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Satisfaction with social and residential environments of adults with mental retardation in supported independent living and group homes

Shelley L. Potter
Wilfrid Laurier University

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Satisfaction with Social and Residential Environments of Adults with Mental Retardation in Supported Independent Living and Group Homes

By

Shelley L. Potter

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Abstract

The philosophy that has permeated Ontario's policies and planning in the realm of adults with mental retardation has been that of integration into the community. Community based residences vary greatly in terms of size, type, and care given; however they generally fall in the category of the "least restrictive alternative". The present study is focused on the similarities and distinctions between two of these alternatives, and in the satisfaction experienced by the consumers in these two programs themselves: community group homes and supported independent living programs.

In the present study interviews with 40 adults with mental retardation were conducted. Twenty adults resided in community group homes, while 20 were clients of supported independent living programs. Clients were asked to answer questions based on the Halpern, Close and Nelson (1986) survey of independent living programs in the U.S., regarding five areas of their lives. They were also asked to provide information concerning their social support according to the Arizona Social Support Interview Schedule (Barrera, 1981). These interviews were used to provide a comparison between feelings of satisfaction and levels of concern within the two residence types. Some authors had urged caution with respect to independent community living programs for these populations, due to concerns about social isolation, residential quality, increased vulnerability and so on.

Results indicated that there were few differences between the two residence populations. Those differences that were found primarily favoured the independent living group, and included level of independent social skills, satisfaction with program and residence, and supportiveness of one aspect of the client's social network. However, residents in supported independent living programs continued to show considerable dependence on counsellors for many aspects of their functioning. Overall, the participants in this program reported very similar attitudes and levels of satisfaction to those described in the similar programs studied by Halpern et al. (1986).

The relative lack of differences between programs has differing implications for each of them. While it shows that people in both programs are not isolated in the community, it also demonstrates that people in both programs rely on their counsellors as the person turned to in time of need. It is necessary to break this cycle if people are to be truly independent. The results of this study confirm the need to diversify clients' social support networks beyond program staff.

Table of Contents

List of Tables

List of Figures

Satisfaction with Social and Residential Environments of Adults with Mental Retardation in Supported Independent Living and Group Homes

The focus of the present research is on the satisfaction and perceived needs of individuals with mental retardation in varied life situations. Residential programs have sought in recent years to allow these individuals to move gradually toward more independent living. While much literature exists concerning the characteristics and classification of group homes (Baker et al., 1977; Bruininks et al. 1981; Gollay et al. 1978; Hill & Lakin, 1986; and Janicki et al., 1983) and some literature exists regarding the description of independent living programs (Crnic & Pym, 1979; Halpern et al., 1986, Schalock & Harpur 1978; & Schalock et al., 1981), few studies have been conducted comparing how the residents of these facilities actually experience these steps toward independence. The present study attempted to address this lack by asking clients in the two types of living arrangements whether or not they were satisfied with where they are in their lives. As the trend towards deinstitutionalization is a relatively new one, many clients were able to provide information regarding previous living arrangements, as well as their satisfaction with the current residential program.

The current study first examines the trend of deinstitutionalization in Ontario, and what this policy has meant for adults with mental retardation. It also examines the role of normalization in community facilities and whether or not this

principle is followed. Group homes are discussed with respect to normalization and the problems involved in describing and classifying these homes. The relatively new program of independent living is discussed in detail, as this is the main focus of the research.

One of the important features of this study is that it relies quite heavily on the information supplied by clients themselves. This has not been a common procedure in most studies. However this author sees it as crucial to an adequate understanding of residents' life situations.

Deinstitutionalization

Deinstitutionalization as a process is extremely complicated, although it is doubtful whether or not this complexity is typically recognized.

> Deinstitutionalization encompasses three interrelated processes: (1) prevention of admission by finding and developing alternative community methods of care and training; (2) return to the community of all residents who have been prepared through programs of habilitation and training to function adequately in appropriate local settings; and (3) establishment and maintenance of a responsive residential environment which protects human and civil rights" (National Association of

Superintendants of Public Residential Facilities for the Mentally Retarded, 1974, pp.4-5).

The term deinstitutionalization masks the complexity of the process at hand. The term lends itself to the simple definition of moving persons out of institutions. While it is true that this is a component of the process, it is not the only part of the process.

The process of deinstitutionalization arose out of the exposure of the deplorable conditions of many institutions in the early 1950's and 1960's. Blatt and Kaplan's (1966) pictorial essay entitled "Christmas in Purgatory" depicted the stark reality some institutions had to offer. Willer and Intagliata (1984) state that deinstitutionalization reflected a concern for the rights of mentally retarded persons and that, as such, this was quite consistent with the social climate of the times.

By 1969, the deinstitutionalization movement had clearly been linked to the principle of normalization by Wolfensberger who proclaimed that institutions should fade away and be replaced by small community residences because they represent more "normal" living environments (Craig & McCarver, 1984). Since the late 1960's, in the United States tens of thousands of mentally retarded people have been moved from state institutions to smaller residential facilities, to their natural families, to independent living, and to other types of community based alternatives. Thousands more requiring some sort of residential

service have been placed directly into non-institutional settings (Lakin, Bruininks & Sigford, 1981).

Ontario began its process of deinstitutionalization in 1973. During the period from 1973 to 1982 there has been a decline in the use of public institutions for mentally retarded persons, an increase in the use of community residential facilities, and no apparent change in the number of mentally retarded persons residing in private institutions (Willer & Intagliata, 1984).

One of the first and arguably most important influences for Ontario with respect to deinstitutionalization was the Williston Report. On 8 June, 1971, in response to two local incidents in which residents of institutions had been injured, Walter Williston, a Toronto lawyer, was appointed to investigate all institutions and community care facilities serving the mentally retarded in Ontario. Williston heard submissions from the Ontario Association for the Mentally Retarded (OAMR), the Canadian Association for the Mentally Retarded (CAMR), and many local associations. The Williston report, handed down in 1971, recommended that: "large hospital institutions for the mentally retarded be phased down as quickly as is feasible" (Simmons, 1982, p. 193). Williston cautioned, however, against doing this immediately, noting the lack of support for this population in the community.

Williston's recommendations from that year can be seen to be largely in effect today.

'Every mentally retarded child should be with

> his own family until he reaches adulthood unless he imposes an undue burden on them.' Adults should have access to community-based residences located in population centres and as close as possible to their homes. They should 'be as similar as possible to a typical house or apartment so that the residents will be educationally furnished with life conditions similar to the ones they will meet in other parts of the community....' (Simmons, 1982, p. 194).

There have certainly been criticisms of the deinstitutionalization movement. Throne (1979) states that he has a conceptual problem with deinstitutionalization. He claims that "the issue is not one of institutionalization or noninstitutionalization for anyone. The issue is what kinds of institutions best serve everyone, retarded and nonretarded alike" (p. 171). Throne (1979) also states that there is a danger in advocating deinstitutionalization. He claims that the danger lies in exchanging one institution for another while ignoring the true problem and possible solution.

Nevertheless, deinstitutionalization as a process has been widely accepted by North American society. Some problems with deinstitutionalization may actually be partly the result of this wide, unconditional acceptance. There is a great lack of empirical research into the follow-up of mentally retarded

persons that have been placed in the community. Craig and McCarver (1984) state that, as usual, research has followed the changing position of society. They maintain that decisions about the lives of mentally retarded persons are usually made on philosophical and political, as opposed to empirical, grounds.

Thus the role of careful empirical research on the questions of appropriate treatment is often ignored. Normalization has also become a rallying cry in this movement, creating similar tendencies to narrow the scope of empirical research. We turn next to a discussion of this important concept.

Normalization

According to Wolfensberger (1972), normalization is the "utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible" (p. 28). The original definition of normalization was that all handicapped persons should have the same rights and benefits as all citizens (Willer & Intagliata, 1984). The term, however, underwent many changes to evolve into Wolfensberger's (1972) variation that handicapped persons should be exposed to experiences that encourage normalized behavior.

Whatever the actual definition of the term normalization, the concept quickly became the "norm" for services to mentally retarded persons from 1969 and onward (Craig & McCarver, 1984). Heal, Sigelman, & Switsky (1978) argue that the popularity of the normalization principle is due to the congruence of its theme to

the equality of opportunity principle that has guided recent American history. According to normalization principles, the ideal living environment for the mentally retarded person should be as close as possible to normal. For example, the living environment should be separate and distinct from the school or work environment (Willer & Intagliata, 1984), as that is what is "typical" in our social system.

Normalization, however, is not without its problems and difficulties. Aanes and Haagenson (1978) criticize normalization on the grounds that it has become a conceptual nightmare. These researchers claim that professionals are too readily defining normalization in terms of itself rather than seeing it as a process or goal. These researchers clearly state that normalization as a goal is different from normalization as a means, and that it is the "enlightened" principle of normalization that society should be aiming for, not simply the appearance of being normal. The confusion appears to be centered on whether normalization is a means to an end, or simply an end. Normalization as an end refers only to the actual outcome. Thus non-normal techniques may be used to achieve the normal end. As a means, normalization techniques may be used to achieve the normalization goal; however, these same techniques may be used to obstruct achievement of the goal. Those who adhere stringently to the "means" aspect of normalization may actually be defeating the normalization process.

For example, a social outing for residents of a group home

for adults with mental retardation can be a contentious issue for "normalization-as-a-means" advocates. If it is decided that a play will be the focus of the outing - which play should be seen? Romeo and Juliet, although certainly age-appropriate and therefore a "normal" play for this population to see, might not be enjoyed. A Charlie Brown play, on the other hand, although questionably inappropriate for this age group, might be more entertaining. If the "means" advocates rule and the Charlie Brown play is discounted as an outing possibility, the ultimate goal of the normalization principle is being ignored. The issue of importance here is getting residents out into the community. Going out certainly breaks one's monotonous daily routine and it is very "normal" to go out. It is also very "normal" to experience other people, and other sights, sounds and experiences. The age-appropriateness of the play should not interfere with such a "normal" experience.

Throne (1975) agrees that the normalization principle used as a "means" may actually interfere with normalization as an "end". He explains the problem with the principle as one of interpretation. He states that confusion results when people wrongly assume that adhering to normalization techniques will automatically result in normalized behavior.

McCord (1982) sheds an interesting light on the normalization confusion when he states that normalization as a concept is a statement of an ideal which has not yet been fully adopted by human service agencies. He goes further in stating

that while an increasing number of human service agencies purport to use the principle of normalization, most have only achieved a partial implementation of normalization in service provision. McCord (1982) also states that the major obstacle to implementing the normalization principle has been the inability of human service agencies to change from their protecting role to the role of assisting the individual with integration into the community.

Dern (1983) counters McCord's (1982) central argument by stating that the major obstacle to the implementation of the normalization principle in human service agencies is the unrealistic funding the agencies receive, coupled with:

> restrictive governmental regulations, the battle for resources between institutional and community based programs, the relatively short history of the community care concept, communities' resistance to accepting developmentally disabled individuals, a sufficient lack of understanding on the part of practitioners and administrators, and legal and political obstacles (p.76).

McCord (1982) presents an interesting point of view when he states that since normalization has not been fully adopted by the human service agencies, criticism of the principle itself is premature. McCord (1982) believes the answer lies in improving the implementation of this principle.

Normalization is an important guideline in residential

services. However many problems exist with respect to implementation of the principle itself. The normalization principle is often confused with others (e.g., age-appropriateness). It is, however, key in the movement to less protective community environments.

Group Homes

Upon perusal of the literature on group homes, it becomes apparent that these are complex facilities to study (Baker et al., 1977; Bruininks et al., 1977; Heal & Fujiera, 1984; Hill & Lakin, 1986; Janicki et al., 1983; Willer & Intagliata, 1982, 1984.) A quick check of the literature will garner various names of the living environments for mentally retarded people: private residential facilities (Bruininks et al., 1981); community residential facilities (Bruininks et al., 1981; Janicki et al., 1983); community residences (Birenbaum & Re, 1979; Bruininks et al., 1981); community based facilities (Bruininks et al., 1981); community residential alternatives (Bruininks et al., 1981); group homes (Landesman-Dwyer et al., 1980; Malin, ; Willer & Intagliata, 1982) and countless variations of the above terms.

As the names vary, so does the classification of such living arrangements (Bruinicks et al., 1981; Baker et al, 1977). It appears that all of the above terms are used interchangeably in the literature, and there are no operational definitions for the terms. These alternative living environments "vary widely in size, staff, composition, age, and disability of residents, and in services provided" (Bruininks et al., 1981, p. 17).

Baker et al. (1977) surveyed and described numerous community residential alternatives for adults with mental retardation. They developed a classification system that used as criteria both program type and size. While the majority of the facilities could have been termed group homes, the researchers decided that some variables, such as the particular population being served, necessitated a different system to depict such contrasts. Baker et al. (1977) developed the following classification system (pp.17-18):

1. Small group home - serving 10 or fewer retarded adults
2. Medium group home - serving 11 to 20 retarded adults
3. Large group home - serving 21 to 40 retarded adults
4. Mini-institutions - serving 41 to 80 retarded adults
5. Mixed group homes - serving retarded adults and former mental hospital patients and/or ex-offenders in the same residence
6. Group homes for older adults - serving only older retarded people and often nonretarded people in group homes or rest homes
7. Foster family care - serving five or fewer retarded adults in a family's own home
8. Sheltered villages - providing a segregated, self-contained community for retarded adults and live-in staff in a cluster of buildings usually located in a rural setting
9. Workshop-Dormitories - serving retarded adults where the living unit and work training program are associated

administratively and sometimes physically

10. Semi-independent units - providing less than 24-hour supervision of retarded adult residents

According to Baker et al. (1977), the chief distinction between group homes is size. They found group home size was negatively correlated with: individual autonomy within the home; resident responsibilities; staff-to-resident ratio; and quality and participation in work training programs. The researchers also found that smaller group homes were more oriented to the principle of normalization. We can only assume that smaller is better for the client.

Very little literature exists as to client satisfaction with group home living. The concept of the "least restrictive alternative" does exist however, and it is based on the assumption that since community residences provide a more normal living environment than that of institutions, they are therefore better for the clients (Pagel & Whitling, 1978). It seems as if yet again public policy has prevailed without adequate research.

Research does exist comparing the quality of care offered in group homes with that of the care given in institutions. Balla (1976) found that "smaller is better" in his investigation into the relationship between institution size and the quality of care. In the Pratt, Luszcz, and Brown (1980) study, quality of care was assessed with respect to: daily management practices, the physical environment, resident community involvement, staff-to-resident speech, and staff attitudes. Scores on all

measures were generally higher for group homes as compared to institutional residences. The community residences appeared to be more personalized than the institutions; however, there was also considerable range observed in many of the measures, suggesting a great variance between small residences.

It would appear then, that while community residences are less restrictive in terms of environment, the quality of life has not been assessed from the viewpoint of the individual, the consumer. The present study attempts to address this issue.

Independent Living

While many variations exist with respect to community-based residential alternatives, the most recent addition is that of independendent living programs. Halpern et al. (1986) refer to this type of living as Semi-independent living. In Southern Ontario these programs are called Supported Independent Living (SIL). These programs offer less than 24-hour-per-day supervision and vary on content area from client to client.

Semi-independent living programs typically serve high functioning adults. These individuals generally possess a high level of motivation to live independently and moderate independent living skills (Crnic & Pym, 1979; Halpern et al., 1986; Hill & Lakin, 1986; Schalock & Harpur, 1978; and Schalock, Harpur & Carver, 1981). Generally, there exists quite a degree of flexibility with regard to the criteria necessary for placement of an individual in an SILP. In a telephone conversation with an administrator of such a program, the

following list of skills and requirements were given as prerequisites for admission to an SILP. SILP clients are expected to be ambulatory and in good health. They must possess the motivation and ability to care for their own personal hygiene, and the motivation and ability to work. Clients must know how to use public transportation, and, if necessary, be able to self-administer medication. Clients must also possess basic housekeeping and cooking skills, be able to make small routine purchases, and be able to initiate leisure activities for themselves.

While the above criteria exist, there is no measure accompanying each variable stating at what level of skill development an individual is ready for entry into an SIL program. This is usually a judgement call made by staff people. A person who is highly motivated to live independently, yet without some of the necessary skills, may be recommended for such a program whereas a non-motivated person with all of the required skills may not be recommended for a semi-independent living program.

