ANNOTATED DIRECTORY OF MEASURES OF ENVIRONMENTAL QUALITY

for use in Residential Services for People with a Mental Handicap

by

NORMA V RAYNES Ph.D.

Department of Social Policy and Social Work
University of Manchester
MANCHESTER
M13 9PL

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INTRODUCTION.

Evaluating and monitoring the residential services we provide in our society are difficult tasks. This directory is the first of a proposed 3 volume work in which existing tools, designed to facilitate those tasks, are brought together to make them more readily accessible to service providers, planners and consumers. The directory summarises 62 instruments which can be used to evaluate aspects of the environment provided for mentally handicapped people. The other 2 volumes will focus on instruments developed in services for elderly and mentally ill people. It is hoped that users of the instruments will then be able to see for themselves how an instrument developed for one client group might be of relevance to another. There are aspects of environmental quality which are of concern irregardless of differences in the characteristics of clients who use residential services, e.g., privacy.

The primary purpose of the author in compiling this directory was to identify instruments whose focus was residential services, but as will be seen, many of the instruments included extend beyond the home or residence of individuals and concern themselves with other aspects of the environment provided for mentally handicapped people. Thus environmental aspects have been defined broadly to cover the physical facility, its location, daily activities and the management of clients by staff.

As a means of evaluating the quality of residential provision or contributing to a monitoring process, the instruments listed in this directory may be to some extent contrasted with measures of individual client performance though it will be seen that measures

of clients' interacting with their environment are included here.

The directory contains instruments developed in England, Wales and the U.S.A. Some are sets of standards, some are scales and some are data collection instruments. It is necessary to distinguish between these three types of tools.

Standards consist of a universe of items focussing on as many aspects of service systems as possible. The standards are identified by panels of experts.

Scales are subsets of items focussing on particular aspects of an environment which they attempt to measure. Scales generate numerical scores which enable us to summarise the performance of a facility. When using scales it is important to know about their validity and reliability. Such information helps us to be more or less confident about the results we get from this application of the scale. To interpret the results it is also helpful to have information about the standardisation of the scale. We need to have evidence of the validity of the scale, that is the extent to which it is measuring what it purports to. We need to know how reliable it is. Will it generate reproducible results whoever administers it or whenever it is administered. The internal reliability of the scale gives us an indication of the extent to which all the items in it are measuring one aspect of the environment, the extent to which items "hang together".

Information about the standardisation of the scale tells us about the rules set up to ensure a measure will be used in the same way in different settings by different users and about the existence of standards or norms of performance, based on samples of scores

characterising a range of residential facilities. This helps compare our performance data with that of other similar facilities.

Data collection instruments are questionnaires or observation schedules or data abstracting systems used to obtain information. Data collection instruments can be used for any purpose. Those in this directory had as their whole focus some aspect of the service environment for mentally handicapped people.

The information about these tools has been collected in two ways. A review of the literature was undertaken by the author of the directory. Individuals or agencies involved in the development of tools were contacted for further information about them. The published information and that obtained through correspondence with the authors of the standards, scales and data collection instruments is the basis for the annotated summaries of the tools in this directory. The annotated summaries were all then sent to the authors of the tools to check their accuracy. An appendix at the end of the directory gives the name and address of a person from whom further information about the instrument and the means of access to them can be obtained. The instruments appear alphabetically by author's name. Each instrument is annotated following a standard format. Eight pieces of information are provided.

1. The title.
2. Authors' names.
3. The dates of the most recent edition.
4. Purpose. This identifies the possible uses of the tool, the settings and clients for whom it is applicable are

indicated and, where applicable, its theoretical base is described.

5. Content. This provides a description of the areas covered.

6. Administration. This provides information about persons and procedures involved in using the tool.

7. Scientific Credibility. The psychometric information available about the tool is described focussing on standardisation, reliability and validity.

8. References.

In no way has the author intended to critique the tools. The descriptions of the tools are intended to aid service providers and users in their consideration of instruments available for monitoring and evaluating services.

Norma V. Raynes. December, 1987.

STANDARDS FOR SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. (ACDD STANDARDS)

AUTHOR: Accreditation Council on Services for People with Developmental Disabilities.

DATE: 1987.

PURPOSE.

The ACDD STANDARDS were designed to assist service providers to evaluate the quality of the services they provide for people with developmental disabilities. The standards which are part of the ACDD'S accreditation process focus on the individual and how well his or her needs are met. The standards are organised according to the method or process used to meet an individual's needs rather than by setting, programme component, or type of agency. These processes - which include training, education, health maintenance, social and employment services - are applicable in a variety of settings such as residences, day treatment centres, workplaces, and schools.

The STANDARDS emphasize the development and implementation of Individual Habilitation Plans with goals and objectives that reflect the values of normalization, least restriction, autonomy, and the affirmation and protection of rights. The STANDARDS were developed through consensus by more than 1500 national experts in the field of developmental disabilities and are designed to enhance the independence, productivity, well-being and community integration of people served.

The Accreditation Council on Services for People with Developmental Disabilities is a comprehensive quality assurance

programme established in 1969 to develop and implement standards that would result in the improvement of the quality of life for people with developmental disabilities.

CONTENT.

The STANDARDS are presented in four major sections:

1. Values: rights, normalization, age-appropriateness, least restriction.
2. The Agency: co-ordination, prevention, community education, human resource development, advocacy, information and referral, case finding, governance and management, fiscal affairs, personnel, staff qualifications, research, evaluation.
3. Habilitation: admission, the interdisciplinary process, assessment, the individual habilitation plan (IHP), IHP implementation, behaviour management, IHP co-ordination, records, discharge, transfer, follow-up.
4. Environment: physical environment (accessibility, safety and sanitation), social environment.

The principles underlying each section and subsection describe the basis of the standards in current research and clinical practice.

ADMINISTRATION.

The ACDD survey and accreditation process proceeds in a stepwise manner:

Step 1: An agency interested in ACDD accreditation obtains a copy of the ACDD Standards Manual. After review of the Manual, the agency decides when it is ready to pursue accreditation. At that point, the agency contacts ACDD to obtain an application. The application is then completed and returned to the Council with a $500 non-refundable application fee. ACDD requests application six months prior to the desired survey date to allow adequate time for the self-assessment and scheduling process.

Step 2: When ACDD receive an application, it will send the agency a copy of the Self-Assessment Form. The agency then completes the Self-Assessment and returns it to ACDD. The results of this process provides the surveyors with the agency's perspective as to where it stands related to each standard and supplies necessary documents and information to facilitate the survey.

Step 3: Upon receipt of the agency's Self-Assessment Form ACDD arranges the survey process, liaising with the agency. From 45 to 15 days prior to the survey, a letter confirming the survey and providing the names of the members of the survey team are sent to the agency. Invoice for payment of the survey will be included in the survey notification letter.

4: The survey is carried out on-site. To assess the quality of the services offered, an in-depth audit of services provided to a representative sample of individuals served is conducted; discussions with all levels of staff and observation of individual programming and overall service delivery are undertaken.

During the course of the survey a Public Forum is held at which individuals served, their family members, and other community members have an opportunity to offer their opinions as to the services provided by the agency.

At the conclusion of the survey process, the surveyors provide the Executive Officer with a listing of the standards that were found to be in less than full compliance. At this stage the agency may provide evidence that it is in compliance with standards cited or formulate questions related to the deficiencies.

The survey is concluded with a Summation Conference at which the agency staff and ACDD surveyors discuss the survey findings. The agency can use the opportunity of the Summation Conference to obtain guidance from the surveyors on how best to meet the specific standards of concern.

The number of surveyors and number of days required for a survey is determined by such factors as the size of the agency, the geographic location of the various service sites, and the variety of programmes offered.

Step 5: The survey findings are then reviewed by the Accreditation Committee of ACDD's Board of Directors. The Committee's decision as to the level of accreditation awarded is sent to the agency's Executive Officer generally within eight weeks following the survey. Procedures for appeal are available to an agency that does not agree with the decision. Copies of those procedures and decision making rules may be obtained from ACDD.

Step 6: An accredited agency is sent a plaque which can be displayed to provide public evidence of the agency's accreditation.

The following are possible outcomes of the ACDD survey process:

Two Year Accreditation - An agency meets the above eligibility requirements and is within the stated percentage of compliance or better, as determined by the Council,

One Year Accreditation - The agency meets the above eligibility requirements and is within the stated percentage of compliance but, in the opinion of the Council, has deficiencies identified in the survey report that should be corrected within one year.

No Accreditation - An agency does not meet the above eligibility requirements and/or does not meet the stated percentage compliance.

SCIENTIFIC CREDIBILITY.

A research study of the STANDARDS has been carried out.

Hemp, R., Braddock, D., and Fujira, G. (1985). ACDD Accreditation: An Analysis of Survey Results, 1980-84. Chicago: Institute for the Study of Developmental Disabilities.

REFERENCE.

Accreditation Council on Services for People with Developmental Disabilities (1987) Standards for Services for People With Developmental Disabilities, ACDD, 120 Boylston Street, Suite 202, Boston, Massachusetts 02116.

LIFE EXPERIENCES CHECKLIST (VERSION 4)

AUTHOR: Ager, A.

DATE: 1986

PURPOSE:

The Life Experiences Checklist (LEC) is designed to assess a broad range of the life experiences of individuals who are mentally handicapped and receiving residential services. It focusses on the range of life experiences enjoyed by individuals derived from other questionnaires measuring the quality of care practices within service settings, and areas of human experience that are commonly judged as valuable by people in the general population. It can be used to compare the life experiences of groups of individuals, including people without a mental handicap. It is designed to facilitate the assessment of aspects of the quality of life of mentally handicapped people, and also as an instrument for staff training and sensitisation. The author is developing general population norms based on the use of the instrument in different socioeconomic and demographic subgroups. These population norms will facilitate the interpretation of scores on the LEC

CONTENT.

The Life Experiences Checklist consists of fifty items. These are grouped into five sections reflecting different areas of experience:

Home

Leisure

Relationships

Freedom

Opportunities

There are ten items in each section. Each of the items consists of a statement e.g. "my home has a garden". The respondent has to indicate with a tick whether the statement applies to him or her. There are ten items in each of the five sections.

ADMINISTRATION.

The LEC can be used as a self-administered questionnaire, or an individual's response recorded on it by someone else. The items have been developed through a series of revisions of the measure to reflect a reading age required for a reliable completion of the checklist. Each of the fifty items is ticked if it is applicable to the informant.

No prior training is required to complete the questionnaire. The positive responses are added to give five sectional and one overall score. No published information about scoring procedures is yet available. Further information can be obtained from the author.

SCIENTIFIC CREDIBILITY.

Standardisation.

A number of studies of the current version of the LEC have been carried out. Details are available from the author, who reports a study of 346 people in a random sample, in Leicester City, a LEC mean score of 34.2, and in a random sample of 63 people in rural areas, a LEC mean score of 37.7. Other studies are in process.

Reliability.

Ager (1988) reports test-retest reliability of 0.93 for the overall scores (with section scores ranging from 0.91 to 0.96).

Look (1987) reports a figure of 0.80 for informer consistency and a similar figure (0.80) interviewer reliability.

Validity.

Ager et al. (1988b) reports the socioeconomic and demographic correlates of scores on the LEC to give some indication of construct validity.

REFERENCES.

Ager, A. (1988) Life Experiences and Quality of Life in the General Population: A Study of Undergraduate Students Using the Life Experiences Checklist. Mental Handicap Research Group Working Paper 3, Department of Psychology, University of Leicester.

Ager, A., Bendall, S., Callwood, J. and Epps, G. (1988a) From Hospital to Community: A Procedural Guide. Mental Handicap, 4, 138-140.

Ager, A., Ametts, S., Barlow, R., Copeland, C., Kemp, L. and Sacco, C. (1988b) Life Experiences and Quality of Life in the General Population; A Study of Leicester and its Environs using the Life Experiences Checklist. Mental Handicap Research Group Working Paper 2, Department of Psychology, University of Leicester.

Look, R. (1987) The Quality of Life of Mentally Handicapped People: Assessment of Life Experiences within a range of Institutional and Community Settings. Unpublished Master's Dissertation, University of Birmingham.

AUTONOMY SCALE.

AUTHORS: Baker, B.L., Seltzer, G.B. and Seltzer, M.M.

DATE: 1977.

PURPOSE.

The scale was developed in a study of community residences for mentally retarded adults in the USA. It was designed to measure the extent to which restrictions were imposed upon the activities of people living in these residences.

CONTENT.

The scale consists of four items covering policy concerning entertaining the opposite sex, alcohol use within the residence, the curfew times and rules relating to bedtimes.

ADMINISTRATION

The items comprising this scale were incorporated in a questionnaire which was completed by heads of establishments who received the questionnaire through the post. The items are rated in terms of the presence or absence of restrictions and the type of restriction where restrictions operate. The percentage of areae in which restrictions operate is obtained by summing the responses to the items.

Completion of the items requires no special training. No indication of the time taken to complete these items is given.

SCIENTIFIC CREDIBILITY.

Standardisation. No research data are available.

Reliability. No research data are available.

Validity. The measure clearly differentiated between different

kinds of residences for retarded adults operating in the community in the United States. Autonomy being found to be highest in semi independent community residences.

REFERENCES.

Baker, B.L., Seltzer, G.B., Seltzer, M.M. (1977) As Close As Possible. Boston, Little Brown.

THE RESPONSIBILITY SCALE.

AUTHORS: Baker,B.L., Seltzer, G.B. and Seltzer, M.M.

DATE: 1977.

PURPOSE.

The scale was designed to ascertain the extent to which adult mentally handicapped people living in residential facilities assume increased responsibility for daily chores. The measure was developed and used in a postal survey of community residential facilities for mentally retarded adults in the United States.

CONTENT.

There are eleven items in the measure. These relate to cleaning activities, shopping, serving and preparing meals and laundering own clothing. Each of the 11 items are scored on a 3-point rating scale. The score indicates whether the tasks are performed exclusively by the residents; by house parents, or some combination of these groups of people. A single overall score is obtained by adding up these item scores. High scores reflect greater numbers of activities carried out exclusively by residents.

ADMINISTRATION.

The scale is completed by someone knowledgeable about the resident and practices with regard to these activities in the residential facility. No special training is required to complete it. No indication is taken of the time involved to complete it.

SCIENTIFIC CREDIBILITY.

Standardization. No research data are available.

Reliability. No research data are available.

Validity. The measure clearly differentiated between different kinds of residences operating in the community for retarded adults in the United States.

REFERENCES.

Baker, B.L., Seltzer, G.B. and Seltzer, M.M. (1977).

As Close as Possible. Boston, Little, Brown.

ALTERNATIVE LIVING ENVIRONMENTS RATING AND TRACKING SYSTEM. (ALERT)

AUTHOR: Budde, J.F.

DATE: 1976

PURPOSE.

The tool was developed to help planners by facilitating the classification of residential environments for mentally handicapped people, in terms of their degree of restrictiveness. The assessment of the extent of the restrictiveness of the residential environment is based on the facility's degree of physical and social integration and the availability of culturally acceptable opprotunities in the commmunity. It can be used for monitoring the deinstitutionalization of persons with developmental disabilities of all ages who reside in various facilities. It offered planners a simple single sheet summing up of the restrictiveness of their environments.

CONTENT.

ALERT comprises a matrix of living situations. In the matrix nine specific service delivery models are described. These range from the most institutionalized to the most normalized. Observations are made of the environment. A manual of instructions and definition is provided. After observing each residential service, the evaluator uses the criteria provided in the manual to classify it.

ADMINISTRATION.

ALERT is designed to be administered by an external evaluator, and preferably a team of three such evaluators.

Observation and assessment of a residental service environment takes no longer than one half hour. Total time and cost involved in assessing an entire service system depends on the number of separate components in the system which are to be rated.

When the residential services have been assigned to matrix categories a classification of them is visually available on a single sheet of paper. The user can then illustrate, using graphs, the current status and projected changes in environmental types and client placements.

ALERT is reported as being fairly simple to understand. No professional background or specific training is required to facilitate its use. Instructions are provided in the manual.

SCIENTIFIC CREDIBILITY.

No research studies are available about ALERT.

REFERENCE.

Budde, J.F.(1976). Analysing and Measuring the Institutionalization Across Residential Environments with Alternative Living Environments Rating and Tracking System. Kansas University, Affiliated Training Center.

HOME OBSERVATION FOR THE MEASUREMENT OF THE ENVIRONMENT. (HOME)

AUTHORS: Caldwell, B.M. and Bradley, R.H.

DATE: 1984.

PURPOSE.

The HOME inventories were designed to be used as screening instruments to evaluate the extent to which the environment of the child is likely to foster optimal development. It has been used in a wide variety of settings with a wide variety of children and their parents, including families with handicapped children and children at risk of developmental delay.

The theoretical base of the inventories derives from the work of Murray (1938), Hunt (1961), Bloom (1964), and Bernstein (1971). From their work and other empirical studies Caldwell and her colleagues identified a number of environmental factors and processes which appear to show a relatively consistent positive relationship to development. It is the list of these environmental characteristics which forms the base of this revised measure of an earlier scale developed by Caldwell and her colleagues, (Caldwell, Heider and Kaplan, 1966). These aspects of environment were seen as more sensitive measures of environmental influence than gross indicators of class or status.

CONTENT.

a) Infant and Toddlers Form. This version of the HOME inventory contains 45 items, derived as a result of factor analysis from the initial measure which contained 72 items. The reduction in the number of items used was intended to increase the measure's

efficiency. The items are grouped in six subscales. These are:

1. Emotional and verbal responsitivity of parent. (11 items).
2. Acceptance of child. (8 items).
3. Organisation of physical and temporal environment. (6 items).
4. Provision of appropriate play materials. (9 items).
5. Parent involvement with child (6 items).
6. Opportunities for variety in daily stimulation. (5 items)

b) The Pre-school age form. There are 55 items on this form. The measure also has 8 sub-scales. These are:

1. Learning stimulation. (11 items).
2. Language stimulation. (7 items).
3. Physical environment. (7 items).
4. Pride, warmth and affection (7 items).
5. Academic stimulation. (5 items).
6. Modelling and encouraging of social maturity.(5 items).
7. Variety of stimulation. (9 items).
8. Physical punishment. (4 items).

c) The Elementary age form. There are 59 items on this form. The measure is composed of 8 subscales. These are:

1. Emotional and Verbal Responsivity of Parent. (10 items)
2. Encouragement of Maturity. (7 items)
3. Emotional Climate. (8 items)
4. Growth Fostering Materials and Experiences. (8 items)
5. Provision for Active Stimulation. (8 items)
6. Family Participation in Developmentally Stimulating Experiences. (6 items)
7. Aspects of the Physical Environment. (8 items)
8. Paternal Involvement. (4 items)

ADMINISTRATION.

For all forms of inventory an interviewer carries out an interview with the child's primary caretaker in the child's home, when the child is awake. It is important that the child can be observed in his or her normal routine setting, since scoring on at least one third of the items is predicated on interaction between mother or primary care-giver and the child during the visit. The interview takes approximately one hour.

No special training is required. It is recommended that before a first interview, the prospective interviewer accompanies a person already trained in the use of the inventory on several visits. The manual provides detailed instructions about the conduct of the interview.

All of the items on the inventories are scored in binary (Yes-No) form. Subscale and total scale scores are obtained by simply summing the number of "Yeses" on items in the scale.

SCIENTIFIC CREDIBILITY.

Standardisation. Forms of the inventory were standardised on families in Arkansas (N = 174, N = 232, N = 124) and mean and standard deviation scores and standard error of measurement are available, for 3 age groups for the infant and toddlers form and 2 age groups for the pre-school age form.

Reliability.

a) Infant and Toddlers Form.

Internal consistency of the inventory using the Kuder-Richardson 20 formula gave coefficients ranging from .44 to .72 for the sub-scales and .89 for the inventory.

Test re-test reliability was established using 3

assessments for each of 91 families at 6, 12 and 24 months. These gave coefficients ranging from r = .162 to r = .77 for the total score.

b) Pre-school Age Form.

Data relating to the internal consistency of the inventory show Kuder-Richardson coefficients ranging from .59 to .83 for the sub-scales and .93 for the total inventory. Test re-test reliability data were gathered on 33 families with an 18-month interval between assessments. The correlations ranged from r = .05 to r = .70 for the sub-scales and was r = .70 for the total score.

c) Elementary Age Form.

Data on the internal consistency of the inventory show Kuder-Richardson ranges from .57 to .80 and .90 for the total inventory.

Validity.

a) Infant and Toddler Form.

Correlation with IQ and language, (up to .71) are reported. Correlations with SES indications are also reported.

b) Pre-school Age Form.

Correlation with IQ with later achievement are reported (up to .58). Correlations with some indicators of SES are reported.

c) Elementary Age Form.

Correlation with achievement is reported (up to .41). Correlations with some indicators of SES are reported.

REFERENCES.

Bloom, B. (1964). Stability in Changing Human Characteristics. New York, Wiley.

Bernstein, B. (1971). Class Codes and Control. London, Routledge & Kegan Paul.

Caldwell, B.M. and Bradley, R.H. (1984). Home Observation for Measurement of the Environment. Little Rock, Arkansas. University of Arkansas.

Caldwell, B.M., Heider, J., Kaplan, B. (1966). The Inventory of Home Stimulation. Paper presented at the Annual Convention of the American Psychological Association, 1966.

Murray, H.A. (1938). Explorations in Personality. New York, Oxford University Press.

Hunt, J. (1961). Intelligence & Experience. New York, Ronald Press.

