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A QUALITY OF LIFE INTERVIEW FOR THE CHRONICALLY MENTALLY ILL.

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ABSTRACT

During the past few years there has been increased interest in assessing the quality of life of the chronically mentally ill to assist in planning and evaluating programs for these patients. New initiatives to integrate and expand psychiatric, medical, and social services for the chronically mentally ill make such broad-based service evaluations all the more relevant. This paper describes the development and psychometric evaluation of a structured, 45-minute Quality of Life Interview for the chronically mentally ill. Based upon studies with nearly 500 chronically mentally ill patients, the interview has satisfactory reliability and validity. After a description of the interview, the author discusses several issues regarding the status of QOL assessments in this population, the potential relevance of such assessments to program development and evaluation, their potential applications in clinical practice, and persistent problems in interpreting and applying the results of QOL evaluations.

INTRODUCTION

Evaluating the well-being of the chronically mentally ill has become crucial to revising our national plans for serving them in the wake of three decades of deinstitutionalization. These persons typically require assistance in several life areas, including housing, finances, family support, opportunities for social interaction and personal development, legal and safety problems, medical care and mental health services. Major new initiatives are underway at federal, state, and local levels to more effectively integrate the many services needed by these patients. For example, the Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development have just launched a grant program to stimulate large cities to consolidate and expand services for the chronically mentally ill (Robert Wood Johnson Foundation, 1986). It has been advised that such innovations be evaluated from the standpoint of their impact on patients' quality of life, as well as their effects on patients' mental and general health status, families, communities, and service costs (Schulberg & Bromet, 1981). This has stimulated mental health program administrators and evaluation researchers to pay more attention to the assessment of quality of life (Bigelow, Brodsky, Steward, & Olson, 1982; Baker & Intagliata, 1982; Lehman et al., 1982; Schulberg & Bromet, 1981; Tessler & Goldman, 1982; Diamond, 1985; Heinrichs, Hanlon, & Carpenter, 1984).

Interest in assessing the quality of life of chronic mental patients was brought forward most strongly in the mid-1970s by the Community Support Program (CSP), an initiative by the National Institute of Mental Health to stimulate states and localities to develop more comprehensive community-based services for the chronically mentally ill. The stated goal of CSP was to improve patients' quality of life (Schulberg & Bromet, 1981; Tessler & Goldman, 1982), which was broadly defined as the extent to which "improvements in system performance actually translate into humane, dignified, and satisfying conditions of community living for chronically disabled clients" (Tessler & Goldman, 1982, p. 186). Research teams in two participating states, Oregon (Bigelow et al., 1982) and New York (Baker & Intagliata, 1982), worked extensively to operationalize the notion of quality of life within the context of CSP.

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The Oregon Quality of Life Questionnaire (OQLQ) (Bigelow et al., 1982) focused on role functions and included items on satisfaction and actual performance in four areas: personal adjustment, interpersonal adjustment, adjustment to productivity, and civic adjustment. In New York, Baker and Intagliata (1982) developed a 15-item Satisfaction with Life Domains Scale (SLDS) to assess CSP clients' life satisfaction with various areas of their lives. In a subsequent paper, Bartlett and Intagliata (1985) reported on a 21-item Life Satisfaction Profile which assesses the value assigned by chronically mentally ill patients to various resources: basic needs, advice, special affiliation, autonomy, personal accomplishment, religion, and general affiliation. Hence, the CSP initiative promoted significant work on assessing the quality of life of chronically mentally ill persons. However, no single QOL measure emerged as definitive and the researchers involved in this work urged more extensive research into the development of adequate and relevant measures of QOL.

In summary, the assessment of QOL among the chronically mentally ill has progressed in recent years but much remains to be done. The Quality of Life Interview described herein has been under development during the past seven years and has now been used with nearly 500 chronically mentally ill patients in various settings. The purpose here is to describe the development of this interview and report on its psychometric properties.

INTERVIEW DEVELOPMENT AND ADMINISTRATION

The Quality of Life Interview reflects the conceptual model depicted in Figure 1 based upon the seminal studies of the quality of American life by Campbell et al. (Campbell, Converse, & Rodgers, 1976) and Andrews and Withey (Andrews & Withey, 1976). The model views the experience of general well-being as a product of personal characteristics, objective life conditions in various life domains, and satisfaction with life conditions in these various domains. The formulation allows for comparisons across populations on any given component of the model, such as comparisons of general well-being or functioning within a particular life domain, as well as assessments of the salience of various life domains to general well-being within a population by means of regression models. For purposes of evaluating the quality of life experienced by the chronically mentally ill, this model has the attraction of evaluating a broad variety of current life experiences that can affect the patient's sense of well-being, thus integrating areas that may relate to the need for and be affected by the delivery of psychiatric, general medical and social services. Such an integrated model acknowledges current emphasis on comprehensive service plans for these patients (Schulberg & Bromet, 1981; Talbott, 1984).

