# A Quarter-Century of Normalization and Social Role Valorization: Evolution and Impact

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# A comprehensive review of research conducted with the program evaluation instruments PASS and PASSING

#### **ROBERT J. FLYNN**

Given the international prominence of the principles of Normalization and Social Role Valorization (SRV) in service policy, planning, and practice over the last quarter-century, as attested in many chapters of the present volume, it is not surprising that the main program evaluation instruments that these theoretical approaches have inspired have also been influential. Program Analysis of Service Systems (PASS 3; Wolfensberger & Glenn, 1975, 1989) and Program Analysis of Service Systems' Implementation of Normalization Goals (PASSING; Wolfensberger & Thomas, 1983, 1989) are currently used in the United States, Canada, the United Kingdom, France, Spain, Switzerland, Australia, and New Zealand, in fields such as mental retardation, mental health, and aging, to assess the quality of residential, vocational, recreational, and other types of community services, in terms of their consistency with Normalization and SRV principles, respectively. PASS and PASSING sessions are also organized on a regular basis in several of the countries just mentioned to train evaluators and teach the specific service implications of Normalization and SRV theory (see Thomas, chapter 15, this volume).

The present chapter is intended to provide a virtually exhaustive review of studies carried out during 1971-1998 with the various editions of PASS (Wolfensberger & Glenn, 1969, 1973, 1975, 1989) and PASSING (Wolfensberger & Thomas, 1980, 1983, 1989). The primary purpose of the review is to bring

the entire body of PASS and PASSING research to the attention of users of the instruments and of a wider audience of interested evaluators and researchers. The chapter covers every published or unpublished study that was based on a sizable number of PASS or PASSING evaluations and of which I was aware. The review excludes reports from routine PASS or PASSING evaluations of single programs or of a small number of services (hundreds of such reports exist).

A total of 48 studies are reviewed herein: 1 conducted with PASS 1 (Wolfensberger & Glenn, 1969), 3 with PASS 2 (Wolfensberger & Glenn, 1973), 20 with the regular (i.e., complete) version of PASS 3 (Wolfensberger & Glenn, 1975, 1989), 7 with short forms of PASS 3, 5 with adaptations of PASS 3, and 12 with the second edition of PASSING (Wolfensberger & Thomas, 1983, 1989). (No studies appear to have been carried out with the initial, experimental version of PASSING; Wolfensberger & Thomas, 1980.) The 48 studies have been grouped according to the instrument in question, and, within their respective groupings, they are discussed in chronological order of appearance. The review includes as many methodological details and substantive findings from each individual study as I thought necessary to enable readers to understand the study and assess its relevance to their own needs and interests. The chapter concludes with several critical comments and practical suggestions intended to encourage the publication of more high-quality PASS and PASSING research in the future.

Several search procedures were used to locate the 48 studies. Those appearing during 1971-1979 were covered in an earlier review (Flynn, 1980), the essence of which has been retained here in the interests of comprehensiveness. The great majority are from 1980-1998 and were located through computerized searches of the *Social Science Citation Index*, PsycINFO, and *Dissertation Abstracts International* databases, as well as through manual searches of relevant journals. Unpublished studies known to the author were also included.

# **1 STUDIES BASED ON PASS**

#### 1.1 STUDIES BASED ON PASS 1

Macy (1971) carried out the only PASS 1 study, based on the initial, unpublished version of the instrument (Wolfensberger & Glenn, 1969). PASS 1 was used in 1970 and 1971 to assess and allocate funding to new community mental retardation services in Nebraska. Macy found that total PASS scores correlated highly with movement by clients with mental retardation from a less advanced to a more advanced status (e.g., from training to independent employment).

#### 1.2 STUDIES BASED ON PASS 2

Flynn (1975, 1977) and Flynn and Sha'ked (1977) conducted the only published studies that used PASS 2, the second edition of the instrument (Wolfensberger & Glenn, 1973). Flynn's (1975) monograph, a summary of which may be found in the PASS 3 *Handbook* (pp. 25-27), consisted of a statistical analysis of 102 PASS 2 program evaluations that had been carried out in the US and Canada during 1973-1974. The 102 programs were an accidental sample of PASS assessments, comprising an estimated one-third of all assessments made with PASS 2. The results suggested that average service quality (as indexed by a mean total PASS score of +229 on a scale ranging from -849 to +1,000) was only modestly above zero.

The latter was the point defined by the authors of PASS as constituting a "minimally acceptable" level of service quality.

A subsequent study (Flynn, 1977), based on an enlarged accidental sample of 151 PASS 2 evaluations, extended the findings of the earlier monograph. The internal consistency of PASS 2 was estimated to be 0.90 (coefficient  $\alpha$ ) in the sample of programs, 93% of which were community-based and 72% of which served persons with mental retardation. Average service quality (as indexed by a mean total PASS score of +276) was only modestly above the minimally acceptable level, and performance on those ratings tapping social integration was particularly weak. In fact, despite their primarily community-based nature, the 151 programs were found to be more socially segregative than integrative. Ratings concerned with service proximity and accessibility and with features of the service setting tended to be more satisfactory than those concerned with aspects of the service program. Finally, PASS 2 was found capable of discriminating between different types of programs. Specifically, community programs had a higher mean total PASS score than institutional programs (p < .001). Also, an inverse monotonic relationship emerged between program quality and the age category of the clients served (young children, school-aged children and adolescents, adults, and elderly): the older the clients, the lower the total PASS score (p < .05).

In the third PASS 2 study, Flynn and Sha'ked (1977) conducted a further analysis of the data from this sample of 151 programs. A primary objective of this study was to determine the major PASS correlates of the rating *Age-Appropriate Sex Behavior*, and to offer recommendations for improving the quality of sex-related agency services. The strongest correlates of normative sex behavior included an agency emphasis on physical and social integration, normative personal appearance, specialization (coherence) of the service model, and developmental growth.

#### 1.3 STUDIES BASED ON PASS 3

Although PASS 3 (Wolfensberger & Glenn, 1975, 1989) has been largely superseded by PASSING in training and service-evaluation activities in the USA, Canada, Australia, and New Zealand, it is still used in the United Kingdom, France, and some other countries and has been the subject of more research than earlier versions of PASS or PASSING, PASS 3 is used by a team of external raters trained to evaluate a human service program on 50 different items or "ratings." Following detailed guidelines in the PASS Field Manual (Wolfensberger & Glenn, 1975), individual team members first rate the service independently. Then, in an often lengthy "conciliation" session, the team pools its information, resolves any discrepancies among individual members' ratings, and generates a single, team-conciliated set of ratings. Later, the team forwards a detailed written report containing its findings and recommendations. The total PASS score (the sum of the scores obtained on the 50 individual ratings) is an index of overall service quality. Seventythree percent of the total score reflects Normalizationrelated ratings, with the other 27% covering administrative issues, broadly defined.

Berry, Andrews, and Elkins (1977) reported on their evaluation of 36 educational, vocational, and residential programs serving persons with moderate and severe mental retardation in the three Australian states of Queensland, Victoria, and New South Wales (Andrews and Berry, 1978, provide a brief published version of the original research report). The 36 programs constituted a nonrandomly selected quota sample. In each state, 12 programs (3 schools, 3 sheltered workshops, 3 residential programs, and 3 activity-therapy centers) were assessed. The major findings of Berry et al. (1977) were as follows. First, the mean total PASS score of +316 indicated that service quality in the 36 programs was somewhat higher than minimally acceptable. (Flynn [1980] suggested, however, that this mean score was considerably higher than that observed in similar North American services because of a possible upward bias in scoring, due to the inability of the Australian raters to attend the standardized PASS 3 training sessions that, at the time, were conducted only in North America.) Second, large differences emerged among different types of programs: Schools (serving younger clients) had the highest PASS scores, followed by sheltered workshops, residential programs, and activity -therapy centers. Third, several common weaknesses were apparent across all 36 programs, in the areas of administration, culture-appropriateness, accessibility, and geographical setting.

positive

As part of a research program aimed at discovering which environmental variables promote growth in adaptive behavior in developmentally disabled persons, Eyman, Demaine, and Lei (1979) tested the predictive validity of six PASS 3 factors that Demaine, Silverstein, and Mayeda (1980; see below) had derived on a sample of 98 residences serving 245 persons with developmental disabilities. Eyman et al. related the residential facility factor scores to longitudinal measures of adaptive change obtained on the 245 residents, most of whom had remained in the same home during the 3-year study period. At least three annual ratings made by case workers using the Adaptive Behavior Scale (ABS; Nihira, Foster, Shellhaas, & Leland, 1974) were available for each resident. Three ABS factor scores were computed for each resident: personal self-sufficiency, community self-sufficiency, and personal-social responsibility. Average annual change on each of the three ABS factors was then calculated for each client over the 3year period. In order to test whether differences in residential environments were related to differences in client developmental gains, Eyman et al. used a pathanalysis framework in which the dependent variable in each of three separate analyses was the mean annual client change on each of the ABS factors, the exogenous (predetermined) variables were client age and IQ, and the intervening variables were the client's initial score on the respective ABS factor and the client's residence's scores on the six PASS 3 factors. The main findings of this validation study were as follows. Residents who were older (18 years and over), or who had mild or moderate retardation, showed greater developmental gains than did younger or more impaired residents. On the ABS dimension of personal self-sufficiency, residents who gained the most were older, had higher IOs, or lived in facilities with higher scores on the PASS 3 factors of environmental blending with the neighborhood, location and proximity of services, and comfort and appearance, and lower scores on ideology-related administration. Average annual gains in community self-sufficiency were greater in clients who had higher IQs or who lived in settings with higher scores on the PASS 3 factors of administrative policies, location and proximity, and comfort and appearance. Average annual gains in personal-social responsibility were positively related to older age, higher IQ, or residence in a facility with higher scores on location and proximity, and on comfort and appearance, but with lower scores on ideology-related administration. The first PASS 3 factor, application of Normalization principles, was not related to developmental gain on any of the ABS domains. (It should be noted that the labeling of the first PASS factor as "application of Normalization principles" is potentially misleading, because several other PASS factors-environmental blending of services with the neighborhood, location and proximity of service, and comfort and appearance of service setting-also assessed the application of Normalization principles and were related to developmental gains.) Finally, a moderately strong, statistically significant, canonical correlation of .456 (p < .001) was found between the six PASS 3 factors and the three ABS domain changes.

Demaine, Silverstein, and Mayeda (1980) examined the validity and utility of PASS 3 by assessing whether the instrument was able to fulfill one of its main purposes, namely, quantitatively evaluating the quality of human service programs. Demaine et al. factoranalyzed PASS scores gathered on 98 residential facilities serving developmentally disabled persons in California. Of the residential settings, 83% served 6 persons or fewer, 8% served 7 to 50, and 9% served more than 50. Slightly more than half of the settings were in suburban neighborhoods, with 40% in rural areas. Instead of being conducted by a team of trained raters, the PASS evaluations were conducted in a nonstandard way, by a single trained rater familiar with each facility who rated it from a PASS-structured written report. A pilot study, carried out to check on this nonstandard method, found that conventional PASS team evaluations, conducted on 5 of the 98 facilities, produced a statistically nonsignificant mean difference of only 40 points. The factor analysis by Demaine et al. yielded seven factors, six of which were interpretable: I: compliance with Normalization principles; II: administrative policies pertaining to Normalization principles; III: Issues of Normalization with regard to programming and physical setting; IV: issues related to the administration of services; V: physical location and availability of services; and VI: comfort and functional nature of the physical setting. Demaine et al. noted that Eyman et al. (1979) had already provided initial evidence of the validity of the six PASS factors for predicting behavioral outcomes of developmentally disabled persons.

Flynn (1980) used a sample of 256 American and Canadian programs (58% in the field of mental retardation and 63% conducted during PASS training workshops) to compare service quality in five different types of programs: institutional residences and community-based residential, child development, educational, and vocational programs. The service quality indices used were the total PASS score and four subscales empirically derived through factor and item analyses. Internal consistency (Cronbach's a) was high in the case of the total PASS scale (0.91) and of the two longest subscales, Normalization-Program (19 items,  $\alpha = 0.90$ ) and Normalization-Setting (12 items,  $\alpha = 0.80$ ). It was lower but still adequate in the case of the two shorter subscales, Administration (8 items, a = 0.64) and Proximity and Access (4 items,  $\alpha = 0.67$ ). To facilitate comparisons among these different service quality indices, all weighted PASS scores were linearly transformed to a common metric, the percentage of the maximum possible score (cf. Flynn, 1980, p. 337). There are both similarities and differences in the composition of the six factors found by Demaine et al. (1980) and the four discovered by Flynn (1980). The differences may be due to differences in factor-analytic techniques, in the procedures used to carry out the PASS evaluations, or the size and composition of the respective samples (the greater homogeneity of the exclusively residential sample used by Demaine et al. may, for example, have produced somewhat lower inter-item correlations and the emergence of a somewhat larger number of factors).

