions Scales for the Outaouais Sample

Preferences in Life Domain	GSQL Indicators		Satisfactions with Life domain[c]
	Measure A[a]	Measure B[b]	
Living Situation	-.10	-.11	-.24*
Family	.17	.16	.36**
Social Relations	.06	.09	.20
Leisure	.00	.09	.02
Finances	-.49****	-.38***	-.47****
Law-Safety	-.15	-.18	-.23
Work[d]	-.25	-.30*	.28
Education[e]	.18	.35	.61**
Health	-.20	-.22	-.19
Religion	.16	.24*	.28*

Note: $N = 70$ except where indicate otherwise.

Although worded as "preferences", the living situation and finances domains actually were measured with scales assessing the importance of living situation and perceived financial needs, respectively. Both scales are in keeping with the concept of person/environment fit characteristic of the other preferences scales.

[a] Measure A = Average of the Item du Bien-être Global (French version of the Global Well-being Item asked at the beginning and again at the end of the quality of life interview with 70 chronic mentally disabled citizens living in small community-based residences in the Outaouais area.

[b] Measure B = Échelle de Satisfaction de Vie (French version of the five-item Satisfaction with Life Scale (Blais et al., 1989), completed by 70 chronic mentally disabled citizens living in small community-based residences in the Outaouais area.

[c] Satisfaction scales for the 10 different life domains assessed.

[d] Correlations for the work domain based upon sub-sample ($n = 24$) of respondents holding some type of job during the past year.

[e] Correlations for the education domain were based upon sub-sample ($n = 19$) of respondents attending some type of school program during the past year.

* $p < .05$; ** $p < .01$; *** $p < .001$; **** $p < .000$

Appendix C
Table C-23

Correlations Between Domain-specific Preferences and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residences in the Outaouais.

Preference Indicator in Life Domain	Objective Indicator	r	df	Significance
	Demographics:			
	Sex	.01	68	n.s.
	Age	-.01	68	n.s.
	Education	-.12	68	n.s.
	Marital Status	.03	68	n.s.
Living Situation	Placement stability/security	-.01	68	n.s.
	Privacy	.27	68	p = .02
	Autonomy	.08	68	n.s.
	Cohesion	.01	68	n.s.
	Independence	.14	68	n.s.
	Number of Co-residents	-.05	68	n.s.
	Total months in resdidence	-.23	68	p = .06
	Total number of different residential placements[a]	.01	68	n.s.
	PASSING total percent score	.07	68	n.s.
	PASSING setting percent score	.13	68	n.s.
	PASSING program percent score	.01	68	n.s.
	PASSING comfort percent score	.07	68	n.s.
	PASSING accessibility percent score	-.01	68	n.s.
	Activities	-.01	68	n.s.
	Activities within residence	-.02	68	n.s.
	Activities outside residence (a weak indicator of social integration)	.02	68	n.s.
	Social integration (defined in terms of accompaniment; a strong indicator of social integration	-.19	68	n.s.
Family	Frequency of personal and telephone contacts	-.02	68	n.s.

(table continues)

Table C-23 (continued)

Correlations Between Domain-specific Preferences and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residences in the Outaouais.

Preference Indicator in Life Domain	Objective Indicator	r	df	Significance
Social Relations	Total frequency of contacts	.29	68	p = .01
	Frequency of contacts in home	.28	68	p = .02
	Frequency of contacts outside of home	.20	68	n.s.
	Intimacy of Contacts	.18	68	n.s.
	Friends	-.09	68	n.s.
	Activities	.18	68	n.s.
Leisure	Total frequency of leisure activities	.23	68	p = .06
	Total freuquency of leisure activities within the residence	.17	68	n.s.
	Total frequency of leisure activities outside of residence	.21	68	n.s.
Work[b]	Work Scale	-.19	22	n.s
	Current employment status	---	22	----
	Hourly wage of current job	.07	22	n.s.
	Total hours worked per week	-.22	22	n.s.
Education[c]	Education Scale	-.24	17	n.s.
	Student status[a]	.19	17	n.s.
	Days or evenings per week of school attendance	-.22	17	n.s.
Personal Security	Legal/safety Scale	.06	68	n.s.
	Criminal Activities Scale	-.07	68	n.s.
	Victim of Crime Scale	.19	68	n.s.
Religion	Frequency of religious activity scale	.65	68	p = .000
	Frequency of attending church mass	.46	68	p = .000
	frequency of listening to religious programs	.55	68	p = .000
	Frequency of reading bible	.38	68	p = .001

(table continues)

Table C-23 (continued)

Correlations Between Domain Specific Preferences and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residences in the Outaouais.

Preference Indicator in Life Domain	Objective Indicator	r	df	Significance
Finances	Monthly spending money	-.08	68	n.s.
	Monthly income	-.13	68	n.s.
Health	No. of illnesses	.21	68	n.s.
	Behavior handicaps[d]	.03	54	n.s.
	Physical handicaps[e]	.01	53	n.s.
	Total use of health care	-.02	68	n.s.
	Use of acute psychiatric services (i.e., number of psychiatric admissions[a])	-.14	68	n.s.
	Total current dose of antipsychotics[a]	n/a	n/a	n/a
	Use of general medical services	.06	68	n.s.
	Use of general psychiatric services	-.03	68	n.s.
	Use of general social services	-.03	68	n.s.

Note. Correlations based on full sample (n = 70) except where so indicated.

a Pertains to past year.

[b] Work scale based on subsample (n = 24).

[c] Education scale based on subsample (n = 19).

[d] Behavior handicap scale based on partial (n = 55).

[e] Physical handicaps scale based on partial (n = 56).

Appendix C
Table C-24

Item/Total Correlations for Behavior Handicaps Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Unkempt appearance.	14	.47
Is impatient.	15	.46
Is interested in activities.	17	.52
Remains seated if not directed.	18	.37
Is easily angered or upset.	19	.40
Has auditory hallucinations.	20	.36
Keeps personal clothing clean.	21	.38
Tries to socialize with others.	22	.35
Easily upset if not satisfied.	23	.16
Refuses to do simple things.	24	.38
Is irritable.	25	.39
Refuses to speak.	27	.15
Laughs at appropriate times.	28	.35
Has poor table maners.	29	.33
Initiates conversations.	30	.22
Reports feeling depressed.	31	.15
Talks about personal interests.	32	.23
Has visual hallucinations.	33	.19
Needs reminding of what to do.	34	.67
Sleeps unless directed to activities.	35	.43
Reports feeling worthless.	36	.21
Needs reminding of rules.	37	.64

(table continues)

Table C-24 (continued)

Descriptors of Scale Items	Item Number	Corrected Item/Total Correlation Coefficient
Needs supervision to do simple things.	38	.30
Talks or mumbles to self.	39	.44
Reports feeling useless and rejected.	40	.31
Squeals, laughs without apparent reason.	41	.19
Is easily unhinged.	42	.31
Keeps self clean.	43	.39
Is self-oriented without help.	44	.20
Is unbearable.	45	.38
Says and thinks strange thoughts.	46	.33
Steals things.	47	.21
Becomes confused.	48	.33
Is oriented to place.	49	.13
Is a negligent smoker.	51	.46
Pinches, pushes, or slaps others.	53	.20
Gets along with others.	54	.42
Exposes self or masturbates in public.	55	.21
Insults others.	56	.19
Shows bizzare or ritualistic behaviors.	57	.32
Defecates or urinates in public.	58	.16
Talks of suicide or dying.	59	.12
Seems to enjoy what he/she does.	60	.48
Causes trouble (is a troublemaker).	62	.36
Knows the names of staff and residents.	63	.10

Note: $N = 55$.

[a] Cronbach's alpha for the Behavior Handicaps Scale = .86 (Total n of items = 45).

[b] Scale Item numbers refer to the number corresponding to each item on the scale in Appendix B (Level of Care Survey).

Appendix C
Table C-25

Scale Reliabilities for Services Received and Needed Scale for French Version of Quality of Life Interview

Scales (number of items/ Descriptors of items	Internal Consistency (Chronbach's alpha)	Corrected Item-total Correlation Coefficients
Services Received and Needed (32)	.76	
Dental received.		.42
Dental care needed.		.35
In-patient psychiatric care received.		.35
In-patient psychiatric care needed.		.42
Out-patient group counseling received.		.40
Out-patient group counseling needed.		.32
Out-patient individual counseling received.		.30
Out-patient individual counseling needed.		.35
Out-patient family counseling received.		.41
Out-patient family counseling needed.		.34
Medication for emotional problems received.		.24
Medication for emotional problems needed.		.31
Assistance for emergencies received.		.43
Assistance for emergencies needed.		.36
Self-care learning program received.		.31
Self-care learning program needed.		.36
Assistance in scheduling activities received.		.38
Assistance in scheduling activities needed.		.37
Assistance with finding work received.		.31
Assistance with finding work needed.		.31
Family support program received.		.28
Family support program needed.		.33
Civil rights education received.		.37
Civil rights education needed.		.26

(table continues)

Table C-25 (continued)

Scale Reliabilities for Services Received and Needed Scale for French Version of Quality of Life Interview

Scales (number of items/ Descriptors of items	Internal Consistency (Chronbach's alpha)	Corrected Item-total Correlation Coefficients
Services Received and Needed (32)	.76	
Out-patient alcohol rehabilitation received.		.30
Out-patient alcohol rehabilitation needed.		.27
In-patient alcohol rehabilitation received.		.35
In-patient alcohol rehabilitation needed.		.31
Out-patient drug rehabilitation received.		.39
Out-patient drug rehabilitation needed.		.41
In-patient drug rehabilitation received.		.30
In-patient drug rehabilitation needed.		.31

Note: Total number of respondents = 70.

Appendix C
Table C-26

Scale Reliabilities for Services Received Scale for French Version of Quality of Life Interview

Scales (number of items/ Descriptors of items	Internal Consistency (Chronbach's alpha)	Corrected Item-total Correlation Coefficients
Services Received (16)	.62	
Dental received.		.36
In-patient psychiatric care received.		.20
Out-patient group counseling received.		.25
Out-patient individual counseling received.		.27
Out-patient family counseling received.		.25
Medication for emotional problems received.		.15
Assistance for emergencies received.		.28
Self-care learning program received.		.27
Assistance in scheduling activities received.		.32
Assistance with finding work received.		.32
Family support program received.		.31
Civil rights education received.		.44
Out-patient alcohol rehabilitation received.		.29
In-patient alcohol rehabilitation received.		.37
Out-patient drug rehabilitation received.		.42
In-patient drug rehabilitation received.		.29

Note: Total number of respondents = 70.