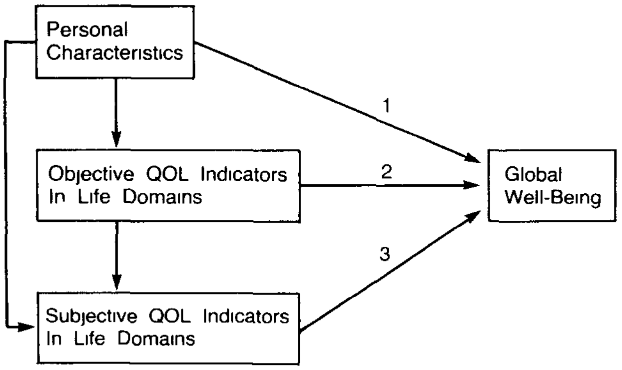

Figure 1. Quality of life model.

In developing an instrument to assess the quality of life of these impaired persons, several criteria were emphasized. An interview format was selected over a written questionnaire because many of these persons may have problems understanding written questionnaires and may have difficulty sustaining interest in completing such questionnaires. Furthermore, many of these patients enjoy the one-to-one contact with an interviewer, which aids in patient cooperation and motivation to complete the interview.

This obviously increases the expense of such assessments compared to pencil and paper self-reports, but seems necessary for many patients. Some chronically mentally ill persons can certainly complete extensive written questionnaires, but many others either cannot or will not. Much briefer self ratings of QOL, such as global life satisfaction, would increase the feasibility of less costly, self-administered ratings, but would also be less rich in specific information about life domains and therefore less useful for program development.

The interview is highly structured to ensure consistency, to minimize interviewer effects and to permit its use by non-clinical interviewers. Because these patients may have difficulty recalling how they were doing or feeling in the past, the interview is oriented mainly to current feelings of satisfaction and current or recent functional status and access to resources. Every effort has been made to keep questions brief and concrete. Pilot trials of question formats that relied on conditional thinking confirmed the validity of this approach. For example, such questions as, "If you wanted to go downtown, would you be able to get there?", proved too difficult for some patients and were rendered non-usable by others due to such responses as, "But I don't want to go downtown.", or "I don't like the bus." Pilot question formats were modified until most patients were able to comprehend and respond. Finally the interview needed to be sufficiently long to sample a variety of life domains with adequate reliability, yet short enough to keep interview burden at a tolerable level. As currently organized, the interview requires approximately 45 minutes.

The selection of life domains for inclusion in the interview was based upon national quality of life studies (Andrews & Withey, 1976; Campbell et al., 1976), several available measures of resources and functioning (Gurland, Yorkston, Stone, Frank, & Fleiss, 1972; Hogarty & Katz, 1971; Katz & Lyerly, 1963; Linn, Sculthorpe, Evje, Slater, & Goodman, 1969; Paykel, Weissman, Prusoff, & Tonks, 1971; Serban, 1978; Stein & Test, 1980; Weissman, 1975), conceptual reviews on quality of life (Flanagan, 1978; George, 1979; Zautra & Goodhart, 1979), and key references on the chronically mentally ill (Lamb, 1979; Lamb & Goertzel, 1977; Segal & Aviram, 1978; Talbott, 1979). Initially eight life domains were selected: living situation, family relations, social relations, leisure, work, finances, safety, and health. Subsequently, a ninth domain, religion, was added on the basis of open-ended responses from patients. For each life domain, pools of items were culled from existing instruments or created anew. Often the wording of the items and their response formats were modified to increase their comprehensibility and to increase the response variance among this generally seriously impaired population. The interview begins with questions about demographic characteristics and general life satisfaction; proceeds through each of the nine life domains, asking first about objective life conditions or level of functioning and then about satisfaction in each domain; and concludes with repeat general life satisfaction questions and some open-ended probes. Copies of the interview are available from the author upon request. Examples of some scales are included in the Appendix.

