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ACCOMODATION TYPE AND DAILY LIFE SKILLS OF PERSONS WITH INTELLECTUAL DISABILITIES[1,2]

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SUMMARY

Social participation represents the capability of a person to realize life habits which enable participation in the life of the social community corresponding to the person's social role. The goal of this research is to establish the influence of the type of accommodation (family accommodation, supported community accommodation or accommodation in an a residential setting) on the level of social participation regarding the three domains of life habits: Communication, Responsibility and Life in the community.

The sample comprised 111 adults with moderate intellectual disability (48 participants live with their family, 19 live in a supported community and 44 are residentially accommodated. All participants are, functionally, at the level of moderate intellectual disability.

It is demonstrated that the accommodation type influences the level of life habits development in adults with moderate intellectual disability for the Responsibility domain. The results show, however, that for the categories Communication and Life in the community the influence of social environment is not at the level of statistical significance.

Key words: Life skills, Accommodation type, Intellectual disability, Adult persons

INTRODUCTION

According to the International Classification of Functioning, Disability and Health (ICF) model the ability is defined as the capability of a person to accomplish a certain activity of a given life domain in a particular moment, while the participation reflects the level of personal involvement in a life situation (World Health Organization [WHO], 2001). The level of development of the ability as well as the level of participation is measured against the factors of immediate surroundings which are part of the general social context and represent the interaction of the individual and social perspective of person's everyday functioning. Thus, measuring the participation and capability to accomplish certain activity allows simultaneously for assessment of the quality of a person's social adaptation. The ICF model offers nine domains of activity and

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participation. Life situations, in which the participation of a person is in any way hindered, are considered a restriction in participation, and activity is considered limited when an individual has difficulties to perform a task (WHO, 2001). According to the Quebec Model or the Disability Creation Process (DCP) (Fougeyrollas et al., 1999), the problem of disability can be understood only if considered in context of impact of environmental factors(Fougeyrollas et al., 1998), while the social participation is determined by the concept of life habits distributed over twelve groups.

There are more differences than similarities between the ICF and DCP models. Differences are related to the basic concepts of these two models, components constituting the participation and approaches to measurements of participation (Levasseur, Desrosiers,& Tribble, 2007). Although domains presented in ICF are similar to the categories of life habits in DCP, the dilemma remains whether the activity and participation are considered two different phenomena (Desrosiers et al., 2004).

Cummins and Lauy (2003) stated that life of individuals with intellectual disabilities (ID) in the community is qualitatively different from life of the individuals of the population without a diability. They tend to be physically present and exposed to the community, but not socially integrated. A life in a community does not, by itself, guarantee the social integration. The mere active involvement in the social life is only the primary stage in the process of integration and a chance for improvement of the life quality (Duvdevany, 2008). Apart from personal characteristics, such as physical and mental health of a person, competence in different domains of life activities and social relations, factors of the environment are also the predictors of social integration (Fougeyrollas et al., 1999; WHO, 2001). The emphasis is, increasingly, placed on creating defining rehabilitation programs which would improve efficacy of life activities in different domains, acceptance of social roles and responsibility typical for a particular environment (Cummins & Lauy, 2003; Simeonsson, Carlson, Huntington, McMillen, & Brent, 2001) as well as active support to the parents in their care for children with ID (Chan & Sigafoos, 2001; Dempsey & Keen, 2008). The parents should aim their activities at reducing the pressure their children are exposed to when they are in contact with the community (Forsyth & Jarvis, 2002). Development of positive social identity of these individuals requires serious personal effort of children and adolescents with ID, and particular intellectual and cultural orientation of their families (Abraham, 1989; Abraham, Gregory, Wolf, & Pemberton, 2002). In addition to the family support, partcipation of persons with ID in the community is positively correlated with positive attitudes of the society and proffesionals (King et al., 2010), and with other factors of the evironment, including the ability to meet the decisions autonomously, independance, availability of the services, adequate accommodation and variety and stimulation of the environment of facilities (Saaltink, MacKinnon, Owen, & Tardif-Williams, 2012; Verdonschot, De Witte, Reichrath, Buntinx, & Curfs, 2009).