General agreement does exist in the literature that certain independent living skills must be present before an individual is ready for placement in an independent living program (Crnic & Pym, 1979; Halpern et al., 1986; Schalock & Harpur, 1978; Schalock, Harpur, & Carver, 1981). The most important factor in successful independent living appears to be resident motivation (Crnic & Pym, 1979; Halpern et al., 1986). Edgerton (1967), although not specifically referring to SIL programs but instead

to successful adjustment of residents to the community, also pointed out the importance of clients wanting to learn new skills. Successful clients in Edgerton's (1967) sample were highly motivated, as they did not want to return to the institution from which they had been placed.

Crnic and Pym (1979) identified the following factors as being associated with successful independent living:

1) resident motivation
2) group home and parental support
3) adequate coping skills
4) behavioral living skills
5) adequate self-concept
6) social support system
7) service agency support
8) adequate housing and employment

Resident motivation is described by Crnic and Pym (1979) as a "verbalized desire as well as ongoing attempts to acquire and maintain IL [independent living] skills" (p. 15). This study also showed that behavioral skills were the next most important factor after motivation, and that the service providers had an effect on both motivation and skill level.

Factors that impede successful independent living placement according to Crnic and Pym (1978) include a regression of behavioral skills, which is thought to arise out of anxiety or fear associated with becoming independent. Coping skills were also found to be necessary for adequate adjustment to independent

living. Problems occurred as "residents were ill-prepared to cope with the situations from which they were previously protected in the group home" (Crnic & Pym, 1978, p. 15). For example, "threats of eviction were made to residents for not adequately maintaining their apartments.... Job losses resulted from not getting to work on time...."

A final conclusion drawn by Crnic and Pym (1979) about factors impeding successful adjustment in an independent living program was that loneliness and the lack of social support were major factors in the independent living process. Social support in this study was operationally defined as a peer-oriented social system. The researchers stated that most of the clients no longer had access to their former friends when they moved to independent living situations, and this proved difficult to cope with for many of the clients.

Schalock and Harpur (1978) also investigated successful independent living placement. In their research, the 131 participants actually had the benefit of a training program which included basic skills, independent living, and competitive employment. Clients would participate in the training program, follow this with placement into an independent living situation, and then receive follow-up for successful placement for six months on a weekly basis, and every three months thereafter. The researchers defined successful placement as "remaining in the independent living or competitive employment placement; failure was defined as returning to the training component any time after

placement" (Schalock & Harpur, 1978, pp. 242-243).

Schalock and Harpur (1978) found that different skills were necessary for competitive employment and successful independent living skills placement. Participants who were successful with regard to independent living were intelligent and more skillful; the skills they possessed were behavioral and included basic personal maintenance, clothing care and use, socially appropriate behavior and functional academics. Successful placement with regard to competitive employment was related to skills in sensorimotor functioning, visual-auditory processing, language, and symbolic operations (Schalock & Harpur, 1978). Job placement success was not found to be significantly related to intelligence.

Schalock, Harpur, and Carver (1981) followed up on clients who had participated in the "Mid-Nebraska adult training program" (p. 120) in order to assess successful independent living placement on a longitudinal basis. The researchers found that eighty percent of the original clients were still living in their original independent living situation. Schalock et al. (1981) found the successful client to generally be younger, more intelligent, and possessing more independent living skills than did unsuccessful participants. People who could not adjust to independent living successfully usually exhibited some form of bizarre behavior, had nutritional problems, and lacked basic home care skills.

The Crnic and Pym (1979), Schalock and Harpur (1978), and

the Schalock, Harpur, and Carver (1981) studies are concerned with predictor variables associated with successful independent living. The main source of information in these studies come from service providers' assessments of individual clients. The problem with their research is that some very valuable information is missed (Gollay et al., 1978; Wyngaarden, 1981). Clients themselves have not been asked about their needs, problems, and experiences in independent living situations.

A recent study by Halpern, Close and Nelson (1986) remedies this lack. The clients in the Halpern study were drawn from a cross-section of communities in California, Colorado, Oregon, and Washington. Clients in this research were relied upon heavily as sources of information through the use of structured interviews. The Halpern et al. (1986) work managed a merging of information from both the service providers and the consumers of SIL programs. The researchers interviwed 300 adults with mental retardation from 30 programs in the U.S. Their research resulted in indepth views of clients' lives and aspirations.

Halpern et al. (1986) delve deeply into the area of semi-independent living programs. The study reveals both the advantages and disadvantages associated with such a living arrangement. The chief advantage is the ability of residents of SIL programs to live in reasonably "normal" environments. The chief disadvantage is that residents may not have someone available to help if needed. "With the dignity of choice comes the risk of defeat and despair" (Halpern et al., 1986,p. 3).

The purposes of the Halpern et al. (1986) work were: 1) to examine the accomplishments and problems of SILP clients with respect to community adjustment (i.e., residential environment, employment and finances, and social/interpersonal networks) 2) to document current residential services and categorize these services in terms of the restrictiveness of the settings; 3) to make recommendations based on the study's findings.

Data of the Halpern et al. (1986) research. Halpern et al., (1986) found that on the average, SILP clients were approximately 28 years old. While the range in age went from 18 to 59 years, relatively few people were over the age of 40. IQ data yielded a wide range of scores (29-93). The majority of the group was at or below the mild level of retardation. It should be noted, however, that IQ scores were only available for 56% of the population. This finding may not hold true for the entire group. A look at the gender of SILP clients revealed that an approximately equal number of women and men were included in the sample.

The physical health questions indicated that about two thirds of the sample's participants had other chronic health problems besides mental retardation. Health practices were seen to be relatively satisfactory. Stress management practices were found to be quite appropriate, as were responses associated with diet, nutrition, and oral hygiene. These behaviors, however, may not actually mirror the clients' interview responses, as SILP staff felt that clients required assistance with proper eating

habits. Generally, clients of SIL programs in the Halpern et al., (1986) study were satisfied with their personal health and the care provided for them by the health care profession. These same people, however, were not satisfied with their own knowledge of health care practices (i.e., treating minor illnesses or handling medical emergencies).

Adaptive behavior was also investigated in the Halpern et al., (1986) study. Clients were rated by SILP staff on their abilities to perform tasks. The average score for the group indicated a 68% level of independent functioning. The scores for this item ranged from 0 to 28, a high score indicating a high level of adaptive behavior.

Client motivation has been shown in previous studies to be of prime importance for successful adjustment to community living (Crnic & Pym, 1979; Edgerton, 1967; Schalock & Harpur, 1978; and Schalock et al., 1981). In the Halpern et al., (1986) study, clients in the group had medium to high motivation to participate in SIL programs.

The Halpern et al. (1986) study investigated the quality of residences for people with mental retardation. Halpern et al. (1986) found a wide range of residences and discovered that no "typical" residence existed. The majority of SILP clients (76%) lived in apartment complexes that did not exist for the sole reason of housing people with disabilities. Most of the people in the Halpern et al. (1986) study shared a home with one or more roommates. A surprising finding of this research was that even

though a large number of SILP clients have housemates, seldom do these individuals have any choice in this matter.

Housekeeping, although seemingly of little importance, is a very serious matter and can have grave implications for SILP clients who lack these skills (Crnic & Pym, 1979; Halpern et al., 1986). Those who do not maintain a residence properly may be subject to eviction. This study did not find many clients who lacked these skills. Of the sample, more than three-fourths lived in relatively clean dwellings. Approximately 90% of clients felt that they had a nice house and that they maintained the home well. Eighty-seven percent of clients in the Halpern et al., (1986) research liked their current residence, yet 47% of clients said they would like to live in a different home. This was attributed to wanting something better if possible, yet liking the current residence. Nearly all of the clients lived in neighborhoods of good to moderate quality. The safety of the neighborhood was also rated well. Regarding client satisfaction with the quality of the neighborhood, 41% said they would like to live in a different neighborhood.

Client safety was based on a rating of the frequency of different types of abuses to an individual (e.g., robbery, sexual assault, threats, and teasing). A greater percentage of the clients were victims of minor abuses, with teasing primarily responsible for this statistic. Sexual assault was reported by 21% of the female clients in the first data collection, and only 5% in the next round. Robbery was fairly stable at 12% and 11%

respectively.

Most people in the Halpern et al. (1986) study were happy with their financial and employment situations. Data from the study indicated that approximately 37% of SILP clients were employed in sheltered workshop situations. Only 29% were competitively employed. Twenty-nine percent of the group were unemployed. For those who were unemployed, it appeared that social assistance served as a disincentive to work. The positions held by competitively employed people were bus persons, dishwashers, janitors, nurse's aides, child care workers, and zoo employees.

The major source of income for clients in the Halpern study was governmental assistance. This assistance was in the form of social assistance, food stamps, medical assistance, and housing subsidies. Other sources of income were jobs, family and friends. A few had inheritance or trust funds. The average monthly income of the clients was $428.81; 37% of clients were at or below poverty level.

When comparing those who worked in sheltered workshop settings with those in competitive employment situations, some interesting differences appeared. Nineteen percent more people in sheltered workshops wanted a different job than did those in competitive employment. More people in competitive employment situations thought they worked too hard, yet those people who were competitively employed were happier with their wages.

The Halpern study investigated social relationships and

leisure activities by asking clients various questions concerned with friends, benefactors, intimate relationships, sexuality, leisure activities, and community integration. When clients were asked if they had close friends, ninety-six percent said they had a "best friend". Most (65%) clients visited their friends every week, and 50% of clients were also visited by their friends every week. Yet 77% of the clients were not satisfied with this arrangement and said they wanted to spend more time with friends. Most people, however, reported that they thought they had enough friends.

Edgerton (1967) coined the term "benefactor" in his work on the community adjustment of people with mental retardation and their social support systems. In the Halpern study, a benefactor was defined as "someone who provides help to the client when needed, on an ongoing basis, without pay" (Halpern et al., 1986, p. 101). Program staff assessed the type of support the benefactor gave the client. In the Halpern study, approximately half of the clients had one or more benefactors. Over half of the benefactors were family members. Some of the agency staff were also listed as benefactors. This relationship existed if the staff member was providing help to the client that was seen as not part of, or extra to, the job. Halpern et al. (1986) termed this relationship "beyond the call of duty" (p.102). The type of assistance that benefactors provided ranged from that of advice to help with employment.

Only 12% of clients in the Halpern study were married.

However, a high percentage of the clients were involved in a paired relationship. Most of the married couples had been together for 1-2 years (43%), 24% had been married 3-4 years, and 22% had been married five or more years. Of the paired relationships, 10% had been together five or more years, 27% had been together for 1-2 years, and approximately 25% of client were involved in recent relationships of 0-6 months.

Eighty-six percent of the clients said they were satisfied with their leisure activities. Over 80% of the group said that they had hobbies. The activities and hobbies were shown in the sample to be very diverse in nature, and also were seen to closely resemble the rest of the American population (e.g., watching T.V.; listening to music; going for a walk; and participating in arts and crafts). However, clients in the Halpern study were not very successful in achieving community integration. Most SILP clients spent most of their time with other people with handicaps. Less than one-third of clients' time was spent with non-handicapped people.

Halpern et al. (1986) evaluated SIL programs on many characteristics; the most important to the present study focusing on client satisfaction with the program. Seventy-one percent of clients in the Halpern study were satisfied with "the way the SILP usually does things" (Halpern et al., 1986, p. 147). Eighty-seven percent of clients were satisfied with the content of the training they received, and felt they received sufficient support from the program. Many clients (68%) did report,

however, that the program had too many rules.

As can be seen, independent living programs are relatively new and have not yet been entirely evaluated. The Halpern et al. (1986) work comes the closest as it describes the programs and the people in the programs. It would seem a logical next step to compare people in independent living situations with people in group home situations to see just what contrasts can be made and what similarities can be found. Is independent living characterized by greater client satisfaction, sense of autonomy, and self-esteem, as we might expect based on the program philosophy? Given the concerns expressed in some studies (e.g., Crnic & Pym,1979) about social networks and social isolation among SILP clients, it seems important to compare these programs in this area especially. Such comparisons from the client's point of view require carefully designed interview techniques.

Interviewing Mentally Retarded Persons

While many studies exist which attest to the deplorable conditions that mentally retarded persons have been subjected to in institutions, and conversely, that community-based residences enhance the independence and quality of life of these individuals, few studies actually ask the receivers of this care what they themselves are experiencing (Wyngaarrden, 1981).

Gollay et al. (1978) interviewed 440 mentally retarded persons in their assessment of the adjustment of deinstitutionalized, mentally retarded people to community life. Wyngaarden (1981) states that the decision to interview these

persons was based on two assumptions, that people with mental retardation are valid sources of information regarding their own experiences, and that they are the only sources of this information. These assumptions appear to be very basic. The literature, however, does not reflect them.

Many considerations exist with respect to interviewing mentally retarded individuals (Wyngaarden, 1981). A major issue for the researchers in the Gollay et al. (1978) study was the concern that respondents might try to please the interviewer by giving the "right" answer. Also, the interviewers did not want respondents to worry about voicing a negative opinion. To combat this, interviewers used simply phrased, open-ended questions. Interviewers were not permitted to supply suggestive answers to questions but were allowed to rephrase questions in order to elicit a response. In fact, researchers found that they often had to rephrase questions to get the most complete response.

Another helpful tip garnered from the Gollay et al. (1978) study is that the timing and location of questions were extremely important. The interviewers found that it was helpful to begin with easy questions such as "Do you go to school?" and progress to more complex questions such as "What do you like about being here?" later on in the interview.

Wyngaarden (1981) mentions other issues with respect to interviewing mentally retarded persons. Respondents must be told that all answers are private and confidential, and that there are no right or wrong answers, It also helps if the interview takes

place in a private area, although this is somewhat dependent upon the individual. Also, needless to say, an interviewer must possess the virtue of patience. Only an interviewer possessing this quality will obtain complete responses from individuals.

Wyngaarden (1981) concludes with the statement that "mentally retarded people can and are eager to provide complex and moving accounts of their experiences in returning to community life" (p. 113). A comparison of the answers given by mentally retarded persons and their respective family respondents revealed a high degree of agreement. Also, of the 440 mentally retarded persons, 41% were mildly retarded, 31% were moderately retarded, 24% were severely retarded, and 4% were profoundly retarded; yet only 13% of the population could not be interviewed (due to their non-verbal condition). Generally then, most mentally retarded persons, regardless of the degree of mental retardation, could provide valuable information through personal interviews.

Research Aims and Objectives of the Study

Ontario began its move to deinstitutionalize mentally retarded persons in 1973 (Willer & Intagliata, 1984). The thrust was not only toward deinstitutionalization, but also to the prevention of institutionalization. In Ontario, the deinstitutionalization movement has been termed the "five-year plan" (Simmons, 1986). The focus of the present research was on the progression of mentally retarded individuals from institutions, and particularly group homes and related facilities

to independent living programs.

"The simple physical placement of persons into small residential facilities located in a community of whatever size in no way assures that the resident will automatically have a normal life" (O'Connor, 1976). Nor does it guarantee that residents will be happy with their situation. The purpose of the present research was to determine the extent to which the present living arrangement is suitable and satisfying to the consumer.

In this study, participants included people living in semi-independent living (SIL) programs and persons living in group homes. I feel that mentally retarded individuals in these living arrangements are able to provide relevant and reliable information about their own personal life experiences (Edgerton, 1967, 1976, 1981, & 1984; Gollay et al., 1978; & Wyngaarden, 1981). A very important feature of this research is that it includes a multiplicity of perspectives. Not only were the agencies and service providers interviewed, but the clients themselves were also interviewed and their views included in the study.

Interviews with clients were expected to deliver a life picture, a snapshot of clients' lives at various times, and at various residences. The client interviews were based on the work of Halpern et al. (1986). They were designed to gather information from the clients' points of view. Questions covered such items as current life satisfaction; perceived needs of the client; current residence satisfaction, neighborhood quality, and

social relationships. In certain areas, the interviews asked about the quality of life in the client's current environment versus the quality of life in the old environment.

This research focused more extensively on the existence of, and satisfaction with, social support networks with respect to this type of independent living program. Social support has been shown to be of the utmost importance in the functioning of individuals (Cohen & Hoberman, 1983; Cohen & Wills, 1985; Edgerton, 1967; Edgerton & Bercovici, 1976; O'Connor, 1983) Very simply, social support refers "to the various resources provided by one's interpersonal ties" (Cohen & Hoberman, 1983). It is the extent to which an individual feels "support" on an emotional, material, and informational level by family, friends, service providers or others when necessary (O'Connor, 1983). It has been demonstrated that mentally retarded persons place a high value on social relationships (Edgerton, 1967). Consequently social support structures may have an important effect on clients' satisfaction with their respective living arrangements. A number of researchers and service providers with whom I have been in contact have expressed concerns about this area of clients' lives in independent living environments. Thus it was hoped that a comparison of this population with a comparable sample living in group homes could shed some light on the interpretation of these clients' experiences and feelings.