The interview can be administered by non-clinicians after a relatively brief training period. Training for interviewers begins with study of the instrument to become familiar with its organization according to life domains and objective and subjective QOL measures within each domain, clarification of skip patterns, and the use of the visual rating scales with which respondents rate life satisfaction. The next step involves viewing either a video tape of the interview or a live interview conducted by an experienced interviewer, followed by discussion of any questions. Most prospective interviewers then have little difficulty conducting an interview themselves observed by a trainer for feedback and become quite comfortable with the flow of the interview after doing several themselves.

Most respondents quickly become comfortable and familiar with the use of the life satisfaction rating scale (1 = terrible through 7 = delighted), presented periodically in the form of a visual analog. In some cases the interviewer may have to reiterate for the respondent the need to use the scaled response options when describing how they feel about various aspects of their lives, a process which is greatly facilitated by the visual scale. The interviewer occasionally must set limits on a particular respondent's tendency to digress into lengthy narrative responses. Most interviewers have little difficulty with this because the interview offers a highly structured format for reference, and respondents usually are able to orient themselves to this. However, some interviewer judgment must at times be exercised to balance the benefits to interviewer-respondent rapport achieved by occasional unstructured conversation with the problems that arise from frequent digressions from the interview format. Interviewers must also judge when a respondent is too disturbed or disoriented to tolerate the interview or provide meaningful responses. Our experience has been that with some practice and occasional advice from an experienced clinician, most interviewers with associate or bachelor level degrees have little trouble making these judgments.

Patient Samples

Three chronically mentally ill patient populations have been surveyed with this instrument: (a) 278 mentally ill residents of 30 large board-and-care homes in Los Angeles; (b) 99 chronically mentally ill inpatients at the Rochester (N.Y.) Psychiatric Center; and (c) 92 chronically mentally ill residents of various supervised community residences in Rochester, N.Y. These three samples will be referred to as Los Angeles board-and-care patients, Rochester inpatients, and Rochester outpatients, respectively. All three samples included only persons between age 18 and 65 and were selected on a systematic random basis in each facility. The results of these surveys have been described in more detail elsewhere (Lehman, 1983a; Lehman, Possidente, & Hawker, 1986; Lehman, Ward & Linn, 1982). Some basic characteristics of these three populations are shown in Table 1.

Reliability

Internal consistency reliability coefficients (Cronbach's alpha) were computed for interview scales based separately upon the Los Angeles and Rochester (inpatients and outpatients combined) samples. Also, one-week test-retest reliabilities (*r*) were computed on a subsample of the Rochester population ($N = 45$). These reliability results are displayed in Table 2. As shown, the levels of internal consistency reliability for most scales were comparable across the Los Angeles and Rochester populations and were adequate for survey purposes and group comparisons. Also, the test-retest reliability correlations revealed significant levels of stability for most interview items and scales.

TABLE 1
SAMPLE CHARACTERISTICS

Characteristic	Los Angeles	Rochester Inpatients	Rochester Outpatients
N	278	99	92
% Female	34 5	47 5	57 1
Mean Age (*SD*)	42 1(12 5)	38 5(13 4)	43 4(15 0)
Mean Years of Education (*SD*)	11 6(2 9)	11 0(3 2)	10 8(3 7)
% Caucasian	74 8	78 8	90 2
Parental Social Class (*SD*) Duncan Index. (1 = lowest, 100 = highest)	42 4(24 9)	42 1(26 5)	36 0(22 6)
% Never Married	55 4	67 7	71 7
% Currently Married	4 3	11 1	6 5
Mean Age (*SD*) at First Psychiatric Hospitalization	26 4(11 1)	23 7(10 6)	27 5(12 9)
Diagnoses (%)*			
Schizophrenia	63 3	76 8	56 5
Affective Disorder	16 5	13 1	10 9
Alcoholism	10 8	6 1	5 4
Drug Abuse	4 0	1 0	1 1
Organic Brain Syndrome	10 1	4 0	1 1
Mental Retardation	6 8	9 1	14 6
Personality Disorder	9 4	5 1	7 6
Current Length of Stay at Facility (months, *SD*)	39 9(41 8)	53 4(96 1)	28 9(31 9)

*Patients may have > 1 diagnosis

Two alternative forms of the general life satisfaction scale were administered to each population during the same interview: (a) a two-item, seven-point Delighted-Terrible scale, and (b) seven adjective pairs, each rated on a seven-point scale (Andrews & Withey, 1976). The correlations between these two alternative measures were: Los Angeles, $r = 0.68$ ($p < .0001$); Rochester inpatients, $r = 0.72$ ($p < .0001$); Rochester outpatients, $r = 0.63$ ($p < .0001$). In all subsequent analyses, the former, two-item scale is used as the measure for general life satisfaction because of its relative brevity and recommendations from previous studies of alternative general life satisfaction measures (Andrews & Withey, 1976).

