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ARTICLE

Community Rehabilitation for Persons with Psychiatric Disabilities: Comparison of the Effectiveness of Segregated and Integrated Programs in Israel

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This study compares the effectiveness of a segregative and an integrative psychosocial recreational program for persons with psychiatric disabilities in Israel. Comparison of changes in 97 members of a segregated social club with those of 89 participants in an integrative program in their local community center shows that both reported significantly greater satisfaction with their social life, having more friends than previously, increased support from friends, less loneliness, greater social support, and engaging in more leisure activities. The only significant differences were that the participants in the segregative program reported making more new friends, while those in the program reported a greater increase in the number of leisure activities in which they engaged. With this, the findings also show that the participants in the integrative program were generally stronger and in better clinical condition than those in the segregative program. These findings point to the need for different types of recreational programs to meet the needs of persons with different levels of disability.

Keywords: recreational program, community rehabilitation, segregated and integrated programs, persons with psychiatric disabilities

The quality of life of persons with psychiatric disabilities has consistently been found to be low (Kelly, McKenna, Parahoo & Dusoir, 2001; McCormick, 1999; Perese, Getty & Wooldridge, 2003). Among the reasons suggested are their poor social relationships and lack of social support (Nelson, Wiltshire, Pierson & Walsh-Bowers, 1995; Yanos, Rosenfield & Horwitz, 2001). Findings show that the social networks of persons with psychiatric disabilities are much smaller than those of other people (Erickson, Beiser, Iacono, Fleming & Lin, 1989; Sullivan & Poertner, 1989); consist largely of relatives, mental health professionals, and clients (Horwitz & Reinhard, 1995); and are typified by non-mutual relationships in which they receive more than they are able to give (Baker, Jodrey & Intagliata, 1992). Loneliness is a major problem for them (Davidson & Stayner, 1997).

Research among persons with psychiatric disabilities living in the community shows that reciprocal social relationships and the social support they provide increase their ability to deal with life stresses (Boydell, Gladstone & Crawford, 2002), reduce the likelihood of psychiatric deterioration and breakdown (Breier & Strauss, 1984), decrease the likelihood of rehospitalization (Davidson & Stayner, 1997), facilitate adjustment and integration into the community (Nelson, Hall, Squire & Walsh-Bowers, 1992), and improve their quality of life, well-being, and satisfaction with their social relations, family relations, and leisure (Boydell et al., 2002; Nelson et al., 1995; Yanos et al., 2001). All in all, the findings suggest that the social deprivations of persons with psychiatric disabilities undermine their adjustment, impair their quality of life, and place them at risk for further deterioration and breakdown. In light of these implications, professionals widely regard improving the social lives of persons with psychiatric disabilities to be of paramount importance.

Evaluative studies (Browne et al., 1996; Davidson et al., 2001; Linhorst, 1988; Nelson et al., 1995; Petryshen, Hawkins & Fronchak, 2001; Wilson, Flanagan & Rynders, 1999) support the widely held conviction that social recreation programs can contribute substantially to this end by providing persons with psychiatric disabilities with opportunities to develop social ties, make friends, and interact with peers or others in the community, as well as by improving the participants' social and interpersonal skills (Segal & VanderVoort, 1993; Sullivan & Poertner, 1989). The question that arises is what kind of program will best improve their social relations and reduce their loneliness: segregative programs, solely for persons with psychiatric disabilities, or integrative programs that are open to all members of the community.

Most social recreation programs for persons with psychiatric disabilities are segregative programs, which strive to improve their social lives by providing them with a framework for interacting with others like themselves and by bolstering their peer support. These programs attempt to circumvent the societal stigmatization of persons with psychiatric disabilities and the discomfort they may feel in interaction with "normal" people. Their basic assumption is that contact with peers with similar problems will improve the quality of life of the psychiatrically disabled by enabling them to feel greater security, acceptance, and belonging than they would feel with "normal" people (Mead, Hilton & Curtis, 2001; Rosenfield & Wenzel, 1997).