THE STANDARDS MANUAL FOR ORGANISATIONS SERVING PEOPLE WITH DISABILITIES.

AUTHORS: The Commission on Accreditation of Rehabilitation Facilities. (CARF)

DATE: 1987.

PURPOSE.

CARF standards are used to monitor, evaluate, and provide for the accreditation of organisations which provide rehabilitation and residential services to people of all ages, including those with developmental disabilities. The standards can also be used as a guide to planning, developing and implementing such services.

CONTENT.

The Standards Manual contains approximately 1,700 standards. These standards represent the national consensus opinion of providers, consumers, advocates, third party fundings agents, and others concerned with rehabilitation and residential services as to what is necessary to provide effective and efficient services of the highest quality for people with disabilities.

The standards are organised into three basic sections: Standards for the Organization, Standards for all Programmes, and Standards for Individual Programmes or Services. The standards in the first two sections are applied to all organizations seeking CARF accreditation. The third section contains standards for eighteen different types of programmes and services in which organizations may seek accreditation e.g., comprehensive medical rehabilitation, infant and early childhood developmental programmes, work services, residential services, alcoholism and drug abuse

treatment programmes, etc.

The Standards Manual also provides information on the Commission, a description of its policies and procedures, a listing of resource documents needed for survey and guidelines for programme evaluation.

ADMINISTRATION.

An organisation desiring CARF accreditation, applies to the Commission for a site survey. Typically the Commission will assign a two person team of surveyors who will spend, on average, two days on site. The team observes the service environments and service delivery, interviews programme staff, administrators and other informants and examines written materials and client records.

Since each standard is simply a statement of expected performance, the site survey team indicates in its exit interview with the organization and in the written report of the survey if the organization is not in compliance with a given standard. In addition, surveyors also make a note of the strengths of the organizations and make appropriate commendations in those areas. Based on the survey report, the accreditation outcome is rendered by the Commission's Board of Trustees and communicated to the organization in a timely manner. An organization may be accredited for three years or one year, depending on the level of compliance with the standards.

CARF surveyors are active practitioners in the field of rehabilitation and are recognised leaders in the field. Prior to becoming CARF surveyors, these individuals receive intensive

training in the application of the standard and in appropriate survey techniques. In addition, surveyors are continually evaluated through the Commission's utilisation of a feedback process by which organizations that have been surveyed can evaluate the effectiveness of the surveyors as well as the effectiveness of the overall accreditation process.

Another value of the CARF standards is their use to organizations undergoing a self-evaluation process. To facilitate this process, organizations have available to them a Self-Study Questionnaire that provides a structured mechanism by which they can conduct their self-assessment. The Self-Study Questionnaire is only available to organizations that have also purchased a Standards Manual.

Training is available to any group that is interested in learning in-depth about the Commission's standards and its survey and accreditation process.

CARF accreditation has been used extensively in the United States with CARF currently being mandated in 37 states. Over 2100 organizations, providing approximately 6300 programmes, are now CARF accredited.

SCIENTIFIC CREDIBILITY.

Dr. David Braddock, Institute for the Study of Developmental Disabilities, University of Illinois at Chicago, Chicago, Illionois undertook an analysis of CARF surveys of organizations providing services to people with developmental disabilities. Dr. Braddock's study provided descriptive information on organizations that underwent CARF accreditation over a three year period and

reported on a standard-by-standard analysis of the outcomes of the surveys.

REFERENCES.

Commission on Accreditation of Rehabilitation Facilities (1987). Standards Manual for Organizations Serving People with Disabilities. Tucson, Arizona. Commission on Accreditation of Rehabilitation Facilities.

Commission on Accreditation of Rehabilitation Facilities (1987). Self-Study Questionnaire for Organizations Serving People with Disabilities. Tuscon, Arizona. Commission on Accreditation of Rehabilitation Services.

CHOICEMAKING SCALE.

AUTHOR: Conroy & Feinstein Associates.

DATE: 1986.

PURPOSE.

The Choicemaking Scale was designed as part of a research evaluation of the effect of relocating mentally handicapped persons from a State School in the U.S.A. to alternative kinds of residences in the community. The scale was developed to estimate to what extent staff elicit expression of residents' preferences and encourage and support residents' efforts to make choices. It has been used in a study of 1,350 people in Connecticut.

CONTENT.

The Choicemaking Scale has 24 items. There are six sections in the measure:

Section 1 covers items related to food, e.g., what to eat for dinner or breakfast.

Section 2 covers items related to house and rooms, e.g., choosing to be alone.

Section 3 covers items relating to clothes, e.g., what to buy.

Section 4 covers items relating to sleeping and waking, e.g., when to go to bed on weekdays.

Section 5 covers recreation, e.g., what to watch on TV.

Section 6 contains 4 items, 1 each relating to money, medication, affection and "minor vices", e.g., alcohol, tobacco.

Each item is rated on a 5-point scale. The item scores are summed to give a total score. The possible score range is 0 to 96. Low scores represent no opportunities provided by staff to elicit or

encourage or support or teach choicemaking for the residents.

ADMINISTRATION.

In the research study the 24 items are incorporated in a questionnaire used in interviews with staff in residential settings as part of a wide ranging evaluation of the environment provided for the residents and the residents' functioning.

Instruction for coding the items and for probing to clarify the interviewee's responses are given with the questionnaire.

No details are given about the length of time it takes to complete the choicemaking scale.

SCIENTIFIC CREDIBILITY.

No information is yet available, but studies are planned.

REFERENCES.

Conroy, J.W., and Bradley V.J. (1985). The Pennhurst Longitudinal Study: A Report of Five Years Research and Analysis. Philadelphia, Temple University Developmental Disabilities Center.

LIVING IN A SUPERVISED HOME (STAFFED OR UNSTAFFED)

A QUESTIONNAIRE ON THE QUALITY OF LIFE.

AUTHORS: Cragg, R., and Harrison, J.

DATE: 1986.

PURPOSE.

The Questionnaire on the Quality of Life is designed to help identify good practice in homes for mentally handicapped people and pinpoint aspects to consider for improvement. It facilitates the assessment of the extent to which a home provides the quality of life which most people in society would enjoy. It is based conceptually on the philosophy of normalisation. It can be used as a monitoring and management tool. It involves residents and staff in the evaluation process. It has been developed from a pilot version prepared by the West Midlands Campaign for People with a Mental Handicap (1984). An evaluation of that pilot version seeking information from users as to whether each question was easily understood and whether the scoring codes for items were correct, resulted in the Questionnaire on the Quality of Life.

CONTENT.

The questionnaire is divided into three parts and contains a total of 70 items. These cover:

i. Physical details.

ii. Decision making.

iii. Access to community facilities.

iv. Leisure.

v. Integration with the Community.

vi. Routines.

vii. Education and Training.

viii. Staff Behaviour.

The items are rated in one of three ways. In Part 1 for all items except those relating to Decision Making a 4-point rating is used. For items relating to decision making a 4-point rating reflecting degree of involvement of staff and residents in decisions, is used. In parts 2 and 3, a 4-point rating reflecting the degree of normantiveness present is used.

Each page of the questionnaire is clearly marked at the top right-hand corner with the area to which the questions on the paper belong. All questions relating to decision making are indicated by the heading 'Decision Making'.

ADMINISTRATION.

It is recommended one questionnaire per home be used. Completion of the questionnaire requires two or three visits. Each is estimated to take up to two hours. On the first one or two visits Part one (questions 1 to 53) are to be completed. Part One involves asking staff and residents questions. The questions are to be asked firstly of the residents (on their own if appropriate) and then with staff on their own. Differences in responses are to be noted on the questionnaire. In the last visit staff and residents are to be interviewed together, using the issues raised in the previous interviews.

Part 2 has to be completed on the last visit (questions 54 to 62). These questions involve recording objective observations.

Part 3 (questions 63 to 70) is to be completed as soon as possible after the last visit by taking account of everything seen and

heard in the preceding visits. Part 3 involves recording a subjective rating of one's own attitude to the home.

Detailed instructions for interviewing and completing the scoring of items and their transfer to summary grids representing each area explored are incorporated in the questionnaire.

SCIENTIFIC CREDIBILITY.

Standardisation. No information is yet available.

Reliability. All but two items are reported to have a quantitative definition in scoring which promotes reliability. Cross checks between response of staff and residents are encouraged.

Validity. No information is yet available.

REFERENCE.

Cragg, R., and Harrison, J. (1986). Living in a Supervised Home (Staffed or Unstaffed). A Questionnaire on Quality of Life. Birmingham, Campaign for People with a Mental Handicap.

LIFE SAFETY CODES INSTRUMENT.

AUTHORS: Feinstein, C.S.

DATE: 1985

PURPOSE.

The Life Safety Codes Instrument was designed for use in the Pennhurst Longitudinal Study carried out as a result of the court ordered de-institutionalization of Pennhurst State School for mentally retarded residents in Pennsylvania. Its focus is the safety of the living environment provided in the range of community living alternatives developed to accomodate residents from the institution. It has been used since 1982. It records compliance with Life Safety Codes, (US regulations concerning fire and medical emergencies), the existence of emergency procedures and preparation of staff for emergencies. It incorporates some standards from the Federal Government's regulations for intermediate care facilities.

CONTENT.

It contains 14 questions. Nine relate to handling behavioural and medical emergencies. The other five relate to preparation for fire emergencies. The items are mixed in format, some multiple response alternatives, some dates, e.g., of fire drills. Some items appear to be scored on 1 to 4 and 1 to 5 scales.

ADMINISTRATION.

Information for the Life Safety Codes instrument is obtained by interview with direct care staff. The corroboration of written evidence is required for several questions, e.g., relating to written plan for meeting medical emergencies and observation of

efficacy of fire detection and alarm systems.

The interviewers were trained in the use of this instrument.

Conroy and Bradley (1985) indicate that the use of the instrument and two others added half an hour to interview time.

SCIENTIFIC CREDIBILITY.

Standardisation. No research data are yet available.

Reliability Inter-rater and Test-retest reliability coefficients are both reported (Devlin, 1987) (based on the number of reported situations flagged as life threatening or indicative of abuse) not on total scores of .368 and .452 respectively. These are below an accepted level.

No other form of reliability has been computed.

Validity. The measure has been reported to differentiate between residential facilities.

REFERENCES.

Conroy, J.W., and Bradley, V.J. (1985) The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis. Philadelphia, Temple University Developmental Disabilities Center.

Devlin, S.J. (1987). Reliability Assessment of the Instruments used to Monitor the Pennhurst Plaintiff Class Members. Philadelphia, Temple University, PH.D. Thesis.

A SHORT FORM OF PASS 3.

AUTHORS: Flynn, R.J. and Heal, L.W.

DATE: 1981

PURPOSE.

The short Form of PASS 3 was designed to permit the evaluation of a service for developmentally delayed persons using a standardised measure of normalization in a shorter time than that required using the full-scale PASS-3 assessment procedures. Flynn and Heal (1981) argue that full scale evaluations "are necessary when the purpose is to guide official decision making about individual programmes" within services (p.360) but spot checks and monitoring would be facilitated by a shorter less time and cost consuming instrument. The short Form of PASS-3 has been used in institutional and community based service settings for mentally handicapped people in the USA and Canada.

The short Form of PASS-3 was developed to

a) correlate with the complete PASS-3 and be psychometrically sound and

b) establish whether a simple averaging of team members ratings generates scores similar to those produced via the lengthy process of team reconciliation used in the full PASS-3 and

c) produce data comparable in quality to those obtained by larger teams in the full scale evaluations.

CONTENT.

The Short Form of PASS-3 contains 18 items (a subset of the 50 PASS-3 items generated by statistical analyses). The items are grouped into three sub scales.

These are Normalization Program, (8 items); Normalization-Setting, (6 items); Administration, (4 items).

The "Normalization-Program" subscale focusses on the programmatic aspects of a service. High scores on the subscale reflect a service which provides many opportunities for social integration, avoids over-protection, provides individualised care, promotes client's autonomy and rights and exhibits "high model coherency" (Flynn and Heal, 1981, p.865). By model coherency it is meant that there is a good fit between programme goals, methods and staff training to ensure that client's developmental needs will be met.

The Normalization-Setting subscale focusses on the physical aspects of the service. A high score on this subscale reflects small size, a facility design congruent with local and national cultural patterns and comfortable to live in.

The Administration subscale focusses on the "administrative and self-renewal aspects of a program" (Flynn and Heal, 1981). A High score on this subscale reflects research and/or training ties with an academic institution, good staff development programs and procedures for client and programme monitoring.

Scores are obtained for the subscales and the total scale using the same procedures as for the full PASS-3.

ADMINISTRATION.

The 18 items are rated by individual raters following the same procedures as for full PASS-3.

The authors say that if raters are adequately trained, averaging

of individual raters scores for the two Normalization subscales, can be used. This avoids the lengthy reconciliation rating sessions used in the full PASS-3 evaluations.

Team reconciliation of individual ratings is necessary for the Administration subscale and team reconciliations are indicated as a desirable practice on the two other subscales where time is not at a premium. The time taken for the team reconciliations is given as about 90 minutes. The individual ratings take 40 minutes using the Short Form of PASS-3. It is suggested that in administratively homogeneous samples low-inter-rater reliability is to be expected on the administrative subscale.

Formal training in the complete PASS-3 instrument is required with further training and practice with the Short Form. Inter-rater reliability coefficients should be systematically computed for team members and levels on all subscales should reach at least .800.

SCIENTIFIC CREDIBILITY.

Standardisation. No research data are available.

Reliability. The subscales are reasonably homogenous and relatively independent of each other. Cronbach alphas are reported between .62 and .84. Inter-rater bias is a relatively negative source of error in the scores and inter-rater reliability is high on the two normalization subscales. Small teams are reported to make very reliable assessments and almost no gain is derived from having a third rater. Conroy and Bradley (1985) used one rater per site on the grounds that their inter-rate reliability levels were sufficiently high to justify this.

Validity. Convergent and discriminant validity were shown to be

high for the two normalization subscales, as was concurrent validity. The Short-Form of PASS-3 correlates highly with the full scale PASS-3 scales.

REFERENCE.

Flynn, R.J. and Heal, L. (1981). A SHORT FORM od PASS-3. A Study of Its Structure, Inter-rater Reliability and Validity for Assessing Normalization. Evaluation Review, 5, 357-376.

Conroy, J. and Bradley, V.J. (1985) The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis. Philadelphia, Temple University Developmental Disabilities Center.

A NORMALISATION AND DEVELOPMENT INSTRUMENT. (ANDI)

AUTHORS: Flynn, A.G. and Weiss, S.K.

DATE: 1977 (second edition)

PURPOSE.

ANDI is intended to provide a way of reviewing services for mentally handicapped persons of all ages. It addresses principles and practices relevant to day care and residential facets of whole programmes. It is based on the principles and concepts of two other evaluation tools, Program Analysis of Service Systems (PASS) and the Accreditation Council for Mental Retardation and Developmental Disabilities for the Joint Accreditation of Hospitals. (JCAH, ACMRDD). It facilitates identification of strengths and weaknesses in part or all of a programme.

CONTENT.

ANDI is divided into 5 sections. Within each section are 15 subsections. (Number of items per subsection is in parenthesis).

Programme, containing subsections relating to Integrity of Service (13); Developmental Programming (15); Individual Development Plan (26); Co-ordination of Clients Program (8); Personal Identity (11); Personal Relationships (8).

Rights, containing subsections relating to Childrens' and Adults' Rights and Responsibilities (13); Legal, Civil and Human Rights (17); Consumer Involvement and Public Information (8).

Social Integration, containing subsections relating to positive interpretations (10); Integrated Activities.

Facility, containing subsections relating to Community Resources (8); Comfortable Features (12);

Administration, containing subsections relating to Staff Training Efforts (11); Agency Organisation and Co-ordination.

The items are descriptive statements indicating expected performance by the service and each is presented along with notes which anchor some of the descriptive statements. Each item is rated according to the agency's level of compliance with the statement. (yes, no, partial, not known or not applicable).

ADMINISTRATION.

The rating can be done as an agency self-evaluation. It can be carried out by anyone and does not require a professional background. There are also trained raters who carry out external reviews on request. Standardized training for raters takes one day of lecture and discussion and two days using the tool for a complete site assessment. Training is arranged via the authors. A team of two raters is regarded as the minimum for each programme assessment. Time is spent in observation as well in review of supporting documents and a sample of clients are in relation to individual development, planning and implementation. Each rater makes his own assessment and at a team meeting a team concensus is prepared.

No indication of the time a self-review takes is given, but an external review for most purposes requires six hours on site and five to complete the evaluation and report.

A numerical score representing the sum of weighted item scores is established and in an external review recommendations as well as

areas for commendation are identified.

SCIENTIFIC CREDIBILITY.

No details have been given. ANDI has been used as part of a treatment evaluation design in the State of California, Department of Health (1979) and to evaluate specially funded projects throughout California.

REFERENCES.

Flynn, A.G., and Weiss, S.K. (1977). A Normalization and Development Instrument. Sacramento, California, Andi, P.O. Box 60964.

"39 STEPS".

AUTHOR: Gunzburg, H.C.

DATE: 1973

PURPOSE.

This check-list is intended to provide an indication of the extent to which the environment promotes normalization, socialization and personalization. It was designed for use in hospital living units with not more than twenty 'able-bodied' (Gunzburg, 1973, p.92) mentally handicapped adults.

It can be used by planners and managers at different levels, concerned to improve living conditions. It permits the identification of areas in which they have authority to effect change. A "full score" on the list is seen to represent the existence of "some basic requirements of 'normal' living". (Gunzburg, 1973). A "low score" identifies deficits and can thus assist managers to raise questions about reasons for the deficits.

CONTENT.

Each of the 39 items consists of an identified area of the living environment, or behaviour of the staff within it.

The 39 items are grouped in three sections. Section A contains items which have to be decided about by Top Departmental Managers. The items in this section refer to aspects of environment which can only be changed if Top Managers signal change is needed. These changes may have cost implications. There are 16 items in this section.

In Section B there are 4 items which would require agreement in

relation to a decision which would involve both top and first line managers.

In Section C there are 19 items, all of which can be addressed by first line staff and where change is indicated involvement by more senior managers is not required. Each of the items in this section are intended to heighten staff awareness of what they are doing and assist them in making a homely atmosphere characterized by "normal living practices", (Gunzburg, 1973, p.96). The completion of the checklist will indicate in what areas deficits and strengths lie.

Items cover both physical environment and the management of daily activities by first line staff. Two statements describing the practice (or behaviours) within the area are presented. The 'desirable' practice is marked with a +, the undesirable (not productive of personalization, normalized and socialized) is marked with a -).

ADMINISTRATION.

No description of the way in which this checklist should be used is provided. It would appear that anyone could use it. Most of the information could be obtained by observation, some information would need to be provided by staff.

There is no information as to the length of time taken to complete the checklist.

SCIENTIFIC CREDIBILITY.

There are no research studies about the checklist.

REFERENCE.

Gunzburg, H.C. (1973). The Physical Environment of the Mentally Handicapped. B.J.M.S. 19 91-99.

HENDERSON ENVIRONMENTAL LEARNING PROCESS SCALE. (HELPS)

AUTHOR: Henderson, R.W.

DATE: 1972.

PURPOSE.

The Henderson Environmental Learning Process (HELPS) was designed to measure characteristics of the home environment which were intellectually stimulating or which might influence motivation to pursue academic interests in young children. Its primary purpose is thus to identify aspects of environment which predict intellectual performance. The instrument has been used to study environmental similarities and differences between and within socioeconomic and ethnic groups.

CONTENT.

HELPS is designed as an interview schedule. There are 55 items. There are 10 which relate to the aspirations of the family; 25 to the range of environmental stimulation; 9 to parental guidance; 5 to the range of adult models available and 6 to reinforcement practices.

Each of the 55 items is rated on a 5-point scale, represented as a visual continuum, each item being scored 1 to 5 with 5 representing the response which indicates the greatest amount of experience or exposure to stimulating environments. The author states that the instrument should be modified to fit the age of the sample and reflect the kinds of intellectual responses available in the local community.

ADMINISTRATION.

It is recommended that a trained interviewer reads each item to the child's parent or caretaker. Interviewers, it is suggested sit with the subject, go through the instructions which are attached to the questionnaire and go through the items one by one, pointing to the ends of the continuum saying the relevant stimulus words. Once the item is understood, the respondent indicates the level of importance of the item on the 5-point scale. The scale was developed to be administered by trained para professionals. Experience in interview techniques, is recommended and special attention should be paid to the task of reducing socially desirable responses in informants.

A total numerical score representing the sum of non-weighted item scores can be computed. High scores reflect environments which promote high levels of intellectual stimulation. Spanish and English scores of HELPS are available.

SCIENTIFIC CREDIBILITY.

Standardisation. No research data are available .

Reliability. Coefficients obtained for the sub-scales of the instrument, range from .60 through .80. Reliabilities for the total score, using Cronbach Alpha method, have been obtained, ranging from .71 to .85.

No other form of reliability data are available.

Validity. A significant relationship between the HELPS environmental assessment and standardised measures of school achievement and intellectual performance have been demonstrated in several studies.

REFERENCES.

Henderson, R.W., Bergan, J.R., and Hurt, M. (1972). Development and Validation of Henderson Environmental Learning Scale. Journal of Social Psychology, 88, 185-196.

Valencia, R.R., Henderson, R.W., and Rankin, R.J. (1985). Family Status, Family Constellation, and Home Environmental Variables as Predictors of Cognitive Performance of Mexican American Children. Journal of Educational Psychology, 77, No.3, 323-331.

