Original Research

Patient Opinions on the Benefits of Treatment Programs in Residential Psychiatric Care

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Objective: To assess patients' opinions on the perceived benefit of treatment delivered during their stay in a residential facility.

Method: We administered the Opinions on Curative Factors Questionnaire (OCFQ), which was developed from previous studies and assesses several treatment modalities and therapeutic factors, to a sample of 157 severely ill psychiatric patients admitted to a residential facility.

Results: All therapeutic factors tested by the OCFQ were considered helpful or very helpful by most of those sampled. The item with the highest score was "talking to doctor," followed by "free pass," "medication," "visitors," "nonhospital setting," "making friends with patients," "structure of daily life," "support from team," and "talking to nurses." The least-valued item was "group activities."

Conclusion: Psychiatric patients consider several treatment factors to be helpful, especially those based on individual approaches or on a less restrictive therapeutic milieu that allows interactions with the outside world. These results may be a valuable contribution to improving treatment planning in residential facilities.

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Clinical Implications

- When delivering psychiatric care, clinicians should consider patients' subjective perceptions and opinions regarding therapeutic factors.
- Patients find factors based on individual approaches (for example, talking with their doctor and medication regimens) and milieu approaches (for example, having few restrictions, efforts to destigmatize their condition, and interaction with the outside world) to be very helpful.
- Patients perceive verbal group activities (for example, group therapy and journal reading) to be less helpful.

Limitations

- Data on patients' subjective opinions regarding treatment helpfulness are lacking in residential facilities.
- The sample selection (that is, voluntarily admitted patients) did not allow generalization about patient opinions on treatment helpfulness.
- Opinion ratings regarding treatment helpfulness do not provide information on treatment efficacy.

Key Words: *patient opinions, treatment helpfulness, residential facility, residential psychiatric care, quality of care*

In recent years, patient needs and satisfaction with psychiatric care have been increasingly studied. This research has generated information that is useful for improving the quality of care and for implementing therapeutic programs based on evidence-based criteria and on patients' subjective experiences (1–7).

A relatively new research area is represented by studies exploring patient opinions on the benefits of treatment provided in both inpatient (8–10,12) and outpatient services (11). McIntyre and others described the opinions of 99 psychiatric inpatients regarding the care they received in a London psychiatric teaching hospital (mean length of stay, 21 weeks) (8). Patients were asked to answer 10 questions about drug treatment, the ward round, being in hospital, having free passes, having visitors, talking to doctors, talking to nurses, talking to other patients, ward groups, and occupational therapy. Patients rated these components on a 5-point scale ranging from 0 ("not at all helpful") to 4 ("extremely helpful"). According to the patients, the following aspects of care were the most helpful: having free passes, having visitors, talking to the doctor, talking to nurses, drug treatment, being in hospital, occupational therapy, ward rounds, talking to other patients, and ward groups.

Frager and others studied 500 patients at the Menninger Memorial Hospital, using the Client Satisfaction Questionnaire and the Components of Treatment Questionnaire (9). Their results indicated that the most helpful treatment components were individual time with the hospital doctor, the psychotherapist, the chaplain, the social worker, and the primary nurse; educational and vocational testing; and counselling on individual problems and goals. Patterns of dissatisfaction focused on community meetings and group therapy. The authors suggested that having at least 1 key ongoing treatment relationship as a central organizing component of therapy is a key treatment factor.

Vartiainen and others used a questionnaire to ascertain the attitude toward treatment of 203 psychiatric patients in a maximum security hospital (10). These patients were asked to respond to the following: "What kind of treatment seems to help you at the moment?" and "Assess the meaning of the following types of treatment and rehabilitation and check the item that best fits your opinion." A total of 38 common forms of treatments were assessed, and the possible answers were as follows: "I have not participated or have no experience," "seems harmful," "no help," "a little help," "quite a lot help," "very much help." The last open question was "What else do you want to say about the treatment?" Most patients experienced help from medication (41%), from conversations with psychiatric nurses (26%), and from occupational therapy (for example, confidential tasks, hygiene education, and duty to work in the ward) (21%). Among the 38 treatment forms evaluated with the second question, the most successful were free walking, holidays, trips, individual sessions with a psychiatrist, having a personal psychiatric nurse, communication, and support from the staff. The third open question revealed that most patients were satisfied with their treatment. The authors concluded that liberties (such as free walking and holidays), interactive treatment forms (such as a personal psychiatric nurse, support from personnel, and communication), medication, and some form of rehabilitation or occupational therapy were experienced as more helpful, while restrictions and isolation were considered less helpful.