According to the normalization process, individuals with intellectual disability, disregarding the level of their disability, are entitled to attain different experiences and perform activities not substantially different from the activities of individuals of the same age belonging to the nondisabled population (Nirje, 1969; Wolfensberger, 1983). The model named as Social Role Valorization is a strategic concept, which enables implementation of the principles of the normalization movement. It defines

the activities aimed at helping persons with ID to take over the social roles highly appreciated in a particular social context. This is expected to have positive influence on their social affirmation and self-esteem (Wolfensberger, 1983). The prerequisites of the normalization process include the process of deinstitutionalization which, for children with ID, represents exchange of accommodation in a residential setting with the life in the primary family or a foster family; for adults with ID, deinstitutionalization involves independent living or certain type of supported accommodation.

Lack of possibilities for social participation and improvement of the life quality of these persons is particularly noticeable in specific life contexts. These include residential settings or a community with rigid attitude towards possibilities of these persons to take over social roles corresponding to their chronological age and personal preferences.

The life habit scale comprises the most of the life domains. It is based on the model of social participation defined in DCP (Fougeyrollas et al., 1999) and it largely overlaps with the concept presented in the ICF model. The important thing is that it measures the way a person conducts a certain skill, and the level of difficulties and necessary support in doing so. This represents a way to detect the variability in children with developmental disabilities. Parents particularly emphasize the representativeness of some dimensions of the scale, such as mobility, life in a community, communication (Noreu et al., 2007). This information is of great importance to our research, since strategies for dealing with persons with ID and the formal support services are underdeveloped in Serbian society. Currently in Serbia, there is lack of studies conducted with the goal to evaluate the influence of limited resources of formal support on development of adaptive capabilities of adults with ID and also the effects of process of deinstitutionalization. This fact was the primary impetus for our study.

Research Design

This research assessed functional communication through which social participation is achieved. Communication, defined in this way, represents the capability of a person to establish social interactions of different types that encompasses variable life skills – verbal, non verbal, academic capabilities and the use of information and communication technologies.

Responsibility is conceptualized as the group of life habits which include skills of money management, respect for the others, their possessions, as well as self-esteem in different life situations.

Community life includes activities such as involvement in various social organizations, religious or spiritual activities.

Three hypotheses were proposed:

1. The type of social environment influences the development of communication in adults with moderate intellectual disabilities;
2. The type of social environment influences the development of responsibility in adults with moderate intellectual disabilities;
3. The type of social environment influences the level of involvement in community life in adults with moderate intellectual disabilities.

METHOD

Participants

The sample consisted of 111 participants of both sexes male N=51 (45,9%), female N= 60 (54,1%), of chronological age between 22 and 59 years (mean (M) 34,45, standard deviation (SD) 8,32). All participants are at the functional level corresponding to the moderate intellectual disability (IQ 34-49). Participants were divided in three groups according to their accommodation type: the first group consisted of persons living with their primary family and visiting day-care centre, named in this research as family group (FG), the second were participants who underwent the process of deinstitutionalization and now live in the community as a part of program of supported accommodation – support living group (SLG) and the third was the group of participants living in a residential setting – residential setting group (RSG) (Table 1). Participants from the second group live in the flats (in groups of up to five) in urban aria. This group of participants (SLG) is considerably smaller (only 19 participants) than the other two. The reason for this is limited number of individuals who got the chance to live in a community in a supported accommodation after the process of deinstitutionalization. Although this project started in 2004, the number of people who moved fromresidential setting to the community gradually increased in Belgrade which is the area under study reaching today's number of 24 persons included in the project and provided with community based services. There were no statistically significant differences between compared groups in terms of sex $\chi^2(1, n=111) = 2,2$; $p<,01$ and age $\chi^2(1, n=107) = 55,73$; $p<,01$ of participants.

Table 1 The description of the sample

	N	sex				calendar age*	
		Male		Female			
		N	%	N	%	M	SD
Family (FG)	48	19	39,6	29	60,4	34,29	6,824
Support (SLG)	19	8	42,1	11	57,9	38,68	8,603
Institution (IG)	44	24	54,5	20	45,5	32,74	9,116
Total	111	51	45,9	60	54,1	34,45	8,321

* Data on age of one participant from family accommodation and 3 participants living in an institution is missing.

Procedure

This research was conducted during the year 2012 on the territory of the city of Belgrade, Republic of Serbia. Informants were special educators engaged in providing formal support to the participants in all three subsamples. The informants knew well the persons with ID they reported about, since they had been in contact with them regularly for at least one year before the research started. Out of 149 distributed questionnaires, the full range of data was obtained for 111 participants. The data on

intellectual functioning, calendar age, sex and use of medication were obtained through the access to the documents of the psychological and medical service. One of the criteria for inclusion of participants in the study was that the person had no dual diagnosis.

