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CORRESPONDENCE IN RESIDENTS' AND STAFF MEMBERS' ASSESSMENTS OF THE QUALITY OF LIFE OF CHILDREN IN RESIDENTIAL CARE FACILITIES

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ABSTRACT. This paper employs Shye's (1979, 1985, 1989) Quality of Life (QOL) model to examine the QOL of 920 boys and girls in 46 Residential Care Facilities in Israel, from the perspective of both the residents and the staff. Specifically, it examines the degree of correspondence in the residents' and staffs' assessments of the residents' QOL and the association between the degree of correspondence and the quality of the facility. Findings showed that while residents and staff made similar assessments in various areas of the residents' cultural and social QOL, the residents rated their physical QOL higher and their psychological QOL lower than the staff did. Findings also showed that while residents and staff agreed on the residents' QOL in the poorest facilities, they disagreed in the others. In the better facilities, the staff rated the residents' QOL lower than the residents' did; in the poorer facilities, the residents rated their QOL lower than the staff. These findings raise concern about staff awareness of the psychological hardships and distress of the juveniles in their care, as well as about their ability under these circumstances to provide adequate psychological care.

INTRODUCTION

Thousands of children and youths throughout the world live for shorter or longer periods of time in Residential Care Facilities, where they spend 24 hours a day, seven days a week without their families, except for brief visits. They reach these facilities for a variety of reasons, including their being at risk for neglect or abuse at home, as well as a range of physical, emotional, and cognitive disorders, and anti-social or delinquent behaviors. The facilities provide them with physical care, social learning opportunities, specialized behavior training, and the promotion of general health and well being (Fulcher, 2001; Bates et al., 1997; Wozner et al., 1997). Often less restrictive alternatives are unsuitable or unavailable. Yet despite the clear need that such facilities serve, they

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are generally ill regarded (Courtney, 1993; Poertner et al., 2000). Among other things, they have come under repeated criticism for their restrictiveness, lack of permanency, and lack of familiness. Of all the out of home placement alternatives, they are considered the least desirable. Such criticism, coupled with restricted government budgets, the natural interest of child welfare agencies to ensure the effectiveness of their services, and the family preservation movement, which objects to out of home placement of any sort, highlight the need for the evaluation of these facilities (Mcnaul, 2000; Fulcherm 2001).

In recent years, various attempts of different kinds have been made to address this need. The literature includes comparisons between the effectiveness of Residential Care Facilities with that of other out of home placements and of family preservation (Morison and Ellwood, 2000; Bates et al., 1997; Cummins and Dunt, 1988); evaluations of specific treatment programs carried out in these facilities (Bowers et al., 2000; Bowers et al., 1999; Moore and Shannon, 1993; Wilcox and Dowrick, 1992); and assessments of residents outcomes, as measured by their clinical status (Lyons et al., 2001; Shapiro et al., 1999) or their cognitive development (Wright, 1995).

On the whole, however, aside from a previous paper published by the present authors (Wozner et al., 1997), neither these studies nor the various evaluative guidelines that have been offered (Fulcher, 2001; Coughlan and Coughlan, 1999; LeBuffe and Pfeiffer, 1996; Green and Newman, 1996) pay much attention to the quality of life of the residents of these facilities while they are living there.

This is an unfortunate oversight. A fundamental assumption of child development theory is that adequate quality of life is important to the development of the child, whether on the physical, cognitive, social, or psychological planes. Children are placed in alternative care, including Residential Care Facilities, when, for one reason or another, they are not able to enjoy an adequate quality of life at home, whether because of parental abuse or neglect or because of their own special needs (Davidson-Arad and Wozner, 2001). For alternative care facilities to promote the development of the children in their domains, they must be able to provide them with a decent quality of life. Moreover, within the facility, the residents'

quality of life is likely to have an important effect on their levels of achievement.

It also seems important that the residents and staff of Residential Care Facilities make similar appraisals of the residents' quality of life. The staffs of such facilities are intimately involved in the day-to-day lives of the residents. Essentially, it is the staff who are responsible for providing for almost all of the residents' needs, from their physical care through their education and socialization, and for fostering their psychological well-being. Where the staffs are out of tune with the residents' perceptions of their quality of life, especially where they assess the residents' quality of life higher than the residents do, they are unlikely to be able to adequately plan and provide for the residents' needs.

This paper examines two issues: (a) the degree of correspondence in the residents' and staff's assessment of the quality of life of residents in a variety of Residential Care Facilities in Israel, and (b) the connection between the degree of correspondence and the quality of the facility, as defined by the residents' assessments of their quality of life. Our assumption is that greater correspondence will be found in better quality facilities. Quality of life (QOL) in this study is defined on the basis of Shye's (1979, 1985, 1989) Systemic Quality of Life Model as the effective functioning of the individual in four fields – psychological, physical, social, and cultural – and four modes of functioning in each – expressive, adaptive, integrative, and conservative, as described in a previous paper (Davidson Arad and Wozner, 2001).