McGrew and others enrolled a sample of Assertive Community Treatment (ACT) patients (11). Between 6 and 12 months after discharge, they asked patients "What do you like best about ACT?" Patients identified the following features: staff availability (17.6%); help with daily problems such as transportation and money management, as well as assistance with medical care, obtaining housing, and living resources (15.8%); recreational support (10.9%); home visits (5.5%); intensity of service (4.2%); and shared caseloads (3.0%).The helping relationship was perceived as precious by clients presenting a high level of functioning on the Global Assessment of Functioning scale. The authors indicated that attention to daily living was rated as the key element in preventing hospital admissions.

These briefly summarized studies highlight specific treatment components, in particular, components with a relational value (for example, talking to one's doctor, staff availability, conversation, and time with hospital doctors) and components that indicate a less restrictive setting and the preservation of contacts with the outside world (for example, free passes, free walking, visitors, and holidays) (8–11) . These findings agree with findings from studies focusing on patient requests concerning psychiatric care, which emphasized the relevance of interventions based on psychological expertise and psychodynamic insight (12).

In Italy, the dismantlement of psychiatric hospitals has been followed by the implementation of a network of outpatient psychiatric services acting in close conjunction with inpatient wards set up in general hospitals. In addition, residential facilities have been developed to provide care for patients with chronic disorders and, more recently, as possible alternatives to hospital admission for acutely ill patients accepting voluntary treatment (13).

However, data assessing patient opinions on the benefit of residential treatment are lacking, both in the literature and in our country. This study therefore aimed to assess patients' subjective perception regarding the helpfulness of treatment delivered in a residential facility for intensive, short-term care.

Material and Methods

The study was carried out in a community residential facility located in the middle of the north Italian city of Ferrara. This facility is part of the Department of Mental Health (DMH) Local Health Agency, which serves the population of the town and its province (catchment area, 350 000 inhabitants). The residential facility wherein this study was carried out is part of the University Unit of Psychiatry, which is linked with the DMH. It provides short- to medium-term care (that is, a length of stay between 1 and 3 months) for patients with acute and subacute psychiatric conditions who accept voluntary treatment. The facility is staffed by 2 psychiatrists and 1 psychologist, who are present during the day, and 15 nurses, who rotate during the 24-hour period (specifically, 3 nurses in the morning, 2 in the afternoon–evening, and 2 at night). There are 8 bedrooms (2 with 3 beds, 4 with 2 beds, and 2 with 1 bed). The unit is also equipped with a private courtyard for the patients. Patients may be transferred from the general hospital acute inpatient unit, or, at the request of the outpatient mental centres, they may be admitted for worsening of psychiatric conditions. Treatments include individual psychological support, group psychotherapy, rehabilitation activities, individual meetings with a doctor or nurse, leisure time activities, and medication.

Patients

All psychiatric patients consecutively admitted to the residential facility between November 1, 2000, and December 31, 2001, were screened for inclusion. Eligible patients were those with any psychiatric diagnosis according to ICD-10 criteria, with the exclusion of mental retardation (ICD-10 codes F70 to F79). All patients were informed of the aims of the study and gave their written consent to participate.

Measurements

At admission, all the patients had a psychiatric interview for diagnosis according to ICD-10 criteria. Sociodemographic and clinical data (for example, length of illness and number of previous psychiatric hospitalizations) were also collected.

The expanded version of the Brief Psychiatric Rating Scale (BPRS-E) (14) was used to assess psychopathological symptoms at admission and immediately before discharge.

Before they left the facility, a researcher not belonging to the staff asked patients to complete the Opinions on Curative Factors Questionnaire (OCFQ), developed from research findings by McIntyre and others (8) and Gunderson (15) and adapted to the characteristics of the residential facility. The OCFQ is an 18-item questionnaire asking patients to rate the benefit and helpfulness of the single components of their psychiatric care on a 5-point Likert scale (from 0 = "not helpful at all" to 4 = "very helpful"). Of the 18 questions, 3 refer to the benefit of talking privately to doctors, talking to nurses, and talking to family members; 1 asks about support received from the team; 3 concern different aspects of group psychotherapy (that is, feelings expression–catharsis, clarifications, and universality); 1 concerns group activities (such as journal reading and movie watching); 1 inquires about making friends with other patients; 1 investigates opinions about medication; 1 concerns opinions about rehabilitation activities; 1 deals with the structure of daily life; 1 is about facility regulations (for example, the prohibition of sexual or aggressive acts); 1 is about leisure activities; 1 is about free pass; 1 is about visitors; 1 is about separation from the daily-life milieu; and the last refers to the helpfulness of being in a nonhospital setting.