It is expected that individuals in supported independent living programs will be proud to have achieved such independence

and will therefore score high on many measures of self and program satisfaction. It is expected that these same people may score lower on measures of social support, and that they may be experiencing feelings of alienation from society. It is expected that the converse will exist for residents of group homes. As they are surrounded by friends they will probably be satisfied with this aspect of their lives and score accordingly on the social support measures. However, it is also expected that they will have feelings of inadequacy with respect to their living situation as they have not yet "graduated" to higher levels of independence.

Method

Participants

The present study included 20 clients of semi-independent living programs in Kitchener- Waterloo and Cambridge. These clients have come from institutions, group homes, other community living facilities and family homes. This sample was obtained with the assistance of the director of K-W Habilitation Services, Ms. Judy Vellinga and the director of the Cambridge Association for the Mentally Retarded, Ms. Jayne Neath. A comparison group of 20 clients of group homes in these same areas were also interviewed. These clients were recruited by program staff and were roughly matched for age and sex with the SIL clients.

Instruments

All instruments, except the social support measure (see

Appendix A) used in this study, were developed by Halpern, Close, & Nelson (1986) for their research concerning independent living programs for adults with mental retardation. The scales are as follows:

Independent Living Skills Scale. This is a 28-item behavior rating scale. This scale was adapted for the Halpern et al. study (1986) from the Adaptive Behavior Scale (Nihira, Foster, Shellhaus, & Leland, 1974). It consists of items that cover personal appearance, health care, nutrition and cooking, home management, and communication. This scale is completed by service providers and each item is rated as "independent" or "assistance needed".

Inappropriate Behavior Scale. This scale consists of 29 items. It was designed by the Halpern et al. staff to examine behavior problems. Behavior problems include physical or verbal aggression, property destruction, activity disruption, lack of cooperation with staff, irresponsibility, dishonesty, and inappropriate sexual behavior. This scale was also rated by service providers on the basis of three categories: 1) major problem, 2) minor problem, and 3) not a problem.

The Client Specific Questionnaire. This questionnaire was designed by the Halpern et al. (1986) staff in order to obtain information specific to each client. It is completed by service providers and delves into areas that may be difficult for people with retardation to talk about (e.g., behavior problems, length of time in program). (See Appendix B).

The Client Interview Schedule. This interview schedule was developed by the Halpern et al. staff (1986) to be administered by project interviewers to the clients themselves. Information was gathered with respect to personal attributes, health practices, diet, self-esteem, satisfaction with the current residence, and social relationships (see Appendix C).

In the Halpern study, the Client Interview Schedule and the Client Specific Questionnaire, in addition to collecting quantitative information, gathered a large amount of descriptive information (Halpern et al., 1986). Existing scales were reviewed for possible incorporation, in whole or in part into the two instruments. Second, additional items were written by project staff to supplement existing scales or remedy any lack of information. The test-retest reliability of the instruments disclosed over 90% agreement across all quantifiable items. Two rounds of data collection were completed (8 months in between rounds) to ascertain the stability of the project's findings. A high degree of stability was found.

In the present research, items not relating to environmental satisfaction or social support have been dropped (e.g., sexuality). The Client Specific Questionnaire and the Client Interview Schedule are thus shortened versions of the Halpern et al. (1986) originals. Five major areas of the clients' lives are assessed: client characteristics, satisfaction with homes and neighborhoods, satisfaction with employment, satisfaction with social life and leisure activities, and program satisfaction.

Social Support Scale. The scale used to measure social support in the present research was the Arizona Social Support Interview Schedule (ASSIS) (Barrera, 1981). The ASSIS is a compound functional support measure designed to assess six types of support functions: material aid, physical assistance, intimate interaction, guidance, feedback, and social participation (Cohen & Wills, 1985). (see Appendix A).

Procedure

It was necessary to first assess whether or not the present research was reasonable and useful. This was accomplished by contacting the Waterloo branch of the Ministry of Community and Social Services and speaking with the Program Services Manager for mentally retarded people in the Kitchener- Waterloo region, Mr. Brian Knight. A meeting was set up at which time the idea of the progression of mentally retarded individuals from institutions to group homes to independent living programs was settled upon as a reasonable, interesting and useful area to study. Mr. Knight then indicated that it would be useful to speak to the director of K-W Habilitation Services, Ms. Judy Vellinga, in order to get her input on this idea.

A meeting with Ms. Vellinga was set up at which time her interest in this area of research was quite clear. She was more than happy that someone was willing to take this topic on as an area of research, and was very interested in the outcome. Ms. Vellinga gave an overall account of her agency's operations, and she also supplied this researcher with historical information on

Ontario's deinstitutionalization plan.

The next step was to determine the feasibility of such research. Would sponsoring agencies of Supported Independent Living (SIL) programs be willing to participate in the study? This was accomplished at a meeting of all the Residential Directors of Waterloo, Wellington, Bruce, and Grey Counties on 11 March 1987. At this meeting the proposed area of research was discussed in order to elicit any concerns or input of the service providers. A letter was provided to those directors present (and mailed to those who were absent) further indicating the focus of the present research (see Appendix D).

At this meeting the directors were very supportive of the proposed area of research. They stated that they would be interested in getting a copy of the results. Those directors that do not presently have SIL programs indicated that this would be very helpful to them were they ever to implement such a program. Subsequent phone contact with the Residential Directors of Cambridge, Guelph, and Owen Sound to elicit numbers of residents in SIL programs and the criteria necessary for entry into such a program also demonstrated a high interest level in the outcome of the research.

Subsequent contact was made with the director of K-W Habilitation services, Ms. Judy Vellinga, and the program managers of group homes and supported independent living programs in the K-W area on the subject of questionnaire content. On 28 May 1987, a meeting was held for the purposes of eliciting any

concerns or input the actual service providers might have. At this meeting the managers offered suggestions as to the wording of some of the questions and also suggested additional questions. All of their concerns and suggestions were responded to by making the required changes to the questionnaires.

Meetings were held with the program staff of the Cambridge Association for the Mentally Retarded on 6 August, 1987, to examine the questionnaires. These meetings resulted in contacts being made with program managers and staff of SIL programs and group homes. Subsequent contact occurred in the form of meetings with individual staff members to explain the research more thoroughly. Staff members, in turn, explained the nature of the research to their respective clients, thus gauging the interest level of these people. Staff members then notified the researcher of the interested parties. Appointments for interviews were then made between those interested and the interviewer. It was felt that this was the least intrusive way for the proposed interview to take place as only interested people were contacted.

I feel that the people who volunteered to be interviewed for the study were indeed a representative group. I interviewed all of the people living in SIL programs that were willing to be interviewed in the Cambridge and Kitchener-Waterloo area. I interviewed people from all four group homes in Kitchener-Waterloo, and five people from one group home in Cambridge. The timeline was such that I interviewed people who

were available. While I might have sacrificed the randomness of the selection process, I felt it was the only way to proceed with such a small population to draw from.

At the beginning of each interview, the nature of the research was explained to participants. Participants were then asked to sign a consent form (see Appendix E) signifying their understanding of the research. Participants were then interviewed according to the Client Interview Schedule and the modified version of the ASSIS. At the end of the interview clients were asked to sign a release of information form (see Appendices F and G) in order that their counsellors could fill out the Client Specific Questionnaire.

SIL and group home staff were asked for information about their programs, and the individual clients. They then completed the Client Specific Questionnaire, which includes the Inappropriate Behavior Scale and the Independent Living Skills Scale (Halpern et al., 1986).

Data Analysis

Data were coded to produce numerical indices according to the Halpern et al. (1986) techniques. These included categorical data. T-tests were used where appropriate with numerical data. Chi-squares and the Fisher Exact test were conducted to test for differences between the two groups.

Feedback

A letter informing participants of the results of the study and thanking participants for their help was mailed out to people

on 11 December, 1987 (see Appendix H).

A presentation was made to the director of the Cambridge Association for the Mentally Retarded, Ms. Jayne Neath, on 7 January 1988. A brief overview of the findings of the research was discussed. I also informed Ms. Neath that a copy of the final document would be sent to her upon its completion.

A presentation was also made to the director, Ms. Judy Vellinga, and the frontline staff of K-W Habilitation Services on 19 January, 1988. This presentation turned into a very interactive session. I gave a short introduction to my research, followed with a brief description of the results. This was in turn followed by a question and answer period. I found this an excellent way to give feedback as those present got exactly what they wanted out of the discussion. This was also a helpful process for me to enter into as I got feedback on my feedback. For instance, the statement I made with regard to people being better off with benefactors, and my suggestion on ways to begin such relationships met with agreement in principle, yet disagreement in a pragmatic sense. The staff members agreed that while outside relationships, once established, were beneficial to clients, the start of such a relationship can be harmful. They cited cases in which volunteers after having worked with a person for a short time, decided to terminate the relationship. In these cases the person will often wonder what it is he or she has done wrong. The person will often end up feeling abandoned. The process of discussing all of the issues proved very helpful to

both myself and those present.

Pilot Study

All instruments were pilot tested with two participants in July, 1987. This testing resulted in a slight modification of the ASSIS. Two questions in each section of the ASSIS were dropped and one added in its place (see Appendix A). It was felt that this modification made the test more concrete for participants to understand and thus increased the validity of responses.

Results

Halpern et al.(1986), described the residents of SIL programs on a wide range of measures. The present research goes one step further and compares clients of group homes and SIL programs on many of these same characteristics. A description of the clients in the present study will be presented. When the data from Halpern's study are available, they will be compared and contrasted with these results. Further, when appropriate, comparative analyses of the two resident populations will be conducted.

Because of the smaller than expected sample in the present study, sex by program patterns could not be analysed as had originally been hoped, since cell sizes were simply too small. In most cases, however, a look at the data revealed no significant differences in program patterns by sex.

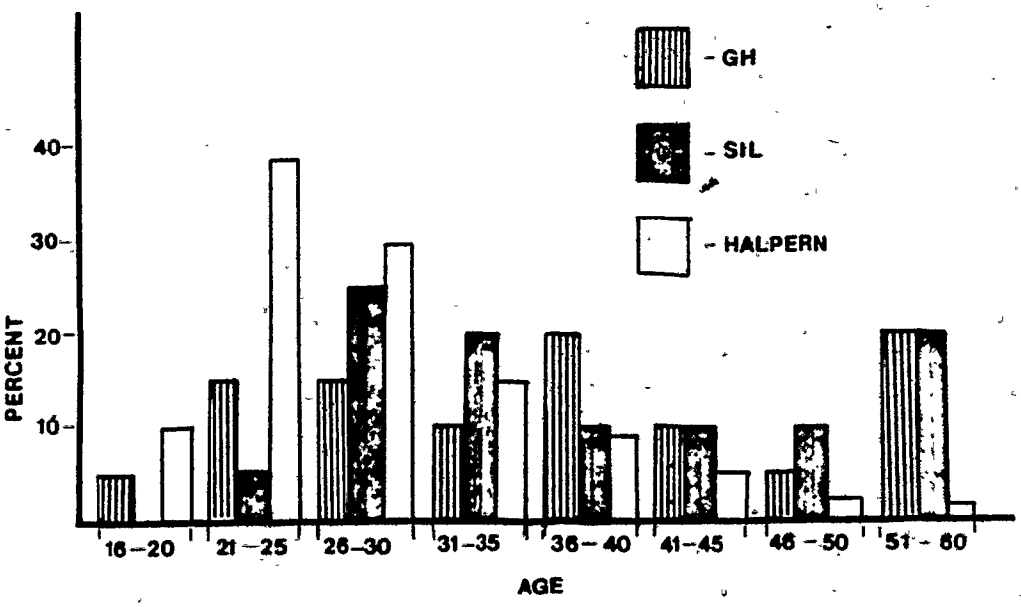
The five areas reviewed below include: a description of the clients, homes and neighborhoods, employment, social relations

and leisure, and client satisfaction with programs.

Description of Clients

Age. Clients in the study ranged in age from 20 to 58 years. SIL clients ranged in age from 20 to 55 years, group home residents ranged in age from 20 to 58 years.

Figure 1: Distribution of SIL and GH Clients by Age



Program differences for the two groups were not significant. Halpern's clients (Halpern, 1986) ranged in age from 18 to 59 years. He found that very few people in his sample were above the age of 40 (see Figure 1). The percentage of SIL clients above the age of 40 in the present sample is more sizeable, about 35%.

Sex. As in Halpern's study, an approximately equal number of women and men were represented in the present sample (See Table 1).

Table 1: Distribution of Participants by Sex

Sex	Halpern #1	Halpern #2	Present Study		
			SIL	Group Home	Total
Male	48%	45%	60%	55%	57.5%
Female	52%	55%	40%	45%	42.5%
Total	100	100	100	100	100

Physical health. In the present study, only 52.5% of clients received medication for any chronic health problems or disabilities. There was no significant difference found between residents of group homes and SIL programs on this variable.

As a group, clients were highly satisfied with their personal health. Approximately 97% of clients reported they liked the way their doctor takes care of them. There was no significant difference found between programs. Approximately 19% reported that they get sick often, and again no significant difference was found between programs. Approximately 98% reported they could get to a doctor if necessary.

When discussing minor health problems, approximately 38% of participants expressed a desire to have more information on treating headaches, coughs, and small cuts. No significant differences by program type were found. With respect to handling medical emergencies such as broken bones and deep cuts, nearly all clients (98%) said they did not know enough about how to help

someone. No significant difference was found for program on this measure, but this concern was significantly more common for both groups than those in the Halpern study (see Table 2). For example:

> Interviewer: "Do you think you know enough about how to help someone who has a bad accident like a broken bone or a deep cut?"
>
> Participant: "If it's a deep cut, you'd have to learn first aid."
>
> Interviewer: "Do you know first aid?"
>
> Participant: "No, not exactly. I wish I did."

Table 2: Satisfaction with Health

Question	Halpern %	SIL %	Group Home	Total
Do you like the way your Doctor takes care of you? (percent yes)	94	94	100	97
Do you get sick too often? (percent no)	85	89	72	81
Can you get to a Doctor if you want to? (percent yes)	91	100	100	100
Do you need to know more about how to take care of you own headaches, coughs, and small cuts? (percent no)	66	58	61	59
Do you know enough about how to help someone who has a bad accident? (percent no)	50	100	100	100

Sustenance and nutrition. All clients in the present study reported that they usually got enough food to eat, contrasted with 93% in the Halpern Study. Approximately 97% of clients get to eat their favorite foods as often as they wish. No significant differences were found between residence type. Sixty percent of clients would like to get to eat different kinds of foods than they usually eat, but no significant differences were found between groups. Halpern reported that nearly two-thirds of clients wanted "more variety in their diets". (Halpern, 1986, p. 30).

Approximately 68% of clients wanted to learn more about how to cook different foods. While the data showed no significant differences between program type, there was a trend for group home residents to more often report a need to learn how to cook different foods more often (SIL = 55%, GH = 83%, $X^2(1)=2.65$, $p=.10$).

Approximately 93% of clients reported they ate enough "healthy foods like fruits and vegetables" compared to 80% in the Halpern study. Thirty-three percent of participants reported they are hungry most of the time, and no significant difference was found for residence.

Dressing and personal appearance. All clients in the sample reported that they could get their hair cut or styled the way they wanted to, although approximately 58% of people stated they would like to look differently. Overall, clients were satisfied with their personal appearance (see Table 3). One client summed

it up quite nicely for himself when he said he liked the way he looked and he "just wanted to stay normal". There was one difference between groups; SIL clients were less likely to report wishing they could buy more expensive clothes (see Table 3).