These programs have several drawbacks. Findings show that many participants complain that they are a constant reminder of their limitations, mark them as psychiatrically disabled, and channel them into contact with persons whose behaviors are non-normative. Dissatisfied participants state that, in addition to relations with others like themselves, they would like to form relationships that are based on more than the shared experience of disability and hospitalization (Davidson et al., 2001; Pyke & Atcheson, 1993). Indeed, findings in Israel show that only a very small proportion of persons with psychiatric disabilities choose to participate in these programs (Ministry of Health Statistical Yearbook, 2003). In addition, professionals express concern that segregated programs are not a transition to social integration for persons with psychiatric disabilities, but a permanent setting that increases their stigmatization and their segregation in a pathological environment (Farbstein & Hidas, 1997).

Integrative programs were introduced in an effort to overcome the drawbacks of the segregative ones. The integrative approach maintains that the more relationships that persons with psychiatric disabilities have in the community, the better their quality of life (Rosenfield & Wenzel, 1997). In keeping with the support system model of psycho-social rehabilitation (Carling, 1990; Sullivan, 1992), this approach attempts to enable them to obtain the help and support they need via the ordinary, natural services for the population as a whole. In keeping with the supported socialization approach (Davidson et al., 2001), it tries to promote their social rehabilitation and integration in the community by expanding their access to the society and the leisure activities of their community.

Empirical evidence supports the effectiveness of both types of programs. Findings show significant associations between participation in segregated programs and happiness (Linhorst, 1988), improved quality of life (Browne et al., 1996), improved social skills, and enlarged social support networks (Wilson et al., 1999). Other findings show associations between participation in integrative programs and life satisfaction (Nelson et al., 1995), reduced loneliness (e.g., Skirboll, 1994), greater satisfaction with social relations and leisure activities (Petryshen et al., 2001), enlarged social networks and increased participation in community activities (Davidson et al., 2001), and increased social self-efficacy (Stein & Cislo, 1994).

There is no research, however, comparing the efficacy of the two approaches. We found only two studies that have any bearing on the issue. One, Accordino and Herbert's (2000) comparison of four different kinds of segregative psycho-social rehabilitation programs, found no significant difference in their impact on the partici-

pants' self-reported quality of life. The other, which is somewhat closer to the issue here, is Schneider, Wooff, Carpenter, Brandon and McNiven's (2002) comparison of services aimed solely at the psychiatrically disabled and services aimed at a diversity of clients including the psychiatrically disabled. Here, too, no significant difference was found in the participants' self-reported quality of life.

To fill the gap, the present study compares the outcomes of an integrative and a segregative social recreational program for persons with psychiatric disabilities in Israel. In a fair number of areas in Israel, persons with psychiatric disabilities can choose to attend either a segregated social club or an integrative program at the local community center. The aim of both types of programs is to improve the quality of life of persons with psychiatric disabilities by helping them to reduce their loneliness and social alienation and to increase their social support.

The first segregated social clubs for persons with psychiatric disabilities were established in Israel in the 1970s. At the time of this writing, there are 59 such clubs for adults in Israel, in 47 communities, with a total of over 2,600 members (Ministry of Health, Statistical Yearbook, 2003). The clubs provide organized leisure and social activities. They are generally open between three and four afternoons and evenings a week, and the members can come as often as they like, whether to participate in specific activities or simply to be in the company of others. In addition, these clubs offer organized picnics, trips, parties, and annual group vacations. Most of the clubs are run by the NGO Enosh (Israel Association for Mental Health), with oversight and support from the Ministry of Health. With the exception of violent individuals and persons with a background of criminality or substance abuse, all persons with psychiatric disabilities may participate in the clubs' activities (Farbstein & Hidas, 1997).