The OCFQ also has 3 open questions: "Which component of treatment seems to be most helpful to you?" "What do you think about the length of stay in the facility?" and "What else could have been helpful to you?" To evaluate the first open-ended question, we grouped the several answers into 7 categories: talking with staff members (doctors or nurses), medication, group therapy, rehabilitation activities, free pass, making friends with other patients, and other.

Statistical Analysis

We used the Statistical Package for Social Sciences (SPSS-10.1) (16) and employed Student's *t* test, chi-square, and analysis of variance to analyze between-group differences. To examine the underlying structure of the OCFQ, we subjected the items to a principal components analysis (with varimax rotation–Kaiser normalization); we investigated the reliability of the factors and the internal consistency of the instrument with Cronbach's alpha coefficients.

Results

Patients' Sociodemographic and Clinical Characteristics

During the study period, 170 psychiatric patients were consecutively admitted to the residential facility. Of those, 2 patients with mental retardation were excluded from the study, leaving 168 who met the inclusion criteria. Among the remaining subjects, 11 (6.54%) did not consent to participate, leaving 157 patients in the study. Table 1 presents the distribution of patients by sociodemographic and clinical characteristics.

There were 66 men (42%) and 91 women (58%) with a mean age of 46.7 years (SD 13.5, range 21 to 77 years). More than one-third had never married (n = 60, 38.2%), and lived with their own family (n = 64, 40.8%). Most patients were unemployed (n = 133, 84.7%). Diagnosed according to ICD-10 criteria, nearly one-half of the patients suffered from affective disorders (n = 76, 48.4%), and one-third had psychotic disorders (n = 50, 31.9%). Personality disorders were diagnosed in 28 subjects (17.8%), whereas neurotic disorders accounted for a minority of the diagnoses (n = 3, 1.9%).

Table 1 Sociodemographic and clinical data of the sample

	n (%)
Sex	
Men	66 (42.0)
Women	91 (58.0)
Marital status	
Never married	60 (38.2)
Married	50 (31.8)
Separated or divorced	38 (24.2)
Widowed	9 (5.7)
Living situation	
Nuclear family	51 (32.5)
Own family	64 (40.8)
Alone	36 (22.9)
Education	
< 5 years	4 (2.5)
5 years	36 (22.9)
8 years	59 (37.6)
13 years	51 (32.5)
18 years	7 (4.5)
Occupation	
Employed	24 (15.3)
Unemployed	133 (84.7)
ICD-10 psychiatric diagnoses	
F20–F29 psychotic disorders	50 (31.9)
F30–F39 affective disorders	76 (48.4)
F60–F69 personality disorders	28 (17.8)
F40–F49 neurotic disorders	3 (1.9)
	Mean (SD)
Age (years) (range: 21–77)	46.7 (13.5)
Age at illness onset (years)	28.8 (12.5)
Number of previous hospitalizations	8.9 (12.6)
BPRS-E (total score) at admission	61.6 (12.9)
BPRS-E (total score) at discharge	37.9 (11.1)

BPRS-E = Brief Psychiatric Rating Scale—Expanded

The mean age at illness onset was 28.8 years, SD 12.5. The mean number of previous psychiatric admissions was 8.9, SD 12.6. The mean length of stay in the facility was 49.9 days, SD 47.4, range 3 to 258 days, with 76 patients (48.4%) staying for less than 1 month and 81 (51.6%) for more than 1 month.

BPRS-E scores significantly improved from admission to discharge (mean 61.6, SD 12. 9 vs mean 37.9, SD 11. 1; $t = 17.45$, $P = 0.001$).