Appendix C
Table C-27

Scale Reliabilities for Services Needed Scale for French Version of Quality of Life Interview

Scales (number of items/ Descriptors of items	Internal Consistency (Chronbach's alpha)	Corrected Item-total Correlation Coefficients
Services Needed (16)	.60	
Dental care needed.		.32
In-patient psychiatric care needed.		.36
Out-patient group counseling needed.		.35
Out-patient individual counseling needed.		.35
Out-patient family counseling needed.		.47
Medication for emotional problems needed.		.29
Assistance for emergencies needed.		.36
Self-care learning program needed.		.32
Assistance in scheduling activities needed.		.42
Assistance with finding work needed.		.25
Family support program needed.		.17
Civil rights education needed.		.22
Out-patient alcohol rehabilitation needed.		.21
In-patient alcohol rehabilitation needed.		.30
Out-patient drug rehabilitation needed.		.32
In-patient drug rehabilitation needed.		.30

Note: Total number of respondents = 70.

Appendic C
Table C-28

Leisure Scale Reliabilities for French Version of Quality of Life Interview

Scales (number of items/ Descriptors of items	Internal Consistency (Chronbach's alpha)	Corrected Item-total Correlation Coefficients
Leisure Activities (24)	.68	
Taking a walk.		.27
Going to see a movie.		.10
Looking at television.		.30
Going shopping.		.31
Going to a restaurant.		.25
Going to a bar/tavern.		.25
Reading a book/newspaper.		.16
Playing cards/table games.		.26
Going for a leisure car/bus ride.		.25
Work on a hobby.		.14
Play a sport.		.27
Go to a social meeting.		.18
Go to a park.		.26
Go to the beach.		.29
Go to a party.		.23
Go to a dance.		.20
Visit family in their home.		.39
Receive family in your home.		.15
Spend time at the plaza/mall.		.35
Go camping.		.13
Go for a bicycle ride.		.21
Visit to beauty salon/hairstylist.		.10
See a sports activity.		.24
Visit a community centre.		.26

Note: Total number of respondents = 70.

Appendix C

Table C-29

Intra-residential Leisure Scale Reliabilities for French Version of Quality of Life Interview

Scales (number of items/ Descriptors of items	Internal Consistency (Chronbach's alpha)	Corrected Item-total Correlation Coefficients
Leisure Activities		
Within the Residence (5)	.37	
Look at television.		.16
Read a book/newspaper.		.15
Play cards/table games.		.17
Work on a hobby.		.29
Receiving family.		.20

Note: Total number of respondents = 70.

Appendix C
Table C-30

Extra-residential Leisure Scale Reliabilities for French Version of Quality of Life Interview

Scale (number of items/ Descriptors of items	Internal Consistency (Chronbach's alpha)	Corrected Item-total Correlation Coefficients
Leisure Activities		
Outside of Residence (21)	.66	
Taking a walk.		.24
Going to see a movie.		.10
Going shopping.		.24
Going to a restaurant.		.21
Going to a bar/tavern.		.31
Going for a leisure car/bus ride.		.27
Play a sport.		.31
Go to a social meeting.		.18
Go to a park.		.28
Go to the library.		.10
Go to the beach.		.31
Go to a party.		.20
Go to a dance.		.22
Visit family in their home.		.38
Attend a fine arts show.		.16
Spend time at the plaza/mall.		.38
Go camping.		.22
Go for a bicycle ride.		.20
Visit to beauty salon/hairstylist.		.12
See a sports activity.		.27
Visit a community centre.		.16

Note: Total number of respondents = 70.

Appendix C
Table C-31

Item/Total Correlations for Activities Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Go for a walk.	1	.31
Go see a film at a movie house.	2	.13
Look at television.	4	.26
Go shopping.	5	.32
Go to a restaurant.	6	.35
Go to a bar.	10	.24
Read a book/newspaper.	13	.23
Play cards/table games.	14	.23
Go for a leisure car/bus ride.	15	.25
Prepare a meal.	19	.38
Work on a hobby.	20	.16
Play a sport.	21	.29
Go to a social meeting.	25	.16
Go to a park.	27	.21
Go to the beach.	28	.38
Go to a party.	29	.24
Go to a dance.	31	.20
Visit with family in their home.	32	.40
Receive family in your home/residence.	34	.23
Spend time at the plaza/mall.	35	.35
Go camping.	37	.10
Work at a paid odd job.	38	.37

(table continues)

Table C-31 (continued)

Descriptors of Scale Items	Scale's Item Number	Corrected Item/Total Correlation Coefficient
Participate in sheltered work.	39	.17
Do volunteer work.	42	.30
Go to the bank.	43	.42
Go to the post-office.	1	.10
Visit to the dentist.	5	.19
Go see doctor for a physical examination.	14	.20
Do grocery shopping.	13	.35
Do inside house work.	19	.11
Go for a bicycle ride.	38	.16
Visit to beauty salon/hairstylist.	43	.15
See a sports activity.	44	.26
Visit a community center.	45	.22

Note: Total number of respondents = 70.
[a] Cronbach's alpha for the Activities Scale = .75 (number of items = 34).
[b] Item numbers refer to the number corresponding to each item on the scale in Appendix A-1.

Appendix C
Table C-32

Item/Total Correlations for Intra-residential Activities Scale[a]

Descriptors of Scale Items	Item Number[b]	Corrected Item/Total Correlation Coefficients
Look at television.	3	.14
Read a book/newspaper.	7	.30
Play cards/table games.	9	.12
Prepare a meal.	11	.21
Work on a hobby.	12	.23
Receive a visit from family.	26	.28
Do inside house work.	41	.24

[a] Cronbach's alpha = .45 (number of items = 7).
[b] Item number refers to the number corresponding to each item on the scale in Appendix A-1.

Appendix C
Table C-33

Correlations of the Échelle d'Estime de Soi with Domain Satisfaction for the Outaouais Sample

Satisfactions in Life domains[a]	Self-esteem		
	r	*df*	significance
Living Situation	.33	68	p = .005
Family	.34	68	p = .004
Social Relations	.42	68	p < .001
Leisure	.40	68	p = .001
Finances	.25	68	p = .03
Law-Safety	.46	68	p < .001
Work[b]	.09	22	ns
Education[c]	.28	17	ns
Health	.54	68	p < .001
Religion	.48	68	p < .001

Note. Correlations based upon total sample (N = 70) unless otherwise indicated.

[a] Satisfaction scales for the 10 different life domains surveyed.

[b] Correlations for the work domain based upon sub-sample (n = 24) of respondents holding some type of job (usually sheltered work) during the past year.

[c] Correlations for the education domain based upon sub-sample (n = 19) of respondents attending some type of school program during the past year.

Appendix C
Table C-34

Correlations of Échelle de'Estime de Soi with Domain Preferences Measures for the Outaouais Sample

Preferences[a] in Life domains	Self-esteem		
	r	*df*	significance
Living Situation	-.13	68	n.s.
Family	.15	68	n.s.
Social Relations	.17	68	n.s.
Leisure	.23	68	p = .06
Finances	-.31	68	p < .01
Law-Safety	-.02	68	n.s.
Work[b]	.06	48	n.s.
School[c]	.17	24	n.s.
Health	-.02	68	n.s.
Religion	.19	68	n.s.

Note: Correlations based upon total sample (N = 70) unless otherwise indicated.

[a] Although worded as "preferences", the living situation and finances domains actually were assessed with scales measuring the importance of living situation and perceived financial need, respectively. Both scales, however, are in keeping with the concept of person/environment fit characteristic of the other preferences scales.

[b] Correlations for the work domain based upon sub-sample(n = 50) of respondents having expressed an interest in obtaining some type of work during the past year.

[c] Correlations for the education domain based upon sub-sample(n = 22) of respondents having expressed an interest in attending some type of school program during the past year.

Appendix C
Table C-35

Correlations Between Self-esteem and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residences in the Outaouais.

Life Domains	Objective Indicator	Self-esteem		
		r	*df*	Significance
	Demographics:			
	Gender[a]	.05	68	ns
	Age	-.05	68	ns
	Education	.10	68	ns
	Marital Status	-.11	68	ns
Living Situation	Placement stability/security	-.18	68	ns
	Privacy	-.17	68	ns
	Autonomy	-.11	68	ns
	Cohesion	.16	68	ns
	Independence	-.18	68	ns
	Number of Co-residents	.14	68	ns
	Total months in resdidence	.12	68	ns
	Total number of different residential placements[b]	-.18	68	ns
	PASSING total percent score	-.01	68	ns
	PASSING setting percent score	-.10	68	ns
	PASSING program percent score	.05	68	ns
	PASSING comfort percent score	.05	68	ns
	PASSING accessibility percent score	-.04	68	ns
	Activities	.17	68	ns
	Activities within residence	.35	68	p = .003
	Activities outside residence (a weak indicator of social integration)	.08	68	ns
	Social integration defined in terms of accompaniment (a strong indicator of social integration)	-.01	68	ns
Family	Frequency of personal and telephone contacts	.04	68	ns

(table continues)

Table C-35 (continued)

Correlations Between Self-Esteem and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-Based Residences in the Outaouais.

Life Domains	Objective Indicator	Self-esteem		
		r	*df*	Significance
Social Relations	Total Contacts	.11	68	ns
	Contacts in home	.14	68	ns
	Contacts outside of home	-.05	68	ns
	Intimacy of Contacts	-.02	68	ns
	Friends	-.07	68	ns
Leisure	Total number of leisure activities	.14	68	ns
	Total number of leisure activities within the residence	.31	68	p = .008
	Total number of leisure activities outside of residence	.04	68	ns
Work[c]	Work Scale	.22	23	ns
	Current employment status	.08	68	ns
	Hourly wage of current job	.13	23	ns
	Total hours worked per week	-.12	23	ns
Unemployment	Unemployment Scale	.01	43	ns
	Number of months without a paying job.	.05	43	ns
	Number of months since leaving best job.	-.05	43	ns
Finances	Monthly spending money	.18	68	ns
	Monthly income	.12	68	ns
Education[d]	Student status[b]	.01	68	ns
	Days or evenings per week of school attendance	.19	17	ns
Personal Security	Legal/safety Scale	-.10	68	ns
	Criminal Activities Scale	-.15	68	ns
	Victim of Crime Scale	-.01	68	ns

(table continues)

Table C-35 (continued)

Correlations Between Self-Esteem and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-Based Residences in the Outaouais.