The first integrative program for persons with psychiatric disabilities in Israel was established in 2001, in a joint venture by Israel's Ministry of Health, and the Israeli Association of Community Centers. The program is termed Amitim, which means "friends" in Hebrew. At the time of this writing, there are 37 Amitim programs in community centers across the country, with a total of about 900 participants. The community centers operate in most communities in Israel, where they provide a wide range of low-priced social, educational, sports, and cultural activities to persons of all ages. In contrast to the social clubs, however, they generally do not serve as a place to hang out. Through the integrative program, adults (aged 18 through 65) with psychiatric disabilities receive numerous types of assistance to enable them to take part in the community centers' leisure activities. The main type of assistance consists of individual and group meetings with the program coordinator to help them develop the social skills they need and to discuss issues that arise in the activities in which they participate. In addition, volunteers are available to help them integrate both into the activities of the community center and into the community at large. The participants select both the activities that interest them and the assistance they want. In tandem, representatives of the program reach out into the community to encourage more understanding and acceptance of persons with psychiatric disabilities.

Method

Sample

The sample consisted of 186 participants: 97 members of a segregated program, 89 participants in an integrative one. For the purposes of comparison, the sample was drawn only from areas that had at least one of each type of program. Eight such areas were identified, with a total of 10 segregated programs and 16 integrative ones. In all the areas, the participants had the option of choosing the program they preferred.

Criteria for inclusion in the study were: a) participation in a segregated social club or integrative program for at least a month; b) agreement to participate in the study; and c) cognitive ability to fill out the study questionnaire, as judged by the program coordinator. These criteria were met by 201 persons: 100 members of a social club, 101 participants in an integrative program. Fifteen persons were removed because they were in both types. At the time of the data collection, the social club sample constituted 3.5% of the total club membership, the integrative sample 16% of all the participants in the Amitim programs.

The sample consists of similar numbers of men (50.3%) and women (49.7%), ranging in age from 19-65 (m = 41, SD 11.13). About a fifth (21%) of the sample have an elementary or junior high school education, 49.7% a high school education, 29.3% a post-high school education, and 9.4% a college or university degree. Somewhat over half (53.3%) are single, 19.6% are married, 23.9% separated or divorced, and 3.3% widowed. Over one third (37%) live with their parents or another relative, 21.2% with a spouse, 26.6% alone, and 11.5% in a hostel or protected residence. Around half (52.2%) defined their economic status as average, 22.2% as good, and 25.8% as poor. Only 3% reported that they lived solely on work income, 33.5% solely on disability allowance; 48.3% reported having several sources of income (e.g., disability allowance, work, family), and the remaining 13.7% have a variety of other sources of income, such as pensions, al-

imony, or income from property. Around two fifths (40.7%) reported being unemployed, 32.3% working either full- or part-time in protected frameworks, 20.3% working either full- or part-time in unprotected frameworks, and 6.6% "other" work. Around three quarters (75.7%) had been hospitalized in a psychiatric ward. Most (89.1%) were taking psychiatric medication.

Psychiatric diagnosis was not queried so as to create a dialogue based on strengths and abilities rather than illness. The participants in the social club had been attending for an average of 66.4 (*SD* = 62.0) months with a mean frequency of three (*SD* = 1.1) times a week. Those in the integrative program had been attending for an average of 14.5 (*SD* = 8.0) months with a mean frequency of 2.8 (*SD* = 1.0) times a week. The large difference in the length of attendance stems from the difference in the length of time the two programs had been in existence.

Measures

Outcome Measures

The following scales were all adapted to the present study after a pilot study conducted on 28 program participants, 14 in each type.

Leisure activities were measured by eight items, each naming a leisure activity, drawn from Laor's (2000) Hebrew version of the Leisure Activities subscale of the Wisconsin Quality of Life Index (W-QLI; Becker, Diamond, & Sainfort, 1993). Respondents were asked to indicate the frequency with which they engaged in each activity outside the rehabilitation program. With respect to five of these (walking, attending a club open to all community members, a hobby, sports, other), respondents were asked to indicate the frequency in the activity in the previous month and in the month prior to their joining the rehabilitation program, on a scale of 1 (never) to 4 (almost every day). With respect to the other three (movie or play, restaurant or café, event in the community), they were asked to indicate the number of times they participated in the activity since they joined the program and in the half year before they joined. The internal consistencies of the eight leisure activities were moderate, both before (Cronbach $\alpha = 0.66$) and during (Cronbach $\alpha = 0.60$) the rehabilitation programs. Based on these figures, we constructed two Number of Leisure Activities variables: prior to joining a rehabilitation program and while attending the program. After the "other" option was removed because few respondents endorsed it, the scores on these indices could range from 0-7.