Factor Structure

We used factor analysis to determine the item loadings and factors for the OCFQ. Six principal factors were derived, with item loading ranging from 0.48 to 0.86. Factor 1 (residential activities) comprises items dealing with the several structured and nonstructured activities delivered (for example, "group activities," "making friends with patients," "leisure activities," and "rehabilitation activities"). Factor 2 (group therapy) includes items indicating the most important therapeutic factors of group psychotherapy. Items included in factor 3 (care) represent the usual components of care (for example, "medications" "talking to doctor," and "structure of daily life"). Factor 4 (separation) includes items indicating separation from family environment and stay in a nonhospital setting with a less restrictive environment. Factor 5 (team support) includes 2 items describing interpersonal support within the residential unit ("support from team" and "talking to nurses"). Factor 6 (family meetings) comprises 2 items regarding family rapport ("talking to family members" and "visitors").

We used Cronbach's alpha coefficient to assess factor reliability and the internal consistency of the questionnaire. A high coefficient was obtained for factor 2 (alpha 0.81), whereas moderate coefficients were obtained for factor 1 (0.69), factor 3 (0.65), factor 4 (0.62), and factor 5 (0.74). A lower coefficient was obtained for factor 6 (0.54). As expected, however, significant correlations between the factors were shown.

Patient Opinions Regarding Therapeutic Factors

Table 2 presents frequencies and mean scores for each of the 18 OCFQ therapeutic factor items.

All therapeutic factors tested by the OCFQ were considered helpful or very helpful by most of the sample. The item with the highest score was "talking to doctor," followed by "free pass," "medication," "visitors," "nonhospital setting," "making friends with patients," "structure of daily life," "support from team," and "talking to nurses." The least-valued item was "group activities." (mean score 2.51, SD 1.21).

The open-ended questions highlighted relational factors such as talking to staff members and making friends (Table 3). Most rated their length of stay as "ideal," and answers to the last open-ended question revealed that about one-half did not request additional treatment.

Differences According to Sociodemographic and Clinical Variables

Factor 1 (residential activity) and factor 4 (separation) were negatively correlated with age ($r = –0.24$, $P < 0.05$ and $r = –0.21$, $P < 0.05$, respectively). Factor 3 (care) and factor 4 (separation) were negatively correlated with BPRS-E total score at discharge ($r = –0.32$, $P < 0.05$ and $r = –0.20$, $P < 0.05$, respectively).

Table 2 Distribution of responses on the single items of the Opinions on Curative Factors Questionnaire (OCFQ)

Components of treatment	Rating scale[a] 0	1	2	3	4	Mean (SD)
1. Talking to doctor	0.0	1.9	4.5	34.4	59.2	3.51 (0.67)
2. Talking to nurses	1.9	6.4	12.1	47.1	32.5	3.01 (0.94)
3. Support from team	2.5	6.4	10.8	41.4	38.9	3.08 (0.99)
4. Talking to family members	11.5	11.5	9.6	36.3	31.2	2.64 (1.33)
5. Feelings expression in group	4.5	15.4	25.6	30.8	23.7	2.54 (1.14)
6. Clarifications in group	4.5	12.7	23.6	36.9	22.3	2.60 (1.10)
7. Universality in group	5.7	10.2	21.0	36.3	26.8	2.68 (1.14)
8. Group activities	8.3	12.7	20.4	36.3	22.3	2.51 (1.21)
9. Making friends with patients	0.6	5.1	12.7	36.9	44.6	3.18 (0.89)
10. Medication	0.6	5.1	12.1	36.9	45.2	3.21 (0.89)
11. Rehabilitation activities	3.2	11.5	12.1	39.5	33.8	2.89 (1.09)
12. Structure of daily life	0.6	5.7	10.2	52.2	31.2	3.08 (0.84)
13. Rules	2.5	9.6	16.6	45.9	25.5	2.82 (1.00)
14. Leisure activities	5.7	17.8	15.9	38.2	22.3	2.53 (1.18)
15. Free pass	3.2	3.2	5.8	42.9	44.9	3.23 (0.93)
16. Visitors	3.2	4.5	6.4	40.1	45.9	3.21 (0.97)
17. Separation from daily life milieu	3.8	11.5	15.9	37.6	31.2	2.81 (1.11)
18. Nonhospital setting	2.5	5.1	10.8	32.5	49.0	3.20 (1.00)

[a]0 = not helpful to 4 = very helpful; values are percentages of patients responding in each category

No differences were found between men and women with regard to the scale factors, except for a higher score on factor 4 among men (mean score 9.17, SD 10.14), compared with women (mean score 8.4, SD 9.4) ($F = 3.93$, $P = 0.049$). No differences were found with regard to the scale factors between the different educational levels and lengths of stay (that is, < 1 month vs > 1 month). After we excluded patients with a diagnosis of anxiety disorder ($n = 3$), we found no difference on the factors scale when we compared the remaining ICD-10 psychiatric diagnoses (Table 4).