Table 3: Personal Appearance

Question (percent yes)	SIL	GH	Significance
Are you able to get your hair cut or styled the way you want?	100	100	—
Would you like to look differently than you do?	50	65	--
Do you think your clothes are nice looking?	100	100	--
Do you wish you could buy more expensive clothes?	68	100	**
Do you know enough about how to fix your clothes when they are torn?	58	60	--
Are you happy with the way you look?	89	95	--

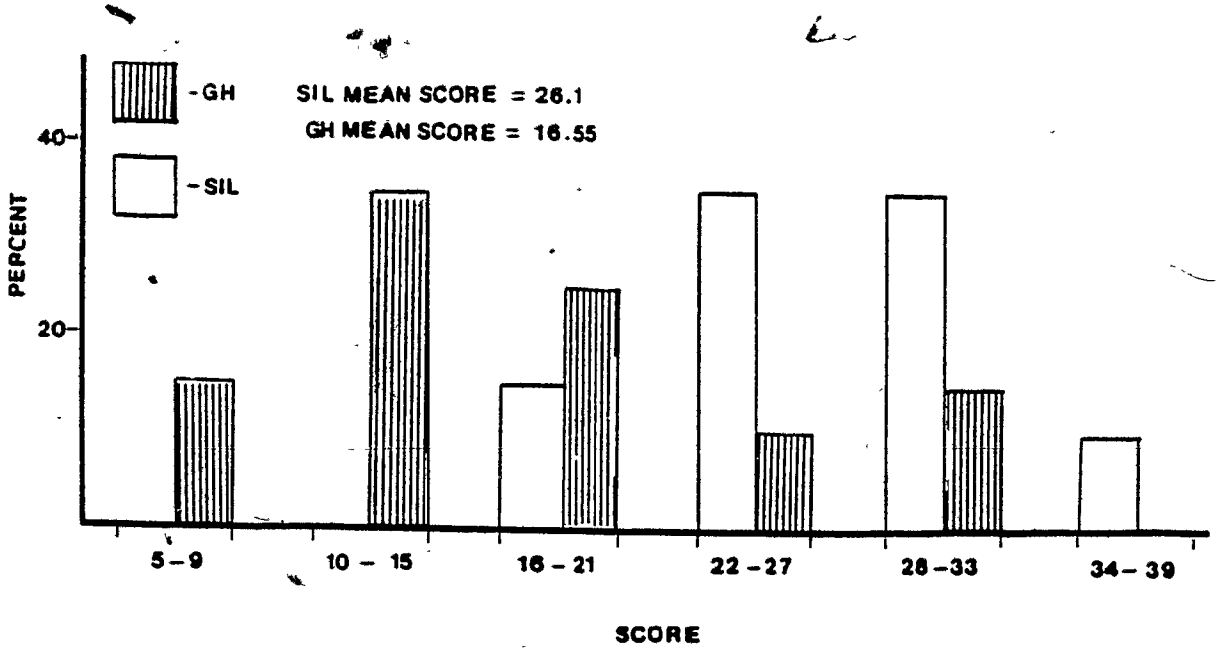
**significant by Fisher Exact Test, $p < .05$.

Adaptive Behavior. The Independent Living Skills Scale, as developed by project staff in the Halpern study, was designed to measure client adaptive behavior. This scale included 39 items and "covered eight content areas: personal appearance, health care, nutrition and cooking, home management, money management,

communication, mobility, and utilization of the service network" (Halpern et al., 1986, p. 31). Items were coded zero or one, with a higher score indicating independence and a lower score indicating a greater need for assistance.

The average score for the total group indicated a 55% level of independent functioning. SIL participants had a 70% level of independent functioning, compared to Halpern's (1986) reported mean of 68%. The group home participants had an average score of 43% (see Figure 2).

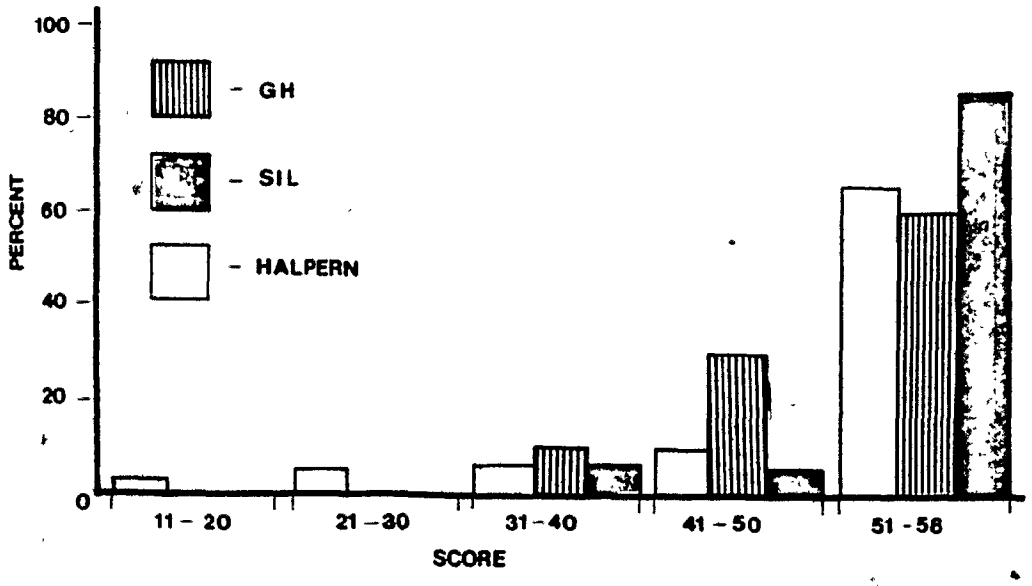
Figure 2: Client Scores on the Independent Living Skills Scale



A t-test revealed a significant difference between program types on the Independent Living Skills Scale (t=3.93, df=38, p < .001). Residents in SIL programs had a mean score of 26.1 compared with a mean score of 16.55 for group home clients.

Behavior problems. The Inappropriate Behavior Scale is a 29-item scale developed by Halpern's project staff to "examine behavior problems, including physical or verbal aggression, property destruction, activity disruption, lack of cooperation with SILP staff and authorities, irresponsibility, dishonesty, and inappropriate sexual behavior" (Halpern et al., 1986, p.35). A high score on this scale indicates few behavioral problems, and the possible range of scores is 0 to 58. The mean score for clients in the Halpern study was 51.9. The mean score for clients in the present study is 52. The mean score for SIL clients is 54.2 and for group home participants it is 50.2 (see Figure 3). As in Halpern's study, the group as a whole had few behavior problems. A t-test revealed no differences on behavior problems with respect to program type.

Figure 3: Client Scores on the Inappropriate Behavior Scale



Client motivation. Participants in the present study, as in the Halpern study, had medium to high motivation to live in their current residence, to participate in their program, to learn new skills, and to be totally independent (see Table 4). No significant differences existed for program type on any of these questions. There was a tendency, however, for SIL clients to want to live in their current residence more (% high = 65% versus 40%).

Table 4: Client Motivation

Item	Client Motivation%								
	Low			Medium			High		
	H	SIL	GH	H	SIL	GH	H	SIL	GH
Desire to live in current residence	6	5	0	22	25	60	72	65	40
Desire to receive services from program	11	5	0	36	45	50	53	45	50
Desire to learn new skills	21	15	5	37	55	60	42	25	35
Desire to be totally independent	13	5	5	34	60	45	53	30	45

In addition, clients were specifically asked: "Would you rather stay in this program or live somewhere else like in another group home, SIL program, or with your family?". Of all SIL clients, 90% said they would stay, while only 50% of group home residents wanted to stay. This difference was significant ($X^2(1) = 5.83$, $p < .05$). Most of the group home participants that

wanted to leave indicated their desire to move into the next phase of more autonomous living - the apartment program. It seemed that all group home residents wanted to move into apartments regardless of the reality of their situations. "I always picture myself living out on my own so I can invite my friends over to my place and say come over anytime. I'd invite them over for supper. I'd cook for them...if I could really cook. If I was in an apartment for example, I can even get out and enjoy myself more in the community, go to shows, take somebody with me." This seemed an important goal for many of the group home participants.

When participants were asked whether or not their move into their present residence was voluntary, or involuntary, 60% of SIL clients said the move was voluntary, while 50% of group home residents reported the move as voluntary. No significant difference was apparent by program type or sex.

Homes and Neighborhoods

Types of residence. The majority of participants of SIL programs in the present study live in apartments or townhouses within integrated facilities (85%). In Halpern's study, 76% lived in apartments in integrated facilities. Fifteen percent of SIL clients live in a house. This compares with seven percent in Halpern's sample.

Number of housemates. All but one of the SIL participants had housemates, contrasted with three-fourths in the Halpern study (see Table 5).

Table 5: Number of Housemates

Number of Housemates	Halpern %	SIL %	GH %
None	26	5	0
1	56	50	0
2	13	30	0
3 or more	5	15	100

Forty percent of group home clients had four housemates. Ten percent had five housemates, twenty-five percent had seven housemates, and twenty-five percent had eleven housemates. There was a significant difference by program type for number of housemates (X^2 (1)=29.19, $p < .0001$), with group home clients all having three or more housemates, while only 15% of SIL clients had three or more housemates.

Home upkeep. Almost all participants in the study lived in well-maintained dwellings. Only two significant differences existed between programs for home upkeep. Significantly fewer SIL clients had smoke alarms in their homes, and significantly more SIL clients had homes with a "noticeable foul smell" ($p < .05$, Fisher Exact Test). Both these differences between programs were quite minor, and need to be interpreted in the context of

overall basic similarity in upkeep (see Table 6).

Table 6: Home Upkeep

Characteristic	SIL (percent yes)	GH
Holes in wall	0	0
Hole in floor covering	5	0
Broken windows	0	0
Missing doorknobs	0	0
Peeling paint/wallpaper	10	0
Smoke alarm	65	100
Leaky plumbing	20	0
Accumulation of dirt, grease or grime on walls, floor, etc.,	10	0
Noticeable foul smell	25	0
Two or more lighting sources in living room	100	100
Couch and chair	100	100
TV and Stereo	80	100
Decorative plants, wall hangings	95	100
Window shades, blinds, or curtains	100	100
Carpeting in living room	95	100
Dining area separate from living room	80	100
Kitchen cabinets	100	100
Bedroom separate from living room	95	100
Toilet and bath/shower within own living space	100	100

Satisfaction with residence. Approximately eighty-eight percent of participants in the present study were satisfied with their present residence (see Table 7). and there were no differences by program type. There were some complaints, however. Some clients of SIL programs expressed an interest in having a pet but they were not permitted to do so. Other people had complaints about how their landlords kept the place up: "We have lots to get fixed, we asked them to fix our tiles and our sliding doors but we have had lots of superintendents. There is a new one now and he is painting and fixing up the outside. He says when winter comes he'll fix our place up."

Table 7: Client Satisfaction with Residence

Item (percent yes)	SIL	GH
Do you really like the home you are living in now?	85	90
Does your landlord have any rules you don't like?	45	35
Does your landlord keep the place fixed up enough for you?	80	95
Would you like to have your home in a different neighborhood?	10	30
Do you feel safe walking alone in this neighborhood at night?	60	50
Would you really like to live in a different home?	50	50
Do you like this home better than where you used to live?	80	85

Neighborhood quality and satisfaction. As stated in the previous section, ten percent of SIL clients and thirty percent of group home clients said they would like to live in a different neighborhood. Reasons given for this answer were varied. Some people wanted to be closer to their place of employment, and so their answers had nothing to do with the quality of their present neighborhood. One participant said she really did not like the long bus ride to work, and that she would rather live closer so she could walk to work. Other people wanted to be closer to their friends, and some people just did not like their neighbors. For example, the neighbor's kids make "fun of me saying I was kind of stupid, dumb, crazy, ridiculous, and retarded. I just ignore them. I talk to their parents about it. They are about 10 and 14." This participant said that the teasing still continues on a regular basis, and that nothing he does will stop it. Now he just tries to ignore the taunting.

The upkeep of the neighborhood was rated with respect to dwellings, yards, cleanliness, building vacancy, zoning and activities of the people in the neighborhoods. It was found that 80% of dwellings in the immediate neighborhood were generally in "adequate or better repair". Yards were, on the average, neat and trim (77.5%). All of the participants in the present study lived in clean neighborhoods. Buildings in all of the participants' neighborhoods appeared to be occupied. Approximately 83% of participants lived in largely residential neighborhoods. In approximately 93% of the clients'

neighborhoods, all persons appeared to be involved in safe and socially appropriate activities. There were no significant differences on any of these neighborhood questions for program type.

Safety. While 92.5% of the participants in the present study stated that they know how to take care of themselves in the community, 20.5% reported they have trouble with people bothering them. Approximately 18% of clients reported they had been threatened or bothered within the last six months. Thirty-two percent of clients said they had been made fun of in the last six months. When discussing these incidents, most clients referred to the local transit as the most common setting for harassment.

> "One of the kids on the bus said, 'Hey, you know who's on this bus, the retardeds are on this bus!. I said,'Who's calling us retarded?' One kid had a knife and he came that close to stabbing me. I got the knife out of his hand and I showed it to the bus driver. The bus driver said, 'Where did you get that knife, what are you doing to people?' You know bus drivers don't give a damn what they do, they could break windows on the bus, they could throw garbage, anything, they got no control. And they think it's better service.... The handicapped and the retarded have no abilities to get on

> the bus because the high school students think they own the world. We suffer ...They get special rates, they pay $24 and we pay $37...Look how much we pay!"

Most complaints referred to students, and most people dreaded the first day of school. One participant summed it all up when he said: "I think there is always crime and bullyism in the community."

Only 7.5% of clients in the study complained of losing money through stealing or unpaid loans. This problem only existed for residents of group homes in this study. All of the incidents involved theft of a small sum of money by a housemate. Once people had had money stolen from them, however, they usually never let it happen again. "I always try to make sure that nobody takes any of it and I always keep it right with me." Most people since the theft have had the foresight to safeguard their money. There were no significant differences found for residence on any of the above questions concerning safety issues.

Employment

The present study revealed that 87.5% of participants worked in sheltered workshops. The remaining people were competitively employed (See Table 8). All of the people who were competitively employed were residents of SIL programs. This program difference, though involving a minority of residents, was significant ($p < .05$ by Fisher Exact Test).

Table 8: Client Employment Status

Category	Percent Halpern	SIL	GH
Unemployed	29	0	0
Sheltered Workshop	37	75	100
Competitive Job			
Subsidized	4	0	0
Nonsubsidized	25	25	0
Temporary	5	0	0
Total	100	100	100

The people who were competitively employed held various positions, from that of janitorial staff, to restaurant persons to animal caretaker. For example: "First I started in the workshop. Then from there, I got out of there too, I got a paper job. Then I got a job at McDonalds and worked there for seven years. Now I work in a restaurant."

Social Relations and Leisure

Friends. In Halpern's study, nearly all clients reported they had at least one person they could call a close friend (96%). In the present study, all clients said that they had at least one close friend. Approximately 83% of clients stated they had two or more friends, compared to 81% in the Halpern study. No significant difference existed with respect to program type for this variable.

Again, as in the Halpern research, peers were named most often as best friends. There was a significant difference by

program type in this pattern, with SIL clients more likely to name peers (SIL=95%, GH=65%, $p < .01$ by Fisher Exact Test). While seventy percent of participants in the present study get to see their best friends once or twice a week or more, 82.5% of clients said they would like to spend more time with their friends. There were no differences by program type in these answers.

Approximately seventy-eight percent of people said they have enough friends (71% = Halpern, 70% = SIL, 85% =GH). However, 44.4% of participants said they feel lonely a lot (46% = Halpern, 36.8% = SIL, 52.9% = GH). No significant differences for program type were found.

In the present study, 78.4% of clients reported that they have more friends now than they did where they were living before. Most people interviewed (73.7%) also said that they get to see their friends that they knew from their previous residence. These two measures of changes in friendship networks did not show any differences by program type.

Benefactors. Exactly replicating the Halpern et al. (1986) data, half of the clients in the present study had one or more benefactors. One person was described as having sixteen benefactors and the person filling out the Client Specific Questionnaire was concerned that she might have been forgetting even more people! There were no differences between program types on this factor.

Thirty percent of the benefactors were family, followed by

peers (25%), community members (20%), and staff (5%). The types of help given by the benefactors are outlined in Table 9.

Table 9: Types of help given by benefactors

Category	Percent		
	Halpern	SIL	GH
Money	33	30	20
Gifts	44	60	70
Help with employment	10	20	10
Leisure	50	80	80
Social Contact	75	100	90
Advice	85	70	80

*no significant differences found for program type on any of the above questions

Intimate relationships. Only one person in the entire sample of the present study was married, and that person was in the SIL program. Seventy percent of SIL clients reported they had a boyfriend or girlfriend, while 85% of people in the group homes reported this. It is important to note however, that a relationship can be defined in many ways. For instance, a relationship can be very important and long term, or it can be a one-sided, adolescent-like crush. Some participants would say they had a girlfriend/boyfriend, and say they were in love, yet further questioning would reveal that they would never see each other. In one instance the person mentioned as a girlfriend was

dead! Other participants, however, were involved in long term relationships; one had been going on now for fourteen years. For those interviewed who did not have a boyfriend or girlfriend, all said they would like one. A significant difference for program type was not observed with respect to such relationships.