Quality of social life was measured by eight items drawn from the Hebrew version of the Satisfaction with Social Life subscale (Dasberg, 1998) of the Wisconsin Quality of Life Index (W-QLI; Becker et al., 1993). The first five items assess the respondents' satisfaction with their social life (e.g., number of friends and with relationships with friends, family members, flatmates, and others) currently and before they joined the rehabilitation program, on a scale of 1 (very dissatisfied) to 5 (very satisfied), with the option of marking 9 (not relevant). Pre-program internal consistency on these items was good (Cronbach $\alpha = 0.81$); current internal consistency was satisfactory (Cronbach $\alpha = 74$). We thus constructed two indices: Current Satisfaction with Social Life and Pre-Program Satisfaction with Social Life, with scores on both being the mean of the responses on the first five items. The sixth item asks how many friends the respondents had in the month before joining the program and currently, on a scale of 1 (none) to 4 (over five). The seventh and eighth items query social support from family members and friends in the month prior to joining the program and in the previous month, on a scale of 1 (little) to 3 (much).

Loneliness was measured by the Hebrew version (Friedman, 1985) of the Revised UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980). This scale consists of 20 statements of feelings about one's social life. Respondents marked the frequency with which they experienced each feeling (e.g., alone, understood) currently and in the month prior to joining the program, on a scale of 1 (never) to 4 (often). Internal consistency was high both before (Cronbach $\alpha = 0.90$) and after (Cronbach $\alpha = 0.88$) joining the program. We thus constructed two Loneliness indices. Scores were the means of each respondent's feelings before and during the program, and ranged from 1 (not lonely) to 4 (very lonely).

Social support was measured by the Hebrew version (Kaduri, 1993) of the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). This measure consists of 12 statements tapping perceived social support from family, friends, and significant others. Respondents are asked to indicate the degree to which each statement describes their situation currently and in the month prior to their joining the program on a 5-point scale, with 1= very well and 5= not at all. The scale showed high internal consistency in the study sample, both before (Cronbach $\alpha = 0.90$) and after (Cronbach $\alpha = 0.91$) they joined the program. A social support index was constructed, with scores ranging from 1 (very low social support) to 5 (very high social support).

TABLE 1—Analysis of Variance: Changes, Programs, and Interactions

Outcome Variable	Segregative Social Clubs				Integrative Amitim Program				*F* change	*F* program	*F* interaction
	Before		After		Before		After				
	Mean	*SD*	Mean	*SD*	Mean	*SD*	Mean	*SD*			
Quality of Social Life											
satisfaction with social life	3.27	.99	3.79	.84	3.02	1.01	3.64	.77	77.36***	3.00	.57
number of friends	2.20	1.11	2.93	1.02	2.13	.99	2.56	.94	63.88***	2.62	4.13*
amount of support from family	2.07	.86	2.09	.89	2.11	.86	2.26	.81	2.40	.82	1.36
amount of support from friends	1.71	.82	2.06	.83	1.81	.81	2.05	.84	23.62***	1.14	.85
Loneliness	2.49	.63	2.01	.57	2.53	.64	2.19	.53	99.75***	2.09	2.99
Social Support	3.15	1.10	3.66	1.12	3.14	1.05	3.55	1.01	67.95***	.13	.79
Number of Leisure Activities	3.30	1.91	3.52	1.75	2.97	1.92	4.44	1.60	40.53***	1.67	22.41***

* $p<.05$, *** $p<.001$

Socio-demographic and clinical information

Study participants were asked to indicate their gender, age, and education; their family, economic, and employment status; and their sources of income and living arrangements. They were also asked whether and how many psychiatric hospitalizations they had had; whether they were currently on medication, and for how many years they had taken medication.