Validity

The validation of any quality of life measure poses major problems because the concept, quality of life, is abstract, and theories about how quality of life ought to behave are limited. However, within these limitations, some assessments of validity are feasible from available data on the Quality of Life Interview. The validity of this instrument was evaluated in the following ways:

1. Do scale items have face validity and do they adequately assess the intended constructs? (content validity)
2. Are the relationships among the measures in the interview consistent across the three populations studied? (construct validity)
3. Does the instrument produce multivariate prediction models of general life satisfaction (as depicted in Figure 1) in the three mentally ill populations studied that are comparable to such a multivariate model developed for the general population? (predictive validity)

A. Content Validity. The content of the interview items cannot be fully reported here, but four selected subscales are presented in the Appendix to provide a sense of the scale contents. As previously noted, these items were developed anew or modified from a wide variety of relevant existing measures in the mental health and general quality of life literature (Campbell et al., 1976; Andrews & Withey, 1976; Katz & Lyerly, 1963; Serban, 1978; Linn et al., 1969; Gurland, Yorkston, Stone, Frank, & Fleiss, 1972; Hogarty & Katz, 1971; Weissman, 1975; Paykel et al., 1971; Stein & Test, 1980; George, 1979; Flanagan, 1978; Zautra & Goodhart, 1979; Talbott, 1978; Lamb, 1979; Lamb & Goertzel, 1977; Segal & Aviram, 1978). Factor analyses support a central factor for each scale, although a few scales could be subdivided if so desired. For example, the scale measuring satisfaction with social relations reliably measures a main overall factor (alpha = 0.70) as well as two subfactors, satisfaction with relations within the treatment facility (alpha = 0.67) and satisfaction with relations outside of the facility (alpha = 0.68).

B. Construct Validity. To examine construct consistency across the three study populations, three sets of correlations among various variables were compared. These included: (a) the intercorrelations of objective and subjective QOL measures within each life domain, for example, correlation of frequency of family con-

TABLE 2
QUALITY OF LIFE INTERVIEW SCALE RELIABILITIES

Scale Name	No Items	Internal Consistency (Cronbach's alpha) Los Angeles	Internal Consistency (Cronbach's alpha) Rochester	One-Week Test–Retest Correlation ($n=45$)
1 Objective QOL Scales				
Living Situation				
1 Security	2	.87	—	—
2 Privacy	3	44	—	—
3. Autonomy	3	35	—	—
4 Cohesion	9	—	64	29
5 Independence	9	—	69	46
6 Influence	8	—	44	65
7 Comfort	9	—	70	52
8 Current Length of Stay	1	NA	NA	98
b Frequency of Family Contacts	2	78	82	89
c. Frequency of Social Contacts	10	70	70	.69
d Number of Leisure Activities	16	69	.68	77
e Work				
Current Employment Status	1	NA	NA	76*
f Frequency of Religious Activity	2	—	55	75
g Finances				
Total Monthly Support	1	NA	NA	93
Monthly Spending Money	1	NA	NA	63
h Safety				
Assaulted/Past Year	1	NA	NA	61*
Robbed/Past Year	1	NA	NA	58*
i Health				
1 General Perceived Health Status	1	NA	NA	71
2 Amount of General Medical Care – Past Year	4	78	68	60
3 Amount of Psychiatric Care – Past Year	5	.70	60	65
2. Subjective QOL Scales				
a General Life Satisfaction	2	.74	79	71
Satisfaction With.				
b Living Situation	7	86	88	79
c Family Relations	5	85	87	85
d Social Relations	8	82	86	62
e Leisure	6	80	84	53
f Work	5	78	88	95
g Religious Activity	4	—	.79	57
h Finances	4	83	86	77
i Safety	7	74	.80	41
j. Health	6	81	82	73

*For these binary variables, the kappa statistic rather than the Pearson correlation coefficient was used to assess test-retest consistency

tacts with satisfaction with family relations; (b) the correlations of demographic variables, domain-specific objective QOL measures and domain-specific subjective QOL measures with general life satisfaction; and (c) correlations of general life satisfaction scores with measures of patient psychopathology. It was hypothesized that the interrelationships among these variables should be reasonably consistent across populations. The results of the first two of these correlational analyses are shown in Tables 3 and 4. Only those interview items and scales used across all three populations are shown. It can be seen that the results are generally quite consistent across populations. First, the intra-domain correlations between objective and subjective QOL measures are modest (Table 3), consistent with findings from other QOL studies (Andrews & Withey, 1976; Campbell et al., 1976). Second, domain-specific subjective QOL measures correlate most strongly with general life satisfaction, objective QOL measures correlate less strongly with life satisfaction, and demographic and diagnostic variables correlate least strongly with life satisfaction (Table 4).