Social support. The Arizona Social Support Interview Schedule (Barrera, 1981) was conducted as an added measure of social support. It yielded information on total network size available with respect to social support, actual size of the network utilized in the past month, and an indication of the amount that was necessary. The ASSIS is divided into seven sections: private feelings, material aid, advice, positive feedback, physical assistance, social interaction, and negative interactions.

The only section that showed a significant difference by program type was material aid. Group home residents were less likely to have people they could rely on when it came to borrowing money than did SIL clients (SIL = 50%, Group home = 5%, X^2 (1) = 8.03, $p < .005$). The other areas showed no differences with respect to program type (see Table 10).

Table 10: ASSIS - Total Network Size Available (percentages)

Item	Network Size					
	0		1		2 or more	
	SIL	GH	SIL	GH	SIL	GH
Private feelings	--	--	20	25	80	75
Material aid	50	95	20	5	30	--
Advice	5	6	45	22	50	72
Positive feedback	10	13	45	31	45	56
Physical assistance	10	11	10	32	80	58
Social interaction	--	12	20	29	80	59
Negative interaction	45	65	20	15	35	20

Leisure Activities. Participants were asked how often they did certain things in their spare time, such as watching television or going out to eat. The following table illustrates

how SIL and group home residents spend their free time.

Table 11: Frequency of Leisure Activities

Activity	Daily		Weekly		Monthly		Hardly Ever	
	SIL	GH	SIL	GH	SIL	GH	SIL	GH
Watch TV	80	80	15	20	--	--	--	--
Listen to music	55	65	15	20	10	5	20	10
Friends come visit	5	5	25	55	45	25	25	15
Read newspapers, books, etc.,	35	55	30	15	--	--	35	30
visit friends	--	--	60	50	15	20	25	30
See a movie	--	--	20	25	40	20	40	55
Go bowling/dancing	--	--	40	50	15	5	45	45
Drink (alcohol)	--	--	--	5	15	20	85	75
Drink (coffee)	10	10	85	75	5	--	--	15
Play indoor games	10	10	15	45	10	5	65	40
Active games	--	--	--	--	20	55	80	45
Walk/bike ride	30	45	40	40	20	--	10	15
Out to eat	--	--	55	55	25	15	20	30

In general, there were no significant differences with respect to how SIL clients and group home residents spend their free time contrasting the "hardly ever" category versus all others. One question did, however, demonstrate that group home residents participate more frequently in active games than do SIL clients (at least monthly, SIL=20%, GH=55%, $X^2(1)=3.84$, $p < .05$).

All other questions showed no significant difference for residence type or sex, though group home people were somewhat more likely to play indoor games as well (weekly or more, 55% versus 25%, $X^2(1)=2.6$, $p = .10$).

Client Satisfaction with Programs

Clients were asked seven questions regarding their like or dislikes about their programs (see Table 12).

Table 12: Client Satisfaction with Program

Item (percent of clients)	Halpern	SIL	GH
Satisfied with content of program	87	90	95.5
Receives sufficient help	87	95	95.5
Would stay in current program given opportunity to leave	68	77	44.5
Feels there are not too many rules	68	90	66
Satisfied with way program does things	71	94.7	100
Wishes program would teach more*	--	75	100
Liked previous program better	--	28	18.7

* significant differences found for this question

Generally, clients were satisfied with their program. SIL clients did seem somewhat more satisfied than group home residents on some dimensions, but most differences were not significant. However, all group home clients wanted their

programs to teach them more, compared to 75% of SIL clients. This difference is significant by the Fisher Exact Test ($p < .05$).

SIL clients tended to feel they did not have as many unwanted rules as did the group home clients. Interestingly, the Client Specific Questionnaire demonstrated that many rules that clients complained of really did not exist. SIL clients would typically say they could not have alcohol in the home, yet no rules existed for this in SIL programs. On the other hand, group home participants in this sample were typically not permitted to have alcohol in the home. This difference was significant for program type, $X^2(1)=12.6$, $p < .001$.

Curfew hours also presented a significant difference with respect to program type. None of the people in SIL programs had to adhere to a curfew, while 70% of group home clients had a curfew of some sort, $X^2(1) = 15.36$, $p < .0001$.

A significant difference was found for rules concerning overnight guests in the home. Eighty percent of SIL clients had no rule on this, but 75% of group home residents had rules on this. $X^2(1) = 10.03$, $p = .001$. Typically, however, when counsellors said rules existed for this area, they also stated that there simply was not room in the home for overnight guests, so that this was a matter of space, not a deliberate limiting of freedom. Overall, there was a stronger trend for group home residents to report they would leave the program if they could be in a different one (SIL=22%, GH=55.5%, $X^2(1) = 2.92$, $p < .10$). Thus

SIL residents might be said to be somewhat more satisfied on this dimension.

Discussion

This section follows the same format as the results section. The five areas, a description of clients, homes and neighborhoods, employment, social relations and leisure, and client satisfaction with programs, are discussed. Also included in this section are a discussion of observations of the interview process, major issues for the programs, and possible ideas for future research.

Description of clients

In the present study, considerable similarities were found between the residents of the two program types. In general, group home clients did not differ substantially from SIL clients. While this has some positive implications, it also brings various concerns to light about the independence of SIL clients. Many similarities were also found between the Halpern et al. (1986) data from the Western United States and the SIL clients in the present study, indicating that the characteristics of residents in SIL programs in both studies are fairly consistent.

The most substantial difference found between groups in the present study was with respect to independent living skills. Clients of SIL programs scored significantly higher than group home clients, indicating a higher level of functioning for SIL clients. It appears then, that people who live in SIL programs

are more likely to have the advanced skills necessary for community living.

SIL clients also described a somewhat higher level of motivation to live in their current residence than did group home residents, although this difference was not statistically significant. The reason for this difference, however, may be found in the system of motivation for individuals in group homes. As will be discussed, group home participants in the present study frequently mentioned moving out into an apartment. As this is the next logical step for people who demonstrate the necessary motivation to be more independent, and for those who possess the needed skills, it appears quite reasonable that residents of group homes do not possess a high level of motivation to live in their current home. On another related question, most SIL residents wanted to stay in their current program, while only half of group home residents expressed the same desire; this was a significant group difference. Group home residents invariably discussed moving out into an apartment, which is the interim stage between group home and SIL programs. Many group home residents who mentioned moving out into the apartment program talked of friends that were currently living in the program. It is important to remember that thirty-five out of forty people in the present study work in sheltered workshops, and therefore the group home clients are exposed to co-workers who experience other, more independent types of living.

From talking to counsellors, it seems that a "pecking order"

exists with respect to living situation. In this light, moving out of a group home is seen as a step up. Moving upwards and onwards is not only seen as successful but also as a goal of the entire program. While this situation may be useful and represent a motivating force in people's lives, it is unfortunate when people cannot be happy about their particular living situation because it is seen as the low rung of the ladder.

Other client characteristics showed similarities by program, with no real differences for program type or sex. Age differed from the Halpern et al. (1986) research. On the average, SIL clients were approximately 38 years old, and group home clients were about 36 years old. This is contrasted with Halpern's mean age of 28 years. Halpern was concerned with the relatively young age of clients in his sample: "It is obvious that a relatively important segment of the population is not being served particularly well by SIL programs" (Halpern et al., 1986, p. 21). For whatever reasons, this concern was less evident in the Cambridge or Kitchener-Waterloo area, in that a larger proportion of older clients were involved here. It seems to be that deinstitutionalization as a process has permeated the region for all age groups.

Most other factors, including sex, chronic health problems, disabilities, and medication were very similar across program type. Neither health problems nor sex was responsible for barring access to SIL programs. When discussing clients' satisfaction with health, both SIL and group home clients seemed

relatively satisfied. When people were asked what they would do in the case of an emergency, most said they would call an ambulance. Thus it appeared that people know how to cope with an emergency, but they do not know what to do in a "hands-on" manner. SIL clients generally expressed an interest in knowing some first aid, and this suggests that a course would be both timely and useful.

When discussing nutrition and personal appearance, clients in both programs appeared satisfied. All participants reported that they usually got enough food to eat, and almost all said they got to eat their favorite foods as often as they wanted. The only question which revealed a group difference with respect to appearance was: "Do you wish you could buy more expensive clothes?". Many SIL clients (68%) replied yes, but all of the group home clients replied in the affirmative. SIL clients appeared to key into the word "expensive" more frequently than did group home clients. One client replied: "I would like to buy more expensive clothes, but not get over my head. I want expensive clothes at cheaper prices." A healthy bargain shopping attitude may be fostered by community living.

The Inappropriate Behavior Scale revealed no program or sex differences on any of the questions. The group as a whole had relatively few behavior problems, the same finding as in the Halpern data. When clients did speak of their own behavior problems, they typically followed up with the comment that they were working on controlling themselves. For example: "When I

get hyper I get angry...it's a relapse in my communication....When I get mad enough I try to walk away but ... I just blurt anything out that comes into my head...I'm getting better, I try to control it."

Homes and neighborhoods

Group homes, in the present study, ranged in size from five to twelve people. The group homes with five occupants are capable of having more people live there, but are restricted by a local bylaw which limits the number of unrelated persons in a single dwelling to five. In contrast, no SIL resident had more than three housemates. Thus as expected, the two residence types differed markedly on the variable of size.

There were a number of similarities between SIL clients in this study and those in the Halpern et al. (1986) data. In fact the percentages differed only slightly with respect to the number of housemates, maintenance of the dwellings, satisfaction with the residence, neighborhood quality, and whether or not participants wanted to move to a different home. Half of the SIL clients in this study had only one housemate, and most lived in well-maintained dwellings in neighborhoods of good quality. Most clients reported they liked the home they were living in. In the present study, half of the people in group homes and SIL programs said they would like to move to a different home. Of the people who said they would like to move, most stated that while their present residence was good, they would move if given the opportunity.

Reasons for wanting to move were varied. One SIL client quite liked where she lived, but simply did not like her housemates. Another SIL resident liked her location, but did not like her room, complaining that it was dark and musty-smelling. This same person did say, however, that she should not complain, but instead be thankful for having a nice place to live. Yet another SIL client liked his apartment and his roommate, but did not appreciate the distance his place was from where he worked. He would have liked to be able to walk to work, but instead he had to take the bus each workday.

Group home residents had some different reasons for wanting to move out, given the opportunity. Many people complained of the noise and lack of privacy encountered in such a residence. Many clients also pointed out however, that where they lived now far surpassed their previous residence, which had been in most cases a larger core residence, in terms of noise and privacy. Still others simply said they were ready to move out into an apartment, yet they liked their present residence.

One difference did exist with respect to the Halpern data and the present research. In the Halpern study, there was no "typical dwelling". Clients lived in anything from miniscule one-room trailers to nicely furnished condominiums. In the present study there was indeed a typical residence. The majority of SIL participants lived in apartments or townhouses in integrated facilities. The residences were usually well-maintained and in respectable neighborhoods. It was

definitely not the case that SIL clients were living in dilapidated dwellings, unable to take care of themselves. The two significant differences between these types of facilities, involving presence of odors and lack of smoke detectors in some of the SIL apartments, were very small effects, and the overall similarities between the SIL and group home residences on furnishings and upkeep were encouraging in this respect.

Vulnerability

We were especially interested to see if residents of the SIL program might be more subject to exploitation or abuse (e.g., robbery, beatings or sexual assault) because of their more independent life situation, as had been suggested by Crnic and Pym (1979). However, the data from this section of the interview did not indicate any differences by program type in such abuse rates. The data seem a positive indication of the community opportunities provided by the SIL program.

As was true in the Halpern study, embarrassment and teasing were the most frequent forms of minor abuse in the present research. There were no reports of major abuse in the present study. This was a welcome difference from the Halpern study, in which there were reports of these types of incidents.

The most frequent form of embarrassment and teasing took place on local transit buses, as participants were called names by teenagers. One SIL resident, after describing a few such incidents, was indignant about these occurrences and said:

You know, retardeds and handicaps have rights

> too. We're people too. Sometimes I don't know what the government is trying to do. They close down the institutions. We're supposed to go back to the community, yet the community crucifies us. Sometimes I don't know why we bother.

The same participant had a very intriguing solution to the above problem. He said: "You should go back to university and tell your professors about this, maybe they could go into schools and tell students we have rights too." When asked how this could be achieved he replied: "I don't know, maybe show films on retardeds and handicaps and let them see what it's like. Maybe they would see we're people to and they would just leave us alone." Insight and solutions to a particularly difficult problem - just who is calling who retarded?

Employment

In the present study, most participants were employed in sheltered workshops (88%). Those few who were competitively employed all lived in SIL programs, but there were no other program differences. While this high level of workshop employment may be a disappointing finding in terms of client independence, it becomes understandable in light of the Family Benefits Act (FBA) and the current minimum wage. As things now stand, persons receiving FBA cheques can not exceed a specific level of income without getting money taken off their cheques. Anyone employed competitively and working a full forty-hour week

would not be eligible for such income. Also, anyone who is competitively employed is probably only earning $180 per week before deductions. Thus, being competitively employed is slightly more risky, and slightly less lucrative, than simply receiving an FBA cheque each month.

People typically complained of the low levels of pay they received at the different area workshops. However, most people seemed to like their jobs.

Social Relations and Leisure

Several authors had previously raised concerns regarding the social networks of retarded persons moved into the community (e.g., Edgerton, 1967). We wanted to assess this important issue in several ways. In the present study, an additional measure of social support (the ASSIS) was used to determine the participants' social support network in addition to the interview.

Social relations and leisure findings for the present study demonstrated considerable similarities with the Halpern data. Clients in both studies were fairly satisfied in this area. Clients in both studies reported that they had at least one person they really liked, trusted, and depended on. Most participants reported having two or more such relationships. Peers were named most often as best friends and most people said they had enough friends. Very often, the person named as a best friend was the participant's boyfriend or girlfriend. Participants also said they have more friends now than they did

previously, although they still get to see the people they knew before they had moved.

Half of the clients in both this and the Halpern studies had benefactors, with the main types of help offered by these people centering on social contact, leisure time, and advice. When speaking of benefactors, clients mentioned going out to movies, eating out, and attending sporting events as general examples of just getting out for an evening. More important than getting out was the luxury of having someone to go out with. Very often, the only mention made of a social event was in connection with the benefactor. It appears that benefactors play a very important role in clients' lives (Edgerton, 1967, 1976). It is unfortunate that only half of the participants in this study benefit from a relationship with such an important provider of social support.

It is difficult to comment on the level of support clients receive from the intimate relationships that may or may not exist in their lives. The reason for this is inherent in the definition of such a relationship. Some clients would speak of a "significant other", yet would not see this person very often. Participants who reported having girl/boyfriends said they saw each other on weekends, but rarely more frequently. While it appeared socially important to have a relationship, it is dubious how "intimate" these relationships actually were.

It was relatively easier to determine the accuracy of reported relationships for clients of SIL programs than for group home clients. The simple reason for this was that almost all SIL

clients in the K-W and Cambridge area were interviewed for this study. Clients often reported going out with other people in their SIL programs, and would invariably name one another when asked if they had a boyfriend or a girlfriend. These couples would speak of meeting and telephoning one another on a regular basis. Also, one person in the SIL program was married, and two people were housemates, a definite testament to the seriousness of the relationships.

SIL residents were more likely to report that their best friends were peers than were group home residents. As this is certainly the normative pattern for adults, this seems to indicate somewhat more "appropriate" patterns of social networks in this group, though the difference was not large. It is interesting to note that while peers were named most often as best friends, participants named their counsellors as those people who helped them out when they really needed it. It would be useful to know what participants' definitions of best friends were. Is friendship merely of a social nature, and if so, why?

The Arizona Social Support Interview Schedule (Barrera, 1981) was conducted to investigate the nature of clients' social support networks. It indicated one reliable difference between groups, with SIL residents reporting more possibilities for tangible aid than group home residents. Again, fears that SIL residents might prove more isolated (Edgerton, 1967) were not supported.