Procedure

Permission to administer the questionnaires was obtained from the Chief Social Worker of Enosh and from the Director of the Amitim Program, and the Ministry of Health was notified. The study was carried out with the cooperation of the directors of all the social clubs and the coordinators of the integrative programs. The questionnaires were administered between January and March 2004. The procedure was somewhat different in the two settings. In the social clubs, where the members came together in segregated groups, the questionnaires were administered by the first author in group fashion. Those members who were present on the day the author arrived and who agreed to fill out the questionnaires did so together, with the author available to answer questions. In the integrative program, where the participants were scattered among "normal" members of the community, the questionnaires were administered on an individual basis by the program coordinator, after she or he received a thorough explanation and directions from the first author. The percentages of persons who refused to participate in the study were not recorded.

Findings

Two-way analyses of variance (type of program x degree of change) was conducted to determine the improvement in the participants' condition, to compare the effectiveness of the programs, and to locate interactions between improvement and type of program. Table 1 presents the means, standard deviations, and *F*-values.

As can be seen, improvement was reported in all the outcome variables with the single exception of amount of support from family. That is, the study participants reported greater satisfaction with their social life, having more friends, increased support from friends, less loneliness, greater social support, and engaging in more leisure activities. In addition, the findings show that there was no difference in the improvements reported by the participants in the two types of rehabilitation programs. Finally, only two interactions were found: between program and number of friends and between program and number of leisure activities. Participants in the segregative social clubs reported having made somewhat more friends, while participants in the integrated program reported engaging in more leisure activities.

TABLE 2—Participants' Socio-Demographic Features

Variables	χ^2/t	*df*	Integrative Program	Segregative Social Clubs
Gender	$\chi^2 = 10.94$ ***	1	*N* = 88	*N* = 97
Male			37.5%	61.9%
Female			62.5%	38.1%
Age	*t* = -0.11	171	*N* = 89	*N* = 95
Range			19-64	23-65
Mean			41.0	40.8
SD			12.2	10.1
Education	$\chi^2 = 14.72$***	4	*N* = 88	*N* = 93
Elementary			5.7%	20.4%
Junior-high			8.0%	7.5%
High school			46.6%	52.7%
Post high school			28.4%	11.8%
Academic			11.4%	7.5%
Family status	$\chi^2 = 7.11$ *	2	*N* = 89	*N* = 95
Single			44.9%	61.1%
Married			27.0%	12.6%
Had been married			28.1%	26.3%

Continued on next page

In view of the possibility that the two types of programs might appeal to persons with different sociodemographic features and/or levels of disability, the two groups' sociodemographic and clinical features were compared using Chi square tests for the nominal and ordinal variables and *T* tests for independent means for the interval and ratio variables. Table 2 presents the findings on the sociodemographic variables.

Significant differences were found in four of the eight variables: gender, education, family status, and employment status. The integrative program had a higher ratio of women to men than the segregative one (62.5% vs. 37.5%). Its members were better educated, with higher percentages of them having post-high school (28.4% vs. 11.8%) or academic (11.4% vs. 7.5%) education, and lower percentages having elementary (5.7% vs. 20.4%) or high school (46.6% vs. 52.7%) education. High percentages of the participants in both programs were single. However, proportionately, there were fewer single persons in the integrative program (44.9% vs. 61.1%) and more who were currently married (27% vs. 12.6%) or had been married (28.1% vs. 26.3%) than in the segregative one. The majority of participants in both programs were employed, with the percentage of employed persons in the segregative program higher than that in the integrative one (63.8% vs. 54.5%). However, of those who were employed, a higher proportion of those in the integrative program were employed in an unprotected workplace (22.7% vs. 18.1%) and lower percentages in a protected workplace (12.5% vs. 33%). No significant difference was found in the age, economic status, source of income, or living arrangements of the participants in the two groups.