Third, of the three dimensions of psychopathology, depression, anxiety, and thought disorder (Brook et al. 1979; Endicott & Spitzer, 1978; Krawiecka, Goldberg, Vaughan, 1977), which were assessed concomitantly

Table 3
CORRELATIONS OF OBJECTIVE AND SUBJECTIVE QOL MEASURES WITHIN LIFE DOMAINS

Domain	Los Angeles	Rochester Inpatient	Rochester Outpatient
Living Situation			
Security	−.04	X	X
Privacy	19**	X	X
Autonomy	09	X	X
Comfort	X	.60****	58****
Cohesion	X	61****	55****
Independence	X	53****	.38****
Influence	X	48****	14
Family	22***	.45****	28**
Social Relations	27****	.35***	23*
Leisure	.07	.37***	06
Work			
Hours/Week	.50***	.27	28
N	41	26	23
Finances	12	18	− 07
Safety			
Assault	− 18**	− 33***	− 06
Rob	−.13*	− 36***	02
Frequency of Medical Care/Past Year	− 19**	−.08	− 30**

$^{*}p < 05$, $^{**}p < 01$, $^{***}p < 001$, $^{****}p < 0001$

with general life satisfaction, depression and anxiety consistently showed significant, negative correlations with general life satisfaction across the various patient populations (for depression, $r = -.17$ to $-.56$, $p < .05$ to $< .0001$; for anxiety, $r = -.25$ to $-.33$, $p < .001$ to $< .0001$). Thought disorder did not correlate with life satisfaction ($r = .06$ to $-.14$). Therefore concomitant assessment of a respondent's level of psychiatric symptoms, especially depression and anxiety, seems advisable in this population.

C. Predictive Validity. The final set of validity analyses examined the performance of the multivariate QOL model depicted in the Figure for the three study populations and compared the overall predictive capacity of the model in these populations with the model's performance in the general population. Only those interview variables obtained for all three study populations were used in the analyses. This analysis consists of a four-stage, step-wise multivariate regression of general life satisfaction on four sets of predictor variables: (a) demographics; (b) diagnoses; (c) objective, domain-specific QOL measures; and (d) subjective, domain-specific QOL measures. In each successive stage, significant predictor variables from the preceding stage were forced into the regression analysis first and then additional significant predictors from the next set of variables were allowed to enter.

It can be seen that the pattern of predicted variance across the three chronic patient populations were similar. Furthermore the predictive performance of the model compared favorably with similar analyses from general population studies as shown in Table 5.

DISCUSSION

The Quality of Life Interview described here is one of but a few instruments with known psychometric properties for assessing the quality of life of persons suffering from chronic mental disorders. The other two comparably developed instruments are the Oregon Quality of Life Questionnaire (Bigelow et al., 1982), and the Satisfaction with Life Domains Scale, (Baker & Intagliata, 1982) later revised to the Life Satisfaction Profile (Bartlett & Intagliata, 1985). While these instruments differ in various ways from each other, a discussion of which is beyond the scope of this paper, they share a common conceptual base in a general quality of life theory which integrates access to resources, fulfillment of social roles in multiple life domains, satisfaction with life in various domains, and general life satisfaction into a multivariate model of well-being (Andrews & Withey, 1976; Campbell et al., 1976; Zautra & Goodhart, 1979). The consistency of findings from studies using these instruments supports certain preliminary conclusions about QOL assessments among the chronically mentally ill. (Baker & Intagliata, 1982; Bartlett & Intagliata, 1985; Bigelow et al., 1982; Bigelow & Gareau, 1983; Lehman, 1983a, Lehman, 1983b; Lehman et al., 1982; Lehman et al., 1986).

1. The chronically mentally ill can provide reasonably reliable information about their QOL.
2. Objective and subjective QOL indicators measure different aspects of QOL. Therefore, both types of indicators are recommended to provide a full view of QOL among the chronically mentally ill.
3. Certain aspects of psychopathology, specifically depression and anxiety, correlate moderately with subjective QOL indicators. This relationship must be kept in mind when interpreting QOL data from a mentally ill population. Psychopathology measures should be employed concurrently with QOL measures.
4. QOL indicators can differentiate among chronically mentally ill subpopulations and appear to be responsive to treatment interventions. Thus, they may offer sensitive discriminant outcome measures in this population.