Global service quality in the sample was only modest: The mean total PASS score represented only 47% of the total possible weighted score. The total PASS score did discriminate, however, among the various types of institutional and community programs in the sample: Community child-development services scored highest, institutional residences scored lowest, and Canadian services scored 5% higher than American programs. As noted by Heal and Fujiura (1984, pp. 215-216), multivariate profile analyses of the four subscale scores provided further evidence of the discriminant and thus construct validity of PASS as a measure of Normalization. For example, child development services (in which integration was relatively more likely than in the other types of programs) outscored the other types of services on Normalization-Program, community residential services scored highest on Normalization-Setting, and the four types of community programs scored higher than the institutional residences on Proximity and Access. The different PASS profiles characteristic of each type of service suggested priority targets for efforts aimed at improving service quality (Flynn, 1980, pp. 352-353): the service setting and administrative processes in the case of the child development programs; program content and administrative issues in the case of the community residences; all three areas in the case of the educational and vocational programs (including a much greater emphasis on integration); and replacement by community residential options in the case of the institutional residences. Flynn (1980) also pointed out that the four empirically derived PASS factors could be used to improve the coherence and quality of evaluation reports. A visual profile of the four subscale scores could be presented, with the presentation of results, analyses, and recommendations organized around the key dimensions of service quality assessed by the four PASS subscales.

In his doctoral research in public administration, Ross (1981) compared the three main accreditation instruments in use at the time in the field of disability: PASS 3, the standards of the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (ACMRDD), and the standards of the Commission on Accreditation of Rehabilitation Facilities (CARF). Based on an analysis of the similarities and differences among these three approaches, Ross prepared a "consolidated" set of standards that incorporated what he saw as the most salient aspects of each; 32 were common to the three instruments, 11 unique. In a survey of administrators of community rehabilitation programs, Ross found that three of the common standards were strongly rejected: use of volunteers, the notion of "cultureappropriateness," and integration of disabled and nondisabled persons within the same program. The administrators appeared to prefer a pluralistic accreditation system adaptable to local circumstances rather than a single instrument or approach.

In her doctoral thesis in clinical psychology, Golden (1982) examined discrepancies between Normalization

theory and actual practices in community residences serving persons with psychiatric disabilities. She hypothesized that community residences do not meet Normalization criteria and that the level of Normalization of the residence is associated with both the interpersonal environment within the home and with residents' social engagement outside the home. Golden assessed 8 community residences in Massachusetts by means of PASS and then compared residences with high and low PASS scores on two dependent variables: internal interactions (as measured by Bales's [1950] method) and the frequency of residents' social involvement. She found that the community residences were physically integrated into their communities but socially distant from ordinary citizens because of programmatic and administrative inadequacies. Moreover, the interpersonal process was found to be powerful in either fostering or undermining Normalization. Overall, the residences were task-oriented and hierarchical rather than socioemotionally and democratically oriented, with staff tending to elicit responses and residents expressing little disagreement.

Gallant's (1983) doctoral research in education investigated 3 elementary school programs for children labeled "trainable mentally retarded," aged 6 to 8, in Michigan and Ontario. The goal was to explore, in a qualitative fashion, differences between integrated and segregated settings. PASS assessments of the three programs showed that the total PASS score of the integrated program (+159) was higher than those of the two segregated programs (-310 and -572), although all three were weak, both programmatically (in the areas of model coherency, individualization, intensity of relevant programming, and developmental growth orientation) and administratively. The integrated program offered a more normalizing support system, greater accessibility, and a more appropriate size.

For her doctoral-dissertation research in social welfare, Perlik (1984) used the physical integration section of PASS (i.e., the six ratings of Local Proximity, Regional Proximity, Access, Physical Resources, Program-Neighborhood Harmony, and Congregation and Assimilation Potential) to assess the physical structure of 30 community residences in Massachusetts for people with mental retardation. Risk-taking by residents was found to be related to their level of adaptive behavior, the presence of other handicaps, the length of time they had been in the residence, and the tenure of the program manager.

In an invited paper delivered at a symposium on the costs and effects of deinstitutionalization, Flynn (1985) reported on an augmented sample of 519 PASS 3 evaluations that included the 256 reported in the 1980 chapter. Two-thirds of the assessments stemmed from PASS training workshops, 69% were of programs located in the United States (with the other 31% in Canada), 85% were segregated (i.e., served only persons with some potentially or actually devaluing condition), 81% were evaluations of community-based programs, 59% involved programs serving adults, 58% of the programs were operated by private, not-forprofit agencies, and 53% were in the field of mental retardation, with a further 10% in mental health, 5% in aging, and 4% in physical impairment. Factor analysis was again used to derive PASS subscales, with those emerging being very similar to those in Flynn (1980). The newly derived subscales were given the same names as before: Normalization-Program, 16 items (Cronbach's  $\alpha = 0.90$ ); Normalization-Setting, 11 items ( $\alpha = 0.79$ ); Administration, 9 items ( $\alpha = 0.71$ ), and Proximity and Access, 4 items ( $\alpha = 0.67$ ). The same kinds of programs were compared as in the earlier chapter (institutional residences and community-based child development, educational, vocational, and residential programs). As in the 1980 study, all four types of community programs were superior, in terms of overall service quality (as assessed by the total PASS score), to the institutional residences, with the child development services better than the other kinds of community programs. Also, on the four PASS subscales, the various types of services tended to have distinctive strengths and weaknesses: The child development programs were the strongest programmatically, while the community residences and child development services were the best in terms of Normalization of the setting. On the other hand, across all five kinds of programs, Proximity and Access was the single strongest dimension of service quality, with Administration tending to be uniformly weak.

Heal and Daniels (1986) investigated the costs and effects of three residential alternatives (natural homes, group homes, and landlord-supervised apartments) in northern Wisconsin. A total of 29 adults with developmental disabilities lived in the community residences. The total PASS 3 score was used to assess

(2 group homes, 2 apartments, and 9 natural homes). The individual resident was the unit of analysis employed, and total PASS scores for residents were related to five other measures: client satisfaction, the individual resident's contribution in labor and money to his or her own residential service, society's contribution in labour and money to the resident's residential service: and Parts I and II of the AAMD Adaptive Behavior Scale (ABS; Nihira et al., 1974). Overall, Heal and Daniels found that with controls for scores on Parts I and II of the ABS and for the individual's contribution to his or her own residential service costs, individuals in apartments and especially in natural homes were exposed to more normalizing environments, were more satisfied, and required lower societal expenditures than those in group homes. Heal and Daniels also suggested that all three forms of community residences were more normalized and less costly than institutional placement would have been. Webb, Wells, and Hornblow (1986) used PASS 3

the level of Normalization achieved in the residences

to measure the level of Normalization of 3 hospital residential units, housing 24 to 38 intellectually handicapped persons, and 4 community residences, each with 6 to 10 residents. In this article, which was based on Webb's (1983) doctoral dissertation research. the behavior of 24 residents was measured before and after they moved from the hospital to the community residences. Webb et al. (1986) found some overlap between the scores in the two types of settings, although the community residences tended to have higher Normalization scores (approximately 50% to 80% of the maximum possible score) than the hospital units (approximately 33% to 52%). Second, whether in the hospital or in the community, units with higher Normalization (PASS) scores had younger and more intelligent residents who also behaved more adaptively and less maladaptively. Twenty-four residents changed living environments, with 19 moving to more normalized settings. Interestingly, during the year following the move, the adaptive behavior of the 19 residents who moved to a more normalized setting actually declined. This was due not to the increased Normalization level of the new home but rather to the fact that the adaptive behavior of those who had moved worsened and became similar to the average adaptive behavior of the other residents in their new home. The maladaptive behavior of those moving to a more normalized environment did not change, although that of comparison residents in one of the hospital units did improve significantly. Also, although the day-to-day behavior of residents who had moved changed very little, they talked less, were socially isolated more often, and were happy less frequently, after the move. Webb et al. concluded that the decline in adaptive behavior and in well-being following the move may have been due to the fact that intensive training programs existed in the hospital units but not in the community residences. They thus suggested that training programs are needed, beyond a mere move from one residential environment to another, to develop and maintain intellectually handicapped people's functioning, social competence, and happiness.

Picard's five-volume study (1988a, 1988b, 1988c, 1988d, 1988e) of adaptation and social integration among mentally retarded persons living in family-care homes ("familles d'accueil") is one of the most ambitious investigations to have been conducted with PASS 3 and certainly the most exhaustively reported. Funded by the Quebec Council on Social Research and the Regional Council for Health and Social Services in the Quebec City area, Picard's research assessed the effects of personal characteristics, the residential environment, and services received on residents' adaptation and social integration. Using a crosssectional, correlational research design, Picard (1988a) studied 52 persons who had moved from institutional settings to one of 22 family-care homes in the Quebec City region. Nine percent of the homes were located in a downtown area, 50% were suburban, 22% were semi-urban, and 9% were rural. Picard (1988b) used Flynn's (1980) PASS subscales to evaluate the degree of Normalization of 21 of the family-care environments. A French version of the Adaptive Behavior Scale (Lessard, 1975) served as the measure of adaptive behavior. Social integration was assessed with a "Questionnaire d'intégration sociale" (QIS) constructed by Picard. Picard (1988b) assessed the reliability of PASS, both between and within teams. Two 2-person PASS rating teams assessed the same family-care home, and each team then evaluated a different set of 10 homes. One team rated the home evaluated in common about 4% higher than the other team (interteam agreement), while members of the same team differed by only 2% in their ratings of their respective set of 10 homes (intrateam agreement).

Substantively, Picard (1988b) found the average quality of the 21 family-care homes to be similar to the norms reported by Flynn (1985) for community residences. Picard also found a high degree of variability in the quality of the homes: The mean total PASS score (summing across 43 rather than 50 ratings) in his sample of 21 homes was 45% of the maximum possible weighted score (range = 28% to 78%). Picard discovered that the two strongest dimensions of quality were Normalization-Setting (M = 62%, range = 36% to 95%) and Proximity and Access (M = 61%, range = 5% to 92%), both related more to physical than to social integration. The two weakest aspects were Normalization-Program (M = 41%, range = 10% to 91%) and Administration (M = approximately 22%. according to Figure 2 in Picard, 1988b, p. 50, with the 21 homes getting the same score on Administration because they were all administered by a single agency).

Picard (1988e) also assessed the degree of association between the characteristics of the 52 residents and the 21 family home environments by assigning to each resident the PASS scores for his or her own home (a procedure that attenuates personenvironment correlations). His findings were largely in conformity with hypotheses derivable from Normalization and Social Role Valorization theory. At the level of the individual resident, for example, higher PASS scores were significantly (p < .05) associated with living in a family-care home that had a smaller number of residents. This relationship was found on Normalization-Program, Normalization-Setting, and the total PASS score. Higher resident-level PASS scores were also associated with living in more specialized, intensive, and developmentally oriented residences (a relationship found on Normalization-Program, Proximity and Access, and the total PASS score) and in urban residences (found on Proximity and Access and the total PASS score).

As he had also hypothesized, Picard found that the PASS 3 scales were better predictors of social integration than of adaptive behavior. The PASS measures accounted for relatively little variance in the 11 measures of adaptive behavior used and none were among the best predictors of the individual resident's global level of adaptive behavior (cf. Picard, 1988e, Table 53, p. 175). There were, however, a few significant (p < .05) PASS/adaptive behavior correlations: Residents in homes scoring higher on

Normalization-Program had higher scores on socialization; those in homes scoring higher on Proximity and Access had fewer economic-activity and self-direction skills; and those in homes scoring higher on the total PASS scale were more competent in the use of numbers and time. In contrast, the PASS scales were systematically and strongly related to Picard's seven measures of social integration, with Normalization-Program emerging as the second best predictor of the resident's overall level of social integration (the best was the length of institutionalization; cf. Picard, 1988e, Table 60, p. 190). Other significant PASS/social integration correlations included: residents in homes scoring higher on Normalization-Program engaged more frequently in integrative activities, needed less assistance in participating in these activities, and had a higher overall level of social integration; those in homes scoring higher on Normalization-Setting had, unexpectedly, fewer diversified social contacts; those in homes scoring higher on Proximity and Access took part in more activities outside the home; and those in homes scoring higher on the total PASS scale had contacts with a more diverse range of persons, including ordinary citizens.

