

A PASS 3 Evaluation of Community Residences in Wales

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Abstract: PASS 3 was used to evaluate 14 residential services for people with mental retardation. Residents had a broad range of abilities. Size of residences ranged from one to seven residents. PASS scores were generally associated with both resident's ability level and smaller size of living unit. Overall, the residences were shown to be well-located and reasonably home-like. However, residence personnel tended to lack organized means and competencies to promote resident development and experience. Administrative practices were also weak. Attention must be given to factors other than residence size, location, building characteristics, and staffing parameters when services are commissioned and when service contracts are specified and reviewed.

The principle of normalization has had considerable influence on recent changes in services for people with mental retardation (Emerson, 1992; Tyne, 1992). In Britain, the concept of normalization (Wolfensberger, 1980), and subsequently social role valorization (Wolfensberger, 1983a), was disseminated by a training initiative that was begun in the late 1970s and is still ongoing (Lindley & Wainwright, 1992; Williams & Tyne, 1988). This period has coincided with major advances in deinstitutionalization and the replacement of large, centralized services by networks of small local services. Deinstitutionalization in England and Wales in the last 10 to 15 years has proceeded at a similar rate and reached a similar stage to that in the United States and some of the Scandinavian countries (Hatton, Emerson, & Kiernan, 1995). In particular, developments in Wales have been undertaken since 1983 under a national policy (Welsh Office, 1983) recommending that the residential services replacing the outmoded institutions should be provided in local residential areas and use typical housing. Later policy guidance stated that residences should house no more than four persons. In general, such services have been developed via partnerships between housing agencies, which provide housing, and indepen-

dent or local authority service providers, which employ staff and manage the service. Residents have the status of tenants.

Program Analysis of Service Systems (third edition)—PASS 3 (Wolfensberger & Glenn, 1975) was developed as an evaluation tool to assess the extent of conformity of a service to the normalization principle. It contains 50 independent rating scales with defined levels and scores. Scores are weighted when ratings are combined; the weights represent the importance of the issues addressed according to the scale's originators. Thirty-four of the ratings reflect adherence to the concept of normalization, and 16 ratings are concerned with administration practices. Normalization-related ratings encompass attention to the quality of the setting, its location, and the characteristics of the neighborhood; access to community resources; and resident social integration, personal appearance, possessions, activity rights (including income, safety, privacy, tenure, and security), and behavioral and sexual development. Such breadth overlaps substantially with definitions of quality of life (Felce & Perry, 1995a; Schalock, 1996) and the focus of service evaluation more generally, at least in Britain (Emerson & Hatton, 1994).

Despite the evident influence of normal-

ization as a set of ideas and interest in PASS 3 as an embodiment of those ideas, PASS 3 has not been widely used as an evaluation tool. However, use of this scale was incorporated into a recent research project we conducted on the measurement of quality in 14 community residences (Perry & Felce, 1995). In the present study we present our findings from this evaluation.

Method

Settings and Residents

The 14 houses were located in South Wales. Seven houses had between 1 and 3 residents and the other 7, between 4 and 7 residents. Ten of the 14 houses were run by local authorities, 2 by voluntary agencies, one by a health authority, and one was privately operated. Four houses were located in cities or large towns, 9 were in small towns, and one was in a rural village.

The houses served a total of 53 residents (28 males) ranging in age from 19 to 67 years (mean = 37). The Adaptive Behavior Scale (ABS), Part One (Nihira, Foster, Shellhaas, & Leland, 1974) was used to assess them. Residents in 3 houses had raw ABS scores that were typical of the lowest quartile of people in the sample from which the reference norms were derived. Residents in an additional 3 houses had raw scores reflecting the upper quartile of the reference sample. The raw scores of residents in the other houses were more or less evenly spread across the second and third quartiles. Staffing levels were, on the whole, related to the behavior of the residents and varied from staff:resident ratios of 1:1 or greater throughout the day to 1:6 or less.

Measurement and Analysis

The PASS 3 contains 34 ratings linked to normalization: (a) 6 concerned with Physical Integration; (b) 8 with Social Integration; (c) 7 with Age-Appropriate Interpretations and Structures; (d) 5 with Culture-Appropriate Interpretations and Structures; (e) 1 with Model Coherency, the way service elements have been established and arranged to meet the major needs of service users; (f) 3 with the Developmental Growth Orientation displayed within the service; and (g) 4 with the Quality of Setting. The Administration ratings include 9 that are considered to derive from an ideological position and 7 that concern good personnel,

organizational, and financial practices. Table 1 lists the names of individual ratings and indicates the weights given to each within the scoring system.