Measures

Assessment of Life Habits for children aged 5-13, 1.0, short form, LIFE-H (Fougeyrollas et al., 2005) was used for assessment of social participation: subscale of communication (8 items), responsibility (7 items) and life in a community (2 items).

The life habits scale measures the following two aspects of the life habits: level of difficulties while performing the activities and the type of support necessary for successful performing of a certain activity. Combining these two measurements a result ranging from 0 to 9 is obtained, 9 being the most successful outcome (without difficulties and assistance in accomplishing activities), and 0 meaning that participant cannot accomplish a life activity. The items representing inaccessible activities are grouped in the separate category. These items are excluded from processing of the results. All raw scores are transformed into 0 to 10 values (Fougeyrollas et al., 2005; Noreau et al., 2007).

The Scale makes distinction between several types of assistance: no assistance, assistive device, adaptation and additional human assistance. It is realistic to expect that assistance would be necessary, as the individuals involved are children with functional limitations, such as cerebral palsy, myelomeningocele, sensory-motor neuropathy, traumatic brain injury and developmental delay (Noreau et al., 2007). These limitations are particularly present, in all domains of life habits, in people with moderate ID independent of their age.

The item content of the LIFE H scale designed for adults is mostly not applicable for population with moderate ID, as it includes life activities and social roles, which are mainly inaccessible to this population in Serbian society, such as respect for the rights and property of others, voting, obeying the law and regulations, taking care of education and health of the offspring. Negative attitude in the society and lack of social support networks services prevents people with moderate ID in our society to participate in the activities represented by the items of this scale. This means that the scale is not sufficiently sensitive to detect differences in the effect of social environment on the development of communication, responsibility and community life in adults with moderate ID. We decided to apply LIFE-H for children, it's short form, since the item analysis has showed that life activities included in this scale are more adequate for representation of the activities of daily living in people with ID, esspecially for severe cases, in Serbian community.

Crombach's alpha values for different subscales are: Communication 780, Responsibility 857 and Life in the community 753.

RESULTS

Total scores

One-factorial analysis of variance (ANOVA) was used for comparison of the results obtained for all three groups.

Comparison of total scores for the subscale Responsibility for all three groups of participants, found the statistically significant differences between groups F (2,107) = 7,523, p=0,001. Post hoc Scheffe's analysis showed that participants in theresidential setting accommodation (M = 7,95, SD = 3) proved to be more successful in this category than participants who live in the family (M = 5,68, SD = 2,51).

The total score for the subscale Communication did not show any statistically significant difference between the three groups of participants F (2,107) = 1,126, p=,328, neither did the score for the subscale Life in the community F (2,93) =,114, p=,893.

Item analysis

The analysis of success for all three groups of participants for the single items of the subscale Communication showed statistically significant difference with the level of significance of ($p<0,05$) for the item number seven (use of computers) F (2,91) = 4,4 p = 0,015. Additional comparison using post hoc Scheffe's test established significant difference between the mean values of FG (M = 5,63, SD = 3,04) and SLG (M = 2,54, SD = 3,20).

Statistically significant difference with the level of significance of ($p<0,05$) between the three groups of participants was found for the fifth item „Respecting other peoples property and rights (personal effects, rules of conduct)" on the subscale Responsibility F (2,101) = 14,329 p = 0,000. Subsequent comparison using post hoc Scheffe's test established significant difference between the mean value of RSG (M = 8,36, SD = 2,09) and FG (M = 5,49, SD = 2,93). It was also found that mean value of the result of participants SLG (M = 7,74, SD = 2,51) significantly differs from the mean value of participants FG (M = 5,49, SD = 2,93). The difference between the groups IG and RSG is not statistically significant.

For the item number six „Taking charge of himself / herself, standing up for rights" on the subscale Responsibility the low statistically significant difference was established between the three groups of participants F (2,103) = 3,133p = ,048. Subsequent comparison with the aid of post hoc Scheffe's test has not confirmed statistical significance of this difference.

Statistically significant difference between FG, SLG and RSG was determined for the item number seven „Helping out at home (doing service for parents or other family members)" of the subscale Responsibility F (2,93) = 8,696 p =0,000. Sheffe's test for this item confirmed statistically significant difference only between FG (M = 4,88, SD = 3,4) and RSG (M = 7,89, SD = 2,83).