METHOD

Study Participants

The research participants consisted of 920 residents and 302 staff members selected from 46 Residential Care Facilities located in Israel. All the facilities are supervised by the Ministry of Labor and Welfare and administered either as voluntary agencies or as private business ventures. They range in size from large youth villages (500 residents) to small family-like group homes. Of these 46 facilities, 24 provide "regular education" (youngsters who do not show special difficulties), 13 provide "special treatment" (special-

ized treatment-oriented interventions), 3 provide "mixed treatment" (regular education with treatment groups), and 6 provide "family-like" treatment (20 youngsters live in a "family-like" setting while attending school and some recreational activities in the community).

Twenty residents were randomly selected from each facility on the basis of the residents' list that each facility provided. Up to seven staff members were selected from each facility, depending on its size.

The residents were boys (61%) and girls (39%) aged 6 to 14. Thirty four percent had been in the facility for at least a year, 57% between two and five years, and the rest for over five years.

The staff participants included headmasters, social workers, psychologists, head counselors, educational directors, housemothers, vocational coordinators, youth-workers, and gardeners. Fifty one percent were male, 49% female. Somewhat under a third (31.8%) had a BA or more; 32.4% had some higher education, 30% a high school degree, and 5.8% ten years of schooling or less. The vast majority (83%) had been working in the facility for five years or more; 12.4% had been working there for between two and four years; and 5.6% had been working there for a year or less.

Instrument

Quality of life was measured by a 16-item questionnaire based on Shye's Systemic Quality of Life Model (1979, 1985, 1989). The questionnaire taps the physical, psychological, social and cultural expression, adaptation, integration, and conservation of the persons studied It has been used in previous studies (as noted below), with modifications of the phrasing in each to fit the study population and setting. In the present study, residents and staff were asked to indicate the degree to which the residents:

1. do things that express their personality
2. have the opportunity to rest and relax from the pressures of the day
3. feel calm and tranquil
4. have a positive perception of themselves
5. organize their physical environment as they want
6. have comfortable living conditions in the facility (food, clothing, sleeping conditions)

7. feel well physically
8. feel secure that they will not be physically harmed
9. have good social status and influence on their peers
10. manage with the various staff members (teachers, counselors, house mother, principal)
11. have good friends
12. feel that they belong to the society around them
13. are occupied with cultural creations (e.g. writing, drawing, music)
14. feel comfortable with the cultural expectations of their society
15. feel honest and decent
16. feel that they have cultural roots

Ratings were made on a 7-point scale (1 = not at all, 7 = very much). The overall QOL of each resident was defined as the mean of the scores in the sixteen subsystems.

Each item in this instrument is phrased in a way that permits the respondents to determine for themselves the concrete variables that go into it. Thus, each item potentially incorporates far more concrete variables than any researcher can think of and more than can possibly be named in any research instrument. The use of such abstract items enables the respondent to relate to the infinite uniqueness of each resident in a relatively short instrument, while freeing the researcher of the need to select among and designate an infinite number of particulars to query.

The model's general, abstract quality has made it possible to assess quality of life of different populations, in different situations and cultures. Among adults, it has been used to gauge the quality of life in Israeli prisons (Wozner et al., 1994), in a work setting in Israel (Elizur and Shye, 1990), a deprived neighborhood in Israel slated for urban renewal (Shye, 1989); and among dialysis patients in Australia (Cairns, 1990). The instrument has also been used in several studies conducted by Davidson-Arad and colleagues to assess the quality of life of children at risk. These studies examined the association between the children's perceived and predicted QOL and decisions on removal from home (Davidson-Arad and Wozner, 2001a, b; Davidson-Arad, 2001a, b) and to follow-up children's well being after the decision was made (Davidson-Arad et al., submitted to publication). Two studies were conducted on the QOL of children

in Residential Care Facilities. Wolins et al. (1980) used the instrument in a before-after manner to identify problem areas in the quality of life of elementary school children living in a boarding facility for youngsters from troubled families in order to plan interventions to improve their quality of life in these areas and then to assess the impact of their interventions. Wozner et al. (1993) administered the questionnaire to the residents, staff, and external experts in 73 boarding facilities for children from troubled families; the assessments revealed the different perceptions of the three groups and enabled ranking the facilities in terms of the quality of life in their walls.

