Quality of Life Assessment Project

QUALITY OF LIFE ASSESSMENT MANUAL

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Preface

Quality of life (QoL) is fast becoming a standard measure of outcomes in clinical trials, cost effectiveness analysis and clinical practice. A confluence of forces including rising health care costs, concern over reported poor QoL of psychiatric patients living in the community and an awakening recognition that customary measures of treatment measures are inadequate has focused attention on the need to measure and improve QoL for persons with mental illness. Unfortunately, methods for combining clinical data with client perceptions and goals for improvement with treatment are not standardized. In addition, there are likely to be differences about the relative importance of different domains. Clinicians, families and the clients themselves may have a very different view of the client's QoL and the important goals of therapy. Quality of life is a subjective construct which varies with the population studied. It is generally conceptualized as a multi-dimensional construct made up of a number of independent domains including physical health, psychological well-being, social relationships, functional roles and subjective sense of life satisfaction. Each QoL domain can be assessed from the point of view of the clinician, client or caregiver, and the relative weighting of the importance of each domain can also vary from one observer to another.

This Quality of Life Assessment Manual is an introduction to seven QoL assessment measures developed by the Quality of Life Assessment Project at the University of Wisconsin - Madison. The manual provides an overview of QoL assessment for three distinct groups including families, older adults and adults with serious mental illness. This document also describes the conceptual framework for the instruments and illustrates some of the ways that outcome data may be presented and used. The instruments presented here embody a multi-disciplinary approach to outcomes and present the work of a diverse team of researchers from the University of Wisconsin - Madison including:

Principal Investigator
Marion A. Becker, Ph.D., RN — *Social Work, Nursing & Gerontology*

Co-Principal Investigator
Ronald Diamond, MD — *Psychiatry*

Co-Investigators
Francois Sainfort, Ph.D. — *Industrual Engineering*
Jeffery Douglas, Ph.D. — *Biostatistics*

Research Assistants
Eric Grodsky, M.A. — *Sociology*
Bret R. Shaw, M.A. — *Journalism and Mass Communication*
Lisa M. Reib — *Journalism and Mass Communication*

Historical Context

The Quality of Life Assessment Tools provided in this manual were developed for clinical and research use. The first Wisconsin Quality of Life Index (W-QLI) was developed for use in mental health in response to a need to provide appropriate information in the Wisconsin Medicaid Program for reauthorization of clozaril. Clozaril was then a new and expensive antipsychotic medication. At the time of development, outcomes in psychiatric patients were being measured predominantly in terms of symptoms. In fact, the Medicaid programs in 30 of 50 states in America were using a symptom improvement criteria for reauthorization of the drug under Medicaid reimbursement. Most were using a

20 percent symptom improvement criteria based on outcome measured with the Brief Psychiatric Rating Scale.[1] When clozaril was approved for use, the field lacked an inexpensive, easy-to-use, comprehensive QoL assessment tool for use in busy mental health settings.

Our primary objective was to develop an inexpensive, easy-to-use, self-report and self-administered instrument that would reflect consumer values and goals for improvement with treatment. An advisory board was convened to guide the scale development and ensure that consumer needs were incorporated. We realized that the clinical and practical usefulness of an assessment instrument would be key to its successful adoption and use in the field. Thus, we developed an instrument that could be used to assess patient status, and that could also be used for monitoring and evaluating patient outcomes over time. Important features of all QoL instruments developed by the principal investigator are their dimensionality, inclusion of consumer goals, and provisions for multiple respondents. Descriptions of the index domains and underlying conceptual frameworks are provided in subsequent sections of this manual. The multi-dimensional conceptual model for the W-QLI is found on page 5.

The Wisconsin Quality of Life Index

The Wisconsin Quality of Life Index (W-QLI) for use in mental health has been made available to investigators in community settings, academia and the pharmaceutical industry. In exchange for early access to the W-QLI, anonymous data sets have been provided to the developers for psychometric evaluation. Early application studies were primarily conducted in community support programs (CSP's). However, the W-QLI has also been used in hospital settings, clinical trials, a private doctor's office, and mental health care units of health maintenance organizations.

Studies currently in the field in the United States focus primarily on persons with chronic mental illness. The majority of responders have carried a diagnosis of schizophrenia, although the W-QLI has also been used in a populations of persons with borderline personality disorder and with major affective disorder. The W-QLI has been used for program evaluation as well as for the purpose of comparing outcomes of different service models (i.e. a Program for Assertive Community Treatment (PACT) and a Fountain House Model Program).

Validation of the Instruments

The W-QLI index was field tested for clients and providers by using local mental health providers known to the authors. Results of the initial validation work have been reported in detail elsewhere.[2] In order to ensure content and face validity of the W-QLI, we based the conceptual framework and the development of the instrument on a comprehensive model of QoL that includes multiple dimensions as well as multiple perspectives on the client's QoL. Furthermore, both consumers and professionals considered to have expertise and extensive experience with persons suffering from severe and persistent mental illness were involved in the development, definition and choice of items and/or scales to be included to represent these multiple dimensions of life quality. Finally, to the extent possible, existing valid scales were chosen to capture some aspects of the various domains and dimensions of QoL.

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[1] See *The brief psychiatric rating scale*, (p. 799-812) by J. Overall, D. Gorham, 1962, Psychological Report, Vol 10.

[2] See *A new patient focused index for measuing quality of life in persons with severe and persistent mental illness*, (p. 239-251) by M. Becker, R. Diamond, F. Sainfort, 1993, Quality of Life Research, Vol 2.

The Quality of Life Index for Older Adults and the Family Quality of Life Index are newer instruments in their initial stages of evaluation. They are designed to follow the conceptual framework of the W-QLI.

Cultural Translations

The W-QLI has been culturally adapted/translated and harmonized for use in 12 countries using accepted international guidelines. Available translations include Afrikaans, Australian, Austrian, Canadian, Canadian French, Dutch, English, Finnish, French, German, Hebrew, Italian, Japanese Portuguese and Spanish. Efforts are currently underway in Canada, Italy and Spain to collect general population norms for the W-QLI.

Cultural Adaptation Methodology:

Cultural adaptation of the W-QLI was funded by in part by Janssen Research Foundation. Janssen wished to use the W-QLI to assess QoL of individuals suffering from schizophrenia. They contracted with Mapi Values in Lyon, France, who directed the work of the cultural adaptation using the following methodology:

- Recruitment of a QoL specialist as project manager in each of the countries involved.

- Production of two independent forward translations of the original questionnaire by two independent professional translators, native speakers of the target language and bilingual in the source language.

- A meeting between the forward translator(s) and the project manager to compare both forward translations and to establish a reconciled version.

- Production of a backward translation of the reconciled forward translation into the source language by one professional translator, native speaker of the source language and bilingual in the target audience.

- A meeting between the backward translator and the local project manager to compare the backward translation and the original, discuss discrepancies and possibly modify the reconciled translation into the target language. Discussion of the discrepancies between the back translation and original source questionnaire between the local project manager and Mapi Research Institute and