The use of leisure time did not demonstrate any

peculiarities for this sample. Participants spend their spare time in various sorts of activities that are likely quite typical of North American adults (i.e., watching television, visiting friends, going out to movies or to eat). People's individual preferences varied as to their favorite activities. The only differences observed for the two programs in leisure were in playing indoor and outdoor games. Group home clients tended to play both more often than SIL clients. It may be, however, that more group activities are organized for group home clients than for SIL participants. As to indoor games, it appeared that group home clients played cards ("Crazy eights") and board games ("Sorry"). Given the younger age level typical for these games, it may be more acceptable for these adults not to play them at all. Why SIL clients did not play more advanced games was not discovered.

Client Satisfaction with Programs

Clients were generally satisfied with their programs. The results for SIL clients in the present study closely resembled the Halpern et al. (1986) results. SIL clients appeared somewhat more satisfied with their program than did group home clients, possibly a direct result of having more input into their programs.

Some significant differences were discovered for program type. For example, all clients in the group homes wanted their programs to teach them more, compared to three-fourths of SIL clients. This could again be a result of the amount of actual or

perceived input each participant has into his or her program. It could also be that group home clients have more to learn than do SIL clients. Clients in group home programs are lower on many skills necessary for community living than are SIL clients. It may be that group home participants are cognizant of this fact, and are more concerned about rectifying it.

Group home clients also had more rules than did SIL participants. For example, curfew hours existed in some group homes and some overnight guests were not permitted. These rules may, in part, account for group home residents being more willing to leave their current programs, given the opportunity, than were SIL clients, though in fact this difference was only a trend in the data.

Observations on the Interview Process

At the beginning of the the interview, participants were often leery about being tape-recorded. Although all participants said they did not mind being recorded, they did seem uncomfortable. In these cases it was advantageous to let participants speak into the tape-recorder about anything they so desired, and then have them listen to their own voice. People appeared fascinated at hearing themselves on tape. This action also helped in that participants were more careful to speak directly into the machine.

Of course, letting certain participants hear their own voices was not without its problems. One individual was so adamant about hearing his own voice that he wanted to hear the

entire interview again, after the completion of the session. This was a serious problem at the time as the interviewer had an appointment immediately after this particular interview. It ended up that just a few excerpts were heard.

This research turned out to be more than just the simple interviewing of clients of SIL programs and residents of group homes. Due to the fact that the interviews took place in people's homes, the interviewer often received more than just answers to questions. Often, people appeared to be a bit uncomfortable at first, but would subsequently relax once the interview got underway.

It was often difficult to leave a person's home after the interview. People usually had pictures of people they had mentioned in the interview, or trophies of sporting events they had won. Sometimes people simply wanted to chat about what the research was to be used for, and wanted to know if they had done a good job at answering all of the questions. It was very heartening to be wished well, and as happened in many cases, to be invited back for a visit.

Conducting the interview was not always easy. Sometimes it was difficult to keep a person's attention for the length of time it took to complete a session (one to two hours). In one case the length of the interview was too much for the participant and it was necessary to conduct the interview in two sessions.

In the cases where keeping a participant's attention was difficult, the data were not always of adequate quality. It was

obvious to the me that some did not really pay attention to, or understand, some questions. This was often apparent in the manner in which the participant replied. One individual always gave yes or no answers. When it seemed that he was just answering and not listening, I would rephrase the question such that if it had received a "yes" response, an affirmative answer would require the answer "no". In those cases where the answers did not change accordingly, the participant's answers were coded as uncertain. The data for this individual were not discarded, as he appear interested in some sections, and his answers seemed reasonable in these areas.

Another very difficult problem for some individuals was the matter of estimating time. Some people simply had no conception of time. When asked: "How often do you go to the movies?", people sometimes did not know what to say. When prompted with: "Once a week, once a month, every day, or hardly ever", they might very well repeat all of the prompts. For example, one participant, when asked "How often do you go visit your friends?", replied "About eight times". This same individual said he had gone out for coffee "about eight times." With this person, it was necessary to ask: "Did you go out for coffee today, yesterday, and so on?" "Do you go out for coffee on Mondays, Tuesdays, and so on?" All avenues had to be explored before one could confidently record an answer. Needless to say, some interviews were longer than others.

Major Implications for the Programs

Few differences were found between clients of group homes and participants of SIL programs overall. It should be pointed out that this lack of differences in many areas is not necessarily bad. It means that SIL clients are not feeling especially isolated out in the community. Neither are they being taken advantage of by others, nor, in general, are they living in places that are dirty and unclean. In fact, SIL clients are doing relatively well in the community. However, any overall lack of differences in the area of independence of functioning might be interpreted in many ways. The two extreme ways of looking at this finding are: 1) Group homes in this study were very successful at promoting independence; or 2) SIL programs are not altogether successful at promoting independence for individuals. In actual fact, a cross between these two polar opposites is more the case. For example, group homes in the area are not just boarding houses. They are places where clients attempt to realize their true potential for community living. Clients have individual program plans to achieve this potential. Independence is encouraged.

There are implications, however, that are raised by this apparent lack of differences. One of the major concerns raised by this research is that people in both SIL programs and in group homes name their counsellors as the people they talk to when they have a problem. While it is a credit to both programs that counsellors are counted on and usually reported on by clients as

being available when needed, it is probably unfortunate that clients are so dependent on their counsellors.

This finding may simply be the result of individuals, who have generally gone the route of institution and onwards, naturally looking to staff as the people to go to in time of need. It is necessary to break this cycle if people are to become truly independent,and this is especially true for clients of SIL programs. After many conversations with counsellors of SIL programs it is apparent that these people would not feel slighted, if someone else was named as the person to go to in times of need. As Halpern (1986) has stated: "Strategies should be developed and implemented within SILPs to help clients establish, maintain, and improve their social support networks" (p.120). The results of this study confirm the need to diversify these networks beyond program staff in many instances.

Concerns with programs were also raised by residents themselves. Most clients expressed an interest in learning more of first aid practices. People also said they would like to earn more money. While the work ethic generally means more pay for more work for the competitively employed, the same ethic does not apply for the sheltered workshop population. Work, in this case, becomes less of a source of pride and more a source of mere time occupation. It would be more independent and rewarding for individuals to have their income linked to their work situation. This would also be a more "normal" and realistic situation in comparison to the real world.

Perhaps the most striking concern of all was the issue of participants being teased by other members of the community. The purpose of SIL and group home living is so individuals can live in, and not be isolated from, their communities. Teasing and taunting are in themselves a form of isolation. Individuals are made to feel different, less than "normal". How can we ever achieve a true integration of all our citizens if this is to continue? Perhaps the solution is to be found in the problem. That is, with increased community integration, more awareness will be achieved. With increased awareness may come increased understanding, and ultimately less teasing. Clearly though, this is an area that needs consideration to help guide such integration.

Yet another issue exists in the need for more benefactors for clients. Only half of the clients in the present study reported having such a relationship. Those who did, however, appeared to benefit greatly as reported long ago by Edgerton (1967, 1976). The creation of a more formal benefactor network may be the answer. This network may have to begin in an artificial manner, through a volunteer or placement agency. However, the chance exists that the match-up could develop into a true benefactor relationship. If such a network were to develop, perhaps the dependence on counsellors would lessen. It would be a definite step to improving client social support networks.

In conclusion, at the inception of this research, I set out to discover whether or not the consumers of two different social

service programs were satisfied with where they were living. I addressed this issue by talking directly to the consumers of such services. On the whole, it does not appear that the consumer is terribly unhappy. These two programs, both group homes and supported independent living programs, appear to be quite valuable to those receiving the services.

Concerns exist, however, with respect to the social support of individuals. The service providers would be well advised to address this issue. Some sort of community intervention (i.e.- a neighborhood buddy system) may be just the remedy for an individual who is feeling alienated from society.

Limitations of the Study

This study was not conducted in a truly random manner. However, due to the nature of the research I felt it would be inappropriate to attempt to conduct a random selection process. From a scientific standpoint it would be more conclusive to randomly assign participants to group homes and SIL programs, and after a certain length of time, test the impact of these programs on participants' lives. This method of research, however, is simply neither workable nor ethical in these circumstances. This, of course, makes causal conclusions regarding the effects of these programs impossible to draw. The limitations of such an observational study as the present one must simply be recognised.

Specific concerns center around the quality and the interpretation of the data. One question may be with respect to the differences found between the two programs and whether or not

these were just random differences. I feel that the differences I found were not random because they demonstrated sensible patterns. For example, SIL participants possessed more independent living skills than did those people living in group homes. SIL participants were also more willing to continue living in their homes than were group home participants. These patterns, along with the overlap with the Halpern et al. (1986) findings, lead me to the conclusion that the differences were meaningful.

The quality of the data in an interview study with a population such as the present one can raise some issues. As the researcher, however, I feel that I elicited reliable information from the participants. People answered consistently to questions that were constantly rephrased if there was any doubt on my part that the answer was unreliable, thus indicating their understanding of the questions.

One last concern may lie with the representativeness of the sample. Sample sizes were indeed small and it is unknown whether the programs in the study were representative of other such programs, therefore the ability to generalize the results of the study may be questionable. The results of the study compare quite favorably to the Halpern et al. (1986) data, however, indicating the reliability of the questionnaires.

Future Research

The level of consistency of the present data with the Halpern research (Halpern et al., 1986) provides some evidence

for the validity of this interview technique with this group of clients. The present questionnaires could be useful as a research instrument for other SIL programs interested in measuring client satisfaction. Other programs could even use specific parts of the instrument, depending on their immediate needs.

It would be useful to use this instrument with clients of apartment programs. Apartment programs are the interim step between group homes and SIL programs. These programs were largely ignored by the present study, yet it would be both interesting and useful to conduct research in this area. The apartment program may be the perfect time to implement such ideas as the benefactor support system and courses on first aid. First, however, it is necessary to describe exactly what goes on in such programs, and the reactions of the clients who reside in them.

The social support area of the present study could be vastly improved upon in future research. In general, the ASSIS proved to be a cumbersome scale. Participants had some difficulty with the subtle difference in questions. For example, when group home clients were asked: "If you wanted to talk to someone about things that are very personal and private, who would you talk to?", the results were almost indistinguishable from the answers to the question: "Who would you go to if a situation came up when you needed some advice?" This population had some difficulty in understanding the term "advice". Another

difficulty with this scale is that it attempts to define whether or not the respondents have indeed used their available support networks in the past month. Some participants had difficulty knowing how long a month was, and the concept simply eluded some participants. In these instances, it was difficult to know whether participants had actually used their social support networks recently. The total network size reported by participants was consistent with answers given in the Client Interview Schedule and appeared reliable. Overall, however, this scale seemed difficult to use with this population. An instrument is needed which will more accurately measure the social support and needs of this population. Another area largely ignored by the present study is that of self-esteem. Whether or not people are happy with themselves may weigh heavily their one's integration into the community. This too, is a difficult item to measure, as few well-validated scales exist for the present population.

A larger sample utilizing these same questionnaires may prove useful in yielding more information on individual differences in relation to program types. Unfortunately, the small sample in the present study made it impossible to break down the variables further as had been originally hoped. For example, client age or sex differences could not be examined systematically across programs, and there may be important differences here in need of study.

Lastly, but certainly not least, it would be interesting to

see how participants of the present study are faring in the years to come. As of the writing of the present study, one participant has left the SIL program. This individual feels he no longer needs the program and has, in effect, graduated. Many other participants have discussed moving on from their present homes. A longitudinal study would help discern the effectiveness of both group home and SIL programs in participants' lives. It is hoped that ultimately as many participants as possible will graduate and achieve their individual goals.

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Arizona Social Support Interview Schedule (Modified)

In the next few minutes I would like to get an idea of the people who are important to you in a number of different ways. I will be reading descriptions of ways that people are often important to us. After I read each description I will be asking you to give me the first names, initials, or nicknames of the people who fit the description. These people might be friends, family members, teachers, ministers, doctors, or other people you might know.

I will only want you to give me the names of people you actually know and that you have actually talked to during the last month. It's possible, then, that you won't get a chance to name some important people if for one reason or another you haven't had any contact with them in the last month.

If you have any questions about the descriptions after I read each one, please ask me to try and make it clearer.

A. PRIVATE FEELINGS

1. If you wanted to talk to someone about things that are very personal and private, who would you talk to? Give me the first names, initials, or nicknames of the people that you would talk to about the things that are very personal and private.

PROBE: Is there anyone else that you can think of?

2. During the last month, which of these people did you actually talk to about things that were personal and private?

Probe: Ask specifically about people who were listed in response to #1 but not listed in response to #2.

3. During the last month, did you want someone to talk to about things that are very personal and private?

B. MATERIAL AID

1. Who are the people that you know that would lend or give you $25 or more if you needed it, or would lend or give you something (a physical object) that was valuable? You can name some of the same people that you named before if they fit this description, too, or you can name some other people.

PROBE: Is there anyone else that you can think of?

2. During the past month, which of these people actually loaned or gave you some money over $25, or loaned you some valuable object that you needed?

Probe: Ask specifically about people who were listed in response to #1 but not listed in response to #2.

3. During the past month, did you want someone to loan or give you over $25, or loan you a valuable object?

Probe: Did anyone help you?

C. ADVICE

1. Who would you go to if a situation came up when you needed some advice? Remember, you can name some of the same people that you mentioned before, or you can name some new people.

PROBE: Is there anyone else that you can think of?

2. During the past month, which of these people actually gave you some important advice?

Probe: Ask specifically about people who were listed in response to #1 but not listed in response to #2.

3. During the past month, did you want someone to give you advice?

Probe: Did anyone help you?

D. POSITIVE FEEDBACK

1. Who are the people that you could expect to let you know when they like your ideas or the things that you do? These might be people you mentioned before or new people.

PROBE: Is there anyone else that you can think of?

2. During the past month, which of these people actually let you know that they liked your ideas or liked the things that you did?

Probe: Ask specifically about people who were listed in response to #1 but not listed in response to #2.

3. During the past month did you want someone to tell you that they liked something you did?

Probe: Did anyone help you?

E. PHYSICAL ASSISTANCE

1. Who are the people that you could call on to give up some of their time and energy to help you take care of something that you needed to do - things like driving you someplace you needed to go, helping you do some work around the house, going to the store for you, and things like that? Remember, you might have listed these people before or they might be new names.

PROBE: Is there anyone else that you can think of?

2. During the past month, which of these people actually pitched in to help you do the things that you needed some help with?

Probe: Ask specifically about people who were listed in response to #1 but not listed in response to #2.

3. During the past month, did you want someone to help you take care of something you needed to do?

Probe: Did anyone help you?

F. SOCIAL PARTICIPATION

1. Who are the people that you get together with to have fun or to relax? These could be new names or names you listed before?

PROBE: Is there anyone else that you can think of?

2. During the past month, which of these people did you actually get together with to have fun or to relax?

Probe: Ask specifically about people who were listed in response to #1 but not listed in response to #2.

3. During the past month, did you want to get together with people to have fun with or to relax?

PROBE: Did anyone get together with you?

G. NEGATIVE INTERACTIONS

1. Who are the people that you can expect to have some unpleasant disagreements with or people that you can expect to make you angry and upset? These could be new names or names that you have listed before.

PROBE: Anyone Else?

2. During the past month, which of these people have you actually had some unpleasant disagreements with or have actually made you angry and upset?

Probe: Ask specifically about people who were listed in response to #1 but not listed in response to #2.

H. PERSONAL CHARACTERISTICS OF NETWORK MEMBERS

Now I would like to get some information about the people you have just listed. For each person on the list, could you tell me:

1. What is this person's relationship to you? For family members specify the exact relationship (mother, father, brother, sister, grandmother, etc.). For professional people, also specify the exact profession (teacher, minister, doctor, counselor, etc.).

2. How old is this person?

Client-Specific Questionnaire

Name of person completing this form:_____

Client Name:_____

Relationship to client:_____

_____

Agency Name:_____

Date:_____

DEMOGRAPHIC INFORMATION

1. Sex: M F (circle one)
2. Date of Birth:_____
3. Residential History Prior to Current Placement (fill in dates and duration for previous five years; e.g., public institution, 1976-1977, 14 months).