Life Domains	Objective Indicator	Self-esteem		
		r	*df*	Significance
Religion	Frequency of religious activity scale	.17	68	ns
	Frequency of attending church mass	.05	68	ns
	Frequency of listening to religious programs	.27	68	p = .027
	Frequency of reading bible	.04	68	ns
Health	No. of illnesses	-.00	68	ns
	Behavior handicaps[e]	-.04	53	ns
	Physical handicaps[f]	-.02	54	ns
	Total use of health care	-.08	68	ns
	Use of acute psychiatric services (i.e., number of psychiatric admissions[a])	-.13	68	ns
	Total current dose of antipsychotics[a]	n/a	n/a	n/a
	Use of general medical services	.02	68	ns
	Use of general psychiatric services	-.05	68	ns
	Use of general social services	-.08	68	ns

Note: Correlations based on full sample (N = 70) except where so indicated.

[a] Value labels for sex variable were 1 = male, 2 = female.

[b] Pertains to past year.

[c] Work scale based on sub-sample size (n = 25) of working clients who responded to self-esteem scale.

[d] Education scale based on sub-sample size (n = 19) of clients who attended school and who responded to self-esteem scale.

[e] Behavior handicap scale based on sub-sample (n = 55).

[f] Physical handicaps scale based on sub-sample (n = 56).

Appendix C
Table C-36

Internal Consistency Reliabilities For Domain-specific Preferences Scales, Service Importance Scale, Perceived Financial Need Scale, Self-esteem Scale, Client Satisfaction Questionnaire, Activities Scale, Strong and Weak Social Integration Scales, and Accompaniment Scales

Scales	No. Items	Internal Consistency (Cronbach's Alpha)
Domain-specific Preferences		
Living situation	2	.59
Family	3	.78
Social Relations	6	.67
Leisure	5	.70
Perceived financial need	1	n/a
Safety	3	.48
Work	5	.65
Education	4	.58
Health	3	.68
Religion	4	.74
Importance of Service-related Variables Scale (related to living situation)	10	.71
Perceived Financial Needs Scale	5	.63
Self-esteem Scale (Rosenberg, 1965)	10	.83
Consumer Satisfaction Questionnaire[a]	3	.66
Activities Scale	34	.75
Activities within residence Scale	5	.37
Weak Social Integration Scale[b]	27	.73
Stong Social Integration Scale[c]	31	.84
Activities with a family member scale	24	.86
Activities with other valued person scale	8	.81

[a] Abridged (3 item) version of the original scale by Larsen et al. (1979).

[b] This scale reflects the range of activities undertaken outside the residence without consideration of the different categories of social accompaniment. As such, it presents only the scope or breadth of social integration. In terms of social role valorization (SRV) theory, it is a weak indicator of social integration. A stronger indicator of social integration would better reflect the depth of social integration in terms of categories of socially valued accompaniment across different activities both within and outside the respondent's residence.

[c] This scale provides a measure of the different categories of social accompaniment by socially valued persons across different activities undertaken both within and outside the residence. It reflects the depth of social integration and is a stronger indicator of social integration.

Appendix C
Table C-37

Average Frequency of Activities (Past Week)

Activity	Mean	S.D.	Median
Watch television	*5.429*	*2.256*	*7.000*
Listen to the radio	*4.786*	*2.823*	*7.000*
Go for a walk	4.514	3.202	5.000
Do housework inside the residence	*3.757*	*2.911*	*3.000*
Read	*3.257*	*2.977*	*3.000*
Do grocery shopping	2.471	2.471	1.500
Go to a restaurant	1.714	2.577	1.000
Play card/table games	*1.286*	*2.030*	*0.000*
Spend time at the plaza/mall	1.143	1.966	0.000
Go for a leisure car/bus ride	1.100	1.746	0.500
Prepare a meal	*0.914*	*1.855*	*0.000*
Visit a friend	0.886	1.838	0.000
Go for a bicycle ride	0.829	2.078	0.000
Play a sport	0.771	1.652	0.000
Go to a park	0.743	1.717	0.000
Go visit family in their home	0.714	1.342	0.000
Go shopping	0.700	1.147	0.000
Doing remunerated work	0.657	1.587	0.000
Go to a post office	0.643	1.494	0.000
Work on a hobby	*0.614*	*1.477*	*0.000*
Work in a sheltered workshop	0.557	1.315	0.000
Do housework on residence grounds	*0.557*	*1.410*	*0.000*
Go to a community centre	0.529	1.422	0.000
Receive a friend at residence	*0.514*	*1.176*	*0.000*
Go to the bank	0.386	0.786	0.000
Go to the beach/swimming	0.371	1.038	0.000
Go to Church	0.357	0.817	0.000
Have a picnic	0.271	0.916	0.000
Go to a tavern/bar	0.257	0.988	0.000
Go camping	0.229	0.995	0.000
Do volunteer work	0.229	1.079	0.000
Visit a barbershop/beauty salon	0.171	0.380	0.000
Visit physician	0.143	0.352	0.000
See a sports activity in person	0.143	0.460	0.000
Visit a library	0.143	0.748	0.000

(table continues)

Appendix C
Table C-37 (continued)

Average Frequency of Activities (Past Week)

Activity	Mean	S.D.	Median
Go to a party	0.129	0.448	0.000
Go to a movie theatre	0.129	0.635	0.000
Receive family in your residence	*0.114*	*0.320*	*0.000*
Attend a community meeting	0.114	0.435	0.000
Go to a dance	0.100	0.302	0.000
Go play bingo	0.086	0.408	0.000
Go to school	0.043	0.204	0.000
Visit a museum	0.043	0.204	0.000
See a fine arts show	0.043	0.204	0.000
Visit to the dentist	0.029	0.168	0.000

Note: Intra-residential activities are in italics. Data are based upon total sample (N = 70) and full range of activities (no. of items = 45).

Appendix C
Table C-38

Average Frequency of Activities (Past Week) By Accompaniment Categories

Activities	Accompaniment Categories						
	1	2	3	4	5	6	7
Watch television	*2.91*	*1.26*	*0.14*	*0.06*	*0.00*	*0.13*	*0.01*
Listen to the radio	*2.16*	*2.43*	*0.00*	*0.00*	*0.00*	*0.20*	*0.00*
Go for a walk	2.91	1.26	0.14	0.57	0.00	0.13	0.14
Do housework inside residence	*2.34*	*1.17*	*0.00*	*0.24*	*0.00*	*0.00*	*0.00*
Read	*1.61*	*1.44*	*0.00*	*0.04*	*0.00*	*0.16*	*0.00*
Do grocery shopping	1.64	0.49	0.10	0.09	0.00	0.11	0.04
Go to a restaurant	0.81	0.61	0.16	0.07	0.00	0.03	0.03
Play card/table games	*0.09*	*0.80*	*0.31*	*0.07*	*0.00*	*0.01*	*0.00*
Spend time at plaza/mall	0.71	0.26	0.11	0.01	0.01	0.03	0.00
Go for a leisure car/bus ride	0.30	0.09	0.00	0.31	0.04	0.30	0.06
Prepare a meal	*0.50*	*0.10*	*0.00*	*0.19*	*0.01*	*0.11*	*0.00*
Visit a friend	0.69	0.06	0.10	0.04	0.00	0.00	0.00
Go for a bicycle ride	0.59	0.24	0.00	0.00	0.00	0.00	0.00
Play a sport	0.17	0.26	0.16	0.11	0.00	0.06	0.01
Go to a park	0.26	0.41	0.03	0.01	0.00	0.01	0.01
Visit family in their home	0.43	0.00	0.00	0.03	0.01	0.24	0.00
Go shopping	0.27	0.27	0.00	0.86	0.01	0.04	0.01
Any type of remunerated work	0.51	0.01	0.01	0.10	0.00	0.01	0.00
Go to the post office	0.50	0.10	0.00	0.03	0.00	0.01	0.00
Work on a hobby	*0.27*	*0.19*	*0.04*	*0.11*	*0.00*	*0.00*	*0.00*
Work in a sheltered workshop	0.19	0.06	0.27	0.00	0.04	0.00	0.00
Do work on residence grounds	*0.36*	*0.03*	*0.00*	*0.16*	*0.00*	*0.01*	*0.00*
Visit a community centre	0.20	0.03	0.27	0.00	0.00	0.03	0.00
Receive a friend in your residence	*0.16*	*0.19*	*0.11*	*0.00*	*0.01*	*0.03*	*0.01*
Go to the bank	0.30	0.03	0.01	0.04	0.00	0.00	0.00
Go to the beach/swimming	0.16	0.06	0.06	0.04	0.00	0.06	0.00
Go to Church	0.21	0.04	0.00	0.07	0.00	0.03	0.00
Go for a picnic	0.00	0.03	0.01	0.20	0.01	0.01	0.00
Go to a tavern/bar	0.10	0.11	0.01	0.01	0.00	0.01	0.00
Go camping	0.03	0.00	0.01	0.17	0.00	0.01	0.00
Do volunteer work	0.09	0.00	0.00	0.10	0.00	0.04	0.00
Visit a barbershop/beauty salon	0.09	0.00	0.00	0.03	0.01	0.04	0.00
Visit your physician	0.07	0.01	0.00	0.06	0.00	0.00	0.00

(table continues)

Appendix C
Table C-38 (continued)

Average Frequency of Activities (Past Week) By Accompaniment Categories

Activities	Accompaniment Categories						
	1	2	3	4	5	6	7
See a sports activity in person	0.07	0.03	0.00	0.04	0.00	0.00	0.00
Go to the library	0.13	0.00	0.00	0.00	0.00	0.00	0.01
Go to a party	0.04	0.04	0.01	0.00	0.00	0.03	0.00
Go to a movie theatre	0.00	0.11	0.00	0.00	0.00	0.00	0.14
Receive family in your residence	*0.01*	*0.00*	*0.00*	*0.00*	*0.00*	*0.09*	*0.01*
Attend a community meeting	0.06	0.00	0.00	0.04	0.00	0.00	0.01
Go to a dance	0.01	0.04	0.03	0.00	0.00	0.01	0.00
Go play bingo	0.00	0.01	0.00	0.07	0.00	0.00	0.00
Attend any school program	0.00	0.00	0.04	0.00	0.00	0.00	0.00
Visit a museum	0.00	0.00	0.03	0.01	0.00	0.00	0.00
See a fine arts show in person	0.01	0.01	0.00	0.01	0.00	0.00	0.00
Visit to the dentist	0.01	0.00	0.00	0.00	0.00	0.01	0.00

Note: Results based upon total sample (N = 70) and full range of items (no. of items = 45). Intra-residential activities are in *italics*.
Accompaniment categories were: 1 = Alone; 2 = With a co-resident; 3 = With another socially devalued person; 4 = With home operator or staff member; 5 = with a visiting professional; 6 = with a member of respondent's family; 7 = With a socially valued person other than home operator, staff, visiting professional, or member of the respondent's family.