Table 3 presents the findings on the participants' clinical status and use of

TABLE 2—Participants' Socio-Demographic Features *(CONTINUED)*

Variables	χ^2 / *t*	*df*	Integrative Program	Segregative Social Clubs
Economic status	$\chi^2 = 2.26$	2	*N* = 89	*N* = 95
Good			17.2%	26.3%
Fair			56.3%	48.4%
Poor			26.4%	25.3%
Sources of income	$\chi^2 = 0.97$	3	*N* = 86	*N* = 96
Transfer payments (TP) + family support (FS)			43.0%	43.8%
TP + FS + work			38.4%	40.6%
Work only			4.7%	2.1%
Other			14.0%	13.5%
Living arrangements	$\chi^2 = 5.8$	3	*N* = 86	*N* = 91
Alone or with spouse			54.7%	45.1%
With family			38.4%	38.5%
Hostel			0.0%	4.4%
Protected living			7.0%	12.1%
Employment	$\chi^2 = 10.93$**	3	*N* = 88	*N* = 94
Not working			45.5%	36.2%
Protected workplace			31.8%	45.8%
Unprotected workplace			22.7%	18.0%

* $p < .05$, ** $p < .01$, *** $p < .001$

other rehabilitation and therapeutic services.

As can be seen, significant group differences were found in three of the four indications of clinical status: having been in psychiatric hospitalization, number of psychiatric hospitalizations, and years of taking psychiatric medication. The majority of participants in both programs had been hospitalized in a psychiatric ward. However, the percentage of those in the segregative program who had been hospitalized was higher (86.6% vs. 63.6%) and their number of hospitalizations greater (*M* = 3.4; *SD* 1.9 vs. *M* = 1.5; *SD* 3.1). Moreover, while similar percentages of participants in both types of programs were currently on psychiatric medication, those in the segregative program had been taking such medication for many more years on average (*M* = 12.0, *SD* 9.7 vs. *M* = 6.9, *SD* 8.3).

Discussion

The examination yielded two key sets of findings. The first is that the participants in both types of recreational program reported significant improvement in their social lives. Both groups of participants reported greater satisfaction with their social life, having more friends than previously, increased support from friends, less loneliness, greater social support, and engaging in more leisure activities. The second is that the participants in the integrative program were generally stronger than those in the segregative program. They were better educated, more likely to be or to have been married, and more likely to be employed in an unprotected workplace. They were less likely to have undergone psychiatric hospitalization, had been hospitalized fewer times, and on average had been taking psychiatric medication for fewer years.

Table 3—Participants' Clinical Status

Variables	χ^2/t	*df*	Integrative Program	Segregative Social Clubs
Psychiatric hospitalization	$\chi^2 = 13.21$***	1	*N* = 88	*N* = 97
No			36.4%	13.4%
Yes			63.6%	86.6%
Number of psychiatric hospitalization	*t* = 4.89***	148	*N* = 84	*N* = 90
Range			0-10	0-15
Mean			1.5	3.4
SD			3.1	1.9
Psychiatric medication	$\chi^2 = 1.29$	1	*N* = 86	*N* = 86
No			8.1%	13.4%
Yes			91.9%	86.6%
Years on psychiatric medication	*t* = 4.89***	151	*N* = 68	*N* = 86
Range			0-43	0-39
Mean			6.9	12.0
SD			8.3	9.7

*** $p < .001$

The findings that the participants in the two types of programs reported similar improvements point to the effectiveness of both segregative and integrative programs, despite their differences in philosophy and approach. This finding is consistent with Schneider et al.'s (2002) finding that those who used services aimed solely at persons with psychiatric disabilities and those who used services aimed at a diversity of clients showed no significant difference in their self-reported quality of life. It is also consistent with Accordino and Herbert's (2000) findings showing no significant difference in the impact of four different types of segregative programs on the participants' self-reported quality of life. The reason for the lack of substantial difference is probably that both the segregative and integrative programs serve as frameworks for social interaction, which provide opportunities for the participants to come into contact with others, to learn and hone their social skills, and to learn to utilize their free time in an enjoyable fashion.