ENVIRONMENT CHECKLIST.

AUTHORS: Hampson, R., Judge, K., and Renshaw, J.

DATE: 1984.

PURPOSE.

The Environment Checklist was designed to obtain a physical description of accommodation, and some indication of, the social environment provided for clients. The client groups for whom it can be used include mentally handicapped people. The settings in which it can be used range from hospitals to community facilities. It was developed by members of the PSSRU during the research evaluation of the development of Care in the Community initiatives (DHSS, 1985) designed to encourage community alternatives for people being moved out of hospitals, for whom hospital-based care was no longer seen as appropriate.

CONTENT.

It is divided into 7 sections. Section 1 has 7 items covering the location of the facility and its appearance.

Section 2 has 6 items and covers aspects of the furnishings and decoration of the living room. Section 3 has 4 items covering furnishing within the dining room.

Section 4 has 6 items relating to the furnishings in the bedroom. Section 5 has 8 items covering kitchen, toilet and bathroom. Section 6 has 10 items covering a variety of aspects of the facility, e.g., temperature, adaptation or durability. Section 7 has 5 items which relate to the social environment e.g., use of age-inappropriate possessions.

The response ratings are mixed. In each section there is at least one item which requires the observer to rate the extent to which the areas under focus is institutionalised. A four point rating is used for this purpose. Other items are rated either in terms of the observer's subjective impression of their pleasantness on a 4 point scale, or coded Yes/No.

ADMINISTRATION.

An independent observer tours the site and makes the ratings. The definition of the categories used for the ratings of pleasantness/unpleasantness and institutionalism are incorporated in the observation schedule. No indication of the time taken to complete the observations, or the procedures for handling the information it generates, are given. No information is given about training needed prior to its use.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCES.

Hampson, R., Judge, K., Renshaw, J. (1984) Care in the Community Project Material. Canterbury, PSSRU, University of Kent.

DHSS (1983) Circular HC (83) 6.

HOSPITAL ENVIRONMENT QUESTIONNAIRE.

AUTHORS: Hampson, R., Judge, K., and Renshaw, J.

DATE: 1984.

PURPOSE.

The Hospital Environment Questionnaire is a self-administered questionnaire. It was designed to assess the social environment provided for clients, the degree of choice open to them, the amount of supervision and privacy they have and their activities and daily timetable. It can be used to assess the social environment provided for mentally handicapped people in settings in the community, as well as in hospital. It was developed as part of a research evaluation of Care in the Community Initiative (DHSS, 1983), which was intended to promote the move into the community of clients for whom long stay hospital care was no longer thought appropriate.

CONTENT.

The questionnaire is divided into nine sections. Section one covers size (living unit and facilities), staffing numbers, location of nearest transport and shop.

Section two covers day rooms, their numbers, amenities in them and opportunities for residents to use these amenities.

Section three focusses on bedrooms, the numbers of people sleeping in the same room, opportunities to share personal possessions and availability of mirrors.

Section four has bathrooms and toilets as its focus, covering numbers of amenities, showers, toilet paper, adaptations for

disability and lockable doors.

Section five covers facilities for recreation, adaptations for disability, mirrors, other than in the bathroom, access to kitchen, availability of non-public transport.

Section six covers opprotunities to use a staff office, information about staff turnover and absenteeism.

Section seven focusses on food, covering menus, opportunities for choice of snacks and drinks, and involvement in menu planning; cooking and food shopping; location of food preparation and purchase of food.

Section eight covers the extent of restrictions imposed on residents; extent of involvement of staff with residents.

Section nine focusses on social contacts with people outside the housing unit, and client turnover.

ADMINISTRATION.

The Hospital Environment Questionnaire is completed by a member of staff who is also asked to provide a menu, a copy of the client's timetable and the staff timetable. No indication is given of the length of time it takes to complete, or of time or procedures to analyse the data it generates.

No prior training for its completion is necessary.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCES.

Hampson, R., Judge, K., and Renshaw, J. (1984) Care in the Community Project Material. Canterbury, PSSRU, University of Kent.

DHSS (1983). Circular HC (83) 6.

PERSONAL PRESENTATION CHECKLIST.

AUTHORS: Hampson, R., Judge, K., and Renshaw, J.

DATE: 1984.

PURPOSE.

The Personal Presentation Checklist was developed as part of a research study to evaluate the Care in the Community Initiatives (DHSS, 1983), developed to promote alternatives to long stay hospital care for people for whom such care is seen as no longer appropriate. The checklist is designed to obtain a picture of the impression formed by anyone meeting the individual for the first time. It is used to assess the personal presentation of mentally handicapped and other client groups in hospitals and community settings. It is argued by the research group that a client's personal appearance may affect the response of local people and that change in appearance may, itself, occur, following a move from a hospital. Thus the research can be used as a monitoring tool for service and individual use.

CONTENT.

The checklist has 22 items covering clothing, face, hair, hands, glasses and teeth; smell, eyes, posture, other unusual traits. Examples of unusual appearance are given to help rate the response. All items have a Yes/No response to the question 'Is there anything unusual about' the feature identified in each item.

ADMINISTRATION.

An interviewer completes the Checklist following a first meeting with the client. No information is available on time taken to complete the form or its subsequent analysis or whether any

training is required prior to its use.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCES.

Hampson, R., Judge, K., and Renshaw, J. (1984) Care in the Community Project Material. Canterbury, PSSRU, University of Kent.

DHSS (1983). Circular HC (83) 6.

SOCIAL CONTACTS RECORD.

AUTHORS: Hampson, R., Judge. K., and Renshaw, J.

DATE: 1984.

PURPOSE.

The Social Contacts Record was designed to identify the level of isolation/integration of clients living in community based facilities. The client groups for whom it can be used include, mentally handicapped persons. The settings in which it can be used range from hospitals to community facilities. It was developed by a research team evaluating the Care in the Community Initiative (DHSS, 1983), which was promoted to encourage the return to normal life of long stay hospital patients for whom such institutional care is no longer thought appropriate.

CONTENT.

The Social Contacts Record has two sections. The first contains two questions. These seek the staff members evaluation of the client's appreciation of contacts with other people and their perceived need for the level of such contact. These questions have multiple response formats.

The second section is a grid. In this a record of the type and duration of all visits to the client in a week, is made. Also recorded is whether such visits involve a group or an individual.

ADMINISTRATION

For most clients the form is completed by a member of staff. More able clients can complete it themselves. No information on time taken to complete the form is given, or on handling information

derived from it, nor on the need for any training prior to its use.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCES.

Hampson, R., Judge, K., and Renshaw, J. (1984). Care in the Community Project Material. Canterbury, PSSRU, University of Kent.

DHSS (1983). Circular HC (83) 6.

TIME BUDGET RECORDING SCHEDUE.

AUTHOR: Hampson, R., Judge, K., and Renshaw, J.

DATE: 1984.

PURPOSE.

The Time Budget Recording Schedule was designed to identify the extent to which clients are involved in activities, or isolated, by use of a diary method. The activities include tasks; leisure pursuits and inter-action with other people. Client groups for which it can be used include mentally handicapped people in hospitals and community settings.

CONTENT.

The form contains a grid to record the time the activity commenced, an activity code, to identify categories of activity; group or individual activity and 'additional information'. There are six activity codes. These cover beds; meals and toilet; work and occupational therapy; TV and radio; active leisure. Additionally, three questions relate to the client's knowledge that he/she is part of the 'Time Budget Recording' activity.

ADMINISTRATION.

A staff member is requested to clarify an activity. A half hour recording frequency is suggested, but need not be adhered to strictly, the time periods can be left open-ended.

It is suggested that an independent observer checks the reliability of the information, recording for a part of the time the diary is being kept. Difficulties occur when clients do not spend time in one place and thus no single member of staff can

record the information. It is suggested that for clients whose lives involve their going out to work (ATC, etc) and to leisure activities in the evening, they can be "assumed to have a varied and active life", which would not be recorded by this method.

The length of time it takes to complete this is not indicated, nor is information given about its subsequent analysis.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCES.

Hampson, R., Judge, K., and Renshaw, J. (1984). Care in the Community Project Material. Canterbury, PSSRO, University of Kent.

DHSS (1983). Circular HC (83) 6.

SIX-MONTHLY INTERVIEW SCHEDULE.

AUTHORS: Humphreys, S., Lowe, K., and Blunden, R.

DATE: 1983.

PURPOSE.

The Six Monthly Interview Schedule was developed as part of the package of measures used in evaluation of NIMROD services for mentally handicapped people in Wales. It was the means by which much of the basic information about client changes was obtained. It covers a range of client behaviours, and service uses. In its design the researchers wanted to ensure that skills whose relevance to the move from institutional to community based living were covered. They wanted to include areas of involvement which would not necessarily be reflected in standardised assessment instruments because of the high floor in the majority of items in such scales. They thus included modified items from the "Pathways to Independence Checklist". (Jeffree and Chesildine, 1982) to supplement data collected by use of the Adaptive Behaviour Scale (Nihira et al. 1974). Additionally, individual goal achievement was abstracted from clients' I.P. documentation. They also recorded verbatim replies from respondents to supplement data with any anecdotal evidence of change.

The section on Problem and Stereotyped behaviours is a modified version of the Disability Assessment Schedule. (Holmes, Shah and Wing, 1982).

CONTENT.

The Six Monthly Interview Schedule is divided into nine sections. These cover:

i. Medication, accidents and illness.

ii. Use of Community facilities.

iii. Use of non-NIMROD services.

iv. Domestic skills.

v. Freedom of movement.

vi. Use of amenities.

vii. Contact with family and friends.

viii. Behaviour problems.

ix. Stereotyped behaviour.

Questions are varied in their response format.

ADMINISTRATION.

In the research study the Six Monthly Interview Schedule was used in an interview carried out by members of the research team. The interviewee has to be the person who has spent the most time with the client in the preceding four weeks.

Interviewees are encouraged to refer to written or recorded information, wherever possible, so that frequency of contacts can be determined accurately. Incorporated in the schedule are definitions of codes. There is also a coding frame for the analysis of data from the interview.

The interview is reported to take about forty minutes to administer. No information on training for use of the interview is given.

SCIENTIFIC CREDIBILITY.

Standardisation. No information is yet available.

Reliability. Inter-rater and inter-respondent reliability studies have been undertaken. Overall levels of agreement of 96% and 90%

respectively are reported.

Validity. No information is yet available.

REFERENCES.

Humphreys, S., Lowe, K., and Blunden, R. (1983). Long Term Evaluation of Service for Mentally Handicapped People in Cardiff. Research Methodology. Cardiff: Mental Handicap in Wales: Applied Research Unit.

Jeffree, D., and Cheseldine, S. (1982). Pathways to Independence Sevenoaks, Hodder & Stoughton Educational.

Holmes, N., Shah, A., Wing, L. (1982). The Disability Assessment Schedule. Psychological Medicine, 12, 879-890.

Nihira, K., Foster, R., Shellhaas, M. and Leland, H. (1974). Adaptive Behaviour Scale for Children and Adults. Washington, AAMD.

CONSUMER SATISFACTION QUESTIONNAIRE.

AUTHORS: Humphreys, S., Lowe, K., and Blunden, R.

DATE: 1983.

PURPOSE.

The Consumer Satisfaction Questionnaire was developed as part of the package of measures used in the research evaluation of the NIMROD Service in Wales. It was designed to obtain the views of family members about services being provided for people with a mental handicap. The views of the NIMROD clients themselves were canvassed using a separate questionnaire (Lowe, De Paiva and Humphreys, 1986).

NIMROD is a pilot comprehensive community-based service for mentally handicapped people in Wales. The questionnaire has been used in the four communities in the Cardiff area which are in receipt of NIMROD services, where the client lives at home with relatives. Additionally it has been used in a fifth 'comparison' community where clients are not in receipt of NIMROD services. The questionnaire has been used three times at 2-yearly intervals in the evaluation of the NIMROD Service.

CONTENT.

The Consumer Satisfaction Questionnaire is divided in ten sections. These focus on:

i. Household composition and whether mother works. (3 items).

ii. Shopping. (5 items).

iii. Transport. (4 items).

iv. Parents' social life. (5 items).

v. Short breaks. (1 item).

vi. & vii. Use of non-NIMROD Services in preceding six month period and level of satisfaction with these.

viii. NIMROD services, use and satisfaction levels.

ix. Consumer group membership.

x. Satisfaction with general mental handicap services and other sources of help.

ADMINISTRATION.

The Consumer Satisfaction Questionnaire is used in an interview with the relative. In the research study in which it was developed it is used biennially in conjection with the Six-Monthly Interview, because of the overlap of certain items (use of non-NIMROD services; day care; short-term care)

Instructions for coding of responses relating to level of satisfaction, improvement required, and suggested changes, are provided with the interview schedule. Response formats to questions are varied.

No indication is given of the length of time taken to carry out the interview, or procedures for handling the information obtained from it.

It is used by NIMROD researchers. No indication of training required for other people who wish to use it is given.

SCIENTIFIC CREDIBILITY.

The questionnaire was piloted on ten families who had a mentally handicapped relative living at home. No further information is yet available.

REFERENCES.

Humphreys, S., Lowe, K., and Blunden, R. (1983). Long Term Evaluation of Service for Mentally handicapped People in Cardiff. Research Methodology. Cardiff: Mental Handicap in Wales: Applied Research Unit.

Lowe, K., De Paiva, S., Humphreys, S. (1987). Long Term Evaluation of Services for People with a Mental Handicap in Cardiff. Clients Views (1986). Cardiff: Mental Handicap in Wales: Applied Research Unit.

ERIE COUNTY RESIDENTIAL GUIDELINES. (ECRG)

AUTHORS: Ihlefeld, R., Campbell, J., Dibiase, J., Hammond, P., Livenstein, M., Orndoff, R., Trowbridge, M., and Wood, R.

DATE: 1975

PURPOSE.

The ECRG provides a measure of certain physical aspects of the residential environment. Its primary use is in the evaluation of a proposed site for a residential programme for mentally handicapped people leaving institutions. It is designed to identify sites which will facilitate the integration of residents into the surrounding community and prevent the over-saturation of neighbourhoods with special service facilities. It is derived from the section of PASS concerned with siting and the external appearance of facilities.

CONTENT.

The ECRG is composed of eleven ratings which derived from PASS. The items are taken directly from that instrument and have been modified slightly to reflect the circumstances in which it was developed. The items include local proximity; access; physical resources; programme neighbourhood harmony; congregation and assimilation potential; programme, facility and location name; function; congruity image; building neighourhood harmony; age appropriate facilities, environmental design and appointments; physical over-protection; environmental beauty.

The format of the items and the scoring procedures are identical to those used in PASS. Thus a total score can be derived from the

completed form. The possible total score ranges from +186 to -186, with the score +84 defined as a minimally acceptable level by the authors.

ADMINISTRATION.

The methods used for collecting the information follow those used in PASS. An external evaluation team of three members assesses a proposed site. Evaluation is based on observation of the site and the neighbourhood and possibly includes the examination of written materials or interviews with programme planners or administrators. The team spends approximately two hours at the site and requires an additional three hours for rating and consultation.

It is specified that all three members of the team should be trained PASS evaluators. At least one of them should have advanced PASS training. It is reported that attempts are being made to simplify the assessment procedures and expedite the evaluation, to enable it to be carried out by people who are not PASS trained.

SCIENTIFIC CREDIBILITY.

To date no research studies on the ECRG have been undertaken.

REFERENCE.

Ihlefeld, R. et al. Erie County Residential Guidelines. Buffalo, New York, Erie County Mental Health Organization.

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT. (CTE).

AUTHORS: (a) Jackson, J., The Original CTE.

(b) Silverstein, A.B., McLain, R.E., Hubbell, M. and Brownlee, L. The Revised CTE.

(c) McLain, Silverstein, Hubbell and Brownlee The CTE: MR/DD Community Home (CTE: MR/DD)

DATES: Jackson (1969), Silverstein et al. (1977) McLain et al. (1977).

PURPOSE.

The CTE was developed by Jackson to facilitate the measurement of the characteristics of treatment environments in psychiatric settings. It was intended to operationalise Schwartz's (1957) concept of therapeutic milieu for patients with mental illness, but it did not assess the therapeutic efficacy of the environment.

The measure was subsequently amended in a series of studiea concerned with the evaluation of residential environments for mentally handicapped people. The settings for mentally handicapped people, in which it has been applied in the USA include institutional and community based facilities, (comparable to English hostels and small group homes) staffed and partially staffed. The measures resulting from this work are called the CTE, which is suitable for comparison of institutional settings and the CTE MR/DD Community Home which is suitable for use in community settings.

CONTENT.

a) The Original CTE.

The measure contained 72 statements about the proximal environment of a patient in a mental hospital; the way staff relate to him, his resources and other aspects of the physical and social environment. The items were originally grouped into 6 sub-scales reflecting Schwartz's therapeutic goals. These sub-scales were abandoned in 1969 following a further study which generated 5 sub-scales which reflect the orientation of the treatment environment. These sub-scales were:

Active Treatment (the extent of staff activity directed toward patient welfare and improvement).

Social-Emotional Activity (extent to which environment encourages normal relations and activity in patients).

Patient Self-Management (extent to which environment encourages patient responsibility).

Behaviour Modification (degree of staff attempts to control patients).

Instrumental Activity (extent to which the environment permits choice or rational problem solving by patients).

The items expressed as statements concerning aspects of the environment rated on an eleven point scale in terms of the degree to which they are true or false descriptions of the treatment environment being evaluated.

b. The Revised CTE.

This instrument contains 59 items. There are two sub-scales, generated as a result of a factor analysis. Items

in the sub-scale Autonomy relate to factors of the environment which encourages this, e.g., residents are encouraged to make their own decisions on spending personal money. Those in the sub-scale Activity relate to factors of the environment which facilitates this in the client, e.g., all residents are encouraged to participate in music, painting, handicrafts or other recreational or self-expressive activities. Each item is presented as a statement describing the environment provided for the client and the response is rated as for the Original CTE.

c. The CTE. MR/DD.

This instrument has 48 of the original items. It excludes those considered irrelevant to community settings and has been reworded to reflect the non-institutional context. Thirty items are in the sub-scale Autonomy and these items assess the degree to which residents are encouraged to learn to function independently. The remaining 18 items constitute the Activity sub-scale. These items assess the variety and frequency of social and recreational activities which are made available to residents.

Items are presented in both positively and negatively worded formats and half the items if answered affirmatively would indicate the presence of desirable environmental conditions. The other half of the items are written so that an affirmative response would indicate the absence of desirable environmental features.

ADMINISTRATION.

For all forms of the measure the instrument is presented as a self-administered questionnaire to be completed by a caretaker in the facility being assessed.

The items are presented as written statements rated on an eleven point scale (from 0 to 100) reflecting the truth or falsity of the statement as it describes the environment being assessed.

Guidance is given to those completing the questionnaire. Completion of the CTE. MR/DD is stated as taking less than thirty minutes.

SCIENTIFIC CREDIBILITY.

a. Original CTE.

Standardisation. No research data are available.

Reliability. No research data are available.

Validity. The instrument discriminated across settings and a factor analysis identified 5 sub-scales.

b. Revised CTE.

Standardisation. No research data are available.

Reliability. Test-retest reliability was established at a one year interval and caretaker coefficients of between .77 and .61 were obtained.

Validity. Factor analysis established the existence of two distinct sub-scales. The measure is also shown to discriminate across facilities of different types and between facilities of the same type.

c. CTE : MR/DD.

Standardisation. Reference and percentile norms were developed from a group of three samples of community facilities in the USA.

Reliability. The data collected on the Revised CTE are quoted.

Validity. The data for the Revised CTE are quoted.

REFERENCES.

Sutter, P., and Mayeda, T. (1979). Characteristics of the Treatment Environment: MR/DD Community Home Manual. Pomona, California, Lantermann Developmental Center.

Jackson, J. (1964) Toward the comparative study of mental hospitals: Characterisitcs of the treatment environment. In A.F. Wesson (Ed.), The psychiatric hospital as a social system. Springfield, IL Charles C. Thomas.

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McLain, R.E., Silverstein, A.B., Brownless, L., & Hubbell, M. (1977) Measuring differences in residential environments among institutions for retarded persons. Psychological Reports, 41, 264-266.

McLain R.E., Silverstein, A.B., Hubbell, M., and Brownlee, L. (1975). The characterisation of residential environments within a hospital for the mentally retarded. Mental Retardation, 13(4), 24-26.

McLain, R.E., Silverstein, A.B., Hubbell, M., & Brownlee, L. (1977) Comparison of the residential environment of a state hospital for retarded clients with those of various types of community facilities. Journal of Community Psychology, 5, 282-289.

Silverstein, A.B., McLain, R.E.., Hubbell, M., and Brownlee, L. (1977). Characteristics of the Treatment Environment: A factor analytic study. Education and Psychological Measurement, 37, 367-371.

Schwartz, M. What is a therapeutic milieu? In M. Greenblatt, D.V. Levison, & R.H. Williams (Eds.), 1957). The patient and the mental hospital. Glencoe, IL: Pree Press.

THE CHILD MANAGEMENT SCALE AND THE REVISED CHILD MANAGEMENT SCALE.

AUTHORS: King, R.D., Raynes, N.V., and Tizard, J.

DATE: 1971.

PURPOSE.