Appendic C
Table C-39

Average Frequency of Activities (Past Week) By Category of Social Accompaniment

Social Accompaniment Categories	Mean	S.D.	Median
Alone	20.100	13.647	18.000
Co-Resident	14.814	11.842	13.500
Other socially devalued person	2.057	3.930	0.000
Home operator/staff	3.000	4.694	1.000
Viciting professional	0.186	0.906	0.000
Family member	2.200	6.522	0.000
Other socially valued person	0.257	0.988	0.000

Note: Results based upon total sample (N = 70) and full range of activities surveyed (no. of items = 45).

Appendix C
Table C-40

Average Frequency of Residential and Extra-residential Activities Compared

Location of Activities	Mean	S.D.	Median
Intra-Residential Activities	21.229	7.60	22.000
Extra-Residential Activities	21.386	13.068	20.500

Note: Results based upon total sample (N = 70) and average frequency of involvement across the full range of intra-residential activities (no. of items = 10) and extra-residential activities (no. of items = 35).

Appendix C
Table C-41

Average Frequency of Intra-residential Activities by Social Accompaniment Categories

Social Accompaniment Categories	Mean	S.D.	Median
Alone	10.414	6.634	10.000
With a co-resident	10.129	6.918	10.500
With another socially devalued person	0.471	1.293	0.000
With home operator/staff	1.129	2.740	0.000
With a visiting professional	0.029	0.168	0.000
With a family member	0.914	4.049	0.000
With other socially valued person	0.029	0.168	0.000

Note: Results based upon total sample (N = 70) and full range of intra-residential activities (no. of items = 10).

Appendix C
Table C-42

Average Frequency of Extra-residential Activities by Social Accompaniment Categories

Social Accompaniment Categories	Mean	S.D.	Median
Alone	11.571	10.634	9.000
With a co-resident	4.686	7.932	1.500
With another socially devalued person	1.586	3.104	0.000
With home operator/staff	1.871	3.097	1.000
With a visiting professional	0.157	0.895	0.000
With a family member	1.286	3.853	0.000
With other socially valued person	0.229	0.951	0.000

Note: Results based upon total sample (N = 70) and full range of extra-residential activities (no. of items = 35).

Appendix C
Table C-43

Correlations Between Strong Social Integration Scale (SSIS) and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais

		Strong Social Integration		
Life Domains	Objective Indicator	*r*	*df*	Significance
	Demographics:			
	Gender[a]	.11	68	n.s.
	Age	-.28	68	p = .02
	Education	.13	68	n.s.
	Marital Status	-.11	68	n.s.
Living Situation	Placement stability/security	-.10	68	n.s.
	Privacy	-.02	68	n.s.
	Autonomy	.11	68	n.s.
	Cohesion	.09	68	n.s.
	Independence	-.04	68	n.s.
	Number of Co-residents	-.18	68	n.s.
	Total months in residence	-.08	68	n.s.
	Total number of different residential placements[b]	-.11	68	n.s.
	Kilometers of residence from nearest town	-.09	68	n.s.
	PASSING total percent score	.17	68	n.s.
	PASSING setting percent score	.20	68	n.s.
	PASSING program percent score	.10	68	n.s.
	PASSING comfort percent score	.17	68	n.s.
	PASSING accessibility percent score	.17	68	n.s.
	Activities	.28	68	p = .02
	Activities within residence	.17	68	n.s.
	Activities outside residence (a weak indicator of social integration)	.28	68	p = .02
Social Relations	Total Contacts	.07	68	n.s.
	Contacts in home	.08	68	n.s.
	Contacts outside of home	.12	68	n.s.
	Intimacy of Contacts	.15	68	n.s.
	Friends	.04	68	n.s.

(table continues)

Table C-43 (continued)

Correlations Between Strong Social Integration Scale (SSIS) and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais

		Strong Social Integration		
Life Domains	Objective Indicator	*r*	*df*	Significance
Family	Frequency of personal and telephone contacts	.13	68	n.s.
Leisure	Total of leisure activities	.14	68	n.s.
	Total of leisure activities within the residence	.06	68	n.s.
	Total of leisure activities outside of residence	.04	68	n.s.
Work[c]	Hourly wage of current job[c]	.07	23	n.s.
	Total hours worked per week[c]	.22	23	n.s.
	Hourly wage of best job ever	-.16	68	n.s.
	Consecutive months in best job	-.17	68	n.s.
Unemployment[d]	Total months without paying work	-.01	43	n.s.
	Total months since leaving best job	.13	43	n.s.
Education	Student status[b]	.08	68	n.s.
	Days or evenings per week of school attendance[e]	.44	17	p = .058
	Course load[e]	.36	17	n.s.
Personal Security	Legal/safety Scale	-.12	68	n.s.
	Criminal Activities Scale	-.10	68	n.s.
	Victim of Crime Scale	-.09	68	n.s.
Religion	Frequency of religious activity scale	.04	68	n.s.
	Frequency of attending church mass	.00	68	n.s.
	frequency of listening to religious programs	-.07	68	n.s.
	Frequency of reading bible	.14	68	n.s.

(table continues)

Table C-43 (continued)

Correlations Between Strong Social Integration Scale (SSIS) and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais

		Strong Social Integration		
Life Domains	Objective Indicator	*r*	*df*	Significance
Finances	Monthly spending money	.04	68	n.s.
	Monthly income	.10	68	n.s.
Health	No. of illnesses	.03	54	n.s.
	Behavior handicaps[f]	-.10	53	n.s.
	Physical handicaps[g]	-.14	54	n.s.
	Total use of health care	.04	68	n.s.
	Use of acute psychiatric services (i.e., number of psychiatric admissions[a])	-.06	68	n.s.
	Total current dose of antipsychotics[a]	n/a	n/a	n/a
	Use of general medical services	.10	68	n.s.
	Use of general psychiatric services	.13	68	n.s.
	Use of general social services	-.03	68	n.s.
	Frequency of contacts with professional practioners	-.28	68	p = .019

Note: Correlations based on full sample (N = 70) except where so indicated.
[a] Value labels for gender variable were 1 = male, 2 = female.
[b] Pertains to past year.
[c] Work items were based on sub-sample (n = 25).
[d] Unemployment items were based on sub-sample (n = 45).
[e] Education items based on sub-sample (n = 19).
[f] Behavior handicap scale based on sub-sample (n = 55).
[g] Physical handicaps scale based on sub-sample (n = 56).

Appendix C
Table C-44

Correlations Between Weak Social Integration Scale (WSIS) and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais

Life Domains	Objective Indicator	Weak Social Integration		
		r	*df*	Significance
	Demographics:			
	Gender[a]	-.16	68	n.s.
	Age	-.32	68	p = .007
	Education	.14	68	n.s.
	Marital Status	-.16	68	n.s.
Living Situation	Placement stability/security	.06	68	n.s.
	Privacy	.14	68	n.s.
	Autonomy	.41	68	p = .000
	Cohesion	.32	68	p = .006
	Independence	-.11	68	n.s.
	Number of Co-residents	-.12	68	n.s.
	Total months in residence	-.02	68	n.s.
	Total number of different residential placements[b]	.00	68	n.s.
	Kilometers of residence from nearest town	-.26	68	p = .03
	PASSING total percent score	.31	68	p = .009
	PASSING setting percent score	.27	68	p = .03
	PASSING program percent score	.26	68	p = .03
	PASSING comfort percent score	.13	68	n.s.
	PASSING accessibility percent score	.36	68	p = .002
	Activities	.95	68	p = .000
	Activities within residence	.38	68	p = .001
	Activities with a valued person (a strong indicator of social integration)	.28	68	p = .02
Social Relations	Total Contacts	.34	68	p = .004
	Contacts in home	.30	68	p = .01
	Contacts outside of home	.33	68	p = .005
	Intimacy of Contacts	.30	68	p = .01
	Friends	.24	68	p = .04

(table continues)

Table C-44 (continued)

Correlations Between Weak Social Integration Scale (WSIS) and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais

		Weak Social Integration		
Life Domains	Objective Indicator	*r*	*df*	Significance
Family	Frequency of personal and telephone contacts	.21	68	p = .08
Leisure	Total of leisure activities	.93	68	p = .000
	Total of leisure activities within the residence	.31	68	p = .008
	Total of leisure activities outside of residence	.95	68	p = .000
Work[c]	Hourly wage of current job[c]	.50	23	p = .01
	Total hours worked per week[c]	.47	23	p = .02
	Hourly wage of best job ever	.25	68	n.s.
	Consecutive months in best job	-.49	68	p = .01
Unemployment[d]	Total months without paying work	-.16	43	n.s.
	Total months since leaving best job	-.02	43	n.s.
Education	Student status[b]	-.11	68	n.s.
	Days or evenings per week of school attendance[e]	.55	17	p = .014
	Course load[e]	.50	17	p = .028
Personal Security	Legal/safety Scale	.04	68	n.s.
	Criminal Activities Scale	.15	68	n.s.
	Victim of Crime Scale	-.11	68	n.s.
Religion	Frequency of religious activity scale	-.19	68	n.s.
	Frequency of attending church mass	-.09	68	n.s.
	frequency of listening to religious programs	-.22	68	p = .064
	Frequency of reading bible	-.09	68	n.s.