In a detailed research monograph, Borthwick-Duffy, Widaman, Little, and Eyman (1992) reported the findings from an ambitious 3-year longitudinal study of foster family care. The goal of the research was to identify characteristics of the individual and of the home environment that were likely to affect development and quality of life. The sample was composed of 333 persons with mental retardation who were 21 years of age or younger at the beginning of the study. They were drawn from a four-county region of Southern California served by a regional center that had a strong preference for community placements, especially family-care placements. The core analyses were based on a subsample of 148 persons who were assessed in Years 1, 2, and 3 and whose placements were stable throughout the 3 years of the study. The sample members resided in a total of 151 family care homes. The primary careprovider in each home furnished data on each resident, as did 95% of the natural parents.

In all, nine instruments were used to assess four targets: the person with mental retardation, the careprovider, the home, and the natural parents. Three

instruments were employed to measure characteristics of the home. The first was PASS 3, with Flynn's (1980) four PASS factors being used: Normalization-Program, Normalization-Setting, Administration. and Proximity and Access. PASS was completed by project staff during the 1st year in which a given family care home took part in the research. It was completed only once because the researchers felt that the characteristics of the home were unlikely to change during the 3-year study period. The second environmental instrument was a modified version of Bradley and Caldwell's (1979) Home Observation for the Measurement of the Environment (HOME). The modified scale (Foster HOME, or FHOME) covered the same domains as the original instrument: provision stimulation through equipment, toys, and of experience; stimulation of mature behavior; provision of a stimulating physical and language environment; avoidance of restriction and punishment; pride, affection, and thoughtfulness; provision of masculine role models; independence of parental control; childcentered flexibility; and family integration. The FHOME was also administered only once, during the 1st year that a given home was in the study, because little variance was found across homes on most items. The third measure of the environment was the Home Quality Rating Scale (HQRS), designed by the project researchers. The HORS was intended to measure the sense of love and attachment exhibited by the caretaker toward the person with mental retardation, the intrafamilial dynamics related to the target person, and family participation in care of the target person. The HQRS covered five domains: harmony of home and quality of parenting, concordance in support of child care, openness and awareness of the careprovider, quality of the residential environment or dwelling, and quality of the residential area or neighborhood. HQRS ratings were completed three times, during each year of the study.

As part of their larger study, Borthwick-Duffy et al. (1992) hypothesized and tested a quality-of-life model consisting of four major dimensions: the residential environment, interpersonal relations, community involvement, and stability (i.e., tenure in placement). The first dimension (residential environment), in turn, was composed of affective, cognitive, physical, and Normalization components. Flynn's (1980) Normalization-Program and Normalization-Setting PASS 3 factors were used to measure the Normalization component. Confirmatory factor analysis (implemented with LISREL 7; Jöreskog & Sörbom, 1988) revealed that a single third-order factor, Environment, provided an adequate fit to the data, when estimated on all 333 sample members. This result was possible only because the affective, cognitive, physical, and Normalization-related aspects of environmental quality had a sufficiently high intercorrelation.

The quality of the residential environment was found to exert a positive influence on interpersonal relationships (within the foster care home and with the natural family and friends and neighbors), though not until the 3rd year. This suggested that some environmental characteristics may have a slow but important cumulative effect on the lives of residents. The Normalization component of the residential environment was found to be, in part, a product of the people-clients and caretakers-living in the home. Specifically, clients who were older or more severely retarded tended to live in homes that were less normalized. Also, careproviders who were older or who had more experience or training were found to provide less normalized environments, whereas caretakers with more formal education had homes that were more normalized. Borthwick-Duffy et al. (1992) speculated that older and more experienced caretakers may have acquired their basic routines and philosophy of care before the advent of Normalization, and that the recency of caretaker training may be more related to Normalization than is the amount of such training.

Mindel and Rosentraub (1992) evaluated the implementation and impact of an experimental program in Texas, Home and Community Services (HCS), in which persons with mental handicaps who qualified for Medicaid assistance moved from state institutions to community-based residences. The new program also maintained people in the community who were at risk of being institutionalized. It placed special emphasis on developing small, family-sized, normalized living environments for each individual served, with tailored treatment programs, individualized daily schedules, and client involvement in planning daily activities. During its 3 years of operation, the evaluation collected data on 72 persons who were in the HCS program for 3 years and on 214 persons who were in it for 2 years only. HCS participants who had lived in an institution prior to the program were matched with a comparison group of institutionalized persons on diagnosis, IO, age, race, and length of institutionalization. HCS participants living in the community before joining the program were also matched with community residents on the same variables (except the last). Implementation of Normalization was assessed with seven (unspecified) rating areas from PASS and three ratings developed by Conroy and Feinstein (1985). Periodic checks on the interrater reliability of these measures produced coefficients in the 0.85-0.95 range. The impact of the new program was assessed in terms of adaptive behavior in four domains (communication, daily living skills, socialization, and motor skills) and of maladaptive behavior. The instrument used was the Vineland Adaptive Behavior Scales (VABS; Sparrow, Balla, & Cicchetti, 1984).

In assessing the implementation of the experimental program, Mindel and Rosentraub (1992) found that the Normalization scores of the living environments of the previously institutionalized HCS clients improved significantly (p < .05) from Year 1 to Year 2, before leveling off between Years 2 and 3. In contrast, no change in the living environments of the institutionalized comparison-group subjects took place over the 3-year period. Thus, compared with state institutions, the HCS program did succeed in creating more normalized living environments. No differences were found, however, between the Normalization scores of the living arrangements of HCS participants living in the community before joining the program and the scores of comparison-group members, nor did the scores of either group change over the 3-year study period. Hence, for participants coming from the community, HCS living arrangements were no more normalized than those of the community-based comparison subjects. Concerning the impact of the HCS program on adaptive and maladaptive behavior, the data suggested that the program was of greatest value for previously institutionalized persons with a diagnosis of severe or profound retardation, regular medical needs, and/or initially high levels of maladaptive behavior. Improvements were slight for other clients. Mindel and Rosentraub (1992) recommended that the U.S. government should expand innovative Medicaid-waiver options such as the HCS but also encourage more flexible approaches to the design of community living environments than were tried by the HCS program.

In Great Britain, Carson, Dowling, Luyombya, Senapti-Sharma, and Glynn (1992) compared two traditional in-patient psychiatric rehabilitation wards with the Tomswood Hill project, a new residential program based on Normalization principles. Designed to prepare "hard to place" hospital residents for eventual resettlement in the community, the new project consisted of a small-scale domestic setting on the hospital grounds. Its creators felt that the advantages of having the backup of experienced psychiatric hospital staff outweighed the "deviancy image juxtaposition" problems posed by close proximity to the hospital. The project manager attended a PASS course and then initiated a program of staff training designed to combine principles drawn from good psychiatric nursing care with the best ideas from Normalization theory (e.g., the use of ordinary housing, the provision of genuine choices, the sharing of information with participants, high-quality staffresident interactions. respectful language, personalization of care, etc.). The researchers compared the Tomswood Hill project, serving 7 residents, with two in-patient rehabilitation wards, serving 31 and 12 residents, respectively. The evaluation instruments included PASS and measures of behavior, quality of life, staff attitudes to treatment, ward management, and resident satisfaction. Carson et al. found that residents in the Normalization project had a significantly higher level of quality of life, were exposed to the most individualized and residentoriented ward-management practices, and were accompanied more frequently into the community by staff members. Staff in the Normalization project were more satisfied with their work. Carson et al. suggested that their study was important because it contributed to the scarce literature comparing innovative Normalization projects with more traditional psychiatric service options and also because it was one of the few studies within a psychiatric as opposed to a mental-retardation context to have examined the application of Normalization principles.

Flynn (1993) reported on the level of physical and social integration in an augmented sample of 626 PASS 3 evaluations in a paper given at an international conference devoted to the theme of integration. Evaluated between 1975 and 1987, the 626 programs

were located mainly in the United States (57%) and Canada (32%), with another 10% in France. Sixty-five percent of the programs served persons with intellectual handicaps, 79% had been evaluated during PASS training workshops, and 58% served adults. Thirty-seven percent were community residences, 16% institutional residences, 15% work preparation or employment programs, and 9% child development programs. The same PASS factors and subscales as in Flynn (1985) were used. In the sample of 626 programs as a whole, overall service quality (as indexed by the total PASS score) was 43% of the maximum possible score, that is, somewhat below the "minimally acceptable" level of 50%. The mean for Proximity and Access was higher than for the other three subscales, with the mean for Normalization-Setting also higher than the means for Normalization-Program and Administration. Moreover, differences among the PASS subscales were considerably greater than were differences among the three countries for which there were enough programs in the sample to permit comparisons: the USA (n = 350), Canada (n =195), and France (n = 59). Overall service quality fell between 46% of the maximum possible weighted score (Canada) and 40% (USA). In the case of all three countries, Proximity and Access was clearly the best dimension of service quality, followed by Normalization-Setting, Normalization-Program, and Administration. Finally, overall service quality (total PASS score) was highest in the subgroup of community child development programs (n = 50), followed by community residences (n = 214), community educational services (n = 38), community vocational programs (n = 87), and institutional residences (n = 93).

Williams (1995) provided an interesting report on the results of PASS 3 and PASSING evaluations in Great Britain. (A brief description of his PASSINGrelated findings may be found in the section of the present chapter devoted to PASSING research.) His chapter was part of a book (Pilling & Watson, 1995) devoted, in large part, to a mainly favorable critique of PASS and PASSING as evaluation tools. Williams presented data from 13 service evaluations that suggested that PASS 3 had an acceptable level of reliability. Concerning the validity of PASS 3, Williams presented data from 52 evaluations of British residential services. As expected, the instrument discriminated among the various types of residences: 5 hospital wards formed the lowest-scoring group (Mdn = 9% of the maximum possible score); a group of 7 ordinary houses managed by social service, voluntary, or private agencies scored considerably better (Mdn = 44%); and 3 life-sharing homes constituted the highest-scoring group (Mdn = 63%). Williams also noted that the average scores for large residences (more than 8 places) in Britain evaluated with PASS 3 (n = 37; Mdn = 20% of the maximum possible PASS score) were similar to those for institutional residences in North America assessed with PASSING (n = 23; M = 21%, as reported by Flynn et al., 1991). Similarly, the average scores for small residences (less than 8 places) in Britain assessed with PASS 3 (n = 27; Mdn = 40%) were similar to the average scores for community group residences in North America evaluated with PASSING (n = 79; M =37%, again as reported by Flynn, LaPointe, Wolfensberger, & Thomas, 1991).

Williams (1995) gave an illustration of how PASS (or PASSING) can be used to compare service programs within a single agency, as well as groups of similar services with each other. He also noted that British data on services that have been evaluated with PASS or PASSING on several occasions suggest that little change takes place over time unless the service has undergone major structural change (e.g., a move from a single large building to smaller dispersed units). He also observed that, as in North America, many British day services (e.g., adult training centers) score poorly on PASS, due probably to a lack of model coherency. Williams's chapter also contains useful discussions of the key evaluation issues of improving services, identifying service users' major life needs, and reporting the results of an assessment to various stakeholder groups.