The PASS evaluations are conducted by a team of raters. Due to the small size of each setting, we restricted team size to three members, all of whom had past experience using the instrument. All teams were led by people who had either conducted PASS 3 workshops or had served in the capacity of team leader in such workshops several times. Each assessment exercise lasted 2 days. Teams visited the residence for a full day, spending time with residents and their support staff. Information was gained during the visit about the neighborhood, community, and town in which the residence was located as well as characteristics of the residences and the residents. Relevant documentary sources were made available to the teams (e.g., operational policies, job descriptions, demographic information on the local area and on the distribution of services, county plans, and budgetary information). Teams also interviewed managerial staff following a sequence of questioning developed as a guide for team leaders in PASS 3 workshops. All of the information gained was organized under the various PASS 3 ratings by each team member. The team then met collectively, pooled information relevant to each rating, and discussed the significance of the evidence for the rating concerned. The final rating score was, therefore, based on consensus among team members.

Rating levels were transferred to the PASS 3 scoring sheet. Scores were then combined according to the rating clusters indicated in Table 1. The four subscores suggested by Wolfensberger (1983b) were also calculated: (a) Service Location Optimality, (b) Physical Facility Appearance, (c) Personal-Clinical Program Emphasis, and (d) Total Administration (see Table 2). Combined scores for all three methods were expressed as percentages of the totals possible instead of retaining the negative to positive scoring spectrum of the original measure. Unacceptable quality in the original scoring system was denoted by negative scores; therefore, in the present study, unacceptable quality is indicated by scores under 50%. Scores higher than 75% are interpreted as *good to excellent* and lower than 25%, as *extremely poor to neglectful*.

Table 1
PASS 3 Ratings Clusters and Weights for Individual Ratings

Rating type/Cluster/item	Weight
Normalization	
Physical Integration	
1. Local proximity	26
2. Regional proximity	10
3. Access	22
4. Physical resources	26
5. Program-neighborhood harmony	22
6. Congregation & assimilation potential	30
Social Integration	
7. Program, facility & location names	10
8. Function congruity image	6
9. Building-neighborhood harmony	10
10. Deviancy image juxtaposition	22
11. Deviancy program juxtaposition	19
12. Deviant staff juxtaposition	26
13. Deviant client & other juxtaposition	34
14. Socially integrative social activities	39
Age-Appropriate Interpretations & Structures	
15. Facilities, environmental design and appointments	15
16. Personal appearance	10
17. Activities, routines, & rhythms	34
18. Labels & forms of address	19
19. Autonomy & rights	34
20. Possessions	15
21. Sexual behavior	15
Culture-Appropriate Interpretations & Structures	
22. Internal design & appearance	0 ^a
23. Personal appearance	30
24. Activities, routines, & rhythms	6
25. Labels & forms of address	22
26. Rights	19
27. Model coherency	40
Developmental Growth Orientation	
28. Physical overprotection	10
29. Social overprotection	15
30. Intensity of relevant programming	39
Quality of Setting	
31. Physical comfort	26
32. Environmental beauty	19
33. Individualization	30
34. Interactions	34
Administrative	
Ideology-Related Administration	
35. Comprehensiveness	19
36. Utilization of generic resources	22
37. Consumer & public participation	22
38. Education of the public	6
39. Innovativeness	15
Human Science Orientation	
40. Ties to academia	6
41. Research climate	6
Regional priorities	
42. Deinstitutionalization	19
43. Age group priorities	15
Administration	
44. Staff development	22
45. Manpower development	6
46. Administrative control structures	26
47. Planning process	19
48. Program evaluation & renewal	26
49. Financial documentation - extent	15
50. Budget economy	22

Note. PASS 3 = Program Analysis of Service Systems (3rd ed.).

^aHighest level has zero weight; lowest level, weight of -15.

Table 2
Rating Composition of Summary Subscores

Subscore	Ratings ^a
Service Location Optimality	1, 2, 3, 4, 5, 6, 9, 11
Physical Facility Appearance	8, 9, 15, 22, 28, 31, 32
Personal-Clinical Program Emphasis	13, 14, 16-21, 23-26, 28-34
Total Administration	35-39, 44-50

^aNumbers refer to items, which are specified in Table 1.

The data were analyzed for any association with resident ability by calculating Spearman rank order correlations between the various PASS 3 cluster scores or summary subscores on the one hand and average ABS scores for residents in each household group on the other (Siegel, 1956). Data were also averaged for two groups of houses, those with residents with the 6 lowest average ABS scores and those with residents with the 8 highest average ABS scores, and the significance of differences was explored using the Mann-Whitney *U* test (Siegel, 1956). This classification was employed because of a large increase in ABS scores between the 6th and 7th residences. Association with size of residence was also investigated. Data for the 7 smaller houses serving 1 to 3 residents were compared to those for the 7 larger houses, again establishing the significance of differences with the Mann-Whitney *U* test. Rank correlations between size of residence and the various rating cluster scores, summary subscores, and total scores were also calculated. Three of the smaller houses were among the 6 serving residents with lower ABS scores and 4 were among the 8 houses serving those with higher ABS scores.