When we analyzed patients' responses to the single items, we found significant differences between diagnostic groups. Compared with patients having other diagnoses, those with a diagnosis of affective disorders perceived as more helpful the items "feelings expression in group therapy" ($\chi^2 = 22.69$, df 8; $P = 0.004$) and "visitors" ($\chi^2 = 17.8$, df 8; $P = 0.023$). Patients with a diagnosis of psychotic disorders perceived the rehabilitation activities to be more helpful ($\chi^2 = 17.34$, df 8; $P = 0.027$).

Discussion

Although not widely used as alternatives to hospitalization for severe mental illness, residential facilities have been proven as effective as hospital care (17,18) and have significantly lower costs (19). These facilities usually provide a wide range of treatment modalities, including psychiatric evaluations, medication, individual or group psychotherapy, rehabilitation, and other group-based activities, offered in a supportive, homelike, nonrestrictive setting (20). To our knowledge, this is the first study investigating patients' opinions on treatment provided during their admission to a residential facility.

The vast majority of patients rated specific modalities of treatment, such as talking with a doctor and medication, as very helpful—a finding that can be considered for individual-based approaches. Further, they also rated aspects of care such as free pass, visitors, and the nonhospital setting as very helpful. These aspects offer patients a home-like environment, that is, the possibility of maintaining a familiar life style (for example, preserving relationships with friends, family members, and their community). These results are comparable to results that emerged in other studies. In fact, McIntyre and others found that free pass, visitors, and talking to a doctor were perceived as the most helpful factors, without significant differences between diagnoses (8). Similarly, Frager and others showed that individualized components of treatment (that is, individual psychotherapy, meeting with a hospital doctor, or medication) achieved the highest scores (9). Vartiainen and others carried out a study in a forensic hospital wherein almost all patients received compulsory treatment (10). These researchers found that patients rated as most helpful liberties (for example, free walking, holidays, and trips) and interactive, individualized treatment forms (for example, sessions

Table 3 Distribution of the responses to the open question of the OCFQ

	Frequencies	%
Which component of treatment seems to be the most helpful to you?		
Talking to staff members	44	28.0
Medication	19	12.1
Group therapy	8	5.1
Rehabilitation activities	5	3.2
Free pass	8	5.1
Making friends	39	24.8
Other	34	21.7
What do you think about the length of stay in the facility?		
Ideal	110	70.1
Too brief	17	10.8
Too long	30	19.1
What else could have been helpful to you?		
Nothing	80	51.0
More relations	18	11.5
More individual sessions	15	9.6
More rehabilitation activities	12	7.6
More drugs	3	1.9
Other	29	18.5

with a psychiatrist and having a personal psychiatric nurse), whereas they considered restrictions and isolation less helpful.

As already suggested, the high score given to such important individualized treatment components as talking to doctors and medication underlines the relevance of linking mind and brain (21) in a process that integrates psychologically and biologically based treatments. From this perspective, the importance of acquiring psychotherapeutic skills seems essential, as suggested by McIntyre and others (8). This observation is also supported by studies on satisfaction with psychiatric care that find high levels of satisfaction to be related to individual therapy (22).

The value accorded to such environmental factors as "free pass," "visitors," and a "nonhospital setting" confirmed the helpfulness of a therapeutic milieu characterized by few restrictions, no stigma, and many social interactions with the outside world. These elements constitute the cornerstone of community care (23). Findings in line with these results come from recent studies documenting a lower level of general satisfaction, as well as less satisfaction with medication, ward equipment, visiting opportunities, and regulations for going out, on a closed ward, compared with an open ward (24), and a higher degree of autonomy in a residential setting, compared with an inpatient setting (25). Answers to open-ended questions in our study seem to further support this: patients rated as highly relevant talking to staff members, individual sessions, and medication; they felt that rules and separation from their daily milieu had low treatment relevance.