In another British study, Perry and Felce (1995) collected data on several measures of service quality (including PASS 3) in a sample of 14 community homes in Wales serving people with learning difficulties (i.e., developmental disabilities). All were small, staffed residences, ranging in size from 1 to 7 places. Each house was observed for 11 hours a day for 3 days over a 2-year period. PASS rating clusters were used to assess the following aspects of quality of life: quality of housing, social and community integration, social interactions, development, activity,

and autonomy and choice. Rank-order correlations  $(r_s)$ were computed to see to what extent different measures of quality within each category agreed with one another. The PASS physical-facility appearance subscore correlated consistently and significantly with the Characteristics of the Physical Environment (CPE) scale (Rotegard, Bruininks, & Hill, 1981), an index mainly of internal housing quality (range of rank-order correlations with the CPE scale = 0.41-0.64). Similarly, several PASS indicators of social and community integration were significantly and substantially correlated with the frequency of social contacts and community activities (range of  $r_{e} = 0.53 - 0.59$ ). The PASS Interactions rating was significantly and negatively correlated ( $r_s = -0.65$  and -0.49 in Years 1 and 2, respectively) with the social distance dimension of the Group Home Management Schedule (GHMS; Pratt, Lusczc, & Brown, 1980), a social-interaction measure. The PASS cluster of ratings known as "developmental growth orientation" was significantly correlated  $(r_{r} = 0.61 \text{ and } 0.46 \text{ in Years } 1 \text{ and } 2,$ respectively) with the personal growth dimension of the Community Oriented Programs Environment Scale (COPES; Moos, 1974). The PASS ratings Age-Appropriate Activities, Routines, and Rhythms and Culture-Appropriate Activities, Routines and Rhythms were very strongly correlated ( $r_{e} = 0.73$  and 0.78) with the Index of Participation in Domestic Life scores for Years 1 and 2, respectively (IPDL; Raynes, Sumpton, and Pettifer, 1989). Finally, the PASS ratings related age-appropriate autonomy and rights and to individualization were strongly negatively correlated  $(r_{s} = -0.59 \text{ and } -0.64)$  with the scores for Years 1 and 2, respectively, of a GHMS autonomy/choice measure calculated by summing across the GHMS dimensions of depersonalization, block treatment, and rigidity of routine. Perry and Felce concluded that broad agreement existed among those measures (including PASS) assessing similar aspects of quality of life. They also recommended that process perspectives on quality of service and quality of life be complemented by data on outcomes.

Felce and Perry (1997) presented and discussed the strictly PASS-related data collected during their earlier study of service quality in 14 community residences in Wales (Perry & Felce, 1995). Three-member PASS teams, made up of experienced raters, visited each home for 2 days, and then arrived at a conciliated score

on each PASS rating. Overall, average (mean) service quality was highest on the PASS rating clusters concerned with physical integration (M = 67% of the maximum possible score), quality of setting (M =45%), and social integration (M = 42%). Average quality was relatively low, however, on the rating clusters concerned with age-appropriate interpretations and structures (M = 32%), developmental growth orientation (M = 18%), model coherency (M = 11%). and administration (M = 16%). The total PASS score was also fairly low (M = 35%). Size of residence interacted with the ability level of the residents, such that smaller residences (1 to 3 residents) serving people with higher scores on part 1 of the Adaptive Behavior Scale (Nihira et al., 1974) were of higher quality than were larger residences (4 to 7 residents) serving less able persons. Overall, Felce and Perry (1997) found the 14 residences, as a group, to be reasonably homelike and to be located well enough to permit residents to have access to the surrounding community. However, the personnel working in them tended not to possess the organized means and competencies necessary to promote residents' development, and administrative practices were also weak. Felce and Perry (1997) concluded that as much attention must now be given to the technical proficiency and quality of community services as has previously been paid to their size, location, accessibility, and staffing. That is, service personnel must focus primarily on understanding people's needs, responding in relevant and intense ways to these needs, and helping people achieve greater self-direction, personal development, and social integration.

Flynn, Guirguis, Wolfensberger, and Cocks (in press) carried out the most definitive factor analysis to date of PASS 3, employing a large sample and cross-validation procedures. Their paper consisted of two separate factor-analytic studies: Study 1 concerned PASS (and will be discussed now), while Study 2 dealt with PASSING (and will be described later, in the section devoted to PASSING research). In Study 1, Flynn et al. were able to use a larger sample of PASS 3 evaluations (N = 626) than had been available in previous factor analyses of the instrument. The evaluations had been conducted in several countries,

including Canada, the USA, France, and Switzerland, during the period 1975-1987. Seventy-nine percent of the evaluations had been carried out during PASS training workshops, and another 14% had been conducted during official evaluations. In all cases, the assessments had been conciliated under the direction of experienced team leaders. Flynn et al. first conducted an exploratory factor analysis (EFA) on a randomly chosen half of the sample (n = 313) in order to identify the number of factors in the instrument and the items that were especially good indicators of each factor (i.e., that had an absolute factor loading of at least 0.50). They followed this with a confirmatory factor analysis (CFA) that successfully cross-validated the model derived in the EFA. Four factors proved necessary and sufficient to represent the factor structure of PASS (see Table 14.1).

The first factor, Program, consisting of the content of a service program, included items tapping service processes consistent with the Normalization principle, such as age-appropriate possessions and culture-appropriate activities, routines and rhythms. The second factor, Setting, assessed the correspondence between the facility and neighborhood in which the program was located and the Normalization principle (e.g., the degree of "fit" between the facility and its function, and between the facility and the neighborhood). The third factor, Administration, assessed program management, evaluation, and self-renewal processes. The fourth factor, Accessibility, measured the proximity and accessibility of the program to client-users and their families and to pertinent physical resources. The subscales formed from each of these four factors were found to be homogeneous and, together, had a very strong multiple correlation with the total PASS score in the overall sample of 626 evaluations (R = 0.97, p <.001). Flynn et al. (in press) suggested that their results promised to enhance the practical usefulness of PASS as an evaluation instrument by providing factorially valid and sensitive measures that would facilitate comparisons among and within programs and enable PASS evaluators to organize their field assessments more coherently around the core service dimensions of program, setting, administration, and accessibility.

# **TABLE 14.1**

# FOUR CROSS-VALIDATED PASS 3 FACTORS—PROGRAM, SETTING, ADMINISTRATION, AND ACCESSIBILITY—AND THE ITEMS COMPOSING EACH (ADAPTED FROM FLYNN ET AL., IN PRESS)

#### Factor 1: Program (14 items)

- 14. Socially Integrative Social Activities
- 16. Age-Appropriate Personal Appearance
- 17. Age-Appropriate Activities, Routines, and Rhythms
- 18. Age-Appropriate Labels and Forms of Address
- 19. Age-Appropriate Autonomy and Rights
- 20. Age-Appropriate Possessions
- 21. Age-Appropriate Sex Behavior
- 23. Culture-Appropriate Personal Appearance
- 24. Culture-Appropriate Activities, Routines, and Rhythms
- 27. Model Coherency
- 29. Social Overprotection
- 30. Intensity of Relevant Programming
- 33. Individualization
- 34. Interactions

#### Factor 2: Setting (3 items)

- 8. Function Congruity Image
- 9. Building-Neighborhood Harmony
- 28. Physical Overprotection

#### Factor 3: Administration (5 items)

- 37. Consumer and Public Participation
- 38. Education of the Public
- 40. Ties to Academia
- 47. Planning Process
- Program Evaluation and Renewal Mechanisms

#### Factor 4: Accessibility (3 items)

- 1. Local Proximity
- 3. Access
- 4. Physical Resources

#### 1.4 STUDIES BASED ON SHORT FORMS OF PASS 3

Fiorelli (1978) derived a 15-item PASS short form by selecting items from PASS 2 and PASS 3 and used the instrument to examine the behavior of 4 adults with mental retardation for 5 to 6 weeks before and for 5 to 6 weeks after they moved from institutional (less normalized) to community-apartment (more normalized) settings. Fiorelli (1978; summarized in Fiorelli & Thurman, 1979) used videotaped recording and a complex behavior-coding system to investigate whether, as Normalization theory would predict, client behavior would become more normalized following movement to a more normalized residential environment. Overall, Fiorelli (1978) found clients manifested many favorable behavioral changes during the initial 5 to 6 weeks of community living.

Flynn and Heal (1981) derived and validated an 18item PASS 3 short form. While recognizing that the full instrument should be used when an evaluation is intended to guide official decision-making about a particular program, Flynn and Heal suggested that a short form of PASS might be useful for other purposes, such as carrying out "spot checks" on a program or group of services or conducting research studies in which a standardized measure of Normalization was needed but in which financial resources would not permit a large number of evaluations to be carried out with the PASS long form. The 18-item short form was derived as follows. The 50 PASS 3 items were first screened for their ability to make relatively subtle discriminations among four types of community residences (i.e., apartments and small, medium, and large group homes). Second, factor and item analyses were conducted on the 25 items that were found to discriminate, ultimately leaving 3 relatively independent PASS subscales: Normalization-Program (8 items,  $\alpha = 0.85$ ), Normalization-Setting (6 items,  $\alpha = 0.64$ ), and Administration (4 items,  $\alpha =$ 0.62). Using data collected by Heal with a 3-person team in another sample of 14 community residential programs, Flynn and Heal found that interrater reliability (intraclass correlations) was generally excellent, for both the long and the short form of PASS. For the complete, 50-item PASS 3 scale, interrater reliability was 0.70 for a single rater and 0.94 for the mean of seven raters. For the 18-item short form, the corresponding figures for Normalization-Program were 0.72 and 0.95, for Normalization-Setting, 0.34 and 0.78, and for Administration, 0.83 and 0.97. Flynn and Heal further studied interrater reliability with data collected by 2 two-person teams that had each assessed 4 institutional cottages with the PASS 3 short form during the initial phase of the longitudinal Pennhurst evaluation (cf. Conroy, 1979). For Normalization-Program and Normalization-Setting, interrater reliability estimates were again high, ranging from 0.82 to 0.97 for single raters to 0.97 to 0.99 for 7-person teams. Very low intercottage variance on Administration produced interrater reliability coefficients that were zero or close to zero. Cross-validation of the PASS 3 short form on 7 independent samples produced multiple correlations between the short and long form that ranged from 0.89 to 0.98. Moreover, the convergent and discriminant validity of the first two subscales of the short form was good. Evidence was also produced that was supportive of the criterion-related validity of the long and short forms of PASS. Regression analyses carried out in a sample of 173 programs with complete data on all PASS and external criterion variables showed that services had significantly higher total PASS and Normalization-Program scores if they were located in Canada rather than in the USA, were communityrather than institution-based, served a smaller number of clients, and had a higher proportion of staff with college degrees. Programs had significantly higher Normalization-Setting scores if they were located in Canada, were integrated, and were residential in nature.

Conroy, Efthimiou, and Lemanowicz (1982) employed Flynn and Heal's (1981) PASS 3 short form in a longitudinal study that addressed the hypothesis that more normalized settings would facilitate more normative and independent client behavior. Conroy et al. compared changes in the adaptive behavior of a sample of 70 persons with mental retardation who remained at Pennhurst Center in Pennsylvania and 70 clients who left Pennhurst (77% had severe or profound retardation). The two groups were matched on gender, level of retardation, chronological age, years institutionalized, self-care ability, and IQ. All 140 subjects resided at Pennhurst at Time 1 (the initial assessment). A follow-up assessment took place 2 years later, when half, under the terms of a Federal court order, had moved to community living arrangements. The research design was a quasiexperimental, prepost, nonequivalent control group design. The goal was to identify specific demographic and environmental variables that might be associated with client growth. The adaptive behavior of the deinstitutionalized clients alone improved significantly, although neither group's maladaptive behavior changed significantly. The partial correlation between the total score on the PASS 3 short form and gains in adaptive behavior, controlling for the client's initial level of adaptive behavior, was -0.25 (p = 0.05), indicating that clients coming from institutional cottages that had lower PASS scores (i.e., lower levels of Normalization, individualization, and physical pleasantness) gained more after moving to community residential settings. The total PASS score was positively correlated with a measure of the physical quality of the institutional cottages derived from the standards of the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (ACMRDD), a finding that is supportive of the concurrent validity of the PASS short form. Overall, Conroy et al. found support for their basic Normalization hypothesis that relocation to more normalized settings would facilitate clients' adaptive functioning.

In their final report on the 5-year longitudinal Pennhurst study, Conroy and Bradley (1985) provided data on the complete set of PASS evaluations carried out both at Pennhurst (with two-person teams) and in the community (with one-person teams only, the latter a data-collection procedure that precluded the assessment of interrater reliability as well as the reliability and validity-related safeguard of conciliation between team members). Conroy and Bradley found that, for 157 study participants, the mean increase in PASS short form scores was 404 points, from -232 at Pennhurst in 1979 to +172 in the community in 1982. (The standard deviation of the increase in scores was not given, however, making interpretation of this gain difficult.) In later waves of measurement, carried out on 320 clients residing in the same community residence in both 1983 and 1984, the total score on the PASS 3 short form had a simple correlation of 0.31 (p <.001) with the 1983 level of adaptive behavior and a partial correlation of 0.12 (p < .05) with gain in adaptive behavior between 1983 and 1984 (cf. Conroy & Bradley, 1985, pp. 156-157). Thus, clients tended to make larger gains in community residences with higher Normalization scores.