(a) The Child Management Scale was developed to provide a measure of one dimension of residential organisations, namely, resident management. It had as its theoretical basis the concept of the total institution developed by Goffman (1961). The characteristics which define this type of institution were identified as defining one end of a continuum of possible resident management practices. The scale thus measures the extent to which inmate management practices are institutionally oriented. These practices are characterised by high levels of block treatment, depersonalisation, social distance and rigidity in routine. The absence of such practice defines the opposite pole of the continuum, namely, resident oriented practices.

The scale was developed in residences for normal deprived children in England (two large cottage-style homes), two hospitals, one for mentally handicapped children and the other a pediatric hospital. It was then applied in two facilities for mentally handicapped children: a Local Authority hostel and a voluntary home.

Items were selected to refer to every day practice. An attempt was made to include items which were not dependent on cultural norms or level of ability or age.

(b) The Revised Child Management Scale.

The items in the CMS (16) all related to areas of child management practices which were to be found in homes for deprived children as well as institutions for mentally handicapped children. The RCMS was developed to permit wider coverage of aspects of management practices in settings which were for mentally handicapped children only. A further 15 items relevant to aspects of management in institutions caring for mentally handicapped children were re-introduced and one of the original CMS items was dropped. The RCMS has thirty items. It was applied in settings ranging in size from 12 to 1,650 beds. (The old and new items intercorrelated highly, (r_s = .92 p .05). (King and Raynes, 1971).

CONTENT.

The CMS contains fifteen items grouped under four headings. There are four items under the heading Rigidity, four under Block Treatment, three under Depersonalisation and four under Social Distance.

The RCMS. Thirty items are grouped under the same four headings. They are presented as if they were sub-scales of the over-all measure. The four original items are retained under the headings under Rigidity and two others added (total = 6). The original Block Treatment items are retained and four more added (total = 8). The original three Depsrsonalisation items are retained and six more added (total = 9).

The original four items are retained under Social Distance and three more added, (total = 7).

In both CMS and the RCMS each of the items is rated on a 3-point scale. A score of zero was given if the response indicated child

or resident oriented management practices. A score of two if the response indicated institutionally oriented management practices and one where the management practices were a mixture of institutional orientation and resident orientation.

ADMINISTRATION.

CMS and RCMS. No special training is required to use the scale. No indication is given of how long it takes to use either measure.

Data are collected using an interview schedule and an observation schedule. The focus of both are daily routines. The interview is carried out with a person in day-to-day charge of running the living unit which is the focus of the evaluation. Observations are made of the management of the early morning routine, bathing, toileting, meal and leisure time and the residents' bedrooms. Data from the interview and the observation schedule are used to score the items on the CMS and the RCMS.

SCIENTIFIC CREDIBILITY.

Standardisation Mean scores and standard deviations are available for hospital wards, hostels and village communities for children.

Reliability. For both the CMS and the RCMS there are data on inter-interviewer and inter-observer reliabilities. For data-derived from interviewing on the RCMS, the levels of reliability ranged from 88.6% to 96.4% and on inter-observer reliability the average level of agreement was 92%. On the CMS the levels were 94% and 92% respectively.

More recent work, including a factor analysis by McCormick, Balla and Zigler (1975) has been carried out. This indicated that the RCMS is measuring one dimension and that there are no valid sub-scales.

Validity. The CMS and the RCMS discriminate between different kinds of residential setting for children. Scores on the RCMS correlate highly with scores on the CMS (r_s = .92 $p < .05$).

REFERENCES.

King, R.D.., Raynes, N.V., and Tizard, J. (1971). Patterns of Residential Care. London, Routledge & Kegan Paul.

McCormick, M., Balla, D., and Zigler, E. (1975). Resident Care Practices in Institutions for Retarded Persons: a Cross-institutional, Cross-cultural study. American Journal of Mental Deficiency, 80, 1-17.

THE ACTIVITY MEASURE.

AUTHORS: Mansell, J., de Kock, U., Jenkins, J., and Felce, D.

DATE: 1982

PURPOSE.

The Activity Measure was developed to identify the extent and nature of the engagement of individual service users in appropriate activity. It has been used for this purpose in research studies involving severely and profoundly mentally handicapped people living in ordinary houses. Its primary use is in the comparison of two or more conditions on the behaviour of subjects who, ideally, act as their own controls.

The Measure was developed because existing direct observational measures generated group scores, not information about individuals and they focussed on client behaviour usually excluding client activities.

The Activity Measure derives directly from The Client Behaviour Measure, CBM, (Porterfield, Evans and Blunden, 1981) which is a measure of individual behaviour and classes of activities. The Activity Measure is a substantially modified form of the CBM designed for use in domiciliary settings. The behaviour codes it contains were designed for use in specific, discrete studies.

CONTENT.

The Activity Measure comprises data sheets, each containing 8 grids. Each grid is composed of 5 rows and 28 columns for recording.

In the grid the observations made of a given individual are

recorded. In the first row of the grid are recorded the room the person is in. Each room has a code. In the second row is recorded the activity in which the individual is engaged. In the third row of the grid, the individual's neutral behaviour is recorded, in the fourth row, the individual's inappropriate behaviour, and in the fifth row, contact with others is recorded. In these four rows numerical codes are used. These codes are given in the accompanying handbook.

ADMINISTRATION.

One observation per minute of a client is undertaken. The client is observed for three seconds and the numeric codes are entered in the appropriate row and column on the grid.

Detailed instructions for the recording procedure are given in the handbook where the definition of the codes are also contained. A stop watch is needed to carry out the observations.

Up to four hours of observations per individual client can be recorded on one data sheet. Alternatively, each grid on a sheet can be used for a different client, up to a maximum of eight.

The material then collected may be used to graph the major categories of an individual's activities and behaviour. Additionally, the proportion of observations in which a particular code was entered can be easily calculated to give, for example, the proportion of time a client is engaged in purposeful activity, or the room used. Similarly, analyses can be carried out to show the frequency in which two or more codes can be scored.

The times taken to complete these records will depend on the length of observation time undertaken.

SCIENTIFIC CREDIBILITY.

Standardisation. It is not customary to standardise direct observational measures in the same ways as tests, since observational measures are not norm-referenced.

Reliability. Inter-observer reliability was calculated for numbers of clients engaged. Reliability levels ranged from 90.4% to 94.8% agreement between observers. Observation of agreement of numbers present ranged from 98.7% to 100%.

Validity. There is a large literature using this general approach across different kinds of populations. The measure has face validity.

REFERENCES.

Mansell, J., Felce, D., de Kock, U., and Jenkins, J. (1982). AM: The Activity Measure, a Handbook for Observers.

Mansell, J., Felce, D., de Kock, U., and Jenkins, J. (1982). Increasing Purposeful Activity of Severely and Profoundly Mentally Handicapped Adults. Behaviour Research Therapy, 20, 593-604.

Porterfield, J., Evans, G., and Blunden, R. (1981). The Client Behaviour Measure and a Manual for Time Sampling Procedures. Cardiff: Mental Handicap in Wales - Applied Research Unit.

THE RESIDENTIAL MANAGEMENT SURVEY. (RMS)

AUTHORS: R.E. McLain, A.B. Silverstein, M. Hubbell, L. Brownlees, P. Sutter, T. Mayeda.

DATE: 1979.

PURPOSE.

The RMS, which is a development of the RCMS and the RRMP, is designed to measure client care practices in residential living environments for mentally handicapped persons to enable an evaluation of the extent of which these care practices are resident oriented or institutionally oriented. The former represent care practices which treat clients as individuals. Institutionally oriented management practices are more inflexible and impersonal and are more likely to subject clients to rigid routines and group care. The theoretical basis and purpose of the RMS, is the same as that of the RCMS and RRMP.

The scale is appropriate for use in institutions and small community residences accommodating adults and children.

CONTENT.

The RMS consists of 23 items derived from an item analysis of the original 30 items in the RCMS and one additional item. (McLain et al. 1975). The RMS items cover the management of observable aspects of care and life style provided for clients residing in the facility. Each item is scored on the basis of three

alternative ratings. High scores indicate the facilities are child-oriented and low scores that they are institutionally oriented.

ADMINISTRATION.

The RMS is designed as a self-administered scale to be completed by facility staff. Instructions to direct care staff on completing it are available. Brief instructions are also printed on the form. Apart from these instructions, no special training is required. It is stressed by the authors that direct care staff should be asked to rate the way things are and not as they wish it to be.

The authors state that direct care staff may need additional reassurance that a residence cannot always be exactly as the caretaker might wish it were.

Completion time for the RMS is approximately ten minutes.

It can be scored either by computer or hand. It requires the caretaker converting choices to numerical scores. These are then summed to provide a total facility score. A scoring form is available. The summary sheet, the Facility Score Interpretation sheet is available for both community homes and institutions. On this is recorded the facilities' RMS score and brief interpretative information.

SCIENTIFIC CREDIBILITY

Standardisation. Reference norms are available for both community homes and institutions. The former were developed from a standardisation group of three samples of community facilities. Both percentile norms and mean and standard deviation reference

norms are available.

Reliability. Reliability was established by administering the RMS twice in ten month periods to 234 staff in 39 institutional settings and 36 family homes and 29 other residence. Reliability levels ranging from .67 to .90 are reported. (McLain et al. 1975).

Validity. Content validity is reported by McLain et al. (1977) and Sutter and Mayeda (1979). The RMS was factor analysed and this procedure indicated that it measures a single factor. McLain et al. (1977) showed that the RMS discriminated between four different types of facility and between different treatment programmes and in living units with the treatment programmes. The measure clearly discriminates between facilities of the same type as well as between facilities of different types.

REFERENCES.

Sutter, P., and Mayeda, T. (1979). Residential Survey Manual. Pomona, California, Lanterman Developmental Center.

McLain, R.E., Silverstein, A.B., Brownlee, L., and Hubbell, M. (1975). The Characteristics of Residential Environments within a hospital for the mentally retarded. Mental Retardation, 13, 24-26.

McLain, R.E., Silverstein, A.B., Hubbell, M., and Brownlee, M. (1977). Comparison of the Residential Environment of a State Hospital for Retarded Clients with those of various type of Community Facilities. Journal of Community Psychology, 5, 282-289.

THE ENVIRONMENT SCALE.

AUTHORS: Mazis, S., and Canter, D.

DATE: 1979.

PURPOSE.

The Environment Scale was developed in a research study of 25 residential facilities for mentally handicapped children to explore aspects of the physical environment and their relationship to other aspects of environment, e.g., staffing ratios; child management practices and organisational structure. Ten aspects of the physical environment were selected (on the basis of a review of relevant literature) as indicating the domesticity and integrated nature of the environment. The scale was intended to help practitioners identify physical structures which are consonant with the desired orientation of management practices, and more readily identify the relevance of physical design where attempts are being made to modify practices of care givers and their clients. The scale can also be used to identify areas for future remedial environmental action.

CONTENT.

The Environment Scale covers ten aspects of the physical environment. These are:

1. The facility is within the community.
2. The facility is divided into smaller units/living units.
3. The facility has small bedrooms.
4. The facility has a kitchen within the living unit on the floor where most of the domestic activity is carried out.
5. The facility has adequate toilet amenities.

6. The facility provides opportunities for privacy.
7. The facility has an interior quality which is stimulating, attractive and uses some non standard materials.
8. The facility has controllable environmental elements.
9. The facility is in a state of good decorative repair and cleanliness.
10. The clients in the facility had made some of the decorations in it.

Each item was scored one if it was positive on an environmental feature. The item scores were summed to give an overall score ranging from 0 to 10.

ADMINISTRATION.

In the research study an architect toured the facilities and using observation and direct questioning of care staff scored the living units on each of the ten items. The scale can be completed by anyone with some understanding of the principles without any additional special training being required. Its completion requires a one day visit.

SCIENTIFIC CREDIBILITY.

Standardisation. No published information is yet available, but additional work on the scale has been carried out. Further information can be obtained from the authors.

Reliability. Exploratory analysis of the internal consistency of the scale was carried out. The authors state that the measure appears to be usable as a cumulative scale but more work is necessary.

No other kinds of analyses of reliability are reported.

Validity. The scores on the environment measure were correlated with scores on the Child Management Scale (King et al. 1971), (rho=0.92). Similar analyses were done within institution type and for each item in the scale. The discriminant power of the measure was demonstrated and seven of the items appear to be predictors of child oriented management practice.

REFERENCES.

Mazis, S., and Canter, D. (1979). Physical Conditions and Management Practices for Mentally Retarded Children in Canter, D., and Canter, S. (eds). Designing Therapeutic Environments. Chichester: John Wiley.

King, R.D., Raynes, N.V., Tizard, J. (1971). Patterns of Residential Care. London, Routledge & Kegan Paul.

SOCIAL CLIMATE SCALES. (SCS).

AUTHORS: Moos, R.H., Gerst, M.S., Humphrey, B., Insel, P., and Trickett, G.

DATE: 1974 - 1987.

PURPOSE.

The Social Climates Scales are a series of scales designed to measure the social milieu provided for different kinds of clients. They are based on the idea that environments have 'personalities' and that these 'personalities' or social climates as Moos calls them, can be assessed by obtaining the perceptions of the participants of the environments. Additionally, they are based on the concept of environmental press. Thus the items in the scales refer to characteristics of the environment which could exert pressure towards, for example, Involvement, Autonomy or Order.

Items for inclusion in the scales were selected from item pools, generated by the literature, observations of environments, and interviews with patients and staff. The item pools were reduced following testing in the relevant environments and scaling analysis. Scales have been developed for use in ten different social mileus. Conceptually these differing environments are seen to be characterized by similar types of dimensions. There are three types of dimensions, within which, subsumed specific areas are identified and measured in subscales. The major types of dimensions identified for each environment are:

1. The Relationship Dimensions. Within this category, the sub-scales are concerned with the amount of support a

programme provides, the extent to which people are encouraged to participate.

2. The Personal Development Dimensions. Within this category, the sub-scales are concerned with the extent to which people are encouraged to be self-sufficient (autonomy) and practical in their orientation.

3. System Maintenance and System Change Dimensions. Within this category, the sub-scales are thus concerned with the extent to which the environment is orderly, clear in its expectations and maintains control and is responsive to change.

The purpose of the scales, is to, a) to provide a detailed description of how various participants in a social environment view the environment, b) to facilitate planning, monitoring or control of environments, and c) to re-evaluate change and the impact of different regimes.

CONTENT.

Only the WAS Scale (the Ward Atmosphere Scale) and the COPES Scale (the Community Oriented Programes Environment Scale) are reviewed here. This is because they appear to be most relevant to an evaluation of residential facilities for mentally handicapped people.

Both WAS and COPES scales have 100 items and are scored on 10 parallel dimensions. All items in these two scales (as in all the others) are scored using a true/false format.

There are three Forms for each scale. The Real Form (Form R) asks people to respond to statements describing an environment and

indicate whether the description is TRUE or FALSE in relation to their residence. Form I and Form E, the Ideal Form and the Expectations Form respectively, are incorporated in the manuals which accompany the printed questionnaires and scale sheets for the Form R questionnaires. Form I, is concerned with an ideal environment and E, with what people expect from the place they are about to enter.

There are short Forms of WAS Form R and COPES Form R. For the WAS scale these consist of the items with the highest item sub-scale correlations, for the COPES scale these use the first four items on each sub-scale. These short forms facilitate a quicker means of assessing the Social environment. These shortened scales are called FORM S and are incorporated in the manuals. For WAS and COPES there are 40 items, 4 from each sub-scale as the aspects of the three major dimensional categories are called.

The WAS Scale has 100, and 10 sub-scales, these are:

i. Involvement, which measures how active patients are in the daily activities of their Ward and the extent of their group spirit.

ii. Support, which measures how helpful and encouraging staff and patients are to patients.

iii. Spontaneity, which measures the extent to which patients are encouraged to express their feelings.

iv. Autonomy, which measures the encouragement of self-sufficiency and independence.

v. Practical Orientation, which measures the extent to which people are prepared to release from hospital and for their futures.

vi Personal Problem Orientation, which measures the extent to which patients are encouraged to be concerned with feelings and problems.

vii. Anger and Aggression, which measures the extent to which a patient is encouraged to argue with his peers and with staff.

viii. Order and Organisation. This measures the importance given to order and organisation on the ward.

ix. Program Clarity. This measures the extent to which patients know what is expected of them in terms of the daily routine, the explicitness of rules and procedures.

x. Staff Control. This measures the extent to which it is necessary for staff to restrict patients in various ways.

The first three sub-scales are seen as measuring Relationship dimensions. The sub-scales four through seven are seen as measuring Personal Development dimensions and the sub-scales eight through ten are seen as measuring System Maintenance dimensions.

The 100 items in the COPES Scale are grouped into the same set of sub-scales as are used in the WAS Scale. There is some overlap in the actual items (despite minor changes in wording), but not all of the items are identical. However, the identical nature of the sub-scales would facilitate comparison in the measurement of the social climates of people living in community based facilities with those living in hospital based facilities.

ADMINISTRATION.

The test items are printed in a re-usable booklet. An answer sheet, which is separate, is provided. The person completing the answer sheet is read the instructions by the test administrator

and asked to indicate whether the statement in the booklet is true or false on their answer sheets.

Detailed instructions are given in the manual for scoring. Scores can be converted into standard scores for individual subjects on the same answer sheet. An overall programme score can be obtained by calculating the average patient score and the average staff score, for each sub-scale. Programme profiles can be generated by comparing these scores with the normative sample scores which are available in the manuals which accompany both of the scales.

The answer forms can be completed by an observer as well as participants in the environment.

The authors state that it takes fifteen to twenty minutes to complete the R Forms and five to ten minutes to complete the short forms.

Scoring on all ten sub-scales of Form R requires only a minute or two per test.

The test may only be administered by qualified investigators. Application for qualified status can be made to the NFER or to the Consulting Psychologists Press.

SCIENTIFIC CREDIBILITY

Standardisation - WAS.

Normative data is given for British and American samples for the WAS Form R. The mean and standard deviations for the samples for the sub-scales are given in the manual.

Reliabiltiy. Test/re-rest reliability and profile stability were explored for individual sub-scale scores and these ranged from .59

to .78 for patients and .60 to .82 for staff. The stability of the profile over time, which is obtained using this scale, has been shown to be high.

Validity. The analysis of the internal consistency of the sub-scales are reported as "varying from moderate to substantial" p.5 (Moos, 1974).

The scale differentiates clearly between programmes.

Standardisation - COPES. Normative data are available for the COPES Form R based on American and British samples. Standard score tables for programmes and individuals are provided in the manual, which accompanies the COPES Scale.

Reliability. Internal consistency of the sub-scales and between the sub-scales, was calculated. The sub-scales have acceptable internal consistencies, ranging from .62 to .89 (Kuder-Richardson Formula 20). Test-retest reliability was calculated for various time intervals and correlations ranged from .60 to .90. Profile stabilities were also calculated and shown to be high.

Validity. The sub-scales have moderate to high overall item to sub-scale correlations and acceptable internal consistency, it is reported in the manual accompanying the Scale (Moos, 1974). The Scales appear to be measuring ten distinct dimensions. The second edition of the manual (Moos, in press) reports that the sub-scales significantly differentiated between 21 programmes studied, for both members and staff responses.

Research is reported showing few, if any, consistent relationships between personal factors and clients' perceptions of treatment programmes as indicated in the COPES sub-scales.

REFERENCES.

Moos, R.H. (1987). The Social Climate Scales: A User's Guide. Palo Alto, California, Consulting Psychologists Press.

Moos, R.H. (in press) Ward Atmosphere Scale Manual. Second Edition. Palo Alto, California, Consulting Psychologists Press.

Moos, R.H. (1974). Ward Atmosphere Scale, Form R. Palo Alto, California, Consulting Psychologists Press.

Moos, R.H. (1974). Community Oriented Programs Environment Scale, Form R. Palo Alto, California, Consulting Psychologists Press.

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Moos, R.H. (1974) Evaluating Treatment Environments: A Social Ecological Approach. New York, Wiley.

IMPROVING THE QUALITY OF SERVICES FOR MENTALLY HANDICAPPED PEOPLE. A CHECKLIST OF STANDARDS.

AUTHORS: National Development Group for the Mentally Handicapped.

DATE: 1980.

PURPOSE.

In the late 1970s Secretary of State for Social Services asked the National Development Group to suggest their own checklist of the criteria for a good mental handicap services. The National Development Group was of the view that there is considerable agreement on most of the basic principles on which services should be based. The principles were identified in chapter 3 of the 1971 White Paper and by the Jay Committee. The Checklist of Standards identifies an overriding principle and four additional principles and presents standards related to each of these.

The primary purpose of the Checklist of Standards developed by the NDG is to facilitate the translation into practice of generally agreed principles of a good comprehensive local service for mentally handicapped people and their families.

It is intended for use in the evaluation, monitoring, and planning of services and as an educational tool for staff. It can be used by representatives of clients and consumers, managers with day to day responsibility for running services and others with managerial responsibilities for services for mentally handicapped people. The principles and standards are seen as relevant to services provided by health authorities, local authority, personal social

services; private and voluntary organisations.

None of the standards relate to services provided by education, housing, or employment authorities or those provided by voluntary organisations, because the terms of reference of the NDG precluded detailed recommendations on this area. The NDG recommend that departments and organisations involved in the provision of such services are encouraged to participate in the uses to which the checklist is put by health and personal social services personnel and other users.

CONTENT

There are 224 standards in the Checklist. The standards are grouped in four major sections, each representating one of the four principles. Within the sections the standards are grouped in subsections relevant to specific aspects of the services to which the principle relates.

Under principle one, twenty standards relating to the provision of interdisciplinary assessment of individual needs and the training to meet these needs are listed. The standards in this section cover prevention, identification of new cases, counselling and family support; training and assessment and implementing the training plan.