Verbal group activities (that is group therapy, journal reading, or watching movies followed by group discussion) were considered less helpful. This finding agrees with the few studies carried out in this area, the results of which indicated that, in patients' opinions, the lowest-ranked intervention components were daily meetings on the ward (8) or group-based modalities such as community meetings, treatment-team meetings, and group therapy (9). In our facility, group sessions are open, short, and heterogeneous (that is, they include almost all the patients admitted, who have different ages and diagnoses). It is possible that these aspects, along with high patient turnover, do not allow cohesive groups to develop and do not allow individual problems to be addressed.

The correlations between the 6 principal factors and demographic and clinical variables documented that patients who improved more considered factor 3 (care) and factor 4 (separation) to be more helpful, whereas older patients attributed less value to factor 1 (residential activities) and factor 4 (separation). In our analysis, diagnosis was not associated with any factor, indicating that all patients perceived the same

Table 4 Differences on the OCFQ according to psychiatric diagnoses

Factors	Psychotic disorders Mean (SD)	Affective disorders Mean (SD)	Personality disorders Mean (SD)	*F*	*P*
1	11.7 (2.6)	10.8 (3.1)	10.7 (3.9)	1.216	0.299
2	7.2 (2.8)	8.1 (2.5)	7.6 (3.6)	1.543	0.217
3	12.4 (2.3)	12.6 (2.5)	12.7 (2.2)	0.249	0.780
4	9.1 (2.5)	9.1 (2.3)	9.7 (1.9)	0.673	0.512
5	5.8 (1.8)	6.2 (1.7)	6.2 (1.7)	0.992	0.373
6	5.5 (2.0)	6.1 (1.5)	5.5 (2.5)	1.761	0.175

components of treatment to be helpful. However, the analysis of the relation between diagnosis and single items revealed that patients suffering from psychosis highlighted the helpfulness of rehabilitation activities specifically organized to improve their disability, whereas patients with affective disorders benefited from catharsis and relationships.

Some limitations should be borne in mind. First, the results reported here apply to voluntarily admitted psychiatric patients only. This sample selection may explain the favourable attitudes toward the treatments received and the preference for a nonhospital setting. To minimize this source of bias, the OCFQ was administered by a researcher not belonging to the staff. The interview took place before patients left the facility but after the discharge decision was taken. Second, we cannot interpret the ratings of helpfulness as ratings of treatment efficacy. These studies can be an interesting way to recognize and describe patients' experiences, needs, and opinion. As well, they help to increase patient involvement in planning therapeutic strategies; however, they cannot provide information on efficacy (12).

In conclusion, our findings appear to document that psychiatric patients consider several therapeutic factors helpful. They rate as very helpful factors based on individual approaches (for example talking with a doctor and medication) or on aspects of the therapeutic milieu that assure few restrictions, no stigma, and interactions with the outside world. The results presented here may be a valuable contribution to clinicians seeking to improve the planning of therapeutic strategies that take into account patient opinions.

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Résumé : L'opinion des patients sur les avantages des programmes de traitement des soins psychiatriques résidentiels

Objectif : Évaluer les opinions des patients sur l'avantage perçu du traitement prodigué durant leur séjour dans un établissement résidentiel.

Méthode : Nous avons administré le questionnaire des opinions sur les facteurs curatifs (OCFQ), qui a été élaboré d'après des études précédentes et qui vérifie plusieurs modes de traitement et facteurs thérapeutiques, à un échantillon de 157 patients psychiatriques gravement malades, hospitalisés dans un établissement résidentiel.

Résultats : Tous les facteurs thérapeutiques vérifiés par l'OCFQ étaient considérés utiles ou très utiles par la plupart des sujets de l'échantillon. L'item qui a obtenu le score le plus élevé était « parler au médecin », suivi de « laissez-passer », « médicaments », « visiteurs », « milieu non hospitalier », « liens d'amitié avec les patients », « structure de la vie quotidienne », « soutien d'une équipe » et « parler aux infirmières ». L'item le moins estimé était « activités de groupe ».

Conclusion : Les patients psychiatriques jugent utiles plusieurs facteurs de traitement, surtout ceux fondés sur des approches individuelles ou sur un milieu thérapeutique moins restrictif qui permet des interactions avec le monde extérieur. Ces résultats peuvent constituer un apport valable pour améliorer la planification des traitements dans les établissements résidentiels.