(table continues)

Table C-44 (continued)

Correlations Between Weak Social Integration Scale (WSIS) and Objective Quality of Life Indicators for 70 Chronic Mentally Disabled Citizens Living in Small Community-based Residence in the Outaouais

		Weak Social Integration		
Life Domains	Objective Indicator	*r*	*df*	Significance
Finances	Monthly spending money	.31	68	p = .008
	Monthly income	-.05	68	n.s.
Health	No. of illnesses	-.06	54	n.s.
	Behavior handicaps[f]	-.28	53	p = .040
	Physical handicaps[g]	-.04	54	n.s.
	Total use of health care	.04	68	n.s.
	Use of acute psychiatric services (i.e., number of psychiatric admissions[a])	.10	68	n.s.
	Total current dose of antipsychotics[a]	n/a	n/a	n/a
	Use of general medical services	.25	68	p = .038
	Use of general psychiatric services	.39	68	p = .001
	Use of general social services	.09	68	n.s.
	Frequency of contacts with professional practioners	-.24	68	p = .043

Note: Correlations based on full sample (N = 70) except where so indicated.
[a] Value labels for gender variable were 1 = male, 2 = female.
[b] Pertains to past year.
[c] Work items were based on sub-sample (n = 25).
[d] Unemployment items were based on sub-sample (n = 45).
[e] Education items based on sub-sample (n = 19).
[f] Behavior handicap scale based on sub-sample (n = 55).
[g] Physical handicaps scale based on sub-sample (n = 56).

Appendix C
Table C-45

Correlations of Domain-Specific Preferences with Strong and Weak Social Integration Scales for the Outaouais Sample

Preferences in Life Domain	Strong and Weak Social Integration Scales	
	SSIS[a]	WSIS[b]
Living Situation (importance)	.19	.02
Family	.14	-.02
Social Relations	.05	.13
Leisure	.26*	.15
Finances (needed dollars)	.07	-.08
Law-Safety	.20	-.04
Work[c]	.12	.24
Education[d]	.38*	.14
Health	.11	-.13
Religion	-.02	-.06

Note: $N = 70$ except where indicated otherwise.

Although worded as "preferences", the living situation and finances domains actually were measured with scales assessing the importance of living situation and perceived financial needs, respectively. Both scales are in keeping with the concept of person/environment fit characteristic of the other preferences scales.

[a] SSIS = Strong Social Integration Scale.

[b] WSIS = Weak Social Integration Scale.

[c] Correlations with work preference were based upon a sub-sample ($n = 50$) of respondents who expressed an interest in having some type of job.

[d] Correlations with education preference were based upon a sub-sample ($n = 26$) of respondents expressing an interest in attending some type of school program.

* $p < .05$

Appendix C
Table C-46

Correlations of Domain-Specific Satisfactions with Strong and Weak Social Integration Scales for the Outaouais Sample

Satisfaction with Life Domain	Strong and Weak Social Integration Scales	
	SSIS[a]	WSIS[b]
Living Situation	-.15	.08
Family	.29*	.20
Social Relations	.10	.22
Leisure	.13	.17
Finances	.09	.23*
Law-Safety	-.10	.06
Work[c]	.28	.05
Education[d]	.41	.46*
Health	-.06	.18
Religion	.11	.05

Note: N = 70 except where indicated otherwise.

[a] SSIS = Strong Social Integration Scale.

[b] WSIS = Weak Social Integration Scale.

[c] Correlations for satisfaction with the work domain were based upon a sub-sample (n = 24) of respondents holding some type of job during the past year.

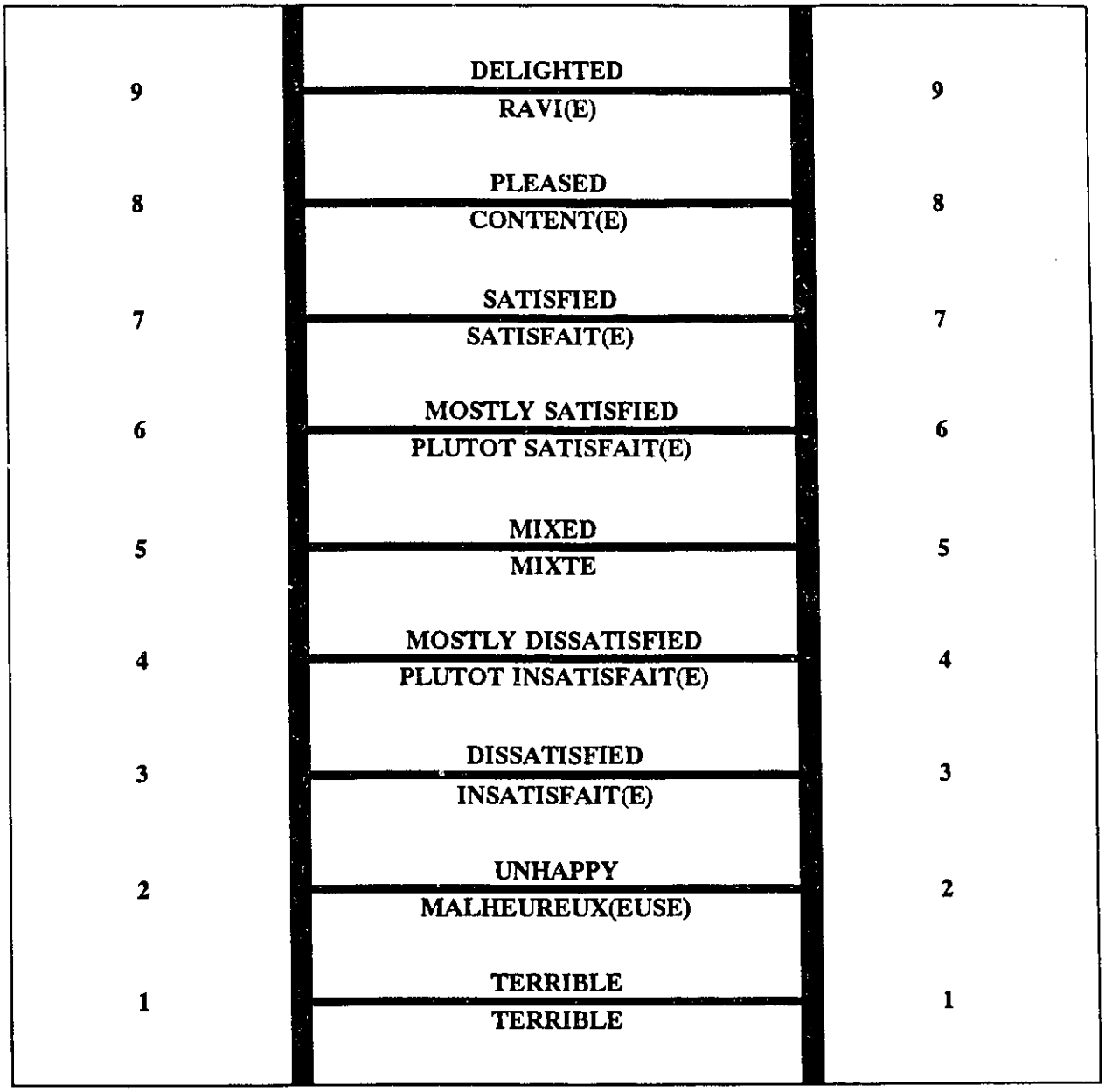
[d] Correlations for satisfaction with the education domain were based upon a sub-sample (n = 19) of respondents attending some type of school program during the past year.

* $p < .05$

APPENDIX D

SATISFACTION GRADIENT SCALE

SATISFACTION GRADIENT SCALE
ÉCHELLE DU GRADIENT DE SATISFACTION



Alternatives

A = Neutral [neither satisfied nor dissatisfied].
B = I never thought about it.
C = Does not apply to me.

A = Neutre [ni satisfait(e) ni insatisfait(e)].
B = Je n'y ai jamais pensé.
C = Ne s'applique pas à moi.

ADMINISTRATION OF THE SATISFACTION SCALE

This satisfaction scale is bilingual adaptation and integration of Cantril's (1965) "self-anchoring scale," a graphic subjective quality of life measure, and the "Delighted-Terrible Scale," a verbal Subjective Quality of Life (SQL) measure (Andrews and Withey, 1976). The Satisfaction Gradient Scale (Ely & FLynn, in preparation) retains the best of both instruments while overcoming limitations inherent to each approach. The greater number of verbal choices along a graphic continuum eliminates response clustering, minimizes method-related variance, and provides a survey methodology for illiterate respondents. The scale has various applications. Please note that the **"Description of Choice"** found below is intended as a guideline only. In all cases, the respondent's frame of reference should predominate.