Interestingly, Conroy and Bradley (1985) found that the PASS short form was useful (i.e., sensitive and discriminating) not only before but also after the focus of their research shifted from Pennhurst to the community. In contrast, the researchers had to abandon other environmental measures after the move to the community, either because of insensitivity to client growth (the case with the experimental ACMRDD standards) or because of "ceiling" effects (found with the Resident Management Survey, developed by King, Raynes, and Tizard, 1971, and with the Characteristics of the Treatment Environment, developed by Jackson, 1969).

On the other hand, Conroy and Bradley (1985, pp. 159ff) expressed dismay upon finding that their environmental measures, including the PASS 3 short form, were correlated with characteristics of the residents of the setting being evaluated, with residents having higher levels of adaptive behavior being found in higher-quality and more normalizing residential settings. In my opinion, however, it seems erroneous to expect environmental measures to be completely independent of resident attributes. The reason is simple: The greater the challenge presented by a particular client or group of clients (in relation to demanding goals such as the promotion and attainment of social integration, developmental growth, or positive social imagery), the more likely it is, empirically, that a program serving such clients will have difficulty in meeting the challenge and will therefore attain a lower score on PASS, PASSING, or other environmental measures. (Incidentally, in chapter 9 of the present volume, Heal presents data that I interpret as consistent with my position on this issue. The findings of Borthwick-Duffy et al., 1992, presented earlier in this chapter, are also consistent with my position.)

Conroy and Bradley (1985) also expressed concerns about year-to-year fluctuations in PASS short form scores, observed during their annual assessments of the same community living arrangements. This issue of potential score (i.e., trait) instability, in the absence of any real change in program quality, is obviously crucial and deserving of further research. It is thus doubly unfortunate that, contrary to standard PASS practice, Conroy and Bradley chose to use single raters rather than teams of raters (even 2-person teams) during the community phase of the Pennhurst study. This decision made it impossible for them to separate true-score variance (i.e., year-to year changes in service quality) from error variance (i.e., changes due to rater bias).

In his doctoral dissertation in special education, Korn (1987) studied the issue of the interteam reliability of PASS. He developed a standardized, videotape-based stimulus called SPIRA (Simulated PASS Inquiry-Related Assessment) based on 20 mainly administration-related PASS ratings. The rating performance of two 5-member PASS teams was compared, one team having received 5 days of training, the other 1 day only. No differences were found between the two formats. Korn recommended SPIRA as one means of enhancing PASS-related reliability research and training.

Conroy (1996) compared the quality of life experienced by people living in small intermediate care facilities for the mentally retarded (ICFs/MR) in Pennsylvania with that experienced by people residing in group homes in the same state. There were 51 people in each group, matched on adaptive behavior, challenging behavior, age, and gender. The typical ICF/MR had eight residents, versus three for the typical group home. Clients were assessed in 1992 on a battery of measures that had evolved from those used in the Pennhurst Longitudinal Study (Conroy & Bradley, 1985) and were compared on a total of 35 indicators of quality of life. One of these was a Normalization Index, which Conroy and his colleagues had created by selecting 10 of the 18 items contained in Flynn and Heal's (1981) 18-item PASS short form. According to Conroy (1996), Devlin (1989) found the Normalization Scale to have interrater reliability of 0.64 and test-retest reliability of 0.90. (Unfortunately, several important details are unclear from Conroy's [1996] article: whether the reliability coefficient of 0.64 was derived on the 18-item or the 10-item PASS short form, the type of reliability coefficient in question, or whether reliability here is that for a single rater or of the mean of several raters.)

Conroy's (1996) methodology and conclusions were criticized by Crinella, McCleary, and Swanson (1998). Besides publishing Conroy's (1998) reply to his critics, Taylor (1998), the editor of *Mental Retardation*, in which Conroy's article had been published, also asked the journal's statistical consultant, Heifetz (1998), to conduct an independent review of the papers by Conroy (1996) and Crinella et al. According to Heifetz's (1998) analysis of Conroy's findings, quality of life was superior for residents in community living arrangements (CLA) on 8 of 34 measures, including the 10-item Normalization Index (p < .01), which was thus shown to be capable of discriminating between the

two types of residential settings. (It may be noted in passing that Heifetz found the quality of life of ICF/MR residents to be higher than that of CLA residents on only 1 of the 34 measures.)

Lemay (1997) conducted the most recent PASS short-form study, a rare longitudinal assessment of program change, over a 5-year period. Working as a 2person team, Lemay and a colleague used Flynn and Heal's (1981) 18-item PASS 3 short form to evaluate. in 1996, the quality of 15 large community residences ("pavillons") in Quebec, each serving 10 to 14 residents with psychiatric disorders. The residences had originally been evaluated with the short form in 1991. Lemay found no significant change in the sample of 15 residential programs over the 5-year period on the Program subscale of the PASS 3 short form (1991 M = 43% versus 1996 M = 42%, ns), but a significant improvement on the other two subscales, Setting (1991 M = 36% versus 1996 M = 45%, p < .05) and Administration (1991 M = 39% versus 1996 M =55%, p < .001). Despite these gains, service quality was still quite low. Lemay made a number of recommendations aimed at improving the residences, including a reduction in the number of residents to no more than 4 to 6 per setting, greater similarity among residents (along dimensions such as interests and age) to promote social interaction and a sense of community, increased personal space and individualization, implementation of a developmental model congruent with the needs and capacities of each resident, and increased involvement with ordinary citizens in each local community.

#### 1.5 STUDIES BASED ON ADAPTATIONS OF PASS 3

These studies have been included in the present review for the sake of completeness and because of their overall relevance for PASS research. In the early 1980s, Hull and Thompson published several papers that were based on an adaptation of PASS 3 (Hull, Keats, & Thompson, 1984; Hull & Thompson, 1980, 1981a, 1981b). In their initial study, Hull and Thompson (1980) examined the degree to which individual, residential, and community characteristics were related to the adaptive functioning of 369 persons with mental retardation living in 144 community settings (board-and-care facilities and staffed residences) in Manitoba. Residents' median age was (range, low 20s to above 90). Sixty-five percent of the residents had previously been institutionalized. Thirty aspects of environmental Normalization were assessed by means of a 172-item measure, itself based on 30 PASS 3 ratings. The median interrater reliability achieved on the new instrument (percentage of identical responses from two interviews) was 93%. Adaptive functioning was assessed with Marlett's (1977a, 1977b) Adaptive Functioning Index (AFI). In a series of stepwise regression analyses, based on cross-sectional data, several aspects of "environmental Normalization" were found to predict various dimensions of adaptive behavior. A higher score on the Personal Routines AFI subscale (assessing the extent to which the activities, routines, and rhythms in a residence are appropriate to adults in North American culture) was predicted by a residential environment that promoted socially integrating activities (i.e., nonsegregated vocational, educational, recreational, and social activities), was urban, had more adequate transportation facilities, and encouraged independence and age-appropriate activities among residents. A higher score on the Community Awareness AFI subscale (tapping skills such as transportation usage, budgeting, shopping, cooking, and leisure) was predicted by a residential environment that promoted residents' independence, was optimistic about residents' potential to live more independently, presented a positive external image, provided opportunities for freedom and initiative, and (unexpectedly) had a physical setting of somewhat poorer quality. A higher score on the Social Maturity AFI subscale (reflecting skills such as communication, consideration, getting and keeping friends, and solving problems) was predicted by a residential environment that promoted socially integrating activities, fostered appropriate interactions between staff and residents, promoted residents' socially appropriate appearance, and (unexpectedly) was characterized by less socially appropriate ways of addressing residents and a less adequate internal physical environment. Finally, a higher total AFI score was predicted by a residential setting that promoted socially integrative activities, fostered residents' independence and socially appropriate appearance, had more adequate transportation facilities, avoided social overprotection, featured more appropriate staff-resident interactions

36 (range, 18 to 73) and their median IQ was 54

and (unexpectedly) had a lower-quality physical setting and less adequate community resources. Overall, Hull and Thompson (1980) interpreted their findings as consistent with growing evidence that "environmental Normalization, in addition to being an ideology, is an effective technology for promoting more independent functioning by retarded persons" (pp. 260-261).

In a conceptually and methodologically parallel study, this time of 296 persons formerly institutionalized because of psychiatric disabilities and now living in 157 community board-and-care facilities in Manitoba, Hull and Thompson (1981a) investigated the extent to which individual, residential, and community characteristics were related to the residents' adaptive functioning. In homes with 1 to 2 residents, all residents were included in the study; in larger homes, data were collected on a maximum of 3 randomly selected residents. The median age of the residents was 57 (range, 19-81); 51% were female. Nearly all had previously been institutionalized, for a median length of time of 7.5 years (range = a few months to more than 20 years). Most (75%) had a diagnosis of "schizophrenia," while the others had diagnoses of "psychosis," "alcohol problems," or "neurotic behavior problems." Marlett's (1977a, 1977b) AFI was again used to assess adaptive behavior, and the 172-item adaptation of PASS used in the previous study served as the measure of environmental Normalization. In several stepwise regression analyses, based on cross-sectional data, various aspects of "environmental Normalization" were found to predict different dimensions of adaptive behavior. A higher score on the Personal Routines AFI subscale (see definition above) was predicted by a residential environment manifesting less social overprotection, more appropriate resident-staff interactions, a more adequate geographic location within its region, less verbal abusiveness, more opportunities for freedom and initiative, more adequate transportation facilities, a greater emphasis on activities promoting social integration, and more ageappropriate possessions and activities. A higher score on the Community Awareness AFI subscale was predicted by a residential setting characterized by less social overprotection, more appropriate resident-staff interactions, a more adequate location within its region, the conveying of a more positive image of residents. more appropriate resident appearance, more opportunities for freedom and initiative, and more adequate community resources. A higher score on the Social Maturity AFI subscale was predicted by a residential environment manifesting less social overprotection, a more adequate regional location, more emphasis on socially integrative activities, more appropriate resident appearance, more opportunities for freedom and initiative, less verbal and physical abusiveness, and more appropriate social activities. Finally, a higher overall AFI score was predicted by a residential environment marked by less social overprotection, more appropriate resident-staff interactions, more activities promoting social integration, more appropriate personal appearance among residents, more adequate regional location, more opportunities for freedom and initiative, and less verbal abusiveness. In general, Hull and Thompson (1981a) found that environmental variables accounted for a much greater portion of the variance in adaptive behavior than did individual-level variables. They concluded, as before, that environmental Normalization appeared to be an effective technology, and not simply an ideology, in services to persons with psychiatric disabilities.

Hull and Thompson (1981b) used the same 172item adaptation of PASS 3 and the same sample of 296 persons with psychiatric disabilities living in the community in Manitoba to study the determinants of the level of Normalization in a residence. A stepwise regression analysis found that environmental Normalization was predicted by a higher average level of resident adaptive behavior, a smaller number of residents, a higher average level of family income in the community, a smaller proportion of male residents, shorter average length of previous a institutionalization, an independent living residence rather than a board-and-care home, and a smaller number of disability groups in the residence. Overall, Hull and Thompson (1981b) suggested that the most normalizing residences tended to be smaller, to provide more opportunities for independence, to serve only one disability group (i.e., persons with psychiatric difficulties), and to be located in a middle-income community with higher-quality homes, more community resources, and more potentially integrating activities. Residence-level characteristics such as these were more important correlates of environmental Normalization than were client variables.

Combining their samples of persons with mental retardation (cf. Hull & Thompson, 1980) and psychiatric disabilities (cf. Hull & Thompson, 1981a), Hull et al. (1984) provided a descriptive overview of the adaptive behavior of 665 intellectually or psychiatrically disabled residents and of the environmental quality obtained in the 278 Manitoba community residences in which they were living. The authors' measures of adaptive behavior and environmental quality were, again, the AFI and the 172-item adaptation of PASS, respectively. Hull et al. found that the psychiatrically disabled residents had a significantly higher average level of overall adaptive behavior than the mentally retarded residents, although the difference was not large. In both types of residents, higher total adaptive behavior scores were associated with higher IO, lower chronological age, longer institutionalization, higher average family income in the community where the disabled person's residence was located, and urban location of the residence. The mean environmental Normalization score for the 278 community residences was 63%, with little difference in quality between mental retardation and mental health residences. Independent living residences scored much higher, however, than board-and-care residences, foster homes, or staffed group homes. The "average" Manitoba community residential service was near the top end of the "minimally acceptable" range of service quality (as operationally defined by the adaptation of PASS), with 8% below minimally acceptable standards and 14% in the "very good" or "near-ideal" range. On the other hand, the mean scores on certain important ratings fell in the "less than minimally acceptable" range: residences tended to be concentrated in certain neighborhoods (which reduced their integrative potential), did not place sufficient emphasis on activities promoting social integration, and unduly restricted residents' freedoms. Across all of the community residences, the level of environmental Normalization in a home and the level of adaptive functioning of residents in that home were moderately and positively correlated (r = 0.49), both for psychiatrically disabled clients (r = 0.54) and for mentally retarded residents (r = 0.41). Hull et al. interpreted these findings as consistent with a reciprocal pattern of causality, in which more normalized environments promoted more adaptive behavior and more competent residents shaped their

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residential settings in the direction of greater Normalization.