DISCUSSION

The fundamental findings, based on general scores on the subscales applied in this research, confirm proposed hypothesis implying that the type of social environment has an effect on the level of development of life habits of adults with moderate ID in the category of Responsibility while the initial hypotheses for the categories of Communication and Life in the community are not confirmed.

The social participation based on the concept of life habits (Fougeyrollas et al., 1999) comprises the domain of interpersonal relationships, social inclusion and exercising rights.

The accommodation type (McConkey, 2007), social network, friendships, participation in the social community's activities, social interaction, exercising certain social role (Buntinx & Schalock, 2010), the age of participants (Darling & Heckert, 2010) represent some of the indicators of levels of individual's involvement in life of the community.

Communication and life in the community were examined in this research in the context of presence and dynamics of social interactions established by the participants in everyday life.

The absence of significant in the category of Communication and Life in the community may be related to the fact that all three groups of participants achieve the uniform level of social interactions whose specificities are determined by the type of the existing social environment. Although living in the different environments, all the participants manifest the tendency to form and maintain social relationships mainly with the persons from their immediate environment. It is considered that adults with ID living in the family environment are keeping the habit originating in the childhood to realize more interaction within the family circle even in the adult period and to engage much less into actualizing social relationships with persons of their own age or other persons in the community (Chadwick, Cuddy, Kusel, & Taylor, 2005).

Aside from dynamics, the quality and the type of interactions existing among adults with ID are in particular the cause for worry, independent from social environment and other persons of population without a disability. It appears that usually we have an example of polite and decent relationship, occasionally professional, and rarely true companionship or friendship. Orsmond, Krauss, and Seltzer (2004) cites several conditions that must be fulfilled in order to classify a relationship as friendship: participating in joint activities with persons of same or similar chronological age, activities should be multifarious, as less as possible stereotypical, reciprocal, spontaneous and beyond settings of everyday life, bound to be pre-organized, in most of the cases by some other adults.

Interactions between persons with ID and professionals in institutions imply emotional and practical support which for professionals, regardless of the frequency of interactions, represents no more than professional engagement. Therefore, this form of interaction cannot be compared to spontaneous social interactions. This raises the question of quality and reciprocity of such relations. According to the research conducted by Banat, Summers, and Pring (2002) members of staff in institutions tend to overestimate communication capabilities of users and often donot adjust adequately

their communication style to the persons with ID. The research has showed that the members of staff use complex sentences or questions with simple „yes" or „no" answers, disregarding non-verbal stimulation and communication contexts, which consequently lowers the possibility of achieving social interactions on equal basis (Healy & Noonan-Walsh, 2007; McConkey, Morris, & Purcell, 1999).

Analyzing the structure of social networks of 213 people with ID, it was determined that a quarter of people with whom participants achieved social interactions are other persons with ID who are using the same ID support services, and 43% are the professionals from the mentioned support services. Only a third of social network of the participants are persons who are not related to support services (Forrester-Jones et al., 2006).Although participants living in anresidential setting have, on average, more social contacts (Dusseljee, Rijken, Cardol, Curfs, & Groenewegen, 2011), they have significantly fewer opportunities to establish reciprocal relationships with persons belonging to population without a disability, compared to the participants living in smaller groups, in the local community (Dusseljee et al., 2011; Forrester-Jones et al., 2006).

Comparing the results of all three groups of participants on the individual subscales of Communication, statistically significant difference ($p = 0,05$) was found only in relation to the ability and dynamics in using computers. Subsequent comparisons using Post hoc Scheffe's test showed that the medium value of the group of participants FG ($M = 5,63$, $SD = 3,04$), significantly varies from the medium value of SLG ($M = 2,54$, $SD = 3,20$). The participants that are part of RSG ($M = 8,09$, $SD = 2,5$) did not differ significantly from the participants that are part of FG and SLG.

Parents and professionals recognized the need for computers and other high technology devices, as these tools enable augmentative and alternative communication, which is especially useful in interaction with individuals with severe ID. When it comes to the use of modern technologies, the family members represent main source of support for children with ID. The parents emphasize several key areas in which the activities should be improved. These include: continuous technical support to the children from the moment when they are ready to use such devices, technical adjustment of devices to the needs of people with ID, appropriate level of knowledge of the professionals in the implementation of these programs in rehabilitation, lastly, trainings for parents who would practice the use of these devices at home (Bailey, Parette, Stoner, Angell, & Carroll, 2006).