INSTRUCTIONS FOR RESPONDENT

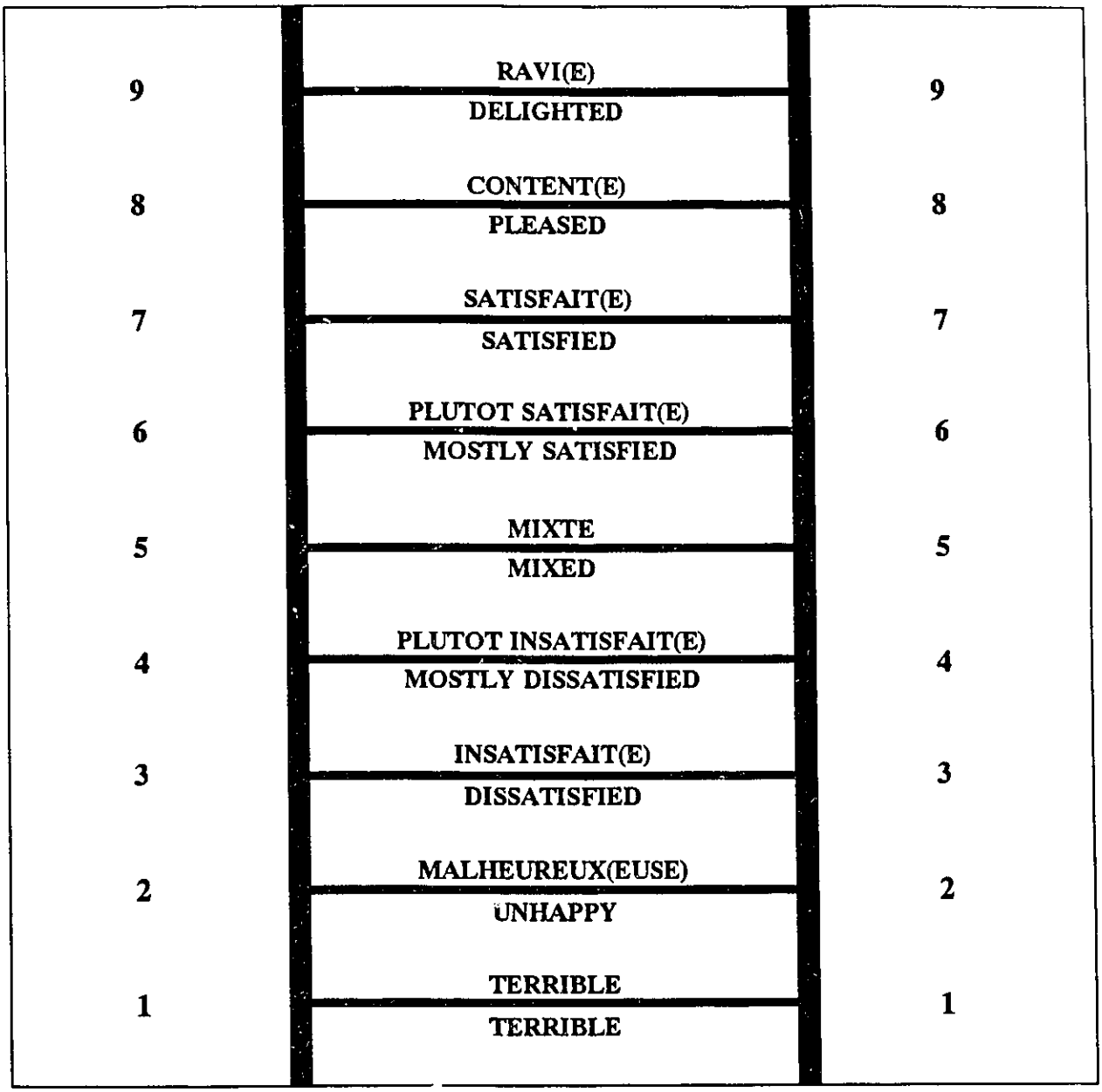
During our meeting, I will be asking you how you feel about your life in general and about different aspects of your life. Please tell me the feelings you have now, taking into account what has happened to you in the last year and what you expect in the near future. I am going to ask a long list of things, but most of the questions can be answered by telling me what number on this card comes closest to how you feel.

SHOW SATISFACTION SCALE TO RESPONDENT

Here is a picture of a ladder with 9 rungs. At the bottom of the ladder, next to the number 1 is the worst feeling you might reasonably expect to have. At the top of the ladder, next to the number 9 is the best feeling you might expect to have. Each rung in between also has a number. Because our feelings from week to week can fall somewhere in between 1 and 9, I want you to consider your general feelings now, taking into account what has happened to you in the last year and what you expect in the near future. Just tell me the number on the ladder that best says how you feel about each; "nine" for delighted: "eight" for pleased; and so forth on to "one" for terrible. If you have no feelings at all on the question, we will note this with the letter "A." If you never thought about something that I ask you, and this probably will not happen, then we will note it with the letter "B." I may even ask you a question that doesn't apply to you, if so, then we will note that with the letter "C." I want your first reaction. So just tell me what number on the ladder gives the best summary of how you feel. Let's start with a very general one...

SELECTION	DESCRIPTION OF CHOICE	NUMBER
Delighted -	All of your expectations have been surpassed.	**9**
Pleased -	All of your expectations have been met.	**8**
Satisfied -	Most of your expectations have been met.	**7**
Mostly Satisfied -	Many of your expectations have been met.	**6**
Mixed (about equally satisfied and dissatisfied) -	Some of your expectations have been met while others have not.	**5**
Mostly Dissatisfied -	Many of your expectations have not been met.	**4**
Dissatisfied -	Most of your expectations have not been met.	**3**
Unhappy-	None of your expectations have been met.	**2**
Terrible-	None of your expectations have even come close to being met.	**1**

ÉCHELLE DU GRADIENT DE SATISFACTION
SATISFACTION GRADIENT SCALE



Alternatives

A = Neutre [ni satisfait(e) ni insatisfait(e)].
B = Je n'y ai jamais pensé.
C = Ne s'applique pas à moi.

A = Neutral [neither satisfied nor dissatisfied].
B = I never thought about it.
C = Does not apply to me.

ADMINISTRATION DE L'ECHELLE DE SATISFACTION

Cette échelle bilingue de satisfaction est une adaptation et une intégration d'une mesure graphique de Qualité de Vie Subjective (QVS), le "self-anchoring scale" de Cantril (1965), et d'une mesure verbale de QVS, le "Delighted-Terrible Scale" d'Andrews et Withey (1976). L'échelle du gradient de Satisfaction (Ely & Flynn, en préparation) retient ce qu'il y a de mieux dans ces deux instruments tout en évitant les limitations inhérentes à chaque méthode. L'addition d'un plus grand nombre de choix sur un continuum graphique élimine le regroupement des réponses, minimise la variance reliée à la méthode, et fournit une méthodologie pour sonder les analphabètes. L'échelle a plusieurs applications. Notez que la **"Description du Choix"** ci-bas doit seulement servir à guider les répondants. Dans tous les cas, le câdre de référence des répondants doit prédominer.

INSTRUCTIONS POUR LES RÉPONDANTS

Durant notre rencontre je vais vous demander comment vous vous sentez envers votre vie en général et envers divers aspects de votre vie. Dites-moi les sentiments que vous ressentez actuellement, prennant en considération ce qui vous est arrivé au courant de l'année passée et de ce que vous vous attendez dans l'avenir proche. Je vais vous demander une longue série de choses, mais la plupart des questions peuvent se répondre en me disant quel numéro sur cette carte se rapproche le plus à vos sentiments actuels.

MONTREZ L'ÉCHELLE DE SATISFACTION AU RÉPONDANT

Voici une figure d'une échelle avec 9 rangs. Au bas de l'échelle à côté du numéro 1 se trouve le pire sentiment que vous pourriez avoir. A la partie supérieur de l'échelle, à côté du numéro 9 se trouve le meilleur sentiment que vous pourriez avoir. Chaque rang entre 1 et 9 possède également un numéro. Puisque nos sentiments changent d'une semaine à l'autre et peuvent se situer entre 1 et 9, je veux que vous vous fiez à vos sentiments actuels, prennant en considération ce qui vous est arrivé au courant de l'année passée et de ce que vous vous attendez dans l'avenir proche. Dites-moi le numéro sur l'échelle qui décrit le mieux vos sentiments actuels pour chaque question; "neuf" pour ravi(e); "huit" pour content(e) et ainsi de suite jusqu'à "un" pour terrible. Si vous n'avez aucun sentiment envers une question en particulier, nous indiquerons cela avec la lettre "A." Si vous n'avez jamais pensé(e) à ce que je vous demande, et cela ne se produirera probablement pas, nous le noterons avec la lettre "B." Il se peut que je vous demande même une question qui ne s'applique pas à vous. Si cela se produit, nous le noterons avec la lettre "C." J'aimerais avoir votre première réaction à ce que je vous demande. Alors, dites-moi quel numéro sur l'échelle décrit le mieux la façon dont vous vous sentez actuellement. Commençons avec une question bien général...

SÉLECTION	DESCRIPTION DU CHOIX	NUMÉRO
Ravi(e) -	Toutes vos attentes ont été surpassées.	**9**
Content(e) -	Toutes vos attentes ont été rencontrées.	**8**
Satisfait(e) -	La majorité de vos attentes ont été rencontrées.	**7**
Plutôt Satisfait(e) -	Plusieurs de vos attentes ont été rencontrées.	**6**
Mixte [à peu près également satisfait(e) et insatisfait(e)] -	Quelques une de vos attentes ont été rencontées et quelques une non pas été rencontrées.	**5**
Plutôt Insatisfait(e) -	Plusieurs de vos attentes non pas été rencontrées.	**4**
Insatisfait(e) -	La majorité de vos attentes non pas été rencontrées.	**3**
Malheureux(euse) -	Aucune de vos attentes ont été rencontrées.	**2**
Terrible-	Aucune de vos attentes sont même venues proche d'être rencontrées.	**1**

APPENDIX E

RECOMMENDATIONS AND PRACTICAL CONTRIBUTIONS OF THE STUDY

Recommendations Specific to Location of residential services:

R1. Develop resources where population density and integrating resources are greatest (e.g., in centre-town areas rather than in suburbs, in villages rather than in on farms and concession roads).

R2. In order to enhance privacy, strive to provide residents with single and private rooms rather than doubling residents in rooms.

R3. Determine the number of residents per service in accordance with the physical and human resources in order safeguard against services that have reduced capacity to meet the needs of residents.

R4. Enhance the establishment of residential services that provide easy access (e.g., bus, roads, etc.) to clients, their families, and the general public.

R5. Avoid the stigmatization of residents by linking the residential service with an identifiable psychiatric location.

R6. Ensure that the residential service is located in an environment that provides the potential for social integration.

R7. Avoid the systematic relegation of residents to basements where adults and elderly residents often find themselves two per room with a small communal space for socializing.

R8. Promote pleasant and comfortable living conditions that provide residents with abundant sunlight and a pleasant view.

R9. Avoid decorations and living conditions that infantize and devalue residents (especially for elderly residents).

R10. Avoid the infantization of adults and elderly residents by avoiding the term "famille d'acceuil," which basically translates to "family-care home."

Recommendations specific to support and activities programs:

R11. Diversify the formulation of residential programs so that they extend beyond their current "structured framework."

R12. Develop and broaden supervisory and cooperative formulae.

R13. Establish an individualized program for each resident.