Residence	Dates	Duration in Months
Parent's Home		
Own Home or apartment (unsupervised)		
Own Home or Apartment (supervised)		
Foster Home		
Group Home		
Community ICF		
Public Institution		
Core Residence		
Other: (describe)		

4. How long has the client been involved in this independent living/ group home program? _____months

5. Prior to 1982, has the client ever lived in an institution for the mentally retarded or mentally ill?

no_____

yes_____ If yes, check which (or both) and fill in number of years total in each. ____MR institution ____years

____MI institution ____years

6. Please list the most recent IQ scores that you have on record for the client.

Instrument (e.g., Stanford-Binet)	Date Administered	IQ score
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____

Health

1. Is the client currently receiving any prescribed medication for any of the following reasons? (CHECK ALL THAT APPLY)

___No

___Seizures

___Sleeping Problems

___A chronic medical condition such as diabetes or allergies

___Behavior problems

___A psychiatric condition

___To reduce tremors or shaking

___Other (for anything else other than a temporary illness)

Specify Reason:_____

Client Motivation

We are interested in your perception of the client's motivation.

Please check ONE option in EACH of the four rows below.

	Motivation		
	Low	Medium	High
1. Desire to live in current residence	___	___	___
2. Desire to receive services from your program	___	___	___
3. Desire to learn new skills	___	___	___
4. Desire to be totally independent	___	___	___

Benefactor

1. A benefactor is often described as someone who helps the client out on an ongoing basis without pay when needed. Sometimes the help consists of money or gifts and sometimes it is in the form of companionship, friendship, and advice. A benefactor presumably has more skills and knowledge than the client and is able to act as "teacher" when necessary.

   Does this client have a benefactor(s)?

   ____no ____yes (How many?____)

IF NO GO ON TO NEXT SECTION.

2. IF YES, how did the client develop this relationship? (Briefly describe for most involved/influential benefactor)

_____

_____

_____

3. Please place a check next to the category which best represents the person serving as the client's primary benefactor.

   ____peer(s)

____staff (offering assistance beyond the call of duty)

____family member(s)

____volunteer (student or from community organization)

____community member (unaffiliated with volunteer agency)

____other (please describe)_____

_____

4. What types of help does this client get from the primary benefactor? (check all that apply)

____money ____leisure activities

____gifts ____social contact

____help with employment ____advice

____other (describe)_____

_____

Emotional Issues

The purpose of this section is to determine if the client has inappropriate feelings, fantasies, or behaviors that interfere with his/her ability to cope with everyday living. Please check the blank that best describes the client.

How often does the client:

1. Withdraw from social contact with others?

____sometimes/never ____often ____most of the time

2. Seem sad and/or depressed (crying, sighing, inactivity)?

____sometimes/never ____often ____most of the time

3. Have unpredictable mood swings between depression and elation?

____sometimes/never ____often ____most of the time

4. Talk to imaginary things or people or appear to be hallucinating?

____rarely/never ____sometimes ____often/most of the time

5. Perform bizarre mannerisms (posturing, hand patterning, expressions)?

____rarely/never ____sometimes ____often/most of the time

6. Strike out at others, verbally or physically, without apparent provocation?

____rarely/never ____sometimes ____often/most of the time

7. Report that others are trying to harm him/her when it is not true?

____rarely/never ____sometimes ____often/most of the time

8. express extreme fear of doing certain everyday things without apparent justification? (e.g., ride in cars, go outside, etc.)?

____rarely/never ____sometimes ____often/most of the time

9. Seem to be adequately emotionally adjusted in most situations?

____rarely/never ____sometimes ____often/most of the time

10. Do you think this client has emotional problems?

____no ____yes IF YES, please describe:_____

_____

11. Are there any (other) symptoms of emotional problems that this client has that are not counted above?

____no ____yes IF YES, please describe:_____

_____

12. Is this client currently receiving therapy for emotional problems?

____no ____yes

CLIENT'S SKILL LEVEL

Items in this section are designed to measure your general sense of the client's skill levels. Accordingly, some of those skills needed for successful community living are listed below.

Please rate the client for each listed skill according to your past observations of the client's performance. For each item, circle one of the three choices provided.

--Circle "Ind." if the client can perform the skill without any assistance at least 90% of the time, i.e. no prompts or reminders at least 90% of the time.

--Circle "Asst. Needed" if the client cannot perform the skill independently and needs prompts or reminders more than 10% of the time.

--Circle "?" for those cases where you have had insufficient opportunity to observe the client to determine if the client possesses the skill.

SKILL	CHOICES
1. The client generally wears clean, odor-free clothes.	Ind. Asst. Needed ?
2. The client wears clothes that fit properly.	Ind. Asst. Needed ?
3. The client wears clothes that are appropriate for the weather and/or occasion	Ind. Asst. Needed ?
4. The client chooses clothes which match relatively well with regard to color and pattern.	Ind. Asst. Needed ?
5. The client buys his/her own clothes.	Ind. Asst. Needed ?
6. The client is clean and without offensive body odor.	Ind. Asst. Needed ?
7. The client's hair is clean and neatly kept.	Ind. Asst. Needed ?
8. The client treats minor health	Ind. Asst. Needed ?

problems (headaches, colds, cuts, etc.).

9. The client has regular dental check-ups (at least once/year) Ind. Asst. Needed ?

10. The client goes to his/her medical doctor when needed (e.g., when ill or in need of a check-up). Ind. asst. Needed ?

11. The client plans his/her own menu. Ind. Asst. Needed ?

12. The client buys his/her own groceries. Ind. Asst. Needed ?

13. The client prepares his/her own meals. Ind. Asst. Needed ?

14. The client eats well balanced meals. Ind. Asst. Needed ?

15. The client uses proper methods for storing foods. Ind. Asst. Needed ?

16. The client compares the prices in different stores before making substantial purchases (i.e., single items over $15.00 such as a couch, television or stereo). Ind. Asst. Needed ?

17. The client goes to appropriate stores to buy needed items. Ind. Asst. Needed ?

18. The client takes responsibility for his/her own money. Ind. Asst. Needed ?

19. The client purchases essential items before buying nonessentials. Ind. Asst. Needed ?

20. The client pays his/her bills on time. Ind. Asst. Needed ?

21. The client recognizes when house- Ind. Asst. Needed ?

hold repairs are needed (e.g., clogged toilets, burnt-out light bulbs, malfunctioning telephone or kitchen appliances).

22. The client performs simple household repairs (e.g., changes light bulb). Ind. Asst. Needed ?

23. The client disposes of accumulated household trash. Ind. Asst. Needed ?

24. The client maintains a reasonably clean home. Ind. Asst. Needed ?

25. The client can tell you the proper thing to do in case of fire in his/her home. Ind. Asst. Needed ?

26. The client utilizes communication skills to converse with persons outside the program in an appropriate fashion (e.g., general conversation, asking for directions). Ind. Asst. Needed ?

27. The client uses a telephone book or a telephone operator to determine a needed telephone number. Ind. Asst. Needed ?

28. The client uses a telephone to make and receive calls. Ind. Asst. Needed ?

29. In conversation, the client usually listens when appropriate without interrupting the other person. Ind. Asst. Needed ?

30. The client gets to and from community destinations. Ind. Asst. Needed ?

31. The client is able to ride the Ind. Asst. Needed ?

bus when needed.

32.	The client avoids potentially dangerous situations when getting around in the community (e.g., dark alleys; walking alone late at night).	Ind.	Asst. Needed	?
33.	If lost the client is able to contact appropriate people or secure help to find the way to his/her destination.	Ind.	Asst. Needed	?
34.	The client safely crosses streets.	Ind.	Asst. Needed	?
35.	The client contacts agency personnel for assistance when appropriate.	Ind.	Asst. Needed	?
36.	The client knows how to respond to emergencies(i.e., events that require contact with the police or fire departments or medical assistance).	Ind.	Asst. Needed	?
37.	The client is on time for appointments.	Ind.	Asst. Needed	?
38.	The client makes his/her programming needs known to agency personnel.	Ind.	Asst. Needed	?
39.	The client contacts community agencies when necessary to acquire or maintain services.	Ind.	Asst. Needed	?

BEHAVIOR PROBLEMS

This section is designed to reflect the client's inappropriately emitted maladaptive behavior. There are 29 behaviors listed under six behavior categories.

Please give your best estimate for each listed behavior according to

your observations of the client. For each behavior, place a check mark at one of the three choices provided.

--Check "major problem" if the client presently engages in the specified behavior without sufficient cause and at an intolerable rate and/or intensity.

--Check "moderate problem" if the client presently engages in the specified behavior without sufficient cause and at an infrequent rate and/or intensity.

	Major Problem	Moderate Problem	Not a Problem
1. Uses threatening gestures	____	____	____
2. Kicks, strikes or slaps others	____	____	____
3. Throws objects at others	____	____	____
4. Pushes, pinches, or scratches others.	____	____	____
5. Rips, tears, or soils own clothes.	____	____	____
6. Damages other's possessions	____	____	____
7. Damages own possessions	____	____	____
8. Damages public property (windows, furniture, etc.)	____	____	____
9. Directly interferes with others' activities	____	____	____
10. Takes things away from others	____	____	____
11. Demands excessive attention	____	____	____
12. Swears, curses, or uses obscene language or gestures	____	____	____
13. Yells or screams at others	____	____	____

14. Verbally threatens others	____	____	____
15. Calls others names	____	____	____
16. Purposefully violates rules	____	____	____
17. Refuses to participate in schedules activities or training program	____	____	____
18. Gets upset if given a direct command	____	____	____
19. Ignores or pretends not to hear instructions	____	____	____
20. Is hostile to persons in authority	____	____	____
	Major Problem	Moderate Problem	Not a Problem
21. Is absent from or late to required activities	____	____	____
22. Disrupts group activities	____	____	____
23. Takes others property without permission			
24. Lies about self or situations	____	____	____
25. Lies about others	____	____	____
26. Cheats in games or other activities	____	____	____
27. Is "hyperactive" (e.g., cannot sit still for any length of time	____	____	____
28. Displays heterosexual behavior that is generally socially unacceptable	____	____	____
29. Displays homosexual behavior	____	____	____

that is generally socially unacceptable

PROGRAM

1. a. Do you think this client is currently placed appropriately?

_____no _____yes

b. IF NO, what would be a more appropriate placement?

_____

2. Does the client have a written, individualized program plan?
_____yes _____no

IF CLIENTS RECEIVE NO TRAINING SKIP TO NEXT SECTION

3. We are interested in your perception of the relative contribution of different people to the training this client receives from your program. Consider the following scale:
1 - most influential
2 - moderately influential
3 - least influential
Using the scale, please rank order the contribution of the following sources to the content of the client's training program.

_____program staff

_____client

_____client's family

4. How often is the client's program plan formally reviewed by a team that includes the client?

_____every 3 months

_____every 6 months

_____every 12 months

_____other (please specify)_____

Program Rules for the Client

1. Check all statements that apply to the following program rules:

a. No alcohol allowed in the home.

_____no rule on this

_____rule applies to all clients

_____rule specifically for this client

_____rule was necessary because of this client's behavior

_____client has violated this rule in the past 3 months (that you know of)

b. Alcohol consumption outside the home is prohibited.

_____no rule on this

_____rule applies to all clients

_____rule specifically for this client

_____rule was necessary because of this client's behavior

_____client has violated this rule in the past 3 months (that you know of)

c. Curfew hours are: (fill in)_____

_____no curfews

_____rule applies to all clients

_____rule specifically for this client

_____rule was necessary because of client's behavior

_____client has violated this rule in the past 3 months (that you know of)

d. Overnight guests of the opposite sex are not allowed.

_____no rule on this

_____rule applies to all clients

_____rule specifically for this client

_____rule was necessary because of this client's behavior

_____client has violated this rule in the past 3 months (that you know of)

e. Sexual activity is discouraged.

_____no rule on this

_____rule applies to all clients

_____rule was necessary because of this client's behavior

_____client has violated this rule in the past 3 months (that you know of)

_____rule specifically for this client

f. House/apartment must be maintained at a certain level of cleanliness or order.

_____no rule on this

_____rule applies to all clients

_____rule specifically for this client

_____rule was necessary because of this client's behavior

_____client has violated this rule in the past 3 months (that you know of)

G. Certain leisure activities or social contacts are prohibited. Specify:_____

_____

_____no rule on this

_____rule applies to all clients

_____rule specifically for this client

_____rule was necessary because of this client's behavior

_____client has violated this rule in the past 3 months (that you know of)

h. Describe any other rule that applies to this client.

_____

_____rule was necessary because of this client's behavior

_____rule applies to all clients

_____rule specifically for this client

_____client has violated this rule in the past 3 months (that you know of)

Client Interview Schedule

Personal and Demographic Information

1. Circle participant's sex: M F

2. Check the appropriate description of the participant's residence.

_____House or duplex

_____Apartment in integrated facility

_____Apartment within special cluster of handicapped people

_____Room in boarding house

_____Group home

____Other, PLEASE SPECIFY_____

_____

3. When were you born? _____

(How old are you?) _____

4. Where did you live before you lived here?

_____Institution

_____Family

_____Foster family

_____Group Home

_____Core residence

_____Nursing or rest home

_____Semi or independent living (another apartment)
a. Run by the same people that help you here? ____yes ____no

5. Does anyone else live here?

_____no

_____yes IF YES
a. Who? _____

b. Are you married? _____yes _____no

c. Do you have children? ____yes ____no

This section is designed to obtain an overview of the your usual week. Its purpose is to provide an overall idea of how you spend your time.

What do you usually do on Mondays?
(When do you get up?)
(Where do you go in the mornings?)
(What do you do there?)
(How long do you stay?)
(Where do you go after that?)
(How do you get there?)
(When do you go home?)
(What do you usually do at home on Monday evenings?)

Are the rest of the weekdays like Monday? (Do you usually do about the same thing every day?)
What do you do on weekday evenings? (Do you do anything different than you do on Mondays?)
What do you usually do on Saturdays?
How about Saturday night?
What do you usually do on Sundays?
How about Sunday night?
Are there special things you do sometimes that you haven't mentioned yet?

Now I'm going to ask you some questions on a lot of different topics. If there is any question that you do not want to answer, just tell me and I won't ask it. Do you understand? Do you have any questions? Don't hesitate to ask me anything during the questions if you don't understand something.

6. When you moved into this house, did you do it

____mostly because you wanted to? (voluntary)

____mostly because other people wanted you to do it? (involuntary)

Why did you want to, or why did other people want you to?

7. All of us have problems sometimes when we wish there was a person around who could help us out? Is there anyone you can think of who helps you out a lot when you really need it?

____no

_____yes IF YES

a. Who is that person (name and relationship)?

_____

b. How often does _____ give you that kind of help?

_____every day

_____about once a week or so

_____about once a month or less

c. What kind of help does _____ give you?

_____

_____

8. Is there anyone else who helps you out a lot when you really need it?

a. Who is that person (name and relationship)?

_____

b. How often does _____ give you that kind of help?

_____every day

_____about once a week or so

_____about once a month or less

c. What kind of help does _____ give you?

_____

_____

9. Would you rather stay in this program or live somewhere else like in foster care, another group home, or with your family?

_____stay here

Why? _____

_____change - list desired setting _____

Why? _____

10. Do you help decide the things you learn here or does someone else decide for you?

_____I help decide _____Someone else does it

11. Do you want to keep learning things from this program?

_____yes _____no

IF NO, why not? _____

12. Do you have a driver's license? _____yes _____no

IF NO, how about a picture I.D.? _____yes _____no

13. Do you vote in elections? _____yes _____no

14. Do you have any pets? _____yes _____no

15. If you moved and I needed to get in touch with you, is there anyone who will always know where you live? (Name, Address, and Phone Number.

_____

_____

_____

Health

Now I'd like to ask you some questions about your health and your doctor. Who is your doctor?

1. Do you like the way your doctor takes care of you?

_____yes (usually, mostly) _____no (rarely) _____unsure (sometimes & don't know)

IF NO, why? _____

2. Do you think you get sick too often?

_____yes _____no _____unsure

3. When you get really sick, can you get to a doctor if you want to?

_____yes _____no _____unsure

IF NO, what do you do?_____

_____

4. Do you think you need to know more about how to take care of your own headaches, coughs or small cuts?

_____yes _____no _____unsure

5. Do you think you know enough about how to help someone who has a bad accident like a broken bone or a deep cut?

_____yes _____no _____unsure

6. If you had to choose between going to your doctor and a different one, would you rather go to a different one?

_____yes _____no _____unsure

Sustenance

Now I am going to ask you some questions about the food you eat?

1. Do you usually get enough food to eat?

_____yes (usually, mostly) _____no (rarely) _____unsure (sometimes, don't know)

IF NO, why not?_____

_____

2. Do you get to eat your favorite meals as often as you want to?

_____yes _____no _____unsure

What is your favorite food?_____

3. Would you like to get to eat different kinds of foods than you usually eat? (Do you get tired of eating the food you usually eat?)