Another study (Palmer, Wehmeyer, Davies, & Stock, 2012), that involved 1617 participants with various types of developmental disorders, which are divided also by the place of residence in the three groups (with family, group home and on own) has shown that almost half of the participants is using the computer for specific purposes such as: writing, internet, entertainment, e-mail, budgeting money etc. When it comes to the training and the use of computers the most frequent support the persons with ID got was from their parents (61%), and slightly less from professional staff (54,9%). The participants who expressed the need to use computer for diverse purposes identified as the main barrier the unavailability of equipment (54,5%) and for 84% of them it was the lack of training. Families of the participants in this study showed more understanding of the importance of the use of modern technologies for the development of their children, than it was the case in mid '90s, which had a great impact on the increase of

the percentage of people who are using computers, especially in the group of people over the age of 40 years.

Similar tendencies are present in Serbian society, with the difference that equipment and training are usually provided by the parents who themselves regularly use computers. However, in residential settings and living support community settings, insufficient competence of staff and limited financial resources represent the main barriers to the application of information technologies.

In assessing the living habits based on the analysis of the total scores on the subscales that estimates the liability category there is a statistically significant difference between the FG and RSG. Better results are achieved by the participants from RSG. Further comparison of the performance of all three groups of subjects on individual items at the Responsibility subscales revealed that participants RSG (M = 8,36, SD = 2,09), as well as the SLG (M = 7,74, SD = 2,51) were showing significantly greater respect for other people's property and rights than the participants FG (M = 5,49, SD = 2,93). Moreover, it was confirmed that the RSGparticipants (M = 7,89, SD = 2,83) were significantly more effective in carrying out activities such as „Helping out at home" (doing chores or minor tasks for others) than the participants FG (M = 4,88, SD = 3,4). The presence of differences between participants RSG and SLG relative to both of these variables were not statistically significant. The initial findings showing that there were statistically significant differences among the three groups of participants in relation to habits such as „Taking charge of himself / herself, standing up for rights" was rejected by the subsequent application of Scheffe's *post hoc* test.

According to the Social Learning Theory (Bandura, 1977), different types of behavior in children develop during the process of identification with others, i.e. models. By observing and imitating, a child adopts certain types of behavior, values and attitudes which they identify in the models. According to this theory, children tend to imitate people in their surroundings, especially persons who are important to them, such as parents, teachers, peers, as well as those who they identify as similar to themselves. The pleasure, praise or reward coming from the imitated person, the sense of belonging to the group and personal needs as well, represent motivation predictors for this type of learning. It is proposed that individuals who spent the most part of their lives in residential setting (RSG), lacking well-founded socio-emotional connections with their parents, have more conspicuous need for the approval and acceptance coming from the staff and peers, as they are symbols of family environment. Therefore, they seek to consistently and efficiently meet the requirements placed in front of them. It is likely that such behavioral patterns, acquired during the childhood, are retained during the adulthood.

The significant difference could not be confirmed between the participants from SLG and RSG regarding the life habits included in the category Responsibility. This finding is partly expected, keeping in mind that for most of the participants from SLG the life in anresidential setting was replaced by the life in a community only a few years ago. Still, we expected somewhat higher level of development of the investigated life habits, bearing in mind that they live in considerably smaller groups today.

According to the previously conducted studies, participation in the household activities such as arrangement of living environment, the performance of daily activities (food preparation, personal and general hygiene), and money management (household

budget) is more exerted after leaving the residential setting, which is a consequence of inaccessibility of these activities in the previous period. The overview of the results of 38 studies, it was established that replacement of residential accommodation with the accommodation in a community with provided support for the people with ID, offers more possibilities for the development of adaptive abilities (Kim, Larson, & Lakin, 2001).

People living by the „supported accommodation" model, which involves on average two persons, participate much more than those living in traditional community group homes, comprised of five household members on average. In contrast to this, some data show that greater „resident-orientation" stimulates dynamics of participation in daily group and individual activities more than in groups with smaller number of household members, where stereotype activities and individual nonparticipation is more present, being potentially connected with the environment created by the staff (Felce & Emerson, 2001).