Results

Table 3 shows average scores for the normalization rating clusters, the summary subscores recommended by Wolfensberger (1983b), and the overall scale total. Physical Integration, Quality of Setting, and Social Integration were the most highly rated. These are reflected in the means for the Service Location Optimality and Physical Facility Appearance subscores. Ratings of Age-Appropriateness and Developmental Growth Orientation tended to be low and resulted in low Personal-Clinical Program Emphasis. In addition, scores on Model Coherency and on the Administration ratings were generally low. The total scale scores were generally below acceptable standards.

Table 3
Normalization Ratings (in %) by Residents', Ability Level and Residence Size

Rating cluster	Residents' ability ^a		Size of residence ^b		Overall average	
	Less able	More able	Smaller	Larger	%	Range
Physical Integration	69	65	75	58	67	26-96
Social Integration	39	44	46	38	42	20-75
Age-Appropriate Interpretations and Structures	15	44	42	20	32	0-69
Culture-Appropriate Interpretations and Structures	24	46	54	19	37	2-76
Model Coherency	10	11	21	0	11	0-20
Developmental Growth Orientation	15	20	21	14	18	0-34
Quality of Setting	39	50	53	38	45	6-67
Service Location Optimality	66	65	72	59	66	30-92
Physical Facility Appearance	50	67	64	55	60	19-87
Personal-Clinical Program Emphasis	24	38	42	22	32	4-58
Total Administration	12	18	16	15	16	0-26
Total	30	39	42	28	35	10-50

^aLess able = average ABS score for handicapped group below 150. More able = average ABS scores for handicapped group 150 or above. ^bSmaller = serving 1 to 3 residents, larger = serving 4 to 7 residents.

Differences According to Resident Ability

Average scores calculated separately for residences serving less or more able residents are also shown in Table 3. Scores concerned with Age-Appropriate and Culture-Appropriate Interpretations and Structures were significantly lower in residences housing less able individuals than in residences for more able residents, $U = 4$, $p = .004$, and $U = 9$, $p = 0.03$, respectively. However, only the age-appropriate cluster ratings were significantly correlated with ability scores, $r_s = .66$, $p < .01$. Significant differences and correlations positively associated with ability were also found with regard to the Physical Facility Appearance subscore, $U = 10$, $p = .041$, $r_s = .51$, $p < .05$, the Personal-Clinical Program Emphasis subscore, $U = 10$, $p = .041$, $r_s = .46$, $p < .05$, and, despite the relatively low average difference between the two sets of residences, the Total Administration subscore, $U = 10$, $p = .041$, $r_s = .47$, $p < .05$.

Differences According to Residence Size

Average scores were higher among the smaller (1 to 3 residents) than larger (4 to 7 residents) residences for every category shown in Table 3. Statistically significant differences and significant inverse correlations with size were found for Physical Integration, $U = 11$, $p = .049$, $r_s = -.47$, $p < .05$, Social Integration, U

$= 8$, $p = .019$, $r_s = -.70$, $p < .01$, Culture-Appropriate Interpretations and Structures, $U = 3$, $p = .002$, $r_s = -.49$, $p < .05$, Quality of Setting, $U = 7$, $p = .013$, $r_s = .46$, $p < .05$, the Personal-Clinical Program Emphasis subscore, $U = 7$, $p = .013$, $r_s = .56$, $p < .05$, and the Total score, $U = 5$, $p = .006$, $r_s = .060$, $p < .05$.

Discussion

Quality of the Residences Studied

This study has shown that the quality of community residential services as assessed by PASS 3 varies and that variation was associated with the ability of the residents and small residence size. Although significant associations were generally found for different rating cluster scores or summary subscores, both factors tended to have a similar relation with the data under study, although they were independent of each other. The interaction of smaller size and greater ability was, therefore, particularly powerful. Smaller residences serving more able residents received higher scores than did other residences and were the only ones to reach acceptable levels in terms of Age-Appropriate Interpretations and Structures and Personal-Clinical Program Emphasis.

In our adaptation of the PASS 3 scoring system, the 50% mark represents minimally acceptable quality. Twelve of the 14 residences

scored at or above this level in terms of Physical Integration and the Service Location Optimality subscore. Ten and 7 residences scored similarly in terms of the Physical Facility Appearance subscore and Quality of Setting ratings. In summary, then, the residences were found to be of a reasonable environmental standard, home-like, a good fit in the neighborhood, and well-located with respect to access to the resources of the wider community.