Under principle two there are 33 standards, which relate to the provision of services to enable mentally handicapped people to stay at home, their own, or their parents. The standards in this section cover field work and the other support services, day services, short-term resident care, alternative homes for children and adults.

Under principle three, ninety-nine standards relating to the provision of services which promote the development and independence of mentally handicapped people are listed. These cover facilities, facets of quality of care; staff/client relationships; clients with special needs; daily life; training; planning training; independence and integration; entertainment, outings, holidays; visiting and contact; physical plant and safety and hygiene.

Under principle four, there are 68 standards relating to joint planning and delivery of services and the primary importance of the needs of families and clients. The standard in this section cover joint planning and policy making; organisation and management of the service; administration, discharge and transfers; records and staff training; monitoring, co-ordination and co-operation; volunteers and voluntary groups; research and publicity.

The standards are presented as open-ended questions, designed to produce a simple Yes/No answer. An answer page is provided facing each page of standards. The answer page contains space to identify the question of standard number; the answer, the action proposed and a signature and date.

It is published in loose leaf form so that the relevant sections can be easily used by each service concerned.

ADMINISTRATION.

The authors state that there is no set way to use the checklist, but they make a number of suggestions. These include:

i. its use at regular intervals,

ii. the inclusion of staff at different levels and in education, housing, employment, in its completion, as well as representatives and consumers.

iii Identifying ways of ensuring the information received is reliable and objective.

iv. The dating and signing of the information and the indication of what action is to be taken, by whom, and when and by whom the results of such action will be reviewed. It is suggested that the Checklist can be completed by groups of staff working together.

The completion of the checklist will provide a range of detailed information on the basis of which the quality of a local service can be evaluated and plans made as necessary to improve them.

No special training is recommended to precede the use of the checklist, but it is suggested that senior officers read through all of the principles and standards to 'gain an overall idea of the scope and nature of the approach being used' (p.vii). They recommend too that discussions take place between officers and member groups and the Joint Care Planning Team before the Checklist is used. In these discussions plans should be made to identify the ways in which the information will be collected and who will be involved.

No indication of the time taken to complete the Checklist is given.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCE.

National Development Group for the Mentally Handicapped (1980). Improving the Quality of Services for Mentally Handicapped People. London, DHSS.

GROUP HOME MANAGEMENT SCHEDULE. (GHMS)

AUTHORS: Pratt, M.W. Luszcz, M.A., and Brown M.E.

DATE: 1979

PURPOSE:

This is a modified version of the Revised Child Management Scale (RCMS), (King et al. 1971). Its theoretical basis and purposes are the same as that instrument. The GHMS was developed for use in seven residential facilities in Canada for mentally handicapped adults. The facilities ranged in size from 8 to 12, with a mean size of 9. The age range of the population served was 17-53. The revisions were undertaken to facilitate a better assessment of the range of care in small community facilities to which the revised CMS did not appear sufficiently sensitive.

CONTENT.

The scale contains 37 items. 15 of these are items from the RCMS and 22 are new items. These 22 were designed to better assess the range of care in small community facilities for adults.
The items are grouped under headings, rigidity of routine (N = 11); block treatment (N = 7); social distance (N = 7) and depersonalisation (N = 12).

The items are scored on a 3 point rating scale, higher scores representing institutionally oriented practices. The scores are summed to give a possible total range of zero to 74.

ADMINISTRATION.

The information for the scale was collected by structured interview with senior members of staff in each residence. No

observations are required. Pratt noted that observations were too intrusive in small settings.

No indication of the time taken to administer the questionnaire is given. The questionnaire was used as part of a larger study, reported in Pratt et al. (1979). The measure has also been used in work by Conroy and Bradley (1985), who report that the measure, along with two others, took half an hour to administer in community residences for mentally handicapped adults in the United States.

SCIENTIFIC CREDIBILITY.

Standardisation. No information is given.

Reliability. Construct reliability was established by correlating the scores from the "old" RCMS items and the new items to establish some measure of the homogeneity of the scales. A Spearman Rank correlation $r_s = .81$, $p < .05$ was obtained. The new items appear to increase the overall difficulty levels of the scales.

Validity was established by using scores on the community residences and comparing them with the scores on the 21 living units in three institutions, (Raynes et al. 1979). This showed the community residences to be more resident oriented, ($U = 14$, $z = 3.15$, $p < 001$).

Pratt also looked at the relationship between a measure of staff attitudes and the performance scores derived from the GHMS, ($r = .90$, $P < .05$).

REFERENCES.

Pratt, M.W., Luszcz, M.A., and Brown, M.E. (1979). Measuring the Dimensions of the Quality of Care in Small Community Residences. American Journal of Mental Deficiency, 85, 188-194.

Pratt, M.W., Luszcz, M.A. and Brown, M.E., (1979). Indices of Carein Small Residences. Halifax, Nova Scotia, Mount St. Vincent University, Canada.

Conroy, J.W., and Bradley, B.J., (1985). The Pennhurst Longitudinal Study. Philadelphia Temple University Developmental Disabilities Center.

Raynes, N.V., Pratt, M.W. and Roses, S, (1979). Organisational Structure and the Care of the Mentally Retarded. London, Croom Helm.

CONTINUOUS AUDIT OF RESIDENTIAL ENVIRONMENT STANDARDS

AUTHOR: Prudhoe Unit

DATE: 1987

PURPOSE:

The Continuous Audit of Residential Environment Standards (CARE) were developed in 1985 and have been updated. The CARE standards were designed to aid in the evaluation in residential environments for people with a mental handicap. They can also be used by managers to set objectives for services with members of the direct care staff; by direct care staff themselves as a basis for action plans, and by educators as a staff development tool.

CONTENT.

The care standards document is divided into twenty-five sections, each section covers a specific area. At the beginning of each section an underlying principle is stated and this is followed by a number of standards. The standards are presented in question form. The twenty-five sections, followed by the numbers of standards within each in parentheses are given below

Policy (8)

Staff Training and Development (10)

Communication (9)

Individual Programmes of Care (4)

Effective Deployment of Staff (6)

Building (26)

Furnishing (11)

Decoration (5)

Hygiene and Maintenance (5)

Food (11)

Volunteers (4)

Pattern of Daily Life (6)

Relationships with Staff and the Outside World (11)

Relationships with the Family (8)

Personalisation/Choice/Advocacy (8)

Day services (7)

Residents with Physical Problems (10)

Residents with Apparent Heating Problems (7)

Residents with Apparent Visual Impairment (8)

Residents who cannot Speak (4)

Residents who are not Continent (6)

Residents who are Elderly (10)

Residents who are Dying (9)

Residents who are Detained (14)

Residents who are Violent (6)

ADMINISTRATION.

There is no set way of using the standards document. No special training appears to be necessary for its use.

SCIENTIFIC CREDIBILITY.

No information is given.

REFERENCE.

Prudhoe Unit. (1987) Continuous Audit of Residential Environment Standards: Prudhoe.

THE CLIENT BEHAVIOUR MEASURE

AUTHORS: Porterfield, J., Evans, G. and Blunden, R.

DATE: 1981.

PURPOSE:

The Client Behaviour Measure was developed to identify the extent to which clients with mental handicap in service settings are engaged, i.e., doing something appropriate; the level of complexity of the activity in which he/she is engaged and the age appropriateness of the activity. It was developed for a research study conducted in a bungalow facility and also used in an evaluation of a comprehensive community based service. The CBM was designed to be suitable for use with all people with mental handicap, regardless of their level of skills and to be useable in a variety of settings. Its design is intended to facilitate the collection and analysis of data about client engagement and activity for both groups and individuals.

CONTENT.

The recording sheet for the Client Behaviour Measure is divided horizontally into ten sections. The client's activity, complexity of engagement, contact with others, inappropriate or neutral behaviour and the explanation for any absence of a recording are recorded in columns on each sheet.

Definitions of the categories and the codes used are provided in a Manual, along with example.

ADMINISTRATION.

Clients are observed sequentially at thirty second intervals. The clients' behaviour at the instant of observation is coded on the observation schedule. The procedure for collecting the information is set out in the manual, as is the procedure for summarising CBM data. A computer programme is available for summarising the data. The length of time taken to carry out the observations will be determined by the number of clients and the number of observations necessary. No guidance is given in the manual with regard to the minimum number of observations required.

No training procedure is described in the manual.

SCIENTIFIC CREDIBILITY

Standardisation. It is not customary to standardise direct observational measures, since these are not norm referenced.

Reliability. Inter-observer reliability was calculated.

Validity. There is a large literature using this general approach across different kinds of populations. The measure has full validity.

REFERENCE.

Porterfield, J. et al. (1981). The Client Behaviour Measure and Staff Behaviour Measure: Manual for Time-Sampling Procedures. Cardiff: Mental Handicap in Wales: Applied Research Unit.

STAFF BEHAVIOUR MEASURE.

AUTHORS: Porterfield, J., Evans, G., and Blunden, R.

DATE: 1981.

PURPOSE.

The Staff Behaviour Measure was developed to identify staff activities in a range of service settings for people with mental handicap. It was developed for a research study conducted in a bungalow facility and used in an evaluation of a comprehensive community based service.

CONTENT.

The Staff Behaviour Measure is an observation schedule. It is designed to permit recording of the inidivudal staff member's type of contact with clients; with client materials; other staff activities, including adminstration, location and interaction with other staff. Numbers of clients in the communal areas are recorded.

ADMINISTRATION.

Staff members are observed at thirty second intervals for five seconds. Activities are coded on to the recording schedule. The coding categories are defined in the accompanying manual. Procedures for recording are also described in the manual as are the procedures for summarising the data. The length of time taken to use the schedule will depend on the number of staff to be observed and the number of observations made. No indication is given of the minimum number of observations required.
A computer programme is available for summarising the data. Procedures for the training of observers are contained in the manual.

SCIENTIFIC CREDIBILITY.

Standardisation. It is not customary to standardise direct observational measures, since these are not norm referenced

Reliability. Inter-observer reliability levels were calculated. No details are reported.

Validity. There is a large literature using this general approach across different kinds of populations. The measure has full validity.

REFERENCE.

Porterfield, J. et al. (1981). The Client Behaviour Measure and Staff Behaviour Measure: Manual for Time-Sampling Procedures. Cardiff: Mental Handicap in Wales: Applied Research Unit.

THE INDEX OF THE PHYSICAL ENVIRONMENT.

AUTHORS: Form I: Raynes, N.V., Pratt, M.W., and Roses, S.

Form II: Pratt, M.W., Luszcz, M., and Brown, M.E.

DATE: Form I: 1979.

Form II: 1980.

PURPOSE.

Form I.

The Index of the Physical Environment was developed in the course of a research study of residences ranging in size from 21 to 92 beds, which were part of three large American institutions accommodating mentally retarded adults. It was designed to identify the extent to which the physical environment provided the individual with opportunities for self-expression, experience and privacy. The 22 items in the scale attempt to explore the extent of depersonalisation generated by the physical environment of the residence and the availability of amenities to facilitate comfort and homeliness. Its theoretical underpinning is the concept of the Total Institution (Goffman, 1961).

Form II.

This is a modified version of the IPE form I. It was developed by Pratt and his colleagues for use in small community based settings for mentally handicapped adults. The purpose of the measure is identical to that of Form I, as its theoretical base. Pratt noted that many of the items in Form I were inappropriate in small group homes. In the research study in which Pratt et al. developed IPE Form 2 the residences accommodated from 8 to 12 people. Form II contains 69 items which include 19 of Form I items, the remainder being new.

CONTENT.

Forms I and II.

Both measures contain a list of items of furniture, furnishings and other amenities available in each of the rooms within a residence. Each item is scored on a 5-point rating scale based on the availability of resource per resident.

Form I.

The 22 item scale covers amenities in bathroom, bedrooms and living rooms. Items are rated either as a percentage of rooms having the amenity or as a ratio of amenities to residents. Each item involves a 5-point rating giving a range of scores from 0 to 88. High scores indicate high levels of depersonalisation in the physical environment.

Form II.

The 69 item scale covers the residence as a whole, amenities in bedrooms, and the communal rooms of the residence, e.g., living room, dining room, kitchen, bathrooms. All the items are scored on a 5-point rating scale. 40 of them are scaled based on the percentage of living areas containing an amenity. The other 29 items are scaled on the basis of the ratio of residents who have to share the item.

ADMINISTRATION.

Forms I and II.

No special training is needed to use the measures. An observer tours the house and completes the observation schedule from which the ratios and percentages for the scales are computed. It is necessary to know the number of people living in the residence. The length of time taken to complete the observations are not given. Pratt reports that information for the IPE was collected

intermittently during the course of visit to the small homes in which it was developed and tested.

SCIENTIFIC CREDIBILITY.

Standardisation.

Forms I and II. No research data are available.

Reliability.

Form I. No research data are available.

Form II Internal scale reliability was examined by Pratt. The old and new items were shown to correlate at .74 $p < .05$.

Validity.

Form I. The measure discriminated between residential units with institutional settings.

Form II. The validity of Form II IPE was assessed using the comparison group method (Anastasi, 1976). Pratt compared the scores of the residences and those of the small homes studied by Raynes et al. on old items in Form II. The measures significantly discriminated between the group homes and the institutions, in the predicted direction ($U = 2$, $z = 3.79$, $p < .001$).

A second measure of validity was established by observing the relationship between reported staff attitudes, using the Attendant Attitude Inventory (Butterfield et al. 1968) and the IPE. The IPE Form 2 correlated highly, ($r = .90$, $p < .05$) with the strictness of standards factor in this attitude measure.

REFERENCES.

Raynes, N.V., Pratt, M.W., and Roses, S. (1979). Organisational Structure and the Care of the Mentally Retarded. London, Croom Helm.

Pratt, M.W., Luszcz, M.A., Brown, M.E. (1980). Measuring Dimensions of the Quality of Care in Small Community Residences. AJMD, 85, 188-194.

Anastasi, A. (1976). Psychological Testing. New York, MacMillan.

Goffman, E., (1961). Asylums. New York, Doubleday.

Butterfield, E., Barnett, C., and Bensberg, G. (1968) A measure of attitudes which differentiates attendants from separate institutions. AJMD, 72, 890-899.

REVISED RESIDENCE MANAGEMENT PRACTICES SCALE. (RRMP)

AUTHORS: Raynes, N.V., Pratt, M., and Roses, S.

DATE: 1979.

PURPOSE:

The RRMP is a revision of the Revised Child Management Scale. Its theoretical basis and purpose are identical to that instrument. The revisions were made to facilitate its use in settings for mentally handicapped adults and to reduce some of the observational time required for completion of the scale. To these ends two items were dropped from the thirty item scale. The item on the way in which staff helped residents with their toileting was considered to be inapplicable to an adult population and was therefore dropped. The item on the proportion of time residents spent in their leisure activities required observation which was very time-consuming and had to occur outside the time periods in which observations for other scale items were carried out. This was dropped. The remaining items are identical to those in the RCMS except that the word child was replaced by the word resident.

CONTENT.

The 28 items in the RRMP are scored on a 3-point rating scale following the procedure for the RCMS. Scores on this measure ranged from zero to fifty-six. The items are not grouped under the four headings, depersonalisation, block treatment, rigidity and social distance. Research has shown that these sub-scales have no statistical validity. (McCormick, 1975). The scale was used in twenty-one living units in three institutions for mentally

retarded adults in the USA. The scale measures one dimension of resident management, namely the extent to which it is institutionally or resident oriented.

ADMINISTRATION.

The person in charge of the living unit is interviewed about the residents' daily and other recurring activities. Observations are required of specified events in the day and the residents' bedrooms. Permission to make these observations has to he obtained. The information from the interview and observations is used to rate the items on the RRMP.

The procedure for collecting information to be rated in the RRMP is identical to that used in the RCMS.

The authors do not indicate anything about the length of time taken to collect the information or scoring the items.

SCIENTIFIC CREDIBILITY.

Standardisation. Mean and standard deviation scores are availahle derived from the English and American studies of hospitals and community residences. The RRMP has been used in the USA and England. (Raynes, Pratt and Roses, 1979. Raynes and Sumpton, 1986).

Reliability. Inter-interviewer and inter-observer reliability for the scale were reported as r_s = .80 $p < .05$. (The 28-item scale correlated at .96 with the 15-item RCMS). (Raynes et al. 1971). Internal reliability of the scale was explored on the sample of English residential provision. Using Cronbach Alpha, an Alpha coefficient of .87 was obtained.

Validity. The RRMP differentiates significantly between different

kinds of residential settings for mentally handicapped adults, with community based facilities showing more resident oriented management in staff care practices. It has been used in a range of settings in England and the USA.

REFERENCES.

Raynes, N.V., Pratt, M., and Roses, S. (1979). Organizational Structure of the Care of the Mentally Retarded. London, Croom Helm.

Raynes, N.V. and Sumpton, R.C. (1987) Differences in the Quality of Residential Provision for Mentally Handicapped People. Psychological Medicine, in press.

Raynes, N.V., and Sumpton, R.C. (1986). Follow-Up Study of 448 People Who Are Mentally Handicapped. Final Report to the DHSS. Manchester, The University, Department of Social Policy.

INDEX OF COMMUNITY INVOLVEMENT.

AUTHORS: Raynes, N.V., Pratt, M.W., and Roses, S. (Form I).
Raynes, N.V., Sumpton, R.C., and Pettipher, C. (Form II).

DATES: 1979 (Form I).
1986 (Form II).

PURPOSE.

The Index of Community Involvement Form I was designed for use in a study of adults with a mental handicap resident in institutions in the U.S.A. Form II is a modified version of Form I designed for use in study of adults with mental handicap living in a variety of residential facilities in England. Both versions of the ICI were designed in a research study to measure the extent of involvement in activities and use of facilities based in the local community. There are two versions of Form II, one scored on a group basis and one scored for individual use of and participation in the local community. Both versions of Form II were used in a study of 28 hospitals and Local Authority hostels and 17 Private and Voluntary residential facilities in England on 145 residents.

CONTENT.

Form I has 13 items. Each item is scored on a 5-point rating scale. Lower scores reflect maximum numbers in the group participating in community based activities. Form II consists of 15 items. For the group-based ratings a 5-point rating scale is used, higher scores reflecting maximum participation in community based activities. For the individual-based ratings, a Yes/No rating is used. For Form I and II the item scores are summed to

give a total index score.

The items in Forms I and II (both individual and group) are similar, and relate to the use of the amenity in the past month, with one exception, which is an item about holidays, which relates to the past year.

ADMINISTRATION.

Both Form I and Form II items were incorporated in both the research studies in questionnaires used in interviews with direct care staff.

No indication is given of the time taken to complete them or of any need for prior training in their use.

SCIENTIFIC CREDIBILITY.

Standardisation. Mean scales and standard deviations are available derived from the study of 67 wards, in 28 hospitals, 28 local authority hostels and 24 living units in private and voluntary facilities.

Reliability. Inter-rater reliabilities are reported for the interviewers in the English study. They are reported to be 95-96% levels of agreement. No other form of reliability is reported as yet.

Internal reliability of Form II (group or individual) were calculated using Cronbach Alpha. Coefficients of .85 (group) and .77 (individual) were obtained on the English sample

Validity. Form I and Form II (group and individual) differentiate between living units accommodating mentally handicapped people.

REFERENCES.

Raynes, N.V., Pratt, M.W., and Roses, S. (1979). Organisational Structure and the Care of the Mentally Retarded. London, Croom Helm.

Raynes, N.V., and Sumpton, R.C. (1986). Follow Up Study of 448 People Who are Mentally Handicapped. Final Report to the DHSS. Manchester, The University, Department of Social Policy.

THE INDEX OF ADULT AUTONOMY.

AUTHORS: Raynes, N.V., Sumpton, R.C., and Pettipher, C.

DATE: 1986.

PURPOSE.

The Index of Adult Autonomy was developed in a research study of adults with a mental handicap who were resident in 3 different types of residential facility in England, 67 wards in 28 hospitals, 28 Local Authority hostels, 24 living units in Private and Voluntary facilities. It was designed to identify the extent to which adults were given opportunities to make decisions about aspects of their daily lives.

CONTENT.

The Index of Adult Autonomy has eleven items which covers aspects of daily life and the opportunity provided for residents to participate in making decisions about them, e.g., choice of clothes to wear each day, having a bank account and front door key. Each item is scored on a 3-point scale and the item scores are summed to generate a total score. The higher score represents maximum opportunity for a resident to participate in decision making.

ADMINISTRATION.

In the research study the items were asked within the context of a wider ranging interview with a member of the direct care staff who knows the resident concerned. The questions are asked about the opportunities provided for an individual resident. No information is given about the time taken to administer the index or of the need for any training in the use of the index.

SCIENTIFIC CREDIBILITY.

Standardisation. Mean and standard deviation scores are available for the hostels, hospital wards and private and voluntary facilities referred to above, (Raynes and Sumpton, op cit).

Reliability. Inter-rater reliability for the interview of which the Index was a part, is reported to range between 95% and 96% levels of agreement.

Internal reliability of the Index was explored using Cronbach Alpha, a coefficient of .77 was obtained.

Validity. The Index appears to differentiate between different kinds of residential environment, but the authors' report that scores in the measure are highly correlated with differences in ability levels of residents.

REFERENCE

Raynes, N.V., and Sumpton, R.C. (1986). Follow Up Study of 448 People Who are Mentally Handicapped. Final Report to the DHSS. Manchester, The University, Department of Social Policy.