Findings

The first aim of the study was to compare the residents' and staffs' assessments of the residents' QOL. To this end a MANOVA was carried out. The analysis yielded an overall significant effect ($F(16,30) = 21.45$; $p < 0.001$). Table I presents means and standard deviations for residents and staff members.

As can be seen, residents' evaluations are higher than staff members' in six of the 16 subsystems (social influence, cultural activity, physical condition, physical health, good friends, physical security); staff members' evaluations are higher than residents' in four of the subsystems (self actualization, personal recreation, self confidence, peace of mind); and there is no statistical difference in their evaluations of the remaining six subsystems (organization of physical environment, institutional roles, cultural compatibility, integrity of values held, social confidence, stable structure of beliefs).

The second aim of the study was to examine whether the differences in the residents' and staff members' QOL assessments were associated with the quality of the facility. As reported in a previous study of the same population (Wozner et al., 1997), a Partial Order Scalogram Analysis by Coordinates (POSAC; Shye, 1985, 1989) was used to determine the quality of the facilities, as defined by their residents' self-reported QOL. This method was selected because it is especially suited for the comparison of profiles. The findings of that study revealed four distinct quality levels: very good, good, fair, and weak. These quality levels were used in the present study to designate the quality of the facility.

TABLE I

QOL assessments by residents and staff: Means and standard deviations?

	Residents		Staff		
	M	SD	M	SD	f(1,45)
1. Expressive-psychological (Self actualization)	4.43	0.57	5.5	0.62	13.85**
2. Expressive-Physical (Organization of physical environment)	4.41	0.57	4.67	0.84	2.78ns
3. Expressive-social (Social influence)	5.27	0.56	4.97	0.68	5.23*
4. Expressive-Cultural (Cultural activity)	5.87	0.37	5.33	0.7	19.23**
5. Adapt-Psychological (Personal recreation)	4.43	0.8	5.26	0.68	35.47**
6. Adapt-Physical (Physical condition)	5.5	0.9	5.02	0.67	10.47**
7. Adapt-social (Institutional roles)	5.55	0.6	5.45	0.56	0.75ns
8. Adapt-Cultural (Cultural compatibility)	5.11	0.67	5.16	0.63	0.13ns
9. Integrative-Psychological (Peace of mind)	5.18	0.57	5.66	0.62	14.21**
10. Integrative-Physical (Physical health)	5.66	0.57	5.3	0.72	4.94*
11. Integrative-Social (Intimate friendship)	5.77	0.48	5.35	0.79	9.51*
12. Integrative-Cultural (Integrity of values)	5.5	0.51	5.63	0.61	1.70ns
13. Conservative-Psychological (Self confidence)	5.29	0.45	5.86	0.54	28.21**
14. Conservative-Physical (Physical security)	5.15	0.67	4.16	1.01	32.63**
15. Conservative-social (Social confidence)	5.38	0.59	5.44	0.86	0.10ns
16. Conservative-Cultural (Stable structure of beliefs)	5.38	0.38	5.43	0.85	0.12ns

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

TABLE II

Staff members and residents evaluation by QOL level

QOL level		Residents	Staff members	T NS
1. Low	M	5.11	5.05	
	SD	(0.32)	(0.44)	
2.	M	5.15	5.58	t(12) = 2.30
	SD	(0.58)	(0.43)	
3.	M	5.75	4.95	t(5) = 2.38*
	SD	(0.84)	(0.77)	
4. High	M	5.96	5.27	t(3.03)*
	SD	(0.22)	(0.54)	

*$P < 0.05$.

A 4 × 4 × 4 × 2 (facility quality Levels × Fields × Functions × Roles – resident/staff) MANOVA with repeated measures for Functions, Fields and Roles was performed. A significant interaction effect was found between Levels and Roles ($F(3,42) = 8.49$ $p < 0.001$). To identify the source and the pattern of the interaction, we compared the residents' and staff members' QOL evaluations at each facility QOL level. Table II presents the results of these comparisons.

As can be seen, at the lowest level there are no significant differences between residents' and staff members QOL assessments; at the next lowest level, staff members' QOL evaluations are significantly higher than the residents'; and at the two highest levels, residents' evaluations are significantly higher than those of staff members.

DISCUSSION

Our comparison of the residents' and staffs' assessments of the residents' QOL shows a mixed picture. Overall, there were more significant differences in their assessments than not; but, on the other hand, the differences were not all that large.