Mulvey, Linney, and Rosenberg (1987) examined the relationship between organizational control and treatment-program Normalization in 30 communitybased settings for juvenile offenders in six U.S. states. A modified version of PASS 3 was used to assess treatment programming. Based on Flynn and Heal's (1981) short form, 35 of the 50 PASS ratings were selected. The descriptors for these ratings were then rewritten to be more relevant to the adolescent population served. Two raters completed the modified PASS instrument independently, with interrater reliability of 0.92. Cluster analysis, based on the total PASS score and data from other measures, was used to group the settings into four clusters, from least institutionalized (most normalized) to most institutionalized (least normalized). Contrary to the researchers' main hypothesis, organizational control and program design were found to be unrelated. The most normalized facilities, however, which had the highest total PASS scores, also had the lowest use of medication, the lowest level of staff concern about assaults, and the most favorable attitude toward the rate of family involvement.

#### 2 STUDIES BASED ON PASSING

PASSING (Wolfensberger & Thomas, 1983, 1989) assesses two major dimensions of Social Role Valorization, client social image-enhancement and client competence-enhancement, in four program areas: physical settings (especially the service facility and neighborhood in which the latter is located); servicestructured groupings and relationships among people; service-structured activities and other time uses; and miscellaneous other issues. PASSING assesses only those aspects of service quality that reflect a program's adoption and implementation of Social Role Valorization. By omitting the administrative issues contained in PASS, the authors of PASSING hoped that a larger pool of people, including ordinary citizens and some service recipients, could learn to apply the tool than had proved possible with PASS (Wolfensberger, 1994). PASSING consists of 42 items or ratings, each composed of five levels, with Level 1 representing very poor service quality, Level 3 neutral quality, and Level 5 ideal quality. Trained evaluationteam members first rate a service program independently, on all 42 items. In a lengthy discussion session, the PASSING team then comes to a teamconciliated (consensual) rating of the quality of the program on each of the 42 items. The conciliated scores are then translated from levels into weighted scores. The total PASSING score, formed by adding the weighted scores of the 42 items, can range from a minimum of -1,000 (extremely poor service quality), through zero (minimally acceptable service quality), up to a maximum of +1,000 (ideal quality).

In her doctoral dissertation, Jacobs (1983) conducted an exploratory methodological study of PASSING. In an evaluation of 5 service programs (3 community residences for mentally retarded persons, an integrated day-care program for preschool-aged children, and a sheltered workshop for adults), she found that PASSING displayed high internal consistency and high interrater reliability. Teamconciliated scores were lower than those resulting from the simple averaging of individual raters' scores, with evidence suggesting that the team leader influenced team members during the conciliation process. Also, teams of 2 to 3 members produced scores that were almost as reliable as those from larger teams. Jacobs made suggestions for simplifying the method of determining the final total score as well as the team process used.

Lutfiyya, Moseley, Walker, Zollers, Lehr, Pugliese, Callahan, and Centra (1987) used PASSING to assess seven community residences serving people with mental retardation ("residents") in New York state. The settings included a home for 3 residents that was part of an intentional Christian community, l'Arche; a staffed apartment for three young men; a group home for 4 women; an intermediate care facility for the mentally retarded (ICF/MR) for 8 adolescents; and three "small residential units" (SRUs), one for 12 children, one for 12 adults, and one for 12 adults with "challenging behavior." The three SRUs were on the grounds of a large state institution located in a rural town. The PASSING assessment was intended to examine the quality of life of residents of the SRUs and to compare it to that of people in other residential settings.

Of the seven residences, the four that were rated the lowest on PASSING were the ICF/MR and the SRUs.

The ICF/MR also appeared to be of lower quality than the other three settings according to the evaluators' subjective impressions. Lutfiyya et al. (1987) acknowledged three limitations of their study: small sample size, a single approach to assessing quality, and a lack of control for possible differences among the residents of the different kinds of settings.

Dansereau, Duteau, Ely, and Flynn (1990) used the French version of PASSING (Wolfensberger & Thomas, 1989) to evaluate the quality of 38 community residences in western Ouebec that served 172 persons with mainly psychiatric disabilities. The study also assessed residents' level of physical and social integration, by means of a newly constructed instrument (Ely & Flynn, 1989), and residents' subjective quality of life (QOL), by means of Lehman's (1988) OOL interview. Of the 172 residents, 72% had an official diagnosis of schizophrenia, paranoid schizophrenia, or major affective disorder, 14% had a diagnosis of mental retardation, 9% another or an unknown diagnosis, and 5% had no psychiatric diagnosis. The residents ranged in age from 18 to 92 (M = 47.3, SD = 13.2) and had been in this type of community residence for an average of 9.5 years (SD = 3.7, range = 24 days to 19.3 years). The 38 community residences included 29 family-care homes ("familles d'accueil"), 2 group residences and 2 apartments that were part of a formal psychiatric rehabilitation program, and 1 group residence and 4 apartments affiliated with a community mental health agency. Most of the PASSING evaluations were carried out by the same three-person team (occasionally, two-person and four-person teams were used). The PASSING teams conciliated their scores in all instances.

The total PASSING instrument had an internal consistency of 0.89. Four subscales were constructed by a factor analysis carried out on the sample of 213 programs investigated by Flynn et al. (1991; see below): SRV-Setting (14 ratings, Cronbach's  $\alpha = 0.62$ ), SRV-Program (15 ratings,  $\alpha = 0.84$ ), Beauty & Comfort (3 ratings,  $\alpha = 0.75$ ), and Accessibility (3 ratings,  $\alpha = 0.86$ ). The mean level of overall service quality in the 38 community residences, as indexed by the total PASSING score, was -156 (*SD* = 228), equal to 42% of the maximum possible weighted score. On the PASSING subscales, the mean level of service quality was best on SRV-Setting (52% of the

maximum possible score) and Accessibility (51%), both reflecting aspects of physical integration. Service quality was noticeably weaker on the SRV-Program (M = 34%) and Beauty and Comfort (M = 42%) dimensions. The urban residences scored significantly higher than the rural residences on the total PASSING scale as well as on three of the four subscales (SRV-Setting, SRV-Program, and Accessibility).

Concerning residents' QOL, the 70 residents willing and able to take part in a lengthy QOL interview rated themselves and their personal life-situations on a 7point scale of global life satisfaction (where 1 = "terrible", 7 = "delighted"). Their overall mean score (M = 3.92) was close to the midpoint of 4 ("more or less satisfied"). The respondents were most satisfied in the specific domains of education (M = 5.6), religion (M = 5.1), and physical security (M = 5.1), least satisfied in that of personal finances (M = 3.6), and at an intermediate level of satisfaction with respect to their living situation (M = 4.9), health (M = 4.8), social relations (M = 4.8), work (M = 4.7), leisure (M = 4.6), and relationship with their own family (M = 4.5). Regarding residents' physical and social integration, their most frequent daily activities were watching television and listening to the radio. Their activities showed little variety and were usually carried out alone or with another resident. The interviewees reported very little contact with ordinary citizens, including their own families.

Flynn et al. (1991) collaborated on a methodologically and substantively oriented analysis of a sample of 213 PASSING evaluations conducted in the United States (51%), Canada (45%), and the United Kingdom (4%), mainly during PASSING training workshops (96%). The programs served mainly mentally retarded persons (40%), clients with "mixed" (different) impairments (38%), or psychiatrically impaired persons (6%). Several findings were of primarily methodological interest. First, the similarity of Pearson and Spearman correlations among the total PASSING scale and Wolfensberger and Thomas's five rationally derived subscales indicated that PASSING data could be treated with interval-level, parametric procedures, with little fear of serious distortion. Second, internal consistency was high for the total scale (Cronbach's a = 0.89) and barely adequate to relatively high for the four subscales that were composed of more than one rating: Intensity (6 items), 0.62; Integrativeness (9 items), 0.66; Image Projection (19 items), 0.80; and Felicity (7 items), 0.60. Third, intraclass correlations, computed on individual raters' preconciliation data, indicated that excellent levels of interrater reliability (near or above 0.90) were attainable for the mean computed across raters in teams of 5 to 9 members, and that for teams of this size even the reliability of a single rater was moderately high (in the 0.54-0.70 range). Fourth, the total PASSING scores established by the standard practice of conciliation were moderately to highly similar to, although lower than, the scores established simply by averaging the individual raters' preconciliation scores. Substantively, the mean level of service quality in the sample (-368, equal to 32% of the maximum possible weighted score) was found to be considerably lower than zero. A score of zero is equal to 50% of the maximum possible weighted score and considered by the authors of PASSING to be the "minimally acceptable" level of service quality. Service quality was especially weak in the clinically crucial domains of Program Relevance (12% of the maximum possible weighted score) and Intensity (26%). An analysis of variance showed that the mean for Canadian services (35% of the maximum possible weighted score) was significantly higher than that for U.S. services (30%), the mean for community group residences (37%) was significantly higher than those for vocational programs (28%) and institutional residences (11%), and there was no country-byservice-type interaction.

In his doctoral dissertation (supervised by the author of the present review), Ely (1991) examined the relationship between the quality of the community residences evaluated with PASSING by Dansereau et al. (1990) (as described earlier) and the quality of life (QOL) and social integration of 70 persons with psychiatric disabilities who were living in the residences at the time of the PASSING assessments. Ely found evidence of the predictive and construct validity of PASSING in examining its links with two types of social integration. Strong social integration was operationalized as the frequency of activities undertaken by a person with a psychiatric disability inside or outside the residence in the company of a socially valued person (i.e., a member of the resident's own family or an ordinary citizen, excluding human service personnel). Weak social integration, on the other hand, consisted of the frequency of the psychiatrically disabled person's activities outside the residence, regardless of his or her accompaniment by another person or the latter's valued or devalued identity. (A synonym for weak social integration, so defined, would thus be "physical presence in the community"). Among the 70 study participants, strong and weak social integration were significantly but only weakly related (r = 0.28, p < .05). Although neither type of social integration was significantly related to global measures of subjective QOL, strong social integration was significantly correlated with subjective OOL in the specific life-domain of satisfaction with family (r = 0.29, p < .05), and weak social integration was significantly related to subjective QOL in the specific life-domains of satisfaction with finances (r = 0.23, p < .05) and education (r = 0.46, p < .05).

Almost all of the PASSING scales (which were the same as those used in Dansereau et al., 1990; Pelletier, 1992; and Flynn, 1993) significantly predicted the level of weak social integration among the 70 persons with psychiatric disabilities, although not their level of strong social integration. The measure of weak social integration was correlated with the PASSING scales as follows: with the total PASSING scale, r = 0.31, p <.01; with SRV-Setting, r = 0.27, p < .05; with SRV-Program, r = 0.26, p < .05; with Beauty and Comfort, r = 0.13, ns; and with Accessibility, r = 0.36, p < .01. It should be noted, moreover, that these correlations were attenuated (lowered) somewhat by the fact that the same PASSING scores were necessarily assigned to all clients living in the same community residence, thereby reducing the variation among the PASSING scores. This reduced variation in the PASSING scores, in conjunction with residents' extremely limited average amount of strong social integration, doubtless contributed to the fact that no significant association was found between the PASSING scales and the measure of strong social integration. PASSING was significantly correlated, however, with residents' subjective QOL in the directly relevant life-domain of satisfaction with their living situation (despite the problem of attenuated correlations just mentioned). Specifically, the psychiatrically disabled person's satisfaction with his or her living situation was significantly related to the total PASSING score of his or her residence (r = 0.28, p < .05) and to its SRV-Setting score (r = 0.30, p < .01). Elv (1991)

discovered that the quality of the 29 family-care homes present in the larger sample of 38 community residences was powerfully predicted by two variables: urban versus rural location, and size. Urban familycare homes and family-care homes housing a smaller number of psychiatrically disabled residents were of significantly higher quality. Using the subsample of 29 family-care homes (15 of which were rural and 14 urban), Ely entered urban versus rural location, size (number of residents), and a location-by-size interaction term in successive steps of a hierarchical regression model. Urban-versus-rural location, by itself, accounted for 57% of the variance in the total PASSING score, 40% in the SRV-Setting score, and 34% in the SRV-Program score (p < .001 in each case). Size accounted for an additional 10% of the variance in the total PASSING score (p < .01), an additional 26% of the variance in the SRV-Setting score (p < .001), but no additional variance in the SRV-Program score. The location-by-size interaction term accounted for no additional variance in any of the analyses. Although these findings are generalizable only to similar samples, in which the rural residences are physically and socially more isolated and larger than the urban ones, they do point to the possibility, in such situations, of making major gains in service quality through careful attention to the two highly manipulable variables of residence location and size.