R14. Establish a normalizing social integration network with residents' natural families and with the community at large (pairing, make better use of volunteers, establish a civic buddy system, similar to that done by big brother's association, etc.).

R15. Promote a positive social image for residents (adequate clothing and dress, dental care, cleanliness, etc.).

R16. Promote resident acquisition of personal belongings that are normalizing (e.g., radio, television, books, etc.).

R17. Promote homogeneous regrouping of residents according to their age, problems, and sex where socially appropriate, in order to enhance their social image and their personal needs.

R18. Promote resident access to certain specialized psychotherapy services when these are specifically needed.

R19. Service providers need to systematically keep records of residents' specific individual needs.

R20. A greater effort needs to be made to promote individualization, autonomy, and the rights of residents.

R21. Establish a policy regarding the placement of residents as close to their natural environment as possible.

R22. Involve the family and environment of residents in efforts to meet the needs of residents.

R23. Signify and dignify the milestones in the life of every individual resident (e.g., celebrate birthdays, arrivals, departures, a job promotion, etc.).

Recommendations specific to activities of daily living:

R24. Make it compulsory that every resident have a day program that is external to the residential service.

R25. Assign to one or more services, the mandate of offering the population of residents affiliated with the network, activities of daily living that are suited to the individual needs of residents in accordance with their age, sex, or other characteristics.

R26. Residents are to have growth promoting activities that are conducted outside their residence.

R27. Promote social accompaniments for work, education, or other specific needs.

R28. Interdict that residents' activities be conducted on the premises (e.g., leisure, work, education, etc.). Enhance a separation of locations for activities of daily living.

General recommendations aimed at the total network of social services:

R1. Provide all home care service providers with a training session on the normalization of social roles (i.e., SRV).

R2. That all effort be made to repatriate individuals toward their community of origin as long as significant others (e.g., family members) are still living there.

R3. Provide individuals with an intellectual handicap with an affiliation with the pertinent resource that is in meeting with their needs (e.g., location and services).

R4. Develop non-residential support programs that are appropriate to meet the needs of the clients (e.g., work, socialization, etc.).

R5. Provide all service providers with intervention tools that are coherent and systematic.

R6. Modify the financial group home operators' mode of financing (per diem), which currently places them in conflict of interest situation, because those with the largest number of residents have the greatest incomes and the loss of residents equates with a loss of income.

R7. Diversify the housing programs in order to meet the range of needs found in the mental health population (fully equipped resources to those that are only lightly equipped).

R8. Establish formal orchestration mechanisms between the residential services and non-residential resources in order to facilitate the social integration of residents.

R9. Formalize within the network of services, a mechanisms whereby clients can be guaranteed respect and the promotion of their civil rights.

R10. Develop and systematize operational criteria for the acceptance of future residential services.

R11. Establish mechanisms whereby regular evaluations of residential service quality and resident social integration is made according to SRV principles and assess annually the implementation of mental health services.

On September 04, 1991., I spoke on the telephone with Mr. Thierry Boyer, director of the CRSSSO. Mr. Boyer could not meet with me but he provided me with a copy of a letter he had sent to Gilles Clavel at the CSSO on April 23, 1991. The letter spoke to the recommendations made in the report submitted to the CRSSSO in March of 1991 (Dansereau et al, 1991). Mr. Boyer's letter to Mr. Clavel reflected the impact of the study on the CRSSSO's program planning. On September 05, 1991., I met with Mr. Jean Dansereau, Coordinator of Rehabilitation Services with the CHPJ. Mr. Dansereau's comments during that meeting reflected the impact of the study

at the level of the service providers. Finally, on that same day, I also met with a community health care nurse who was responsible for the health care provided to residents of services in the Hull, Aylmer, and Gatineau areas. I asked her to reflect on any noticeable changes since the end of the evaluative study. She remarked that she had noticed no remarkable changes in extant residential services, but that recently accredited services (i.e., ones accredited after the recommendations were submitted to the CRSSSO) seemed much better than extant services in terms of physical surroundings, number of residents, and attitudes of home operators.

The meeting with Mr. Dansereau allowed an analysis of the impact of the study at the level of program planners (Mr. Boyer) and service providers (Mr. Dansereau). An analysis of Mr. Boyer's letter in light of the notes taken during the meeting with Mr. Dansereau, revealed that many of the recommendations applicable to program planning were followed, others were still pending, and several others were still in the planning stages. Also, despite numerous changes in program planning, many recommendations were not being well implemented at the level of home care operators. Apparently, some home care operators were having difficulty in implementing the recommendations. For example, Mr. Dansereau mentioned that three residential home care services had been closed for repeatedly failing to make efforts at complying with the new CRSSSO directives that responded to the issues and recommendations addressed in the evaluative report.

The following provides a summary of Mr. Boyer's response to Mr. Clavel's query regarding the impact of the evaluative study on service quality. Immediately following each response, are Mr. Dansereau's comments regarding the degree to which the policy and programming changes have been implemented and have resulted in actual changes in services.

Response to Specific recommendations regarding living environment: (Responsibility of the CRSSSO)

R1. This has become policy and is systematically applied as a criterion for the accreditation of new residential services.

R2. This recommendation now is applied for all new services and is seen as part of the maintenance of extant services. According to Mr. Dansereau, service providers were trying hard to promote single-rooms for residents of family-care homes. In one case, the home operator moved her rurally located home to a house in the city. In another case, the home operators built an extension to their house for the residents. In still another case, the operator took over the basement of the home and gave the ground floor rooms to her residents. However, according to Mr. Dansereau, in some homes, little or no changes had occurred except for the re-location of some residents to other homes in order to decrease the number of residents in the home and to facilitate the implementation of recommendation R2.

R3. This now is applied whenever a placement is made and is seen as part of the maintenance of individual's placement is evaluated. Mr. Dansereau confirmed that only in one residential services were there more than 6 residents.

R4. This will be applied to all new residential programs. However, According to Mr. Dansereau, nothing new has yet been done to extant services in this regard.

R5. The sub-regional model of service organization should favour this non-attachment to an identifiable psychiatric setting. However, Mr. Dansereau noted that he saw nothing else new being done to avoid such an effect.

R6. This is evaluated for all new residential programs and is foreseen each time the maintenance of an individual's placement is evaluated. However, According to Mr.

Dansereau, aside from R1 being respected, no other changes specifically applicable to R6 were noted by him.

R7. This has become an accreditation criterion. According to Mr. Dansereau, the response to recommendation R2 were applicable here and that efforts were being made to emphasize the importance of the milieu on the person's well-being. For example, the physical surroundings (e.g., decorations, fresh paint, etc.).

R8. This now is part of regular expectations for residential services. According to Mr. Dansereau, R7 responded to this and that although some residential services still fell short of being acceptable, the owners now were at least more aware of the importance of physical surrounding on the well-being of their clients. Owners now seemed more aware of the negative impact that poor environment can have on the residents.

R9. This must now be applied whenever it is noted as necessary in residential programs. According to Mr. Dansereau, the infantization in decor has stopped.

R10. The use of the term "Famille d'acceuil," or "Family care home" is now becoming more prominent. The term now is "Résidence" or "domicile d'acceuil," which could translate to "Residential care home." According to Mr. Dansereau, service providers no longer use the infantizing term.

Response to Specific recommendations regarding support programs and activities: (Responsibility of the CSS).

R11. The new development of residential programs is now going in that direction. According to Mr. Dansereau, new resources have been opened with different mandates regarding support and structure.

R12. These activities are beginning to develop in relation to certain day programs. However,

According to Mr. Dansereau, in practice, this has been more or less neglected and that little in terms of coop housing, for example, has been done.

R13. This is now applied. According to Mr. Dansereau, more and more residents are getting individual programs. Before the study recommendations, only 10% of residents had an individual service program (ISP) or what they call "programme de Service Individuel" (PSI). Now, only 15% of residents do not have a ISP.

R14. This is implemented whenever necessary and is seen as part of the evaluation of a person's placement maintenance. According to Mr. Dansereau, an important effort was made to integrate residents with their natural family members in activities. The concept of family and its importance to residents are being emphasized to service providers.

R15. This is part of the responsibilities that normally are assumed by residential programs. According to Mr. Dansereau, home operators are making a mild effort to encourage residents to enhance their social image, by encouraging residents to focus on their appearance (e.g., dress, cleanliness, grooming, etc.) and in their interactions (e.g., manners, etc.).

R16. This should be encouraged by the residential program. According to Mr. Dansereau, financial constraints has prevented many residents from acquiring personal possessions (e.g., television, radio, books, etc.) which no longer are restricted.

R17. This recommendation is being attended to for individuals and for the homogeneous regrouping of persons and this is seen as part of the evaluation of an individual's placement. According to Mr. Dansereau, homogeneity of residents and a balance of genders is encouraged where appropriate. He noted that only two residential services now were gender unique. Native language and age of residents also were considered when individual placements were made. As well, efforts were being made by the placement

committee to match residents with others in the same age range, and client preferences were being tapped systematically before a placement.

R18. The increase of external services within the framework of developing local services or sub-regional services partially enhances this response. However, According to Mr. Dansereau, no concrete changes were made to enhance access the specific psychotherapeutic needs of certain residents.

R19. This is part of the expectations made of residential programs. However, According to Mr. Dansereau, this varies from home to home. A decrease in the number of residents has promoted the attention given to individual residents' needs.

R20. There is an improvement in the sensitivity of service providers and the establishment of "Rights-Access" Outaouais or "Droits-Accès" Outaouais should favour this. However, According to Mr. Dansereau, this varies from residence to residence.

R21. This is now systematically put into place and is seen as part of the evaluation of an individual's placement maintenance. Mr. Dansereau confirmed that this now is part of individual placement protocols with retroactive repatriation of current residents, which in some cases, required that new services be opened in communities closer to the resident's natural family.

R22. This is promoted each time it is desirable and necessary. According to Mr. Dansereau, families now are actively encouraged to maintain contact with clients who so desire such contacts and that this is done via the placement policy and by asking residents if they prefer to increase family contact.

R23. This is part of the responsibilities of the residential programs. According to Mr. Dansereau, some patchy examples reflected to a mild degree, a greater awareness of celebrating the milestones in residents' lives; birthdays now were being celebrated.