TABLE 4
CORRELATIONS OF GENERAL LIFE SATISFACTION (1 = TERRIBLE, 7 = DELIGHTED) WITH DEMOGRAPHIC, DIAGNOSTIC, OBJECTIVE QOL AND SUBJECTIVE QOL DOMAIN MEASURES

	POPULATIONS		
Variables	Los Angeles	Rochester Inpatients	Rochester Outpatients
Demographics			
Sex (0 = male, 1 = female)	04	.01	− 09
Age	.03	10	− 02
Education	− 04	− 11	− 15
Parental Social Class	−.03	01	.01
Race (1 = Caucasian, 0 = Others)	−.06	−.13	.10
Never Married	− 07	.07	− 02
Married	.13	08	17
Diagnoses			
Schizophrenia	.01	00	17
Affective Disorder	− 05	07	− 11
Organic Brain Disorder	15*	− 07	08
Alcoholism	00	14	−.11
Mental Retardation	.06	20	.22*
Personality Disorder	−.06	−.07	− 13
Drug Abuse	− 03	− 13	−.08
Objective QOL Measures			
Current Length of Stay	− 01	.03	05
Frequency of Family Contacts (1 = none, 5 = daily)	− 09	10	−.05
Frequency of Social Relations (1 = none, 5 = daily)	.16**	21*	16
Leisure Activities (0 = none, 16 = maximum)	05	13	−.10
Currently Employed	.09	− 01	− 18
Hours Worked/Week	.47*** (*N* = 42)	22 (*N* = 27)	22 (*N* = 27)
Amount of Spending Money/Month	−.09	− 14	− 09
Assaulted/Past Year	− 23****	−.05	.00
Robbed/Past Year	− 20***	−.19	−.18
Frequency of Medical Care/Past Year	−.14*	00	− 30**
Subjective QOL Satisfaction Measures			
Living Situation	.45****	.42****	.45****
Family	37****	.46****	46****
Social Relations	58****	.56****	.54****
Leisure	.59****	44****	.56****
Finances	.40****	.35****	.39****
Safety	.42****	.50****	.33**
Work	16 (*N* = 61)	.48* (*N* = 26)	.28 (*N* = 25)
Health	.65****	.49****	.61****

*$p \leq .05$, **$p \leq .01$, ***$p \leq .001$, ****$p \leq$ 0001

This concordance of findings among existing studies is promising, but it may now be time to reflect upon the state of the art of these assessments and ask about their value and where we go from here. To sum up very broadly, the progress made during the past ten years in assessing QOL among the chronically mentally ill has moved us from an abstract interest in applying QOL theory in this population to the development of operational measures of QOL for the chronically mentally ill which are comparable to those that exist for the general population, the elderly, and the chronically physically ill (Andrews & Withey, 1976; Berg, Halluer, & Berk, 1976; Campbell et al., 1976; Evans et al., 1985; George & Bearon, 1980; Lawton, 1975; Najman & Levine, 1981). This progress now brings mental health services researchers face-to-face with some of the same issues and problems faced by other services researchers with regard to quality of life. What QOL measures should be used? What do QOL assessments tell us that other service assessment measures do not? Is it fair to apply broad QOL outcome criteria to health care and social service interventions, which may target more narrow outcomes? How can patient-derived QOL data be translated into policy and program changes and how ought these data be weighed in relation to other policy-relevant information, including expert opinion, com-

TABLE 5
STAGE-WISE MULTIPLE REGRESSION PREDICTION OF GENERAL LIFE SATISFACTION FOR PATIENT SUBGROUPS AND GENERAL POPULATIONS

	Predicted Variances (R^2) for Populations			
	Chronic Patient Groups			
Stage	Los Angeles	Rochester Inpatients	Rochester Outpatients	General Population[a]
Demographics	03	0	0	05– 11
Stage 1 + Diagnoses	04	04	09	NA
Stage 2 + Objective QOL Indicators	22	14	27	18
Stage 3 + Subjective QOL Indicators	57	40	49	.42– 61

[a] Data from Andrews Withey (1976, p 141) and Campbell et al (1976, pp 368, 374)

munity needs, and government priorities? Finally, can these assessments be of use to clinicians and other direct service providers in their day-to-day practice? Although much more work is needed to answer these questions, some comments and recommendations can be offered with regard to the chronically mentally ill on the basis of existing work.