Pelletier (1992) reported on an evaluation of an entire regional service system in Quebec conducted by an eight-member team with the French-language version of PASSING (Wolfensberger & Thomas, 1989). The purposes of the evaluation were several: to assess the quality of services in the region in question; to inform the Quebec Ministry of Health and Social Services, regional planning bodies, and service agencies about the degree to which official provincial policies of Social Role Valorization and social integration had been implemented in services to persons with developmental disabilities; to pilot-test a feasible method for conducting regional evaluations of service quality and policy implementation that could be used in other regions in Quebec; and, ultimately, to improve the quality of services. Working in two-person teams over a 1-month period, the evaluators assessed a total of 39 programs (30 urban, 9 rural), selected through systematic and random sampling procedures to be approximately representative of programs in the region. The programs evaluated with PASSING served 282 persons (53% male, 47% female; 73% adults, 27% children and adolescents), who comprised 26% of the total of 1,099 persons with developmental disabilities served within the region during the previous year. The 39 programs included 2 for children and their families, 4 community-support programs for adults, 24 residential programs (11 family-care homes ["familles d'accueil"], 7 community group residences, 3 apartments, and 3 institutional units), and 9 vocational programs (5 sheltered employment programs, 2 community work-placement programs, and 2 work-preparation programs). The four PASSING factors presented in Dansereau et al. (1990) were used to organize and present the findings.

The mean PASSING scores obtained by the sample of 39 services, expressed as a percentage of the maximum possible weighted scores, were as follows: total PASSING score, 47% (SD = 19%), SRV-Setting, 57% (SD = 19%), SRV-Program, 37% (SD = 24%), Beauty and Comfort, 48% (SD = 27%), and Accessibility, 63% (SD = 24%). On each dimension, the mean level of service quality in the region emerged as somewhat higher than that found in a comparison sample of mainly North American services of the same type. Nevertheless, scores on the same two subscales, both related mainly to physical integration-Accessibility and SRV-Setting-were the highest in each sample. The discriminative power of PASSING was illustrated by the fact that the range of quality in the sample of 39 programs was found to be enormous, with total PASSING scores stretching from very high (82% of the maximum possible weighted score, in the case of a child and family service) to very low (17%, in the case of a residential program). Services to children and their families scored highest on the total PASSING score (M = 79%), followed by community-support services for adults (62%), residential services (45%), and vocational programs (38%). Among the different kinds of residential services, apartments (M = 55%) and family-care homes (52%) achieved the highest mean total PASSING scores, compared with 35% for the combined category of community group residences and institutional residences. Among the different types of vocational programs, the community work-placement programs (M = 54%) scored considerably better than the workpreparation (34%) and sheltered-work programs (32%).

Overall, Pelletier (1992) concluded that important gains in service quality had been made within the region during the preceding decade, particularly with regard to the physical integration of service settings and thus of persons with developmental disabilities themselves. Also, consumers had come to reside in and use formal and informal settings that tended to favor their personal development, enhance their social roles, and increasingly approximate culturally valued settings. Furthermore, 6 of the 39 programs assessed (15%) had total PASSING scores that surpassed 70% of the maximum possible weighted score and could thus be considered "excellent." These were spread across the child-family, adult community-support, residential, and vocational areas, and served 34% of the consumers encountered during the evaluation. Another 17 programs (43%), covering the four major categories and eight subtypes of services and serving 60% of the consumers met during the evaluation, surpassed the "minimally acceptable" level. Pelletier estimated that another 6 (15%) could be brought up to this level relatively quickly and easily and that 6 others (15%) could be brought up to this level over a longer period. On the other hand, 10 services (26%), serving 22% of the clients encountered, were judged to be poor. Of these, 5 appeared improvable over the shorter run and 3 over the longer run, but, in Pelletier's opinion, elimination of the remaining 2 merited serious consideration by regional decision makers.

Pelletier (1992) noted that SRV and socialintegration principles had become firmly rooted within the regional system, in a variety of ways, both conceptually and procedurally, and were well understood and accepted by top service leaders and managers. On the other hand, many middle managers and direct-service workers appeared to have a relatively superficial grasp of SRV and socialintegration concepts, and consumers were often not adequately involved in decisions affecting them. Pelletier formulated detailed observations concerning the strengths and weaknesses of each major service subsystem (child-family, adult community-support, residential, and vocational), identified the features characteristic of the high-quality services assessed, made suggestions relevant to the assembling of a highquality PASSING evaluation team, and made recommendations to the regional governing body and service agencies and to the Quebec Ministry of Health and Social Services.

In an invited paper presented to an international conference on the integration of persons with mental retardation, Flynn (1993) compared the quality of different types of services in Canada and the USA, using an augmented sample of 406 PASSING evaluations. More than half (52%) of the programs assessed were located in Canada, 46% in the USA, and the other 2% in the UK. Seventy-seven percent of the evaluations had been made during PASSING training workshops, with the rest conducted during official assessments. Three-quarters of the programs served persons with mental retardation (who often also had other impairments), and 70% served adults. The same PASSING factors and subscales as in Dansereau et al. (1990) and Pelletier (1992) were used. For the entire 42-item instrument, internal consistency (Cronbach's  $\alpha$ ) was high (0.92). For the four PASSING subscales, the a coefficients were as follows: SRV-Setting, 0.82, SRV-Program, 0.89, Beauty and Comfort, 0.69, and Accessibility, 0.76.

The mean overall service quality (total PASSING score) in the sample of 406 programs was 34% of the maximum possible weighted score, considerably below the "minimally acceptable" level of 50%. Comparisons among the four PASSING subscales indicated that the mean level of service quality was higher on Accessibility (M = 57% of the maximum possible weighted score) than on the other three subscales, with the mean for SRV-Setting (43%) also higher than the means for SRV-Program (25%) and Beauty and Comfort (34%). The Canadian means on the total scale and four subscales were 8% to 11% higher than those for the American programs and, in both countries, Accessibility was the single best dimension of service quality, followed by SRV-Setting, Beauty and Comfort, and SRV-Program.

Pilon, Arsenault, and Gascon (1993), in the published version of a longer research report (Pilon, Arsenault, & Gascon, 1994), studied the impact of moving from an institutional setting to communitybased family-care homes on social integration and quality of life. Pilon et al. (1993) followed for one year a sample of 36 adults who were mentally retarded, after they had left one of five institutional environments. The researchers also followed a control sample of 36 mentally handicapped "stayers" who remained in an institutional milieu during the year-long period and had been individually matched with the

group of "movers" on the variables of physical health, deficits, maladaptive behavior, and overall developmental level. Using a quasi-experimental (pretest/post-test, nonequivalent control group) design, Pilon et al. studied the impact of leaving the institution on residents' social integration and quality of life. They were also interested in determining the contribution of selected individual variables (resident and staff characteristics) and environmental factors (residence social climate and level of implementation of Social Role Valorization) on any changes found. Social integration was measured by means of the Inventaire d'Intégration Sociale, a Quebec version of the Valued Outcomes Information System (VOIS; Newton et al., 1988). Quality of life was assessed with the Inventaire de Bien-Être, an instrument constructed by Pilon and his colleagues. The social climate of the institutional and community settings was evaluated with Quebec versions of Moos's Ward Atmosphere Scale (Moos & Hoots, 1968) and Community-Oriented Programs Environment Scale (Moos & Otto, 1972), and the level of residential SRV was assessed with PASSING.

Compared with their peers who remained in an institutional milieu, the "movers" experienced significant gains in quality of life and social integration, even though their social contacts were found to be limited largely to family-care or agency personnel and to other mentally handicapped residents. The social climate of the community settings was also found to be more favorable to social integration than was that of the institutions. Finally, on the four PASSING factors used by Dansereau et al. (1990) and Flynn (1993), Pilon et al. (1993) found that the 10 family-care homes that had been assessed with PASSING scored significantly higher than the three institutional settings evaluated with the tool. Specifically, on SRV-Setting, the family-care homes had a mean score of 69% of the maximum possible weighted score versus a mean of 7% for the institutions; on SRV-Program, the respective means were 37% versus 11%; on Beauty and Comfort, 68% versus 17%, and on Accessibility, 63% versus 23%. Interestingly, the weakest area for the family-care homes was clearly the same one found in the other PASSING studies reviewed, namely, SRV-Program. Pilon et al. also discovered that the image-related ratings on the SRV-Program scale appeared

considerably more resistant to short-term improvement than the competence-related ratings.

Vandergriff and Chubon (1994), in an article based on the first author's doctoral thesis (Vandergriff, 1991), used PASSING to assess the quality of six types of residential environments: natural or family homes, supervised apartments, boarding homes, community training homes, community residences, and regional campus facilities. The purpose of the research was to test two hypotheses: that quality of life would covary with the type of residential setting, and that persons with a higher level of intellectual functioning would experience a higher quality of life. The investigators studied a total of 120 adults who were mentally retarded, 20 from each of the six types of setting, and 30 at each of four levels of intellectual functioning (i.e., mild, moderate, severe, and profound retardation). The four levels of retardation were subsequently collapsed into high-IQ and low-IQ groups. Quality of life was assessed with the Resident Choice Assessment Scale (RCAS; Durant, Kearney, & Mindell, 1987), and the Life Situation Study (LSS; Chubon, 1990). Behavioral competencies were assessed with Parts I and II of the AAMD Adaptive Behavior Scale (Nihira et al., 1974). Unfortunately, PASSING was completed by a single staff psychologist (rather than a team of raters) during visits to each of the residences where study participants lived. Analysis of variance (ANOVA) on the PASSING scores and post hoc tests showed that the six types of residences differed from one another, with the supervised apartments attaining the highest score, on average, followed, in order, by the community training homes, family homes, community residences, regional campus, and boarding homes. Moreover, the PASSING scores from the six types of setting were found to be very highly correlated both with the mean LSS score for each kind of setting (r = 0.91, p < .01)and with the mean RCAS score (r = 0.98, p < .001), but not with the mean ABS-I or ABS-II scores. Vandergriff and Chubon found support for both hypotheses: quality of life did covary with the type of setting, and persons of a higher level of intellectual functioning experienced a higher quality of life (as assessed by the LSS and RCAS) than those of a lower level of functioning.

Williams's (1995) report on PASS 3 and PASSING evaluations in Great Britain noted that the average (median) total PASSING score for large residences (more than 8 places) in Britain (n = 31; Mdn = 16%) was similar to that for institutional residences in North America that had been assessed with PASSING (n = 23; Mdn = 21%, as reported by Flynn et al., 1991). The average total PASSING score for small residences (less than 8 places) in Britain evaluated with PASSING (n = 5; Mdn = 38%) was also similar to that observed in community group residences in North America that had been assessed with PASSING (n = 79; Mdn = 37%, again as reported by Flynn et al., 1991).

Cocks (1998) reported on a Safeguards Project in Perth, western Australia, in which PASSING was used as one among several mechanisms for promoting good service quality. In 1954, an agency was founded by a group of parents of young children who had multiple and severe disabilities. The following year, the agency opened a hostel that eventually provided residential services for 36 young people, as an alternative to a large mental hospital. The children remained in the hostel until adulthood. Between 1987 and 1993, the agency relocated its clients from the hostel to community homes in suburban Perth. In 1993, at the end of the transition, a total of 41 clients were living in 13 community homes (three homes had 2 residents each, six homes had 3 each, three homes had 4 each, and one home had 5).