INDEX OF PARTICIPATION IN DOMESTIC LIFE.

AUTHORS: Raynes, N.V., Sumpton, R.C., and Pettipher, C.

DATE: 1986.

PURPOSE.

The Index of Participation in Domestic Life was developed in a research study of 150 living units in 3 different kinds of residential facilities for mentally handicapped adults in England. It is a modification of an index developed by Baker et al. (1977). It was designed to identify the extent to which residents were given opportunities to participate in everyday domestic tasks.

CONTENT.

The Index of Participation in Domestic Life has thirteen items. These include, for example, shopping for food, washing up, and cleaning rooms. Each item is rated on a 3-point scale, the higher score reflecting maximum opportunity to carry out the domestic task (reflected in the clients actually doing it alone or with other peers). Item scores are summed to give an overall index score.

ADMINISTRATION.

In the research study the thirteen items were asked in an interview with direct care staff. The interviewers covered other aspects of the residents' life. No indication is given of the time taken to administer the Index or of the need for any training to use the Index.

SCIENTIFIC CREDIBILITY.

Standardisation. Mean scores and standard deviations are available for three types of residential setting, (Raynes and Sumpton, op cit).

Reliability. Inter-rater reliability was obtained for the Index as part of an exercise relating to the whole questionnaire, levels of agreement ranged between 95 and 96%.

The internal reliability of the Scale was obtained using Cronbach Alpha. A coefficient of .90 was obtained.

Validity. Scores in the Index differentiate between environments in similar as well as differing Service delivery systems. Differences between environments on the scores on the Index are also reported as remaining significant when differences in client ability levels are controlled for.

REFERENCES.

Raynes, N.V., and Sumpton, R.C. (1986). Follow Up Study of 448 People Who are Mentally Handicapped. Final Report to the DHSS. Manchester, The University, Department of Social Policy.

Baker, B.L., Seltzer, G., and Seltzer, M.M. (1977). As Close as Possible. Boston, Little Brown.

THE FOSTER HOME INVENTORY.

AUTHORS: Research Group at Lanterman Developmental Center

DATE: 1979.

PURPOSE.

The Foster Home Inventory was developed in evaluation research studies of residential services by the Research Group at Lanterman Developmental Center in California. It is an adaptation of The Home Inventory (Caldwell and Bradley, 1984). The modified instrument is appropriate for use in foster homes accommodating mentally handicapped people. The age range for which it is appropriate is not specified, however, the item content is more suited to children than adults.

The primary purpose of the Foster Home Inventory is the evaluation of the extent to which the foster home provides an environment which is characterised by stimulation potential for the development of the fostered mentally handicapped person.

CONTENT.

The Foster Home Inventory contains 96 items which are rated "Yes" or "No". Items are grouped under nine headings. These are:

i. Provision of stimulation through equipment, toys and experience (17 items).

ii. Stimulation of mature behaviour (12 items).

iii. Provision of stimulating physical and language environment (12 items).

iv. Avoidance of restriction and punishment (7 items)

v. Pride, Affection and Thoughtfulness (16 items).

vi. Provision of masculine role models (5 items).

vii. Independence from parental control (7 items).

viii. Child centred flexibility (13 items).

ix. Family integration (7 items).

All the items are marked with a Yes/No response according to the presence or absence of a feature under observation or question. A summary score is obtained by adding the items in each section. The questionnaire is designed in such a way that "Yes" responses always indicate the presence of a desirable condition and "No" the presence of an undesirable condition.

ADMINISTRATION.

In the research studies an interviewer uses the Foster Home Inventory to record information collected in a foster home visit. The Foster Home Inventory is completed primarily by observation. Those items for which direct observations are required are indicated on the schedule. The interviewer is instructed to ask permission to see the home, play yard or garden, the child's possessions and has also to observe the child interacting with the foster parent. Those items for which direct questioning of the caretaker are permissible are identifiable on the questionnaire. Directions which indicate the way each block of items is to be completed are included on the form.

No information is given about the training of the individuals who are using it. No information is given about the length of time taken to complete the observations necessary for the Inventory's completion.

SCIENTIFIC CREDIBILITY.

No information is yet available.

REFERENCE.

Research Group at Lanterman Developmental Center. (1979). The Foster Home Inventory. Pomona, California, Lanterman State Hospital

THE POST-INTERVIEW RATING SCALE.

AUTHORS: The Research Group at Lantermann Developmental Center.

DATE: 1979.

PURPOSE.

The Post-Interview Rating Scale was designed as part of a research study to evaluate alternative forms of residential provision within the community. It taps many of the areas explored by the HOME Inventory (Caldwell, and Bradley, 1984). It explores the general atmosphere of the home, and the attitude of care providers to clients in terms of acceptance and the promotion of growth and development. It was designed for use by interviewers after they had completed the Foster Home Inventory and left the foster home. It not only enabled them to rate the home but also to rate their view of the quality of the information they had obtained from the interview and observations required for the Foster Home Inventory and their own degree to certainty in their post-interview ratings of the environment provided in the foster home.

CONTENT.

The rating scale is in two parts. Part I consists of ratings whose focus is aspects of environment:

a) promoting of client growth;

b) control over client;

c) acceptance and rejection of client by care provider;

d) over-protection of client;

e) caretakers ability to cope with the client and awareness of client's disability;

f) adjustment of care provider's family to client;

g) harmony in the home;

h) involvement of other home members;

i) validity and reliability of the care providers responses to the Foster Home interview and the interview situation.

Part II focuses on a range of aspects of the physical environment of the foster home.

The questions have multiple alternative responses which are precoded. The interviewers also have to rate the degree of confidence they have in their own ratings for each item in Part I on a scale of 0 (low) to 3 (high).

ADMINISTRATION.

The interviewers are instructed to become familiar with three groups of questions which identify the framework within which the rating scale is to be completed. The completion of the rating scale is to be carried out immediately following the completion of the Foster Home Inventory after the interviewer has left the foster home.

No information of the length of time taken to complete the precoded schedule is given.

SCIENTIFIC CREDIBILITY.

No research data are yet available on this rating scale.

REFERENCE.

Research Group at Lanterman Developmental Center (1979). Post Interview Rating Scale. Pomona, California, Lanterman Developmental Center.

GROUP HOME ENVIRONMENT SCALE. (GHES)

AUTHOR: Reynolds, W.M. (1977)

DATE: 1978.

PURPOSE.

This measure was specifically designed to assess the social climate of group homes for mentally handicapped people, ranging in age from adolescence to adulthood. The instrument was developed from a sample of 218 staff in 51 group homes. It derives its conceptual base from the work of Moos, (Moos, 1973) and the principles of normalization. Its primary uses are to describe and evaluate the environments of group homes and to facilitate the monitoring of change in the environmental characteristics of these.

CONTENT.

The GHES has 50 items grouped in 8 sub-groups. These are residents' interaction with staff; with other residents; staff interaction with staff; resident interaction with the environment; staff interaction with the environment; resident, staff and environmental characteristics.

A True-false response format is used for each item. Responses yield single numerical scores representing the sum of non-weighted item scores. The measure is very similar in its appearance to the other measures of social climates developed by Moos and his colleagues.

ADMINISTRATION.

Literate persons who are familiar with the group home being assessed can complete the pencil and paper test, thus both staff and able residents can complete them. It takes approximately fifteen to twenty minutes to complete the GHES. No training is necessary, nor is a professional background. Instructions for its completion are given in the accompanying manual.

SCIENTIFIC CREDIBILITY.

Standardization. No reference norms are available but research is in progress to establish these in the USA.

Reliability. The internal consistency of the GHES has been explored using the Kuder-Richardson-20 formula. A value of .92 was obtained. Overall item correlation with the total score was .59.

No other form of reliability data is available.

Validity. No research data are yet available but studies are in progress in the USA.

REFERENCE.

Reynolds, W.M. (1978). Assessing the Social Climate of Group Homes for Developmentally Disabled Persons.

Paper presented at the Annual Meeting of the American Association on Mental Deficiency. Denver, Colorado. May, 1978.

Moos, R. (1973). Conceptualization of Human Environments. American Psychologist, 28, 652-665.

THE CHARACTERISTICS OF THE PHYSICAL ENVIRONMENT.

AUTHORS: Rotegard, L.L., Bruininks, R.H., and Hill, B.K.

DATE: 1981.

PURPOSE.

The CPE was designed to assess the extent to which the characteristics of the physical environment of a facility are homelike and thus integrated into the community. The concept of normalization which is its theoretical base assumes that the more homelike the residences the less the facilities would be perceived as deviant and therefore the more integrated they would be into their neighbourhood. By extraction those who live in such facilities would appear less deviant to both the staff and other members of the local community.

The CPE was developed in a study of 236 residential facilities including community residential facilities and institutions. The characteristics of the physical environments of 2,271 residents were investigated in these facilities as part of a 2-stage sampling design exploration of the national population of residential facilities, in which mentally retarded persons were resident in the USA.

CONTENT.

In the CPE each of five areas in a residence is rated on a 5-point basis, using an analogue scale. A rating of one is given to a very homelike environment and a rating of five to a non-homelike environment. The areas are dining, living, bathroom, bedroom and garden or yard. For each item an anchor definition is provided

for each pole of the continuum represented by the visual analogue.

ADMINISTRATION.

A trained interviewer completes the ratings for each area, following a tour of the facility which is necessary for completion of the CPE.

No information is given about the time taken to complete the measure.

A convention of giving a score of zero was adopted where one or more items did not apply.

SCIENTIFIC CREDIBILITY.

Standardisation. There are no research data available.

Reliability. The reliability of the measure was tested through intercorrelational analyses of the relationship between item scores and full scale scores. The item concerned with the facilities yard or garden, showed a smaller correlation with full scale scores than other items.

No information on other forms of reliability is given.

Validity. The measure has been shown to discriminate between residences.

REFERENCE.

Rotegard, L.L., Bruininks, R.H., and Hill , B.K. (1981). Environmental Characteristics of Residential Facilities for Mentally Retarded People. Minneapolis, MN, University of Minnesota.

RESIDENTIAL CARE OF THE MENTALLY HANDICAPPED.

AUTHORS: Royal Society for Mentally Handicapped Children and Adults.

DATE: 1986.

PURPOSE.

The checklist Residential Care of the Mentally Handicapped is one of a number of checklists published under the title of Stamina Papers, prepared by the National Society for Mentally Handicapped Children, for use by parents. The primary purpose of the checklist is to acquaint parents with the quality and standards of Services authorities should provide and give them a means to enable them to evaluate the provision made locally. The checklist of items are preceded in the booklet, of which they are a part, by a clear outline of statutory responsibilities and relevant legislation. The checklist is designed to assist in a clear evaluation of what is currently provided in a locality to assist parents and authorities in identifying the shortfalls and agreeing ways of remedying the deficiencies and what is required.

CONTENT.

The checklist is divided into two main sections. Section 1 covers services for children under the age of 16 living at home, with foster parents, or in residential homes and hostels. There are 52 items in this section. In Section 2 services for mentally handicapped adults are covered and services for those living at home. There are 50 items in this section.

The items in both sections are presented as statements of good quality. In Section 1, for example, for those living at home the

checklist items include the statement that "There is a day and programme throughout all school holidays, and a full laundry service is available". In Section 2, statements in the checklist include, for example, the statements:
"That hostels should contain no more than 15 residents" and
"That homs help and other kinds of support for families are available".

ADMINISTRATION.

Parents are instructed to check that all the statements in the checklist characterize the services in their area. Where services fall short of these statements they are urged to discuss the shortfalls with the appropriate authorities. No training in the use of the checklist is indicated.

SCIENTIFIC CREDIBILITY.

There is no research information yet available.

REFERENCE.

MENCAP (1986). Stamina Paper No. 3. Residential Care. London, Royal Society for Mentally Handicapped Children and Adults.

HOSPITALS FOR MENTALLY HANDICAPPED PEOPLE.

AUTHOR: Royal Society for Mentally Handicapped Children and Adults.

DATE: 1986.

PURPOSE.

The checklist for Hospitals for Mentally Handicapped People is one of a series of checklists prepared by MENCAP to assist parents to identify the characteristics of a good quality co-ordinated service for mentally handicapped people and their families. This checklist focusses on features of care provided in hospitals. It is designed to take account of the service for mentally handicapped people of all ages who are in long stay hospitals. It is designed to assist parents in the evaluation and monitoring of the services they and their family members receive and to provide a basis for discussion of ways of improving identified shortfalls with the appropriate providing authorities.

CONTENT.

The checklist is divided into eleven sections and contains 67 items. Section I covers items relevant to quality of service before admission, e.g., family is given the opportunity to visit the hospital before admission. Section II focuses on residence in hospital e.g., that hospital care is as homelike as possible. Section III focuses on the rights and status of individual residents, e.g., they are given every opportunity to make decisions for themselves. Section IV focuses on the quality of life, e.g., furniture is varied and domestic in appearance. Section V focuses on the care staff, e.g., staff ratio of 1 to 3

is maintained for profoundly or severely handicapped children, as are staff guidelines. Section VI focuses on Specialist staff, e.g., that there exists a specialist support team. Section VII is concerned with medical treatment and Section VIII with the education of children and adults. Sections IX and X are concerned with leisure and the community respectively. Section XI focuses on items relating to service monitoring.

The 67 items in the checklist are presented as statements of the characteristics of quality services.

ADMINISTRATION.

Parents are instructed to discuss with staff the items on the checklist and tick off those already provided. They are encouraged to raise as subjects for enquiry and discussion those items which are not ticked. No indication of the time taken to complete the checklist is given. No prior training is required.

SCIENTIFIC CREDIBILITY.

There is no research information yet available.

REFERENCE.

MENCAP (1986). Stamina Paper No. 4. Hospitals for Mentally Handicapped People. London, Royal Society for Mentally Handicapped People.

THE COMMUNITY ADJUSTMENT SCALE. (CAS)

AUTHORS: Seltzer, M.M., and Seltzer, G.B.

DATE: 1976.

PURPOSE.

The purpose of the Community Adjustment Scale is to assess how retarded adults are adjusting to community living. The design of the instrument facilitates its use to describe the residential environments provided for the adult mentally handicapped person and to monitor these. The CAS has been used in a variety of residential settings within the community and within institutional settings in the United States.

The concept of adjustment to community living is seen as a complex process of which several components have to be addressed. These are:

1. Whether the person has the skills.
2. Whether the person performs or uses the skills.
3. Whether the environment provides opportunities to use the skills.
4. Whether the person has the motivation to acquire and use the skills.

Four areas of activity are covered in the scale. For each item within these, an assessment is made of the skills, performance, environmental opportunity and individual motivation with regard to the activity.

Using the measure it is possible to identify the individual's mastery of community living skills; the individual's independent

performance of these mastered skills; the motivation of the individual to perform the skills and the extent to which the community environment provides an opportunity for independent performance. Each aspect of a person's life is considered from these four perspectives.

Within the area called Environmental Opportunity, the scale identifies five dimensions of the environment. These are:

i. In-house responsibilities assigned to subjects.

ii. The amount of autonomy offered to clients.

iii. The extent to which residents have easy access to community and within-house resources.

iv. The favourableness of the expectation held by staff about clients.

v. The extent to which training is provided for residents in areas of mastered skills.

These environmental dimensions can be used independently of the other information in the measure or in conjunction with them.

CONTENT.

There are 337 items in the CAS. The majority of them are questions which require a Yes or No response. Items which relate to the motivation of the individual are rated by the using of a 7-point visual analogue scale. The areas covered from each of the perspectives are:

1. Advanced personal care.

2. Housekeeping (which includes food preparation and serving meals, laundry and clothing care; house cleaning, home repair and maintenance).

3. Communication, (which includes speech and reading and

writing).

4. Social adjustment, (which includes recreational activities and friendship and sexuality).
5. Community participation (which involves telephone, time and calendar and travel and eating in public).
6. Economic management (which includes purchasing and budgeting and backing).
7. Work (which includes finding a job and work activities and work adjustment).
8. Agency utilisation (which includes medical transactions; safety).

Completion of the CAS yields a profile of a resident and of his, or her, environment, which identifies the skills yet to be learnt, skills already mastered, but not regularly performed; motivational deficits and environmental barriers to performance defined on each environmental dimension referred to above.

ADMINISTRATION.

A minimal training appears to be required to complete the CAS. The accompanying manual explains the definitions of the terms used. A supervised practice is regarded as necessary. Details as to the scoring of the environmental dimensions are not published. No information is given about the time it takes to complete the CAS.

SCIENTIFIC CREDIBILITY.

Standardisation. No research data are yet available.

Reliability. All but four sub-scales had an Alpha (Cronbach) reliability of .70 or greater. The skills and performance domains had particularly high reliabilities, ranging from .76 to .96.

Validity. During the development of the CAS, a professional review was conducted to improve the face validity of the items. A pilot study was conducted in order to provide statistical validation of the theoretical structure of the scale, by computing relationships among the four domains. The analyses supported the theoretical assumptions underlying the instrument and also resulted in various modifications in the content and administration of the final version of the scale.

REFERENCES.

Seltzer, M.M., and Seltzer, G.B. (1978). Context for Competence. Cambridge, Massachusetts. Educational Projects Inc.

Seltzer, G.B. (1980). Residential Satisfaction and Community Adjustment. Paper presented at the American Association of Mental Deficiencies, San Francisco. May 14.

IPP EVALUATION CHECKLIST.

AUTHOR: Simons, K.

DATE: 1986.

PURPOSE.

The IPP Evaluation Checklist is intended to monitor an IPP system. This Checklist was designed as part of a research study to evaluate the relocation of mentally handicapped people from hospitals and hostels to alternative accommodation in the community. It was designed specifically to facilitate the collection of information about the case conferences generated by the Individual Programme Plan system used in the development of the new placements for clients by health and social services and voluntary organisations.

CONTENT.

The Checklist covers:

i. Description of the meeting.

ii. Venue of the meeting.

iii. Meeting participants.

iv. Topics covered, e.g., philosophy of care, preparation for the move.

v. A summary of needs, skills, judgemental comments and strengths and problems.

vi. Extent of involvement of client or client's advocate.

vii. Involvement of relatives.

viii. Focus of meeting.

ix. Goals and Tasks recorded.

x. Meeting mode.

The response format is mainly precoded dichotomous response categories with some open ended items.

ADMINISTRATION.

In the research study the IPP evaluation checklist was completed by a research worker after attending a case conference. No information on the time taken to complete it or of the analysis it generates is given.

SCIENTIFIC CREDIBILITY.

No research information is yet available.

REFERENCE.

Simons, K. (1986). Kirklees Relocation Project. IPP Evaluation Checklist. Sheffield: The University.

THE RELATIVE SCHEDULE.

AUTHOR: Simons, K.

DATE: 1986.

PURPOSE.

The Relative Schedule is a questionnaire designed to obtain the views of relatives of mentally handicapped people about a number of aspects of the past, present and future lives of the mentally handicapped member of the family and the effect of these on his or her family. It was designed as part of a research study to evaluate the effect of relocation of residents from hospitals and hostels to alternative accommodation in the community.

CONTENT.

The schedule is divided into five sections. These cover:

i. background information about the resident,

ii. involvement in the resident's care by relatives in the past,

iii. the relatives' views on current placement for mentally handicapped persons,

iv. the relatives' feelings about the move,

v. the relatives' predictions for success of new placement and relative's attitudes to community care.

The questions have variable response formats.

ADMINISTRATION.

The Relative Schedule is used in an interview with a family member. In a research study the relative's co-operation was sought after an interview with staff had been completed and the

planned move for the client has been approved.

Prior to the interview with the family member, basic details about the client were obtained, including the relationship to the family member and the current and proposed placement for the mentally handicapped person.

No information is given about the time taken to complete the interview, or the analysis of the data it generates. No information is given about the training required to administer it.

SCIENTIFIC CREDIBILITY.

Simons, K. (1986). Kirklees Relocation Project, Relative Interview Schedule. Phase 1. Sheffield, The University.

UNIT ORGANISATION SCHEDULE.

AUTHOR: Simons, K.

DATE: 1986.

PURPOSE.

The Unit Organisation Schedule is a self-administered questionnaire designed to collect information about residential units, rather than individual residents within them and to facilitate a comparison of residential units. It was designed as part of a research evaluation of the effect of the relocation of mentally handicapped people from hospitals and hostels into other forms of residence in the community. Its purpose is the collection of information about policies and practices operating at the level of the residential unit.

CONTENT.

The Unit Organisation Schedule covers practices relating to:

i. Visitors.

ii. Bed times.

iii. Weekends.

iv. Holidays.

v. Rooms and furnishings.

vi. Resident's money.

vii. Meal times and snacks.

viii. Staff uniform.

ix. Toilets, bathing and laundry.

x. Occupational activity.

There are thirty questions, with precoded dichotomised response categories.

ADMINISTRATION.

The questionnaire is self-administered, being completed by the person in charge of a member of the residential unit. No information is given on length of time taken to complete it, nor on the analysis of the data it generates.

No prior training is required to complete it.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCE.

Simons, K. (1986). Kirklees Relocation Project Unit Organisations. Sheffield, The University.

THE STAFF SCHEDULE.

AUTHOR: Simons, K.

DATE: 1986.

PURPOSE.

The Staff Schedule is a questionnaire designed to obtain information from staff members about mentally handicapped residents, adults and children, for whom a move from a long term placement (in hospital or the community) to a more independent setting in the community is planned.

It was developed for use in a research study designed to evaluate the impact on both mentally handicapped people or their families of such a relocation.

CONTENT.