Response to specific Recommendations related to day activities: (Responsibility of the CRSSSO).

R24. This is offered whenever desirable and necessary for a person. However, According to Mr. Dansereau, there are no day resources yet exist, because no day programs yet are established outside the residences. Yet, he said that residents now were more active and that this involved others than home operators in activities. He also pointed out that lack of human resources rather than physical resources were the cause.

R25. The development of day activities in all the sub-regions has ensured this. However, According to Mr. Dansereau, there have been no changes in resources.

R26. This is part of the responsibility of the residential program. According to Mr. Dansereau, no changes were noted in this regard.

R27. This is ensured whenever necessary and is seen as part of the intervention planning. However, According to Mr. Dansereau, there currently is no accompaniment for residents, but efforts were being made to resolve the education and work issues. For example, he cited reflections by groups who have had meetings to discuss the importance of work and education, but this has been done only at the level of professionals and did not directly involve those under whom the responsibility fell (i.e., family care home operators) nor residents.

R28. This must be applied for every residential program. Mr. Dansereau confirmed that there is a concerted effort to segregate the location where activities are conducted.

Response to the general recommendations for the network of services (Responsibility of the CRSSSO)

RG1. This will be given in the fall of 1991. Mr. Dansereau confirmed that the CRSSSO has allocated funds for the training seminars on social role valorisation (SRV) theory.

RG2. This currently is in progress and is seen as part of the evaluation of the maintenance of each person's placement. Mr. Dansereau confirmed that this was being implemented.

RG3. This is applied. However, According to Mr. Dansereau, this was being done for many but not all residents. Some cases were given priority based upon need.

RG4. This is ensured within the framework of developing day services in each sub-region. However, According to Mr. Dansereau, nothing in this area has changed. There has been only planing and discussion in an effort to arrive at a consensus.

RG5. This will be developed within the framework of training beginning in the fall of 1991. Mr. Dansereau confirmed this and said that it is to involve various levels of service providers. He noted that the Boston Model of Psychosocial Rehabilitation was to be the approach used and that a contract was signed between the CRSSSO and the people in Boston. Training was to begin in 1991-1992. This will provide service providers, including some home operators, with the necessary training to enhance the rehabilitation of clients.

RG6. This was reviewed within the framework of new contracts between the associations representing the home operators and the social services ministry. However, According to Mr. Dansereau, no significant changes in remuneration of home operators could be noted in the new contracts. In fact, one of the changes made in the new contracts tended to have the potential to negatively impact on the SI of residents. This was confirmed by the community mental health care nurse. Both she and According to Mr. Dansereau, under these new contracts, home operators will not be compensated when a resident is absent

for more than 17 hours from the residence. The health care nurse cited numerous complaints from home operators that this would encourage them to deny residents the privilege of spending the night with relatives, because a resident who had dinner at the residence, then went to spend the evening and sleep over at the home of his natural family to return to the residence the next evening in time for dinner, would spend more than 17 hours away from the residence. In such cases, the home operator would have to shoulder the burden of feeding and supervising the resident during the day but would not be compensated because the resident slept at the home of his relatives.

RG7. This is being developed at the same time as the range of mental health services. However, According to Mr. Dansereau, no changes were noted here.

RG8. This is being done within the framework of organizing services in the sub-regions. Mr. Dansereau confirmed that a group has been formed to facilitate work activity for residents. This group has not yet established concrete ties between residents and prospective employers. Issues to be resolved before this can be done include what sort of support can employers receive if they hire residents and who will pay for this support network?

RG9. The establishment of "Rights-Access" Outaouais will promote and guarantee this aspect. Mr. Dansereau confirmed the implementation of this service.

RG10. This is systematically put into practice and the new criteria are known. Mr. Dansereau confirmed that this was implemented and was especially applied to parameters such as location of residential services. A document now provides a profile of the ideal residential service, its location, and operation. The evaluation of owner competency has yet to be established. However, there now exist instruments and criteria to determine service quality.

RG11. This is put into place and is linked to annual evaluations of the quality of residential

services. According to Mr. Dansereau, although this was not done this year, in principle, it has become part of the directives of the CRSSSO. The intention is to pursue the evaluation of service quality in future studies. New priorities for the next five years will be set in 1991, and these will include the periodic evaluation of services quality and SI in terms of SRV theory. However the CRSSSO does not plan to evaluate clients' subjective QOL directly.

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Education and degrees:

From	to	Institution	Discipline	Degree
1986	1991	U. of Ottawa	Psychology	Ph.D. (Clinical).
1983	1986	U. of Victoria	Neuropsychology	M.A.
1982	1983	U. of Ottawa	Psychology	Ph.D. (Clinical).
1979	1982	U. of Ottawa	Psychology	B.A. (Honours).
1978	1981	U. of Ottawa	Philosophy	B.A.

Professional/Clinical Experience:

1990 - 1990 Ottawa General Hospital/Department of Psychology; summer contract as a psychometrist (neuropsychological assessments of outpatients and psychological assessments of psychiatric inpatients).

1988 - 1988 Theoretical and applied training as a program evaluator using the Program Analysis of Service Systems Implementation and Normalization Goals (PASSING) Model (training coordinator: Susan Thomas).

1980 - 1988 Centre de Réadaptation Les Jeunnes de l'Outaouais; part-time educator/counsellor at a rehabilitation setting for juvenile offenders.

1986 - 1988 U. of Ottawa/Centre for Psychological Services; 2,000 hour APA accredited doctoral internship in adult clinical psychology (clinical assessment, individual psychotherapy, and marital counselling).

1985 - 1986 Royal Jubilee Hospital (Victoria, B.C.) 250 hour. clinical practicum in neuropsychological assessment of adult outpatients.

1984 - 1985 U. of Victoria/Department of psychology; 250 hour. clinical practicum in neuropsychological assessment of adults and children referred to the University's neuropsychology clinic.

1983 - 1983 University of Ottawa/Royal Ottawa Regional Rehabilitation Centre; 500 hour. practicum in rehabilitation psychology with neuropsychological population.

Research Experience:

1988 - 1990 Centre Hospitalier Pierre Janet; renewed contracts as a research assistant on a Quebec Government sponsored study of the implementation and adaptation of the Boston Model of Psychiatric Rehabilitation.

1989 - 1989 Government of Quebec/Conseil Régional de la Santé et des Services Sociaux de l'Outaouais (CRSSSO); summer research contract to evaluate the quality of life and quality of service delivery to psychiatric outpatients living in community-based residences in the Outaouais area.

1983 - 1983 U. of Ottawa/School of Psychology; summer contract as a research assistant in neurophysiology (human evoked potentials during sleep).

1982 - 1982 U. of Ottawa/School of Psychology; summer contract as a research assistant in an animal behaviour laboratory investigating aversive conditioning in long-hooded rats.

1981 - 1982 U. of Ottawa/School of Psychology; research assistant in an evoked potentials laboratory investigating attention disorders with schizophrenic patients.

Teaching Experience:

1986 - 1992 U. of Ottawa/School of Psychology; repeated one-year contracts as part-time professor for an undergraduate course in psychology (Introduction to Psychology).

1986 - 1987 U. of Ottawa/School of Psychology; one year contract as a teaching assistant for an undergraduate course in theories of personality.

1985 - 1986 U. of Victoria/Department of Psychology; one year contract as teaching assistant for a graduate course in multivariate statistics.

1984 - 1984 U. of Ottawa/School of Psychology; summer contract as part-time professor teaching two child development courses (Child Development I and II).

1982 - 1983 U. of Ottawa/School of Psychology; one year contract as teaching assistant for an undergraduate course in statistics.

Theses:

Ely, P.W. (1991). *Quality of life and social integration of psychiatrically disabled citizens in community residences.* Doctoral dissertation, University of Ottawa, Ottawa. Thesis supervisor: Robert J. Flynn, Ph.D., C.Psych.

Ely, P.W. (1987). *Hemispheric asymmetry variance in different conditions and personality types.* Unpublished master's thesis, University of Victoria, Victoria, British Columbia. National Library of Canada ISBN 0-315-39285-1. Thesis supervisor: Roger E. Graves, Ph.D., C.Psych.

Presentations and Publications:

Dansereau, J., Duteau, C., **Ely, P.**, & Flynn, R. (1990). *Évaluation des programmes résidentiels en santé mentale dans l'Outaouais.* March, 1990. (Contract No. 31-90-0099). Hull, Quebec. Conseil Régional de la Santé et des Services Sociaux de l'Outaouais.

Ely, P.W., & Flynn, R.J. *A social integration scale for psychiatrically disabled citizens living in community residences.* Manuscript in preparation.

Ely, P.W., & Flynn, R.J. *Predicting the quality of life and social integration of the chronic psychiatrically disabled living in community housing.* Manuscript in preparation.

Ely, P.W., & Flynn, R.J. (1990, June). *Subjective Quality of Life of Chronic Mental Patients.* Poster presented at the Annual Convention of the Canadian Psychological Association, Ottawa.

Ely, P.W., Graves, R.E., & Potter, S.M. (1989). Dichotic listening indices of right hemisphere semantic processing. *Neuropsychologia, 27* (7), 1007-1015.

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Awards:

1990	Recipient of the Canadian Psychological Association Award for Best Presentation by a Student in the Program Evaluation Division.
1989	Nominee for the William F. Barry award for excellence in teaching (U of Ottawa).
1983 - 1986	U. of Victoria Graduate Fellowship award (renewed).
1982 - 1986	U. of Ottawa Graduate Fellowship award (renewed).
1987	Government of Quebec Graduate Fellowship.
1982	NSERC undergraduate award.

Affiliations:

Student member of the International Neuropsychological Society (1983).
Student member of the Canadian Psychological Association (1983).
Student member of American Psychological Association (1985).
Student member of the Quebec Corporation of Professional Psychologists (1990).

Current Research Interests:

1. Quality of life and social integration of chronically disabled populations. In particular, head-injured patients, psychiatric patients; human immunodeficiency virus (HIV) patients; and cerebrovascular accident (CVA) patients.

2. Attention deficits as a diagnostic indicator of frontal lobe lesions with head-injured and other neurological patient samples. Reliability and validity studies of the Ely Visual-verbal Attention Test (EVVAT), an analog to the Stroop Word-interference Test.

References:

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