_____yes _____no _____unsure

4. Do you feel that you need to learn more about how to cook different foods?

_____yes _____no _____unsure

5. Do you think you eat enough healthy food like fruits and vegetables?

_____yes _____no _____unsure

6. Are you hungry most of the time?

_____yes _____no _____unsure

Dressing and Personal Appearance

Now I'm going to ask you some questions about your clothes and personal appearance.

1. Are you able to get your hair cut or styled the way you want to?

_____yes _____no

2. Would you like to look differently than you do?

_____yes _____no

Why?_____

3. Do you think your clothes are really nice looking?

_____yes _____no _____unsure

4. Do you wish you could buy more expensive (better) clothes?

_____yes _____no _____unsure

5. Do you think you know enough about how to fix your clothes when they get torn?

_____yes _____no _____unsure

6. Are you happy with the way you look?

_____yes _____no _____unsure

IF NO, why not?_____

Residence

Now I am going to ask you some questions about where you live, okay? Remember, you don't have to answer any questions that you don't want to. Also, please stop me if there is anything you don't understand, or anything you want to ask about.

1. Do you really like the home you are living in now?

_____yes (usually mostly) _____no (rarely) _____(sometimes, don't know)

IF NO, why not? _____

2. Does your landlord have any rules that you don't like?

_____yes _____no _____unsure

IF YES, like what? _____

3. Does your landlord keep this place fixed up enough for you? (like fixing the plumbing or the stove?)

_____yes _____no _____unsure

4. Would you like to have your home in a different neighborhood?

_____yes _____no _____unsure

IF YES, why? _____

5. Do you feel safe walking alone in this neighborhood at night? (Nobody hurts you, or takes things from you around here?)

_____yes _____no _____unsure

6. Would you really like to live in a different home?

_____yes _____no _____unsure

Why? _____

7. Do you like this home better than where you used to live?

_____yes _____no _____unsure

Why? _____

Program

Now I am going to ask you some questions about your program. Remember no one will know what you tell me and it can't affect where you live. Also remember that you don't have to answer any questions if you don't want to.

1. Are you learning most of the things you want from this program?

_____yes (usually) _____no (rarely) _____unsure (sometimes, don't know)

2. Do you get enough help from this program when you need it?

_____yes _____no _____unsure

IF NO, what do you mean? _____

3. If you could be in a different program, would you leave this one?

_____yes _____no _____unsure

IF YES, why? _____

4. Are there too many rules in this program?

_____yes _____no _____unsure

IF YES, like what? _____

5. Does this program usually do things the way you like?

_____yes _____no _____unsure

6. Do you wish this program would teach you more?

_____yes _____no _____unsure

IF YES, what would you like to learn?_____

7. Did you like the program you were in before better?

_____yes _____no _____unsure

Why? _____

Leisure

Now I'm going to ask you some questions about what you do when you're not working, in your free time.

1. Would you like to have more free time than you do now? (More time to do things that you want to?)

_____yes _____no _____unsure

2. Do you usually do your favorite things in your free time?

_____yes _____no _____unsure

3. Do you really like the things you do in your free time?

_____yes _____no _____unsure

4. Would you like to have more things to do in your free time?

_____yes _____no _____unsure

5. Do other people decide too often, what you should do in your free time?

_____yes _____no _____unsure

I want you to tell me how often you do certain things in your spare time, like visiting friends or watching television. I'll ask you a question and you should tell me whether you do it every day, once or twice a week, once or twice a month, or hardly ever.

6. For example, how often do you watch television?
READ OPTIONS

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

What is your favorite program? _____

7. How often do you listen to records or to the radio?
READ OPTIONS

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

Who is your favorite group (or singer)? _____

8. How often do friends come to visit you here?
READ OPTIONS ONLY IF NEEDED

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

9. How often do you read newspapers, magazines, or books?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

10. How often do you go to visit your friends?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

11. How often do you go to visit the movies?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

What is the last movie you've seen? _____

12. How often do you go bowling or dancing?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

13. How often do you go out somewhere to have a beer or glass of wine?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

Do you ever have a drink at home? _____yes _____no

13A. How often do you go out for a cup of coffee?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

14. How often do you play indoor games like cards or scrabble?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

What games do you play? _____

15. How often do you play active games or go jogging (volleyball, basketball, or softball)?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

16. How often do you go out for a walk or bike ride in your free time (just to look around)?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

17. How often do you go out to eat?

_____every day or almost every day

_____once or twice a week

_____once or twice a month

_____hardly ever or never

18. Do you have a hobby? _____yes _____no

IF YES, like what? _____

_____

19. What do you like to do best in your free time? _____

_____

20. Do you have enough free time? _____yes _____no

Social/Interpersonal

I am going to ask you some questions about the people you spend your time with: your friends and the people you work with or take classes with. Remember you can say what you really think because no one else will know what you have said about them. Okay? Also remember that you don't have to answer any questions that you don't want to.

1. Do you wish you could spend more time with your friends?

_____yes (usually) _____no (hardly ever) _____unsure (sometimes don't know)

2. Close friends are people we really like, trust, and can depend on. How many close friends do you have?

_____none _____one _____two or more

IF PARTICIPANT HAS FRIENDS ASK:
Who are your close friends? COUNT NAMES _____

3. Who is your best friend? _____

PROBE TO FIND OUT RELATIONSHIP OF BEST FRIEND

_____staff at _____

_____parent

_____brother/sister

_____peer

_____benefactor

4. How often do you get to be with the people you like the best?
READ OPTIONS

_____once or twice week or more _____once or twice month _____not very often or never

5. Do you feel you have enough friends?

_____yes _____no _____unsure

6. Do you have more friends now that you are living here then from where you were living before?

_____yes _____no _____unsure

7. Do you get to see your friends that you knew before you lived here?
_____yes _____no _____unsure

8. How often do you visit with or talk to your neighbors?
READ OPTIONS

_____almost every day _____once or twice/week _____not very often/ never

9. How often do you go to church, church meetings or the synagogue?

_____almost every day _____once or twice/week _____not very often/ never

10. How often do you go to clubs or meetings with other people?

_____once or twice/week _____once or twice/month _____not very often

11. How often are you all by yourself?

_____most of the time _____once in a while _____not very often

12. Do you feel worried or bothered when you are around other people?

_____yes _____no _____unsure

13. Do you feel lonely a lot?

_____yes _____no _____unsure

IF YES, why? _____

14. What do you do when you are feeling lonely? _____

_____

15. Do most people treat you as well as you wish they would?

_____yes _____no _____unsure

16. Do you get to spend enough time with your friends?

_____yes _____no _____unsure

17. Do you have a boyfriend or girlfriend that you like to spend time with?

_____yes _____no _____unsure

IF NO, do you wish you did?

_____yes _____no _____unsure

18. Do you have a place where you can be alone in privacy (no one will interrupt you)?

_____yes _____no _____unsure

IF YES, where? _____

IF NO, why not? _____

Vulnerability - The Victim

This group of questions has to do with having problems with other people. Lot of us from time to time are bothered or taken advantage of by others. Sometimes it's hard to deal with but it's part of life. I want to ask you a few questions about the kinds of experiences you've had. Remember that if a question bothers you or makes you remember

things you don't want to talk about, just say so, and we'll go on to the next question. Okay?

WHEN COMPLETING INDIVIDUAL ACCIDENT REPORTS WITHIN EACH QUESTION, NAME THE PERSON(S) REVEALED BY THE CLIENT AS THE SOURCE OF TROUBLE AS A:

Family Member(s)

Roommate(s)

Friend(s)

Co-Worker(s)

Neighbor(s)

Professional Contact(s) (social worker, agency personnel...)

Business Contact(s) (landlord, bus driver, store clerk...)

Stranger(s)

Unknown

1. Do you think you know enough about how to take care of yourself in the community so that people won't bother or hurt you?

_____yes _____no _____unsure

2. Do you have too much trouble with people bothering you?

_____yes _____no _____unsure

Who do you talk to when someone bothers you? _____

3. Has anyone threatened you or bothered you until you were afraid of them or very upset in the last six months?

_____yes _____no

IF YES, how many times in the last six months? _____times

IF DOESN"T KNOW ASK: _____every month or more often _____once or twice _____never

ASK ABOUT THE INCIDENT THAT BOTHERED THE PARTICIPANT THE MOST.

3a. I don't want to know the person's name, but who bothered you? Was it a neighbor, someone you didn't know, a member of your family?

3b. What did that person do to you? _____

3c. What did you do? _____

3d. Who did you talk to about this? _____

4. Has anyone made fun of you, or embarrassed you by laughing at you, in a way that made you feel real bad in the last six months?

_____yes _____no

IF YES, how many times in the last six months? _____times

IF DOESN"T KNOW ASK: _____every month or more often _____once or twice _____never

ASK ABOUT THE INCIDENT THAT BOTHERED THE PARTICIPANT THE MOST.

4a. I don't want to know the person's name, but who bothered you? Was it a neighbor, someone you didn't know, a member of your family?

4b. What did that person do to you? _____

4c. What did you do? _____

4d. Who did you talk to about this? _____

5. Has someone taken your money by saying they will pay you back? Like by getting you to pay for something you didn't have to of for something you never got. or has someone borrowed money and not paid it back in the last six months?

_____yes _____no

IF YES, how many times in the last six months? _____times

IF DOESN"T KNOW ASK: _____every month or more often _____once or twice _____never

ASK ABOUT THE INCIDENT THAT BOTHERED THE PARTICIPANT THE MOST.

5a. Who took your money? REMIND THE PARTICIPANT THAT NAMES ARE NOT NEEDED

_____

_____

5b. How did it happen? _____

_____

5c. What did you do? _____

_____

5d. Who did you talk to about this? _____

Residential - Observational Items

READ THROUGH THESE ITEMS BEFORE YOU LEAVE TO MAKE SURE YOU HAVE ADEQUATE INFORMATION. THEN COMPLETE THIS CHECKLIST AFTER YOU HAVE LEFT THE CLIENT'S RESIDENCE.

State of repair and comfort.

1. One or more hole(s) in any wall(s). _____yes _____no
2. Hole(s) in any floor covering. _____yes _____no
3. Broken or cracked windows. _____yes _____no
4. Broken door(s). _____yes _____no
5. Missing doorknob(s) or handle(s). _____yes _____no
6. Peeling or cracked paint or wallpaper. _____yes _____no
7. Smoke alarm. _____yes _____no
8. Leaky bathroom or kitchen plumbing. _____yes _____no
9. Accumulation of dirt, grease or grime on walls, floors, furniture, appliances, etc. _____yes _____no
10. Noticeable foul smell. _____yes _____no
11. Two or more lighting sources in living room. _____yes _____no

12. Couch and upholstered chair in living room. _____yes _____no

13. Television and stereo. _____yes _____no

14. Decorative plants, wall hangings, etc, in one or more rooms. _____yes _____no

15. Window shades, blinds, curtains in bedroom and living room. _____yes _____no

16. Carpeting in living room. _____yes _____no

17. Dining area separate from living room. _____yes _____no

18. Kitchen cabinets for storage. _____yes _____no

19. Bedroom separate from living room. _____yes _____no

20. Toilet and bath/shower within own living space. _____yes _____no

Neighborhood Characteristics

21. Dwellings in the immediate neighborhood are:

_____mostly rundown and in poor repair

_____somewhat mixed; some clearly need repair, others are adequately

_____generally in adequate or better repair

22. Yards in the immediate neighborhood consist of:

_____mostly neat, trimmed yards

_____some lawns, some dirt areas

_____mostly overgrown lawns and weeds, or unkept dirt areas

23. The neighborhood is generally:

_____quite clean (no noticeable garbage etc.)

_____clean in places dirty in others

_____very unclean (most dwellings have various trash scattered around)

24. Buildings in the neighborhood appear to be:

_____mostly occupied by people _____mixed vacant and used by people _____1/3 or more vacant

25. The neighborhood is:

_____largely residential _____mixed residential, business industrial _____largely business, or industrial

26. People in the neighborhood appear to be:

_____loitering or engaged in socially inappropriate activities _____involved in mixed appropriate and inappropriate activities _____involved in safe and socially appropriate activities

Interview Debriefing

ASK THE PARTICIPANT THESE QUESTIONS AT THE END OF THE INTERVIEW

I'd like you to tell me something about the interview we just finished.

1. What did you think about the interview?

2. Did any questions bother you? Were there any you didn't like? Which ones?

3. What parts did you like the best?

4. What can I do to make it better? to make it easier to do?

THANK YOU VERY MUCH FOR YOUR TIME.

11 March 1987

Dear Director:

My name is Shelley Potter. I am an M.A. Candidate in Social-Community Psychology at Wilfrid Laurier University, my advisor is Dr. Michael Pratt. I have Psychology from Acadia University in Wolfville, Nova Scotia, and in my fourth year at Acadia I completed an Internship in Mental Retardation.

I am currently in the process of defining a topic for my M.A. Thesis, no easy task I can assure you. Through discussions with Mr. Brian Knight of the Ministry of Community and Social Services and Ms. Judy Vallinga of K-W Habilitation Services for the Retarded, the area I have become most interested in is the progression of mentally retarded adults from institutions to group homes to independent living. I am interested in the social support these individuals receive, as well as other issues such as satisfaction with existing services.

This proposed area of research would necessitate discussions with not only the directors and staff of various facilities but also the people living in the facilities. I would be most interested in hearing your thoughts on this proposal, as well as any suggestions you might have for me. I would like to stress that I am in the preliminary stages of this Thesis and it would be very easy for me to incorporate any ideas you might have. If you have any questions or thoughts on this proposal I may be reached at 746-3982. My supervisor, Dr. Michael Pratt, can be reached at 884-1970.

Thank you for your time,

Shelley Potter

Consent Form

Study on Social and Residential Satisfaction

I agree to participate in the study carried out by Shelley Potter under the supervision of Dr. Michael Pratt of Wilfrid Laurier University, on the satisfaction with social and residential environments. I understand that I will be asked to answer questions about where I live and about where I used to live, and about how I feel about these places.

I understand that I may refuse to answer any questions at any time and may withdraw from the study at any time. I also understand that all information is completely confidential and that my name will be removed from all documents as soon as the study is complete.

Signature of Participant_____

Signature of Interviewer_____

Date_____

CAMBRIDGE & DISTRICT ASSOCIATION FOR THE MENTALLY RETARDED

_____

Date:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby grant permission to the Cambridge & District Association for the Mentally Retarded to obtain/give information from/to

_____

_____

concerning contracts regarding my self

_____

Signed:_____

Witness:_____

AUTHORIZATION TO OBTAIN AND/OR RELEASE INFORMATION

I hereby authorize K-W Habilitation Services to obtain from/or release to _____ any medical, psychological, and/or social information regarding _____ _____ for the purpose of _____ _____ _____

_____ Date:

_____ Witness:

_____ Address:

_____ Date:

_____ Witness:

_____ Relationship if other than client:

THIS AUTHORIZATOON IS VALID FOR ONE YEAR

10 December, 1987

Dear

I am writing to tell you that I have finished my research dealing with the social and residential satisfaction of people in group homes and Supported Independent Living (SIL) programs. I interviewed forty people, twenty people who lived in SIL programs, and twenty people who lived in group homes. The results of my study were quite close to what other researchers have found in such places as California, Colorado, Oregon, and Washington.

I found out that people are living in nice places, and that most people are happy about where they are living. It was true, however, that a lot of people living in group homes want to move into apartment programs. I also discovered that people in both programs generally had good friends they could rely on. In some cases these friends were housemates, and in others they were people from work, or from places where they had lived before.

People who lived in SIL programs generally scored higher on the level of independent living skills they possess in comparison to those who live in group homes, meaning that people in SIL programs are more able to look after themselves and act independently than people in group homes.

It is important for those of you who want to move out of group homes to remember that many people in SIL programs were once in group homes. They learned many of the skills necessary to be more independent and then moved out. It is apparent from talking to those of you in group homes that you too are learning skills in your various programs. I wish you every success.

I would like to thank you for talking to me about how you like where you are living. It was very important for me to talk to you since you are the consumers of the services. You are the only people who could tell me about your lives in your various residences. I am deeply indebted to you for this. I hope the information gathered with your help will be useful in allowing those in charge of the SIL and group home programs to plan for the future. Thank-you for your help.

Sincereley,

Shelley Potter