The Staff Interview Schedule is in two sections. The First section consists of the American Adaptive Behaviour Scale (Nihira et al. 1975). The second section covers:

i. Standard personal data relating to age, use of medication, and aids and the presence of physical disabilities.

ii. Services used by residents, source of service and frequency of up-take, reasons for current needs.

iii. An Index of Community Involvement to reflect the use by residents of ordinary public amenities, e.g., pubs, the context of the use of these and contact with friends and family.

iv. Staffs' perception of residents' relationships.

v. Residents' financial situation.

vi. Residents' behaviour problems and factors which trigger

them.

vii. Staff predictions about the success of aspects of the new placement for the client.

The response format is variable.

ADMINISTRATION.

The schedule is used in an interview with the client's keyworker prior to the client's move. No indication is given of the length of time taken to complete it or the analysis of the data it generates. No indication is given of the need for any training prior to its use.

SCIENTIFIC CREDIBILITY.

No research information is yet available on this schedule.

REFERENCE.

Simons, K. (1986). Kirklees Relocation Project Staff Schedule. Phase 1. Sheffield, The University Sociological Studies.

Nihira, K., et al. (1975). The Adaptive Behaviour Scale. Washington, D.C. American Association on Mental Deficiency.

ENVIRONMENTAL EVALUATION SCHEDULE.

AUTHOR: Simons, K.

DATE: 1986.

PURPOSE.

The Environmental Evaluation Schedule is designed to provide descriptive information about the objectives, policies, and practices of residential facilities used by mentally handicapped people. The schedule was developed in a research study evaluating the effect of relocation on mentally handicapped people of a move from hospitals and hostels to community residences.

CONTENT.

The schedule covers:

i. Numbers of residents in the units.

ii. Staffing complement, qualifications and use.

iii. Philosophy and policies of the unit.

iv. Care practices.

v. Rules and regulations for residents.

vi. Recreation and occupation.

vii. Residents' involvement in decision making.

The response formats to the questions are variable.

ADMINISTRATION.

The Environmental Evaluation Schedule is to be used in an interview with the person in charge of residential units. In the evaluation study it was used in this way by the researchers. No indication is given of the length of time taken to complete it or of the data it generates.

No information is given about necessary training prior to the use of the schedule.

SCIENTIFIC CREDIBILITY.

No research reports are yet available.

REFERENCE.

Simons, K. (1986). Kirklees Relocation Project Environmental Evaluation Schedule. Sheffield, The University.

THE RESIDENT INTERVIEW.

AUTHOR: Simons, K.

DATE: 1986.

PURPOSE.

The Resident Interview is designed to obtain the views of mentally handicapped people about the service being provided for them. It was developed in a research study evaluating the effect of the relocation of residents from hospitala and other settings, to alternative accommodation within the community.

The Resident Interview was designed for use with mentally handicapped adults including people with no speech or with speech impediments.

CONTENT.

The Resident Interview consists of an unstructured, tape-recorded inteview in which a modified life story book is used. The latter comprises photographs of all the people with whom the "movers" have contact, their present, future (and sometimes, past) placements. The photographs are used in the interviews along with happy/sad faces to elicit information about the resident's feelings about past, current, or future placements.

ADMINISTRATION.

Photographs of the residents, their present and future residences and other people who live and work with them need to be taken prior to the tape-recorded interview. In the research study the interviewer was also the person who took the photographs. The photographs are used in the course of a tape-recorded interview.

Three stylised cartoon faces, (happy, sad and neutral) are also used in the interview to enable interviewees to indicate the way they feel about where they live. The interviewee is asked, for example, what kind of face he/she would have if they lived in a particular place shown in one of the photographs.

The presence of the photographs in the interview are said to make people more relaxed, to provide visual prompts for interviewees and enhance the interviewer's comprehension of what the interviewee is saying. The use of the photos assists the non-and nearly non-verbal interviewees to indicate their view by pointing and moving the photos about and ordering them.

No information on the time it takes to complete this interview or the analysis of the data is given. No information is given on prior training requirements.

SCIENTIFIC CREDIBILITY.

No research data are yet available.

REFERENCE.

Simon, K. (1986). Kirklees Relocation Project Information Bulletin No. 2. Interim Report on Progress. Sheffield, Department of Sociological Studies, Kirklees Relocation Project.

GROUP HOME MANAGEMENT SCHEDULE. (Revised).

AUTHORS: Pratt et al. (1980). Modified by Temple University Development Disabilities Center Study. Temple University, Philadelphia.

DATE: 1984.

PURPOSE.

The ten item Group Home Management Schedule (Revised) (GHMS) is a modified version of the Group Home Management Schedule developed by Pratt et al. (1980), which was based on the RRMP of Raynes, Pratt & Roses (1979). The revised GHMS was developed by the research group at Temple University, Philadelphia to cut down the length of time it took to administer. It differs from the GHMS in having fewer items and a simplified scoring procedure. It was used as part of the site package developed to assess the community living alternatives provided for mentally handicapped persons following the Court ordered closure of a State School in Pennsylvania, U.S.A.

Its focus is the orientation of the management of daily activities in residential settings. It measures the extent to which these are resident oriented.

CONTENT.

The schedule has ten items, all taken from the GHMS (Pratt et al. 1980). Four items relate to the timing of daily events and six to the involvement of residents in activities for household and self maintenance, e.g., allocation of household chores, shopping for clothes. The items are scored on a four point rating scale, the lower score indicating a high level of institutionally oriented

management. A total score is obtained by summing item scores. A high total score is stated by the authors to indicate a high degree of consistency with normalization model.

ADMINISTRATION.

In the research studies carried out by the team from Temple University the GHMS (Revised) is incorporated in a site review package which is used by trained interviewers. The staff of the residences are interviewed to obtain the information required.

The ten GHMS (Revised) items take five minutes to complete.

SCIENTIFIC CREDIBILITY.

Standardisation. No research information is yet available.

Reliability. Studies of test-retest, and inter-rater reliability have been carried out as have tests of the internal reliability of the measure. For test-retest rho = .857 $p < .001$; for inter-rater reliability rho = .590 $p < .05$. Cronbachs alpha = .897.

Validity. The measure discriminates across community settings as well as between community and institutional settings.

REFERENCES.

Conroy, J.W.., and Bradley, V.J. (1985). The Pennhurst Longitudinal Study: A report of five years research and analysis. Philadelphia, Temple University. Developmental Disabilities Center.

Devlin, S.J. (1987). Reliability Assessment of the Instrument used to monitor the Pennhurst Plaintiff Class Members. Philadelphia, Temple University, unpublished.

Pratt, M.W., Luszcz, M.A., Brown, M.E. (1980). Measuring Dimensions of the Quality of Care in Small Community Residences. AJMD, 85, 188-194.

Raynes, N.V., Pratt, M.W., and Roses, S. (1979). Organizational Structure and the Care of the Mentally Retarded. London, Croom Helm.

THE PHYSICAL QUALITY INSTRUMENT.

AUTHORS: Temple University.

DATE: 1985 (Developed in 1983 from work carried out by Seltzer in 1982).

PURPOSE.

To provide an assessment of the pleasantness of the residence and the neighbourhood in which homes for mentally retarded people are located in the community. Some of the items suggest that the absence of deviance in the site and its surrounds are of concern. The items relating to the characteristics of the rooms appear to be concerned with dirtiness, scruffiness and dilapidation and with the extent to which the resident's individuaity is manifest.

The measure was used in the assessment of community living arrangements of 320 mentally retarded persons who previously lived in Pennhurst State School and Hospital, a large institution in Pennsylvania.

CONTENT.

In the PQI there are eleven questions, grouped in three sections. Section one contains three items related to the external appearance and the location of the home. They are each rated on a 4-point scale. High scores are given to sites or buildings and neighbourhoods which are described as "very pleasant and attractive". Low scores reflect unattractiveness and dilapidation in the characteristics of these facets of the homes.

Section two contains room-by-room assessment, identifying five

aspects to be rated in living, dining, bed and bathrooms and the kitchen. These attributes are orderliness, cleanliness of walls and floors, conditions of furniture and windows and the presence of odours. In each room the rating for each of these attributes is made. A 4-point rating scale is used. High scores represent cleanliness, good condition, airiness and the absence of odours.

Section three in the PQI entitled "Over-all" consists of three items, two of which rate the resident's rooms in terms of the presence of variation in design and the extent to which these rooms are personalised. The third item is a rating of the "Over-all Physical Pleasantness of the Facility" (Conroy and Bradley, 1985, p.9). These three items are also rated on a 4-point scale.

ADMINISTRATION.

A 4-day training session was used in the study in which the measure was developed to familiarise interviewers with this and other instruments. Three instruments (P.Q.I., Life, Safety Codes and the G.H.M.S.) took half an hour to administer. Thus it would seem that the instrument can be completed in around ten minutes. It is not clear whether this includes the tour of the facility which is clearly necessary to make the ratings.

SCIENTIFIC CREDIBILITY.

Standardisation. No research data are available as yet.

Reliability. Test- retest and inter-rater reliability data are reported, rho = .700 and .384 respectively. The latter does not reach an acceptable level Internal Scale, consistency was measured using Cronbach's alpha. (Reported Alpha = .888). Thus the PQI appears to have a high level of internal consistency (Devlin, 1987).

Validity. The PQI differentiates between different types of residential settings. (Conroy and Bradley, 1985).

REFERENCES.

Devlin, S.J. (1987). Reliability Assessment of the Instruments Used to Monitor the Pennhurst Plaintiff Class Members. Philadelphia, Temple University, Ph.D. Thesis.

Conroy, J.W., and Bradley, V.J. (1985). The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis. Philadelphia, Temple University Developmental Disabilities Center.

NORMALIZATION INSTRUMENT.

AUTHORS: Temple University, modification of Wolfensberger and Glenn (1975)

DATE: 1983.

PURPOSE.

The Normalization Instrument was developed to assess the extent to which the principles of normalization are characteristic of the living environments provided for mentally retarded persons. It was intended to permit such an assessment in a limited time period with limited resources. It was developed by the Temple University Development Disabilities Center Research Group in a research study of institutional and community based residential facilities for adults and children. It derives directly from the PASS 3 instrument and the subset of 18 items developed from the full PASS 3 (50 item) scale and shown to correlate at r. = .965 with the Full Pass Scale (Flynn and Heal 1981). This 18-item scale was modified by the Evaluation and Research Group at Temple University's Departmental Disabilities Center and named the Normalization Instrument or Scale.

CONTENT.

The Normalization Instrument has 14 items. These are grouped into 9 areas:

a) Juxtaposition with other people perceived as deviant. (1 item)

b) Socially integrative activities. (4 items)

c) Age appropriateness. (3 items)

d) Discipline language used (1 item)

e)	Social overprotection.	(1 item)
f)	Individualization	(1 item)
g)	Staff attitudes to clients.	(1 item)
h)	Staff attitudes to their own work	(1 item)
i)	Model coherency	(1 item)

Each item is rated on a 5-point scale representing at one extreme negatively valued (peculiar, odd, unfamiliar, undesirable) attributes and at the other end positively valued attributes (e.g., desirable, worthy, consistent with high expectation).

A total score is obtained by summing the item scores.

ADMINISTRATION.

The training workshop run by PASS-3 trained Team Leaders and Assistant Team Leaders was used to train staff using this instrument.

In 1979 2-person teams were used to do the rating in institutional settings. Subsequently, 1-rater per site was used because the interrater agreement levels appeared high enough to justify this. This approach is reported by Conroy and Bradley (1985) to be cost effective and less intrusive in small community settings.

The length of time taken to administer the instrument is not stated. (but see PASS-3, Flynn and Heal, 1981).

Information for the items to be rated is obtained by interview and observation and follows procedures identified by Flynn and Heal (1981).

An analogue scale is included in the instrument to assist raters in identifying the appropriate rating for each item in an area.

SCIENTIFIC CREDIBILITY.

Standardisation. No research data are yet available.

Reliability. Inter-rater and Test-retest reliability coefficients are reported as rho = .470 and .901 respectively (Devlin, 1987). Both these indicate acceptability levels.

Internal consistency of the measure was examined using Cronbach's Alpha, (Aplha = .901), indicating a high level of internal consistency.

REFERENCES.

Conroy, J.W., And Bradley, V.J. (1985). The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis. Philadelphia, Tenple University Developmental Disabilities Center.

Flynn, R.J., And Heal, L.W. (1981). A Short Form of PASS 3. Evaluations Review. 5. 357-376.

Devlin, S.J. (1987). Reliability Assessment of the Instruments Used to Monitor the Pennhurst Plaintiff Class Members. Philadelphia, Temple University, Ph.D. Thesis.

Wolfensberger, W., & Glenn, L. (1975). Program analysis of services 3: A method for the quantitative evaluation of human services. Toronto: National Institute on Mental Retardation.

PERSONAL INDEPENDENCE, SERVICES AND MANAGEMENT SCHEDULE.

AUTHORS: Wing, L., Holmes, N., and Shah, A.

DATE: 1985.

PURPOSE.

The Personal Independence, Services and Management Schedule was designed for use in an evaluation of the effect on adult mentally handicapped people and their families of the transfer of clients from hospital to community. The focus of the Schedule is the individual client's experience of the living environment, as perceived by a member of staff.

CONTENT.

It covers a number of areas. These are:

1. The independence permitted to the client within the residence. This is rated on a 5 point scale. High scores indicate maximum permitted independence.
2. The independence permitted to the client outside the residence. This is rated in various ways, all to reflect the level of independence permitted.
3. Privacy afforded to the client.
4. Personal possessions permitted.
5. Services available to client and problems relating to these services.
6. Client involvement in decisions relating to activities in the residence using a 3-point rating scale.
7. Clients' personal relationships and roles.
8. Clients' participation in leisure activities and the location of these in a 4-week period.

9. Clients' participation in holidays.

10. Management of client's behaviour problems.

11 Staff predictions about future placement.

12. Resident's feelings about future placement.

13. Psychotropic drugs.

Areas 7-13 have variable response formats.

ADMINISTRATION.

The Schedule is used in a semi-structured interview with someone who knows the client well. No information is given about the length of the interview or the analysis of the data it generates, nor of the need for any training prior to its usage.

SCIENTIFIC CREDIBILITY.

No research information is yet available.

REFERENCE.

Wing, L., Holmes, N., and Shah, A. (1985). Darenth Study Schedule. Personal Independence, Services and Management. London, Institute of Psychiatry, mimeo.

ORGANISATION OF WARD OR HOSTEL.

AUTHORS: Wing, L., Holmes, N., and Shah, A.

DATE: 1985.

PURPOSE.

The organisation of Ward or Hostel Schedule was developed as part of a research study designed to evaluate the effect on clients and their families of the transfer of adult mentally handicapped clients from a hospital to residential settings in the community. Its focus is aspects of the living environment provided for clients.

CONTENT.

The Schedule covers several aspects of the organisation and style of management in the residence. It includes:

i. Orientation of resident management practices. A 20-item form of the Child Management Scale (King and Raynes, 1968) is used to measure the extent of which care practices are institution versus resident oriented. The 20-item revised CMS is scored on 3 or 4 point ratings, the possible range of scores is 0-42. Higher scores indicate resident oriented practices.

ii. The level of management autonomy. This is rated by an 18-item scale concerned with the extent to which staff make decisions about budgeting, resident and staff activities. Each item is rated on a 5 point scale.

iii. The level of functional autonomy of the residence. The extent to which services like laundry, meals, etc., are performed in the residence is measured by 9 items which are rated on a 6 point rating scale.

iv. The number of available leisure pursuits. Amenities for leisure are rated on a 5 point scale reflecting frequency of involvement of at least one resident in living unit, on campus and in the community.

v. The number of available occupations. Occupations available are rated present/absent if at least one resident takes part in a type of occupation in the living unit, on campus or in the community.

vi. The average staff/resident ratio on a day shift.

vii. Monitoring by line managers.

viii. Contact with other professional staff.

ix. Frequency of discussions about clients. Contact with other staff, staff monitoring and meetings are rated on a 5 point rating scale, reflecting level of frequency.

x. Adequacy of available advice, help and support to staff, rated as adequate or inadequate.

Multiple response formats are used for all the questions.

ADMINISTRATION.

The Schedule is used in a structured interview with the person in charge. No indication is given of the length of time taken to complete it, nor if any training is required prior to its use. Summary measures are derived from the interview data for:

i. staff autonomy,

ii. unit functional autonomy,

iii. orientation of management practices,

iv. number and frequency of leisure pursuits and their location,

v. number of available occupations both on site and in the community.

SCIENTIFIC CREDIBILITY.

No research data relating to specific measures derived from the Schedule are given, nor relating to the Schedule itself.

REFERENCES.

King, R.D., and Raynes, N.V. (1968). An Operational Measure of Inmate Management in Residential Institutions. Social Science & Medicine, 2, 41-53.

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Wing, L., Holmes, N., and Shah, A. (1985). Darenth Park Study Schedule: Organisation of Ward or Hostel.

RELATIVES' OPINIONS SCHEDULE.

AUTHORS: Wing, L., Holmes, N., and Shah, A.

DATE: 1985.

PURPOSE.

The Relatives' Opinions Schedule was designed as part of a research evaluation of the effect on clients and their families of the transfer of mentally handicapped adults from a hospital to residences in the community. The focus of the Schedule was the views of the relation of the client about the care and services being provided for the client and the client's proposed transfer.

CONTENT.

The Schedule is divided into four sections. Section one covers aspects of the residence, including physical aspects, regime and staff. The 12 items in this section are rated poor, acceptable or good.

Section two covers visiting, its frequency and relative's feelings about it. The six items in this section are rated in different ways.

Section three covers communication with staff and relative's feelings about this. The five items in this section are rated in different ways.

Section four focuses on relative's feelings about the proposed transfer of the client. The two items in this section have variable response formats.

ADMINISTRATION.

The Schedule is used in a semi-structured interview with parents. No information is given about the length of time it takes or the analysis of the data derived from it, or whether training is required prior to its use.

SCIENTIFIC CREDIBILITY.

No research information is yet available.

REFERENCE.

Wing, L., Holmes, N., and Shah, A. (1985). Darenth Study Schedule. Relative's Opinions. London, Institute of Psychiatry, mimeo.

RESIDENT'S OPINIONS AND BEHAVIOUR SCHEDULE.

AUTHORS: Wing, L., Holmes, N., and Shah, A.

DATE: 1985.

PURPOSE.

The Resident's Opinions and Behaviour Schedule was designed to obtain resident's views of their environments as part of a research study to evaluate the effect of the transfer of mentally handicapped adults from a hospital to residences in the community, on the clients themselves and their familes.

CONTENT.

The resident's opinions about various aspects of his living environment are covered in the first part of the Schedule. The items relating to these have various response formats. In the second part a rating of the resident's personal appearance is made by the interviewer.

ADMINISTRATION.

An interviewer uses the Schedule in a semi-structured interview with the client. No information is given about the length of time taken or the analysis of the information derived from it. No information is given about the training required to use the Schedule.

SCIENTIFIC CREDIBILITY.

There is no research information yet available.

REFERENCE.

Wing, L., Holmes, N., and Shah, A. (1985). Darenth Park Schedule: Resident's Opinions and Behaviour. London, Institute of Psychiatry, mimeo.

SOCIAL & PHYSICAL ENVIRONMENT OBSERVATIONS SCHEDULE.

AUTHORS: Wing, L., Holmes, N., and Shah, A.

DATE: 1985.

PURPOSE.

This observation schedule was design to evaluate the quality of the physical environment, amenities available and aspects of restrictiveness in the care provided in the residences of mentally handicapped adults. It was designed for use in a research study to evaluate the effect on clients and their families of a transfer from hospital to residences in the community.

CONTENT.

The Social and Physical Environment Obervations Schedule has three sections. Section one contains a modified form of the Index of Physical Environment (Raynes et al. 1979). This covers physical amenities available in a residence, e.g., toilets, wardrobes. There are 26 items in this section, rated on 7 point or 5 point rating scales, depending on classification of responses as ratios or percentages.

Section two covers the appearance of the residence and 11 aspects of the residence, e.g., cleanliness of floors, comfort of furniture, are rated as poor, acceptable or good.

Section three covers access to facilites and equipment, inside and outside the residences. The twenty-two items are rated as accessible to majority, inaccesible to a minority, or not accessible.

ADMINISTRATION.

An observer collects the information to record on the schedule. The ratings are pre-coded and defined on the schedule. No information about the length of time it takes to complete the schedule or the analysis of the data derived from it are given. No information about training required to use it is given.

SCIENTIFIC CREDIBILITY.

No research information is yet available.

REFERENCE.

Wing, L., and Rawlings, S. (1985). Darenth Study Schedule: Social and Physical Environment (Observations). London, Institute of Psychiatry, mimeo.

EDUCATION, OCCUPATION, LEISURE QUESTIONNAIRE.

AUTHORS: Wing, L., Holmes, N., and Shah, A.

DATE: 1985.

PURPOSE.

The Education, Occupation, Leisure Questionnaire was developed as part of a research evaluation of the effect on clients and their families of the transfer of adult mentally handicapped persons from a hospital to residences in the community. Its focus is the individual client and his or her reported experience of education, occupation and leisure activities.

CONTENT.

The questionnaire covers the following areas:

1. Participation in, location and duration of education, training or occupation.
2. Participation in, location and duration of leisure activities.
3. Time spent doing nothing, or engaged in simple stereotypes.
4. Client's attitude to work, education, or training.
5. Client's occupation at work, education or training.

The response formats to items in these areas are variable.

ADMINISTRATION.