With this, two significant differences were found in the degree of improvement in the two programs. One is that the participants in the segregative program reported making somewhat more new friends. Several nonexclusive explanations may be suggested. For one thing, the participants in the social clubs had been attending for a longer period of time than those in the integrative programs, giving them greater opportunity to make friends. For another, they met with peers, who, studies show, provide persons with psychiatric disabilities greater mutual understanding, acceptance, support, and feelings of belonging than persons who do not suffer from psychiatric disabilities, and raise fewer fears of rejection (Boydell et al., 2002). Given findings that persons with psychiatric disabilities have fewer friends than those without (Erickson et al., 1989; Sullivan & Poertner, 1989), it may also be that the other members of the social clubs were more open to making new friends than the participants in the community center activities who did not have psychiatric disabilities. Other explanations are related to the features of the two frameworks. While both programs offer a choice of specific activities, only the social clubs are set up so that members can come simply to socialize. Moreover, the segregative programs are explicitly aimed at enabling the participants to develop social support networks and actively encourage them

to interact outside club hours (Farbstein & Hidas, 1997; Naftali, 1986), and the integrative programs do not. Perese et al. (2003) point out that such active encouragement is essential to helping persons with persons with psychiatric disabilities to make and keep friends.

The second significant difference is that those in the integrative program reported a greater increase in the number of leisure activities. The difference may be explained by their exposure to normative activities in the community centers. Their successful integration in these activities may have enabled them to better generalize their learning to venues outside the program.

Notwithstanding these differences, the fundamental finding remains that both programs attained good results. The question thus arises of whether both segregative and integrative programs are needed. Since all the study participants chose the program they preferred, the significant differences in the sociodemographic and clinical features of the participants in the two types of programs suggest that they are. The integrative recreational programs, it may assumed, better suit the needs of persons with stronger personal resources (e.g., education, a spouse) and less psychiatric impairment, who were better able to cope with the challenges entailed in interaction with the normative community. The segregative program probably better suit the needs of the more impaired individuals, who seek the security and protections of being with their peers.

The study has three main limitations. One is that it was not carried out on representative samples, but rather on self-selected individuals who agreed to fill out the study questionnaires and were cognitively able to do so. Although this may be an unavoidable limitation of studies on persons with psychiatric disabilities (Pratt, McGuigan & Katzev, 2000), it raises the question of the generalizability of the findings. The second limitation is the use of retrospective questions to establish the participants' pre-program baseline. We cannot rule out biases created by the vagaries of memory (Hill & Betz, 2005). The third limitation is that the study did not examine outcomes that could better manifest the different philosophies and approaches of the two programs, such as feelings of being normal and equal to others and changes in community attitudes towards persons with psychiatric disabilities.

Nonetheless, the study findings are strikingly coherent. They show that both the segregative and integrative recreational programs improved the social situation of their participants and that the only area where no improvement was obtained was in social support from family, which neither program set as an aim for itself. Moreover, the differences that were found in the outcomes of the two programs suggest that each program was more effective than the other in precisely the area on which it most focused. The segregative program, whose participants reported making more friends, actively focused on the creation of social ties within and outside the clubs. The integrative program, whose participants reported a greater increase in involvement in leisure activities, placed its focus on recreational activities.

In practical terms, the findings suggest that different types of programs are needed to meet the needs of persons with different levels of disability, that both integrative and segregative programs should be made available in the same areas, and that mobility between programs should be encouraged as persons' disability levels change. Professionals in the two types of programs should be made aware of the relative advantages of each and be encouraged to identify and refer persons whose needs might be better met in a program of a different type than that which they are attending.

Further study is strongly recommended. In particular, we recommend examining the associations between programs and participants and a wide range of outcome variables. Longitudinal study starting with the entrance of the individuals into the programs would be helpful to establish a surer baseline and to enable following dropout rates and reasons.

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