At the end of the transition period, in 1993, the agency established its Safeguards Project, to ensure an ongoing focus on the provision of high-quality services and the attainment of good outcomes. The project included internal and external evaluation components. The internal safeguarding process consisted of linking 43 "themes" (i.e., agency aspects or client outcomes) to specific actions that would safeguard each of the themes. The external evaluation consisted of a PASSING evaluation, together with the use of 15 administration-related PASS items and a "modelcoherency analysis." The latter examined the extent to which the service model used by the agency was consistent with clients' needs. The total PASSING scores for each of the 13 community homes were converted to a percentage of the maximum possible weighted score (Cocks, 1998). The mean total PASSING score was 43% (range = 26%-71%), higher than the average of 32% attained in the 213 PASSING evaluations analyzed by Flynn et al. (1991). Also, service quality was found to be significantly better in the 2-person homes than in those for 3, 4, or 5 residents.

Flynn et al. (in press) produced the most definitive factor analysis of PASSING to date, employing a large sample and cross-validation procedures. In the second study contained in their paper (the first study from this same paper was discussed earlier, in the section devoted to PASS 3), Flynn et al. (in press) factoranalyzed a sample of 633 PASSING program evaluations. The purpose of their study was to derive, through exploratory and confirmatory factor analyses, a relatively definitive, cross-validated factor structure for PASSING. They also intended to construct factorbased subscales that would be useful for program evaluation purposes. The sample of 633 PASSING evaluations, conducted between 1983 and 1995, were all "team-conciliated" assessments (i.e., based on the consensus of a group of raters who used the instrument under the guidance of an experienced team leader). Eighty-three percent of the evaluations had been conducted during PASSING training workshops, while 14% had been carried out as official evaluations. Fiftythree percent had been carried out in the United States. 37% in Canada, 7% in Australia, and 1% each in the United Kingdom and France. Thirty-eight percent were assessments of community group residences, 23% of vocational services, 11% of institutional residential programs, and 7% of early-childhood or school-based education programs. Of the programs evaluated, 40% served persons with mental retardation, 10% clients with psychiatric difficulties, 7% people who were elderly; and 36% served persons with "mixed" (different) conditions.

Flynn et al. (in press) first carried out an exploratory factor analysis (EFA) on a randomly chosen half of the sample (n = 316), in order to establish the number of factors present in the 42 PASSING items and identify those items that would provide good indicators of the factors (Bentler & Wu, 1995). A confirmatory factor analysis (CFA) was then conducted on the other random half of the sample (n = 317) in order to crossvalidate the EFA. Three cross-validated PASSING factors, Program, Setting, and Accessibility, emerged from these procedures (see Table 14.2). Factor 1 (Program) reflects the *content* of the service evaluated with PASSING. Its 15 items capture both imagerelated and competency-related aspects of the program, consistent with the SRV conceptual underpinnings of PASSING. Factor 2 (Setting) measures the physical location in which the service is situated, including the building and its surrounding neighborhood. Factor 3 (Accessibility) assesses the degree to which the service setting provides ready access to clients and their families, to the wider public, and to a wide range of pertinent community resources, such as eating places, shops, libraries, post offices, and so forth. Three homogeneous PASSING subscales were formed from their new factors, and these subscales had a very strong multiple correlation (R = 0.97, p < .001) with the total PASSING score in the overall sample of 633 programs. Flynn et al. (in press) suggested that their findings could increase the utility of PASSING as an evaluation tool by providing factorially valid measures that would facilitate comparisons among and within programs and permit evaluators to organize their assessments more tightly around the core service dimensions of Program, Setting, and Accessibility.

#### **3 CONCLUSION**

I wish to conclude this review of PASS and PASSING research with several observations and suggestions that are intended to enhance future research, training, and evaluation practice with the instruments.

1. When assessed against the demanding criteria embodied in PASS and PASSING, the overall quality of many human service programs appears to be quite modest. For example, in the two large samples of evaluations carried out with PASS (N = 626) and PASSING (N = 633) that were analyzed by Flynn et al. (in press), the mean total PASS score was only 43% of the maximum possible weighted score, and the mean total PASSING score was only 32% of the maximum possible weighted score. (The difference between these means-43% versus 32%-is probably due more to inter-instrument than to intersample differences, although both influences may be at work.) These results are consistent with Felce and Perry's recent observation that community services personnel often appear to lack the organized means and competencies necessary to successfully promote the personal development and social integration of the people whom they serve. Felce and Perry (1997) deservedly insist that as much attention must now be paid to improving the technical proficiency and quality of community services as has previously been devoted to the size, location, accessibility, and staffing of such services.

# **TABLE 14.2**

# THREE CROSS-VALIDATED PASSING FACTORS—PROGRAM, SETTING, AND ACCESSIBILITY—AND THE ITEMS COMPOSING EACH (ADAPTED FROM FLYNN ET AL., IN PRESS)

#### Factor 1: Program (15 items)

- 14. Image Projection of Intraservice Client Grouping—Social Value
- Image-Related Other Integrative Client Contacts and Personal Relationships
- 18. Service Worker-Client Image Match
- 20. Image Projection of Program Activities and Activity Timing
- 21. Promotion of Client Autonomy and Rights
- 23. Image-Related Personal Possessions
- 24. Image Projection of Personal Labeling Practices
- 35. Competency-Related Intraservice Client Grouping—Composition
- Competency-Related Other Integrative Client Contacts and Personal Relationships
- Life-Enriching Interactions Among Clients, Service Personnel, and Others
- 38. Program Support for Client Individualization
- 39. Promotion of Client Sociosexual Identity
- 40. Program Address of Clients' Service Needs
- Intensity of Activities and Efficiency of Time Use
- 42. Competency-Related Personal Possessions

### Factor 2: Setting (8 items)

- 1. Setting-Neighborhood Harmony
- 2. Program-Neighborhood Harmony
- 5. External Setting Appearance Congruity With Culturally Valued Analogue
- 7. External Setting Age Image
- 9. Image Projection of Setting-Physical Proximity
- 10. Image Projection of Setting-History
- 12. Image Projection of Program-to-Program Juxtaposition
- 13. Service-Neighborhood Assimilation Potential

#### Factor 3: Accessibility (3 items)

- 28. Setting Accessibility-Clients and Families
- 29. Setting Accessibility-Public
- 30. Availability of Relevant Community Resources

Fortunately, excellent progress has recently been made in identifying and validating the personal competencies needed by human service personnel to promote people's development and integration (see Burchard chapter 11, this volume), and this knowledge deserves wide dissemination and application. In the crucial task of service quality improvement, PASS and PASSING can also be invaluable tools, because they focus attention directly on the priorities mentioned by Felce and Perry (1997): understanding people's needs, responding in relevant and intense ways to these needs, and helping people achieve greater personal development, self-direction, and social integration.

2. The relatively definitive factor analyses by Flynn et al. (in press) show that PASS and PASSING have similar factor structures. Specifically, each instrument includes Program, Setting, and Accessibility factors (PASS alone covers administrative issues and thus has a fourth factor, Administration). This factorial similarity is not surprising, given Wolfensberger's senior authorship of both instruments and his strong emphasis in each on the assessment of human-service "universals" (i.e., issues of fundamental importance to human service programs).

3. Relatedly, it is probably a common emphasis on basic service issues that accounts for a striking parallel between, on the one hand, the PASS and PASSING factors of Program, Setting, Accessibility and (in the case of PASS) Administration and, on the other hand, the core structural and functional service dimensions that ecologically oriented researchers (e.g., Felce, 1988; Landesman, 1988; Meador, Osborn, Owens, Smith, & Taylor, 1991) have identified as central in the evaluation of residential services. According to Meador et al. (1991), structural features of a residential program include the physical characteristics of the service facility (e.g., size, siting, convenience of location, adequacy of furnishings and utilities, etc.), as well as the socioeconomic status and population density of the neighborhood, the experience and training of staff, and so forth. The PASS and PASSING Setting and Accessibility subscales assess many of these structural aspects. Functional features, on the other hand, include the day-to-day operation of the program, such as the amount and quality of interactions between staff and residents, the types of activities in which residents engage, the network of relationships with individuals and agencies in the community, the meeting of clients' needs, the opportunity for habilitation, the independence afforded clients, the administrative organization and resourceallocation pattern in the program, and so on. The PASS and PASSING Program and the PASS Administration subscale evaluate many of these functional features. Consistent with the findings of Meador et al., the PASS and PASSING research reviewed in this chapter suggests that services with similar structural features may have very different functional features. Specifically, the studies reviewed here indicate that the structural aspects of services (as measured by the Setting and Accessibility subscales of PASS and PASSING) are usually of considerably higher quality than their functional aspects (as measured by the Program and Administration subscales).

4. Users of PASS and PASSING who have employed earlier versions of the Program, Setting, Accessibility, and (in the case of PASS) Administration subscales to organize the various phases of an evaluation—data-gathering, teamconciliation, provision of verbal feedback, and reportwriting—have often remarked that the use of these empirically derived subscales adds considerable coherence and unity to the evaluation process. In my opinion, incorporation of the relatively definitive versions of the subscales (Flynn et al., in press) into the organization and scoring of PASS and PASSING would improve both instruments and enhance training and field applications with each.

5. Pelletier's (1992) report is a good illustration of the potential of PASS and PASSING to serve as qualitative frameworks or "lenses," and not merely as quantitative tools, for assessing and improving largescale regional service systems, as well as individual programs or agencies. Pelletier's report is also a particularly useful example of how the PASS or PASSING evaluator can help administrators and service personnel to identify *which* service features are particularly strong or weak, and *why*.

6. Ely (1991) found that the potentially manipulable variables of the urban versus rural location of residential services, and the number of people served in the typical residence, were powerful predictors of PASSING scores. This suggests that, at least in certain residential-service contexts, quality may be considerably enhanced by careful attention to the location and size of services. We may thus add a nuance to our third point (above), namely, that while good quality on the structural dimensions of services in no way guarantees good performance on their functional aspects, structural features such as location and size may, in some situations, act as powerful facilitators or inhibitors of functional aspects such as the frequency and quality of social interactions, relationships, and integration. Attention to the interplay between the structural and functional features of services is thus likely, in any given situation, to be very important for service planning and evaluation.

7. It is clear from the studies reviewed that relatively high levels of interrater reliability and internal consistency are attainable with PASS and PASSING, and that postconciliation scores bear a moderate to strong relationship to (although they tend to be somewhat lower than) individual preconciliation ratings (cf. Flynn & Heal, 1981; Flynn et al., 1991; Jacobs, 1983). In this regard, it should be emphasized that single-rater evaluations (which are contrary to standard PASS and PASSING practice) are to be avoided, because interrater reliability cannot be calculated in such situations and the benefits of pooling information and conciliating ratings by two or more raters are lost.

8. The present review has uncovered a good deal of evidence that is supportive of the concurrent, predictive, discriminant, factorial, and construct validity of PASS and PASSING. The fact, for example, that both instruments consistently differentiate between community and institutional services, as well as between various types of community programs, is supportive of their discriminant validity. The finding that PASS (e.g., Picard, 1988e) and PASSING (e.g., Ely, 1991) predict specific aspects of social integration and quality of life is supportive of their predictive validity. The successful cross-validation of the factor structures of PASS and PASSING (Flynn et al., in press) provides good evidence of factorial validity. Despite these promising findings, however, PASS and PASSING researchers should, whenever possible, gather data on client outcomes, as advocated by Perry and Felce (1995), in order to clarify the conditions under which high service quality and responsive program environments are likely to foster desirable client outcomes.

9. Finally, although I was able to locate 48 studies

for this review, the publication of more systematic research on PASS and PASSING, in peer-reviewed journals, would be highly desirable. To date, PASS and PASSING have frequently been used to educate service personnel in a number of fields and countries about the specific implications of the principles of Normalization and Social Role Valorization (see Thomas chapter 15, this volume). They have also been used relatively frequently on the local level to assess and improve individual service programs or agencies (as noted in several chapters in the present volume). The present review suggests, however, that they have been used considerably less often as instruments in formal research or evaluation studies. While their relatively widespread use as training and evaluation tools in the "real world" is impressive and has played an important role in bringing about positive service changes in a number of countries (as attested by several chapters in Pilling & Watson, 1995, and in the present volume), PASS and PASSING (and the services they are used to evaluate) would no doubt benefit from more frequent use by researchers and evaluators who are oriented to the publication of their findings. Such contributions are likely to have a significant impact on the direction that service policies and practices take over the long term.

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