Part of the information, that relating to areas 1-3 above, is obtained by interviewing a member of staff in the living unit, the remainder by interviewing a member of staff in the work/education or training setting.

Detailed instructions relating to coding are provided with the Schedule.

No information is given about the length of time taken to complete the Schedule or the analysis of the data derived from it, or whether training is required prior to its use.

SCIENTIFIC CREDIBILITY.

No research information is yet available.

REFERENCE.

Wing, L., Holmes, N., and Shah, A. (1985) Darenth Study Schedule. Education, Occupation, Leisure. London, Institute of Psychiatry, mimeo.

PASS 3 (PASS third edition).

AUTHORS: Wolfensberger, W. and Glenn, L.

DATE: 1975.

PURPOSE.

PASS 3 is a development of earlier editions of PASS; Programme Analysis of Service Systems. This was designed to permit the assessment of any service programme, but especially for all kinds of devalued persons (e.g. mentally handicapped, mentally ill, physically injured) and determine the extent to which the Service is normalised, that it promotes the social valuation and acceptance of the people for whom it is provided. It derives from the concept of normalization first developed by Bank-Mikkelsen (1969) in Denmark in the context of services for mentally handicapped people and subsequently described by Nirje (1969). In the USA the principle was elaborated by Wolfensberger (1972) who identified its relevance to a whole range of services for many different kinds of people perceived as 'deviant'. It has been used primarily in the field of services (residential, day, educational and recreational) for mentally handicapped people. It has been used in community and institutionally based services in the USA, Canada, England and Australia. (O'Brien and Tyne, 1981, Flynn, 1975). The French translation has been used in several countries with a French language culture.

CONTENT.

It contains 50 items, organised in five areas. Within these areas 34 items relate to normalization and 16 to administrative issues.

Each aspect of service quality is evaluated using ratings with 3

to 6 levels. The lowest level of rating indicating poor performance and the highest, good. A weighted score ranging from -947 to +1,000 is obtained by converting the item evaluation scores to weighted scores. Zero ratings on any item or the total PASS score (which is the sum of the 50 ratings) signifies minimally acceptable quality. Positive scores signify more than minimally acceptable quality, and negative ratings, less than minimally acceptable quality.

ADMINISTRATION.

An external team of 3 to 7 trained raters are required. A site visit can last from one to three days. The length of this depends upon the size and complexity of the service being evaluated. The raters familiarise themselves with all aspects of the service, using records, other written materials, interviews with clients and staff at different levels in the service. Following these enquiries the team members carry out a rating independently of each other. These rating take about two hours to carry out. Team members then meet and any discrepancies in ratings are resolved in a team reconciliation session which can be of 3 to 8 hours in length.

The weighted scores of the 50 ratings are summed to give a single indicator of the programmes overall quality.

A field manual (Wolfensberger and Glenn, 1975a) is available which provides detailed instructions for making judgements of the 50 aspects of the service. Additionally procedures for undertaking evaluations and reporting results are detailed in Wolfensberger and Glenn, 1975b, Wolfensberger, 1983 and O'Brien (1985). Training for site reviewers is available in England (CMHERA).

SCIENTIFIC CREDIBILITY.

Standardisation. PASS-3 has been ueed extensively in the USA. References norms are available (Flynn and Heal, 1981). A data base for services in England is being established (CMHERA, 1986, personal communication).

Reliability Internal consistency reliability coefficients of .92 were obtained (Flynn, 1980).

Interrater reliability of between .704 and .943 have been obtained with varying numbers of team raters. (Flynn and Heal, 1981).

Validity. PASS-3 discriminates between different types of service programmes and within types. Community programmes constantly outscore institutional programmes.

PASS-3 has been shown to have predicitive validity when correlated with developmental gains in mentally handicapped clients. (Eyman, et al. 1979).

REFERENCES.

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Wolfensberger, W. and Glenn, L. (1975). PASS - Programme Analysis of Service Systems: Handbook. 3rd edition. Toronto, Canada: Allan Roeher Institute.

O'Brien, J. and Tyne, A. (1981). The Principle of Normalization: A Foundation for Effective Services. London: CMH.

O'Brien, J. (1985). Normalisation Training Through PASS 3. Team Leader Manual. Decator, Georgia, USA: Responsive System Associates.

PROGRAM ANALYSIS OF SERVICE SYSTEMS' IMPLEMENTATION OF NORMALIZATION GOALS: "PASSING".

AUTHORS: Wolfensberger, W., and Thomas, S.

DATE: 1983

PURPOSE.

PASSING was designed to facilitate the evaluation of the quality of human service agencies provision for a wide range of clients, the planning of each service and the teaching of Social Role Valorization. Its focus is on the agencies adoption and implementation of social role valorization (SRV). It permits an evaluation of the extent to which service provision reflects social role valorization. It was designed to be accessible for use by a wide range of people both in regular evaluations of local services and as a training tool itself. It builds on the earlier work of Wolfensberger and Glenn (1975).

CONTENT.

The concept of Social Role Valorization and its major goals: social image enhancement and personal competency enhancement of people who are devalued or at risk of becoming so are fully described in the Passing Rating Manual (1983).

There are 42 ratings grouped in terms of the service action domain through which SRV goals may be achieved and the SRV goal it facilitates most. The service domains are: the physical settings (17 ratings); service structured groupings and relationships among people (13 ratings); service structured activities and other uses of time (6 ratings); miscellaneous other service such

as language and symbols (6 ratings). Within each domain the aspect of the service being rated is evaluated in terms of either of the 2 SRV goals, client social image enhancement or client competency enhancement, depending on which the service is most likely to impact. Thus there are 8 potential categories within which a PASSING rating might fall.

Each of the 42 component ratings is explained and differences between the ratings are detailed. The components are rated on a balanced continuum of 5 levels. The weighting assigned to these levels goes from -100% to +100% and is the same for all of the 42 ratings.

ADMINISTRATION.

The instrument can only be used for evaluation purposes by persons who have undergone systematic training. It is stated that PASSING can be applied by anyone who is capable and motivated after a modest amount of training. A six day PASSING training workshop being cited as the minimum pre-training required. Details of training can be obtained from the authors of this instrument.

These trained evaluators follow practices required for a PASS evaluation. The length of time taken to complete a PASSING evaluation will vary with the size of the agency service being identified.

A Ratings Manual Wolfensberger and Thomas, (1983), has detailed descriptions for each rating and guidelines for collecting and using evidence as well as the criteria for each of the 5 levels of service performance in terms of which each rating is to be made. Additional guidelines are provided (Wolfensberger, 1983).

SCIENTIFIC CREDIBILITY.

No details of research studies have yet been published but PASSING has been used widely in the U.S.A. and England.

REFERENCES.

Wolfensberger, W., and Glenn, L. (1975). PASS - Program Analysis of Service Systems: Field Manual 3rd edition. Toronto: Allan Roeher Institute.

Wolfensberger, W., and Thomas, S. (1983). PASSING: Program Analysis of Service Systems' Implementation of Normalization Goals: Normalization Criteria and Ratings Manual. Toronto: Allan Roeher Institute.

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APPENDIX

AUTHOR(S)

Accreditation Council on Services for People with Developmental Disabilities

INSTRUMENT
(PAGE IN DIRECTORY)

STANDARDS FOR SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITY (5)

FURTHER INFORMATION:

Dr M C Cerreto
Chief Executive Officer
ACDD
126 Boylston Street
Suite 202
Boston
Massachusetts 02116
USA

AUTHOR(S)

Ager, A.

INSTRUMENT
(PAGE IN DIRECTORY)

LIFE EXPERIENCES CHECKLIST (11)

FURTHER INFORMATION:

A Ager
Department of Psychology
University of Leicester
Leicester
LE1 7RH
England

AUTHOR(S)

Baker, B.L., Seltzer, G.B. and Seltzer, M.M.

INSTRUMENT
(PAGE IN DIRECTORY)

AUTONOMY SCALE (14)
THE RESPONSIBILITY SCALE (16)

FURTHER INFORMATION:

Dr G B Seltzer
School of Social Work
Boston University
264 Bay State Road
Boston
Massachusetts 02215
USA

AUTHOR(S)

Budde, J.

INSTRUMENT
(PAGE IN DIRECTORY)

ALTERNATIVE LIVING ENVIRONMENTS
RATING AND TRACKING SYSTEM (18)

FURTHER INFORMATION:

Dr J F Budde
Kansas University Affiliated Facility
351 Haworth Hall
University of Kansas
Lawrence
Kansas 66045
USA

AUTHOR(S)

Caldwell, B.M. and Bradley, R.H.

INSTRUMENT
(PAGE IN DIRECTORY)

HOME OBSERVATION FOR THE MEASUREMENT OF THE ENVIRONMENT (20)

FURTHER INFORMATION:

Professor B M Caldwell
University of Arkansas at Little Rock
Centre for Research on Teaching and Learning
33rd and University
Little Rock
Arkansas 72204
USA

AUTHOR(S)

Commission on Accreditation of Rehabilitation Standards

INSTRUMENT
(PAGE IN DIRECTORY)

THE STANDARDS MANUAL FOR REHABILITATION FACILITIES (25)

FURTHER INFORMATION:

C K Pearce
Assistant Director
CARF
2500 North Pantano Road
Tucson
Arizona 85715
USA

AUTHOR(S)

Conroy and Fernstein Associates

INSTRUMENT
(PAGE IN DIRECTORY)

CHOICE MAKING SCALE (29)

FURTHER INFORMATION:

Dr J Conroy
Temple University
Developmental Disabilities Center
Ritter Annex
Ninth Floor
Broad and Columbia Avenues
Philadelphia 19122
USA

AUTHOR(S)

Cragg, R. and Harrison, J.

INSTRUMENT
(PAGE IN DIRECTORY)

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QUESTIONNAIRE ON THE QUALITY OF LIFE (31)

FURTHER INFORMATION:

R Cragg
Department of Psychology
Lea Castle Hospital
Wolverley
Kidderminster
Worcestershire
DY10 3PP
England

AUTHOR(S)

Fernstein, C.S.

INSTRUMENT
(PAGE IN DIRECTORY)

LIFE SAFETY CODE INSTRUMENT (34)

FURTHER INFORMATION:

Dr J Conroy
Temple University
Developmental Disabilities Center
Ritter Annex
Ninth Floor
Broad and Columbia Avenues
Philadelphia 19122
USA

AUTHOR(S)

Flynn, R.J. and Heal, L.W.

INSTRUMENT
(PAGE IN DIRECTORY)

A SHORT FORM OF PASS 3 (36)

FURTHER INFORMATION:

Dr R J Flynn
Royal Ottawa Regional Rehabilitation Centre
505 Smyth Road
Ottowa
Ontario
Canada K1H 8M2

AUTHOR(S)

Flynn, A.G. and Weiss, S.K.

INSTRUMENT
(PAGE IN DIRECTORY)

A NORMALIZATION AND DEVELOPMENT INSTRUMENT (40)

FURTHER INFORMATION:

Dr A G Flynn
ANDI
Box 60964
Sacramento
California 95860
USA

AUTHOR(S)

Gunzburg, H.C.

INSTRUMENT
(PAGE IN DIRECTORY)

"39 STEPS" (43)

FURTHER INFORMATION:

Dr H C Gunzburg
Vogelweide
Pool Head Lane
Henley-in-Arden
Warwickshire
England

AUTHOR(S)

Henderson, R.W.

INSTRUMENT
(PAGE IN DIRECTORY)

HENDERSON ENVIRONMENTAL LEARNING PROCESS SCALE (47)

FURTHER INFORMATION:

Dr R W Henderson
20 - 4
Merrill College
University of California
Santa Cruz
California 95064
USA

AUTHOR(S)

Hampson, R., Judge, K. and Renshaw, J.

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FURTHER INFORMATION:

Corinne Thomason
Research Fellow
PSSRU
Cornwallis Building
The University
Canterbury
Kent
CT2 7NF
England

AUTHOR(S)

Humphreys, S., Lowe, K. and Blunden, R.

INSTRUMENT
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FURTHER INFORMATION:

Simone Humphreys
Research Officer
Mental Handicap in Wales
Applied Research Unit
St David's Hospital
Cardiff
CF1 9TZ
Wales

AUTHOR(S)

Ihlefield, R., Campbell, J., Dibiase, J., Hammond, P., Livenstein, M., Orndoff, R., Trowbridge, M and Wood, R.

INSTRUMENT
(PAGE IN DIRECTORY)

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FURTHER INFORMATION:

Judith A Shanley
Assistant Commissioner
County of Erie
Department of Mental Health
Erie County Office Building
95 Franklin Street
Buffalo
New York 14202
USA

AUTHOR(S)

Jackson, J.
Silverstein, A.B., McLain, R.E., Hubbell, M. and Brownlee, L.
McLain, R.E., Silverstein, A.B., Hubbell, M. and Brownlee, L.

INSTRUMENT
(PAGE IN DIRECTORY)

THE ORIGINAL CTE
THE REVISED CTE
THE CTE: MR/DD COMMUNITY HOME (CTE: MR/DD) (68)

FURTHER INFORMATION:

Dr Sharon Borthwick-Duffy
University of California
Riverside Research Group
at Lanterman Developmental Center
3530 West Pomona Boulevard
P O Box 100-R
Pomona
California 91769
USA

AUTHOR(S)

King, R.D., Raynes, N.V. and Tizard, J.

INSTRUMENT
(PAGE IN DIRECTORY)

THE CHILD MANAGEMENT SCALE
REVISED CHILD MANAGEMENT SCALE (74)

FURTHER INFORMATION:

Dr N V Raynes
Department of Social Policy
Faculty of Economics
University of Manchester
Manchester
M13 9PL
England

AUTHOR(S)

Mansell, J., de Kock, U., Jenkins, J. and Felce, D.

INSTRUMENT
(PAGE IN DIRECTORY)

THE ACTIVITY MEASURE (78)

FURTHER INFORMATION:

Dr D Felce
Director
British Institute of Mental Handicap
Wolverhampton Road
Kidderminster
Worcestershire
DY10 3PP
England

AUTHOR(S)

McLain, R.E., Silverstein, A.B., Hubbell, M., Brownless, L., Sutter, P. and Mayeda, T.

INSTRUMENT
(PAGE IN DIRECTORY)

THE RESIDENTIAL MANAGEMENT SURVEY (81)

FURTHER INFORMATION:

Dr Sharon Borthwick-Duffy
University of California
Riverside Research Group
at Lanterman Developmental Center
3530 West Pomona Boulevard
P O Box 100-R
Pomona
California 91769
USA

AUTHOR(S)

Mazis, S. and Canter, D.

INSTRUMENT
(PAGE IN DIRECTORY)

THE ENVIRONMENT SCALE (84)

FURTHER INFORMATION:

Professor David K. Canter
University of Surrey
Guildford
Surrey
GU2 5XH
England

AUTHOR(S)

Moos, R.H., Gerst, M.S., Humphrey, B., Insel, P. and Trickett, G.

INSTRUMENT
(PAGE IN DIRECTORY)

SOCIAL CLIMATE SCALES (87)

FURTHER INFORMATION:

Professor Rudolph H Moos
Department of Psychiatry
Stanford University School of Medicine
Stanford University Medical Center
Stanford
California 94305
USA

AUTHOR(S)

National Development Group for the Mentally Handicapped

INSTRUMENT
(PAGE IN DIRECTORY)

IMPROVING THE QUALITY OF SERVICES FOR MENTALLY HANDICAPPED PEOPLE. A CHECKLIST OF STANDARDS (94)

FURTHER INFORMATION:

National Development Team
Department of Health and Social Services
Elephant and Castle
London
SE1 6BY
England

AUTHOR(S)

Pratt, M.W., Luszcz, M.A. and Brown, M.E.

INSTRUMENT
(PAGE IN DIRECTORY)

GROUP HOME MANAGEMENT SCHEDULE (99)

FURTHER INFORMATION:

Dr Michael Pratt
Mount St Vincent University
Department of Psychology
Halifax
Nova Scotia
Canada B3M 2J6

AUTHOR(S)

Prudhoe Unit

INSTRUMENT
(PAGE IN DIRECTORY)

CONTINUOUS AUDIT OF RESIDENTIAL ENVIRONMENT STANDARDS (102)

FURTHER INFORMATION:

Mr A Wood
Deputy Assistant Unit General Manager
Prudhoe Hospital
Prudhoe
Northumberland
NE42 5NT
England

AUTHOR(S)

Porterfield, J., Evans, G. and Blunden, R.

INSTRUMENT
(PAGE IN DIRECTORY)

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STAFF BEHAVIOUR MEASURE (106)

FURTHER INFORMATION:

Gerry Evans
Mental Handicap in Wales
Applied Research Unit
St David's Hospital
Cardiff
CF1 9TZ
Wales

AUTHOR(S)

Raynes, N.V., Pratt, M.W. and Roses, S.
Pratt, M.W., Luszcz, M. and Brown, M.E.

INSTRUMENT
(PAGE IN DIRECTORY)

THE INDEX OF THE PHYSICAL ENVIRONMENT
FORM I; FORM II (108)

FURTHER INFORMATION:

Dr N V Raynes — Form I
Department of Social Policy
Faculty of Economics
University of Manchester
Manchester
M13 9PL
England

Dr Michael Pratt — Form II
Mount St Vincent University
Department of Psychology
Halifax
Nova Scotia
Canada B3M 2J6

AUTHOR(S)

Raynes, N.V., Pratt, M. and Roses

INSTRUMENT
(PAGE IN DIRECTORY)

REVISED RESIDENTS' MANAGEMENT PRACTICES (112)

FURTHER INFORMATION:

Dr N V Raynes
Department of Social Policy
Faculty of Economics
University of Manchester
Manchester
M13 9PL
England

AUTHOR(S)

Raynes, N.V., Pratt, M.W. and Roses, S. Form I
Raynes, N.V., Sumpton, R.C. and Pettipher, C. Form II

INSTRUMENT
(PAGE IN DIRECTORY)

INDEX OF COMMUNITY INVOLVEMENT FORM I;
FORM II (115)

FURTHER INFORMATION:

Dr N V Raynes
Department of Social Policy
Faculty of Economics
University of Manchester
Manchester
M13 9PL
England

AUTHOR(S)

Raynes, N.V., Sumpton, R.C. and Pettipher, C.

INSTRUMENT
(PAGE IN DIRECTORY)

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FURTHER INFORMATION:

Dr N V Raynes
Department of Social Policy
Faculty of Economics
University of Manchester
Manchester
M13 9PL
England

AUTHOR(S)

Research Group at Lanterman Development Center

INSTRUMENT
(PAGE IN DIRECTORY)

FURTHER INFORMATION:

Dr Sharon Borthwick-Duffy
University of California
Riverside Research Group
at Lanterman Developmental Center
3530 West Pomona Boulevard
P O Box 100-R
Pomona
California 91769
USA

AUTHOR(S)

Reynolds, W.M.

INSTRUMENT
(PAGE IN DIRECTORY)

FURTHER INFORMATION:

Professor William M Reynolds
University of Wisconsin-Madison
Department of Educational Psychology
1025 West Johnson Street
Madison
Wisconsin 53706
USA

AUTHOR(S)

Rotegard, L.L., Bruininks, R.H. and Hill, B.K.

INSTRUMENT
(PAGE IN DIRECTORY)

THE CHARACTERISTICS OF THE PHYSICAL ENVIRONMENT (129)

FURTHER INFORMATION:

Professor Robert H Bruininks
University of Minnesota
Department of Psycho-Educational Studies
249 Burton Hall
178 Pillsbury Drive SE
Minneapolis
Minnesota 55455
USA

AUTHOR(S)

Royal Society for Mentally Handicapped
Children and Adults

INSTRUMENT
(PAGE IN DIRECTORY)

RESIDENTIAL CARE OF THE MENTALLY HANDICAPPED (131)
HOSPITAL FOR MENTALLY HANDICAPPED PEOPLE (133)

FURTHER INFORMATION:

The Publications Officer
Mencap National Centre
123 Golden Lane
London
EC1Y 0RT
England

AUTHOR(S)

Seltzer, M.M. and Seltzer, G.B.

INSTRUMENT
(PAGE IN DIRECTORY)

THE COMMUNITY ADJUSTMENT SCALE (135)

FURTHER INFORMATION:

Dr G B Seltzer
School of Social Work
Boston University
264 Bay State Road
Boston
Massachusetts 02215
USA

AUTHOR(S)

Simons, K.

INSTRUMENT
(PAGE IN DIRECTORY)

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FURTHER INFORMATION:

Dr Ken Simons
Department of Sociological Studies
Joint Unit for Social Services Research
University of Sheffield
Sheffield
S10 2TN
England

AUTHOR(S)

Temple University

INSTRUMENT
(PAGE IN DIRECTORY)

FURTHER INFORMATION:

Dr J Conroy
Temple University
Developmental Disabilities Center
Ritter Annex
Ninth Floor
Broad and Columbia Avenues
Philadelphia 19122
USA

AUTHOR(S)

Wing, L., Holmes, N. and Shah, A.

INSTRUMENT
(PAGE IN DIRECTORY)

FURTHER INFORMATION:

Dr Lorna Wing
MRC Social Psychiatry Unit
Institute of Psychiatry
De Crespigny Park
London
SE5 8AF
England

AUTHOR(S)

Wolfensberger, W. and Glenn, L.

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FURTHER INFORMATION:

The Publications Office
G Allan Roeher Institute
Kinsmen Building
York University
4700 Keele Street
Downsview
Ontario
Canada M3J 1P3

AUTHOR(S)

Wolfensberger, W. and Thomas, S.

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