In contrast, the residences we evaluated did not prove to be technically proficient services. Only 4 residences scored 50% or above on the Age-Appropriate Interpretations and Structures rating cluster (all of these were small services for more able residents) and 7 scored below 25%. No service scored 50% or above on the Model Coherency rating or on the Developmental Growth Orientation rating cluster, and 13 and 12 residences scored below 25% on each of these rating clusters, respectively. Only 3 residences (all of them small residences for more able residents) scored 50% or above on the Personal-Clinical Program Emphasis subscore; 5 scored below 25%. In particular, every residence received the lowest level assessment on the rating for Intensity of Relevant Programming, which carries the second highest weighting in the PASS-3 scale. These findings are consistent with related studies of these residences in which investigators have noted the lack of procedural focus on such significant resident outcomes as participation in activity (Felce & Perry, 1995) and development (Felce & Perry, 1996).

The majority of residences also scored below 25% on Total Administration. Such low scores were not anticipated and may reflect the stage of service development reached at the time of evaluation. All were relatively new within the context of a wider program of reform to replace institutional services. Most of these residences were operating under a far from comprehensive pattern of services and without a well coordinated pattern of local support. Use of generic resources and consumer and public participation in the operation and management of the services were, at best, embryonic. Issues such as education of the public and manpower development had not been defined as part of the individual residential service's relationship with wider society. Moreover, a lack of innovation, an absence of academic links or research activity, ad hoc staff development, and poor monitoring and self-evaluation mechanisms

were consistent with a low emphasis on working methods and core competencies.

Associations Between PASS 3 and Other Measures

The basis of PASS 3 on a concept that has implicit values and an assigned rather than empirically determined weighting structure has generated much debate (Pilling & Watson, 1995). We have found evidence of concurrent validity between ratings within PASS 3 and other measures of process or outcome that we have employed in our earlier investigation of these residences (Perry & Felce, 1995). Significant correlations were found between the Physical Facility Appearance subscore and the Characteristics of the Physical Environment Scale (Rotegard, Hill, & Bruininks, 1983); the Physical and Social Integration rating clusters and a direct measure of the frequency of community and social activities; the Interactions rating within the Quality of Setting cluster and the social distance items on the Group Home Management Scale (Pratt, Luszcz, & Brown, 1980); the Activity, Routines, and Rhythms ratings within the Age- and Culture-Appropriate Interpretations and Structures clusters and directly observed activity levels (Beasley, Hewson, & Mansell, 1989); and the Autonomy and Individualization ratings and the depersonalization, block treatment, and rigidity of routine items of the Group Home Management Scale (Pratt et al., 1980). The Service Location Optimality subscore was positively but not significantly correlated with the frequency of social or community events, $r = .50$. The Personal-Clinical Program Emphasis was positively but not significantly correlated, $r = .38$, with the residual level of activity once the effect of resident ability was considered through univariate regression, the two being significantly correlated, $r_s = .90$, $p < .01$.

Conclusion

The preceding analysis together with related research suggests that small residential housing services offer a reasonable material standard and home-like environment and are well enough located to allow residents access to the amenities and social world of the surrounding community. True social integration of residents, however, has remained elusive, and services are typified by an inadequate range and

technical sophistication in their approaches to supporting integration (e.g., Walsh, 1986), other activity (Felce, 1996), choice, and development (Emerson & Hatton, 1994; Perry & Felce, 1994). The common features of community housing provision, such as their small size, community location, and typical building characteristics, together with often high numbers of staff members, do not guarantee high quality outcome, although they may be necessary conditions. Consistent with this conclusion, Felce and Perry (1995b) demonstrated that staff do not always provide the practical support necessary to help people with severe mental retardation participate fully in the conduct of their own lives, even under good environmental conditions.

It is clear both from the present study and from the evaluation literature in general that different services have particular strengths and weaknesses. More needs to be learned about the determinants of good practice, and service commissioners and providers must broaden their appreciation of the service design and operational factors that combine to produce high quality. However, if one believes that the focus within planning in the past decade of deinstitutionalization has been on the scale, location, physical fabric, and resource base of the residences provided to replace the institutions, then it is possible to take reassurance from the fact that these design features appear to have been relatively well-determined. What is now needed is equal attention to their technical proficiency. There is no reason to believe that efforts in this area cannot result in these matters being equally well-determined. However, they do relate more closely to an understanding of people's particular needs and what constitutes an intense and relevant response to those needs. It is important that such a specialist perspective is maintained within the continuing movement towards supporting people with mental retardation within natural settings and communities.

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- Received 3/19/96, first decision 5/7/96, accepted 8/26/86.
Editor-in-Charge: Steven J. Taylor
-
- This research was funded by the Welsh Office and Department of Health. We are grateful to the administrators of the residences, their residents, and staff members for their collaboration and to the members of the various assessment teams. All gave freely of their time. We are grateful to Paul Williams for his comments on earlier drafts of this paper.
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