Similarities of perception were found in the cultural, social, and physical fields, but not in the psychological. The greatest similarity

was in the cultural field, where residents and staff more or less agreed on the levels of the residents' QOL in three out of four of the modes: the adaptive, integrative, and conservative. That is, they saw eye to eye with respect to the residents' compatibility with the cultural expectations of the facility, their integrity and values, and possession of cultural roots. There was also a certain correspondence in the social field, where the two agreed on the residents' QOL in the adaptive and conservative modes, that is, regarding the residents' ability to get along with the staff and their sense of belonging. Finally, there was correspondence on the residents' QOL in the expressive mode of the physical field: namely, their ability to organize their physical environment as they wished. Overall, the greatest correspondence seems to have related to the world of values, suggesting that the staff had a fairly accurate sense of the extent to which the residents shared or adopted the normative values that the staff tried to transmit as part of their work at the residence.

In all the remaining areas, the residents' and staffs' perceptions differed significantly. The residents' perceptions of their QOL were higher than those of the staff with respect to their cultural expressiveness, their social expressiveness and integration, and their physical adaptation, integration, and conservation. In the cultural field, the residents rated themselves higher than the staff in their involvement in cultural activities, such as writing, music, and art. In the social field, they gave higher grades than the staff to their social influence and status and to their having close friends. In the physical field, they rated the quality of their physical conditions (e.g., food, clothing, living quarters), their sense of physical health and their sense of security from physical harm higher than the staff.

It is difficult, if not impossible, to know from the data collected in this study the extent to which these differences reflect differences in expectations or the staffs' being somewhat out of tune with the residents' reality. We are inclined to ascribe the differences in the ratings of the residents' physical QOL to the fact that, at least in Israel, the vast majority of children who are placed in Residential Care Facilities are of lower socio-economic backgrounds. Their higher evaluation of their physical QOL may reflect the improvement of their physical conditions and security over what these had been at home. The staffs' lower evaluation of most of the physical aspects of

the residents' QOL probably stems from their having higher expectations of what physical conditions children should have, and maybe also from the relative security and comfort of their own lives.

The residents' perceived their QOL to be lower than the staff in all four modes of the psychological field. They felt that they expressed their personal wishes less than the staff credited them with and that they had less opportunity to rest and relax than the staff thought; in addition, their mood was worse and they had less sense of self-confidence the staff reported they did. The staffs' higher evaluation probably reflects their investment in the psychological aspect of the children's lives, in keeping with their training and the demands of their task. After making a great investment, people may be unable or unwilling to view the outcome as poor. The children's lower evaluation may stem from various non-exclusive sources, including the great psychological difficulties that accompany their removal from home and life in residential group care (REFS) and/or the great psychological injuries they carry with them from their homes. The difference may be a cause for concern. It suggests that the staff do not adequately grasp the residents' psychological hardships and poses the danger that, for all their investment in the residents' psychological welfare, they will not plan adequate interventions and treatment programs.

The second research question was whether and how the gap between the staffs' and residents' assessments was related to the quality of the facility, as defined by the residents' perceived QOL there. Contrary to expectations, the findings showed that the greatest degree of concord was in the poorest facilities, in which the residents judged their QOL to be lowest. In these facilities, there was no significant difference in the residents' and staffs' ratings. Both residents and staff recognized that the children's QOL in these facilities was not very good.

At all three other levels, however, there were significant differences in the ratings. At the second lowest level, staff members' evaluations are significantly higher than those of the residents, while at the two highest levels; residents' evaluations are significantly higher than those of staff. This pattern suggests that staff assess the residents' QOL higher than the residents in the poorer facilities, and lower in the better ones. The meaning of these differences is not entirely clear, however. On the one hand, the staffs' higher evalu-

ations of the residents' QOL in poorer facilities may reflect their defensiveness and efforts to retain their self esteem and job satisfaction in work places that do not adequately fulfill their mission. The other is that these facilities are poorer because their staffs do not recognize the deficiencies in the residents' QOL and make the necessary efforts to improve it. The staffs' undervaluation of the residents' QOL in the better facilities may reflect their high attention to the residents' needs and their concerted efforts at meeting them.

The major limitation of this study is that there was no external evaluation of the quality of the facilities to accompany the evaluations of the staff and residents. Nonetheless, the study findings have a number of implications. The disparity in the residents' and staffs' QOL assessments in the psychological field points to the need to examine residents' psychological well being and needs from their own perspective, and to plan treatment programs in accord. The staffs' higher assessment of the residents' QOL in poorer facilities suggests the need to look into facilities where staff evaluate the residents' QOL higher than the residents' themselves do. These findings raise concern about staff awareness of the psychological hardships and distress of the juveniles in their care, as well as about their ability under these circumstances to provide adequate psychological care. They also highlight the need to evaluate Residential Care Facilities from the dual perspectives of the residents and staff. Finally, the findings further suggest that the QOL instrument, which enables comparison of residents' and staff members' perceptions, may serve as a useful tool for evaluation and service planning.

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