The majority of adults with ID living in the family setting have a significant emotional and social support from their families. This tends to increase social participation of children, but not their independency and autonomy (Abraham, 1989; Abraham et al., 2002). When engaging in social activities, people with ID do not show adequate level of independency and do so mostly in the presence of their parents or other adults (King et al., 2010; Solish, Perry, & Minnes, 2010). For instance, children and adolescents with ID, spend their free time more often with their parents, visiting shopping malls for instance, than their peers from nondisabled population do (Solish et al., 2010). Moreover, the question remains whether in these situations children have an opportunity to do shopping independently and to use cash machines, or they adopt passive attitude and simply follow their parents. Transition from adolescence period to the adulthood in persons with ID does not always involve the change in their social roles. Parents and members of the broader family often perceive persons with ID as „eternal children" (Nirje, 1969). Trying to protect them from all risks and challenges faced by other adults, parents direct their children with ID toward activities appropriate for their mental, but not their calendar age. In doing so, they prevent them from gaining necessary and positive experiences that are integral part of adult life (Gallagher, 2002; Schwartz, 2010). On the other hand, the rehabilitation programs and support provided by professionals are aimed at giving direction and stimulation of adults with moderate ID towards acquiring experience and autonomy in life activities, such as shopping, doing small favors, care about own possessions and those of others, obeying rules, etc. It has been demonstrated that clear procedure in planning and realization of activities represent important predictor of the involvement of the persons with ID in daily life activities (Felce & Emerson, 2001).

Apart from personal competency, the attitudes of the society towards persons with ID stand out as significant predictors of their social participation (King et al., 2010). Attitudes of the community often have negative imprint and as the predictors of the behavior of people who advocate them, they can seriously compromise the improvement of population with disabilities towards inclusion in schools, at work place and social participation in general (Gilmore, Campbell, & Cuskelly, 2003). Significant number of studies concerning these attitudes has contributed to the treatment of persons with disabilities in recent years (Antonak & Livneh, 2000). However, the widely

accepted opinion that people with ID are less capable in attaining academic and social achievements should not be disregarded (Nowicki & Sandieson, 2002). A study that assessed relationship between social participation, self-esteem and stigma in persons with mild and moderate ID, established significant positive correlation between self-esteem and participation in adults, in contrast to younger persons where this correlation was not found. The stigma has negative influence on the level of self-esteem and, thus, on the level of social participation (Abraham et al., 2002).

Contrary to the community attitudes, people with ID who live with support or within residences do not consider personal characteristics as the obstacle for inclusion in the community life. They don't state that behavioral disorders, epilepsy or difficulties in communication represent considerable barriers for accomplishment of the full social participation. Investigation of the attitudes of people with ID shows that participants want to master the money management skill, that they consider the professionals should engage more in providing them with support for participation in the community life, that they need better transportation and that attitudes of nondisabled population should change (Abbott & McConkey, 2006).

CONCLUSION

The results of this research support conclusions of other studies investigating the problem of deinstitutionalization: accommodation of a small number of users is better for most of domains than institutionalized accommodation. People with ID living in an residential settinghave fewer opportunities to spend time in different form of leisure activities in the local community (Beart, Hawkins, Kroese, Smithson, & Tolosa, 2001). The users in small housing communities and supported accommodation have more often chance to make autonomous choices and make decisions independently, they have better developed social network, they are more involved in the community life, they have more opportunities to adopt new skills and to improve or develop the existing ones, and are more satisfied with their way of life compared to people with ID who live in institutions (Kozma, Mansell, Beadle-Brown, & Emerson, 2009). Friendly relationships, better accessibility to different activities, as well as better support in the community are cited as the most important predictors of life satisfaction in adolescents with ID (Bramston, Bruggerman, & Pretty, 2002). However, the process of deinstitutionalization is merely the first phase of social inclusion. In societies such as Serbia, further development of broad network of services, which would provide support for persons with ID and their parents, is essential and especially relevant during the transition period in order to better recognize their needs and apply strategies that would help organize everyday life of their children accordingly.

Limitations and recommendations

The main limitations in this research are related to the small number of participants in support living group (N=19), and an insufficient number of items (N=2) for assessment of life habits in the category Life in the community. This was stressed as a shortcoming by the authors of the scale in the work presenting the results obtained using this instrument.

Recommendations are related to necessity to investigate in the future the broader context of participation of adults with ID in relation to their accommodation type, including other categories of life habits in the research.

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