What QOL measures should be used? The answer to this question depends, of course, upon what and how much one wants to know about QOL. The interview presented in this paper as well as the other instruments mentioned offer many options, ranging from very brief and global measures of life satisfaction to detailed assessments of QOL in multiple life areas. Our experience has been that many mental health services researchers are interested in the Quality of Life Interview, based upon requests for the interviews from around the United States, Canada, and Europe, and most of these researchers integrate subscales from the interview into their own survey instruments. This usage typifies how many assessment instruments are adapted for specific studies, but probably also reflects the continued lack of a definitive theory and method for assessing QOL among the chronically mentally ill. For the evaluator interested in a brief, global evaluation of QOL to broaden more program-specific or illness-related outcome information, the use of a general life satisfaction measure may be sufficient, as evidenced in some studies (Spivack, Siegel, Sklaver, Deuschle, & Garrett, 1982; Stein & Test, 1980). Others will want a more detailed QOL assessment, and the interview described here will provide this.

What do QOL assessments tell us that other service assessment measures do not? QOL assessments broaden program evaluations in two major ways. First, they tell us more about how patients are doing in various areas of their lives, areas beyond health specifically, but areas which may affect and be affected by health. Second, they tell us about these things from the patients' perspective.

But this raises another question: Is it appropriate and fair to apply broad QOL outcome criteria to health care and social service interventions? One can argue that, while quality of life is important, it is unrealistic to measure specific programs against such an encompassing concept, one that is not always well formed. In our opinion, there are valid concerns about the misapplication of QOL assessments. QOL assessments cannot take the place of disease-specific outcome measures nor of more detailed outcomes related to a specific intervention program. QOL measures are not typically health (or illness) status measures. Take for illustration the evaluation of a combined treatment program of antipsychotic medications and sheltered workshop for young adults with chronic mental illness. Such an evaluation should include assessments of symptom response to the medications and acquisition of the job skills taught in the workshop. Program success in these two areas warrants a positive evaluation. Addition of a QOL assessment, as outlined in this paper, would extend the evaluation to other areas of potential impact, but would not take the place of the first two outcomes. On the basis of an extended QOL assessment, we might find that patients in the program are more satisfied, not only with their work and psychological health, but also with their social relations and their finances due to the new friends made at the workshop and because of additional wages earned. Conversely, we may find unexpected negative effects, such as an increased risk of being victimized on the way to work or increased dissatisfaction with their living situation due to their improved mental functioning relative to other patients with whom they live. As discussed below, such findings should not necessarily form the basis for a negative program evaluation, but instead could lead to further service development and revisions that may offset the unexpected negative effects. For example, a van service to transport patients to and from work might reduce the victimization and increase patients' willingness to stay in the work program. The risk in using QOL assessments is that they may become confused with specific health-status measures and either be used in their stead or be equated with them. If this confusion can be avoided, QOL assessments can only add to program evaluations.

How can QOL data be translated into policy and program changes and how ought these data be weighed in relation to other policy-relevant information? Again, looking at what QOL assessments add to service evaluations provides some answers. First, QOL assessments tell us about how patients perceive their well-being and provide information about what they value and want. Particularly for the chronically mentally ill, but for most patient populations in general, such information currently is seldom available to decision-makers, who may assume either that mentally ill patients cannot provide such information reliably or that their judgments will be similar to the more readily accessible opinions of experts, concerned citizens, or government officials. The data presented in this paper as well as by others (Bigelow et al., 1982) argue against prior assumptions of patient unreliability. Also, the pitfalls of "expert" opinions about what the chronically mentally ill need have been well documented and might be improved with some input from patients (Allen, 1974; Hornstra, Lubin, Lewis, & Willis, 1972; Linn, Klett, & Caffey, 1980; Van Putten & Spar, 1979; Wasylenki, Goering, Lancee, Fisher, & Freeman, 1981; Weinstein, 1979). Second, the QOL concept does broaden concerns about the impact of policies and programs beyond narrower illness-related outcomes. This is appropriate in regard to planning of services for the chronically mentally ill (Schulberg & Bromet, 1981) and in fact reflects proposals at the federal level to integrate funding for services for the chronically mentally ill into a comprehensive psychiatric, social and support services program under a new social security title (Talbott & Sharfstein, 1986). Hence, methods for assessing impacts on QOL for the chronically mentally ill may be underrated as well as timely.

Finally, can QOL assessments be of more immediate use to clinicians and direct service providers on a day-to-day basis? Given their relative newness and rare application to date in clinical settings, this question eludes an answer at present. It may be argued that clinicians and other service providers make informal QOL assessments when they spend time "getting to know" the patient, learning what concerns him, what is important to him, the sources of gratification and dissatisfaction in his life. The underlying premise is that by knowing more about a person's particular perspective on himself, his life situation, and his illness, one can better serve him. With regard to the chronically mentally ill, the very few attempts to apply QOL assessment techniques clinically have focused on ascertainment of patients' priorities to guide the clinician in developing service plans or understanding how best to approach problems with patients. Malm, May, and Dencker (1981) recommended the use of a QOL checklist with schizophrenic patients as a guide for treatment planning and ongoing revision of therapeutic goals. Diamond (1985) provided case illustrations of the use of QOL assessments to monitor schizophrenic patients' responses to antipsychotic medications and to understand how individual patient priorities and preferences affect their attitudes toward the medications, their tolerance of side effects, and their acceptance or rejection of treatment. Finally, Liberman (personal communication) has proposed using QOL assessments as a prelude to individualized behavioral treatment programs for chronic mental patients. He hypothesizes that life areas of relative dissatisfaction may be the areas in which patients are most likely to be motivated to work for change. Conversely, efforts to effect change in life areas in which patients are relatively satisfied, no matter how objectively dysfunctional, may be frustrated due to the patients' lack of desire to change. Hence, we have some hints about how QOL assessments might be used clinically.

CONCLUSION

The eventual role that QOL assessment will play in the development and evaluation of policies and programs for the chronically mentally ill remains to be seen. The concept of QOL, both in planning and evaluation, fits current trends in thinking about the needs of the chronically mentally ill. Instruments, including the QOL Interview presented here, now exist to evaluate their QOL, although we may expect continued evolution of these measures as more mental health evaluators attempt to assess QOL. At this juncture, some form of QOL assessments are being employed in several longitudinal studies of treatment services for the chronically mentally ill. As these studies reach fruition, we will have a better idea of the value of QOL assessments in planning for our chronically mentally ill citizens.

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APPENDIX

EXAMPLES OF QUALITY OF LIFE INTERVIEW SCALES

Frequency of Social Contacts

About how often do you do the following things?
(Response options 5 = about daily, 4 = about weekly, 3 = about monthly, 2 = less than monthly, 1 = never).

1. Join with other residents in the house/hospital to play cards, games, or some other activity?
2. Try to make friends with other residents in the house/hospital?
3. Sit and talk with other residents?
4. Talk to a staff member?
5. Visit with someone not in this house/hospital?
6. Telephone someone not in this house/hospital?
7. Write a letter to someone?
8. Do something with another person that you planned ahead of time?
9. Spend time with someone you consider more than a friend like a boyfriend or girlfriend?
10. Spend time with close friends?

Satisfaction with Social Relations

How do you feel about:
(Response options 1 = terrible, 2 = unhappy, 3 = mostly dissatisfied, 4 = mixed, about equally satisfied and dissatisfied, 5 = mostly satisfied, 6 = pleased, 7 = delighted)

1. The things you do with other people?
2. The amount of time you spend with other people?
3. The people you see socially?
4. How you get along with other people in general?
5. The chance you have to know people with whom you can really feel comfortable?
6. The amount of friendship in your life?
7. The amount of love in your life?
8. Your sex life?

Quantity of Leisure Activities

Which of the things listed in this sheet have you done during the *past week*?
Please say "Yes" or "No "

1. went for a walk
2. went to a movie or play
3. watched TV
4. went shopping
5. went to a restaurant or coffee shop
6. went to a bar
7. read a book, magazine, or newspaper

8 listened to a radio
9 played cards
10 went for a ride in a bus or car
11 prepared a meal
12 worked on a hobby
13 played a sport
14 went to a meeting or some organization or social group
15 went to a park
16 went to a library

Satisfaction with Leisure Activities

How do you feel about
(Response options. 1 = terrible, 2 = unhappy, 3 = mostly dissatisfied, 4 = mixed, about equally satisfied and dissatisfied, 5 = mostly satisfied, 6 = pleased, 7 = delighted)

1 The way you spend your spare time?
2 The amount of time you have to do the things you want to do?
3 The chance you have to enjoy pleasant or beautiful things?
4 The amount of fun you have?
5 The amount of relaxation in your life?
6 The pleasure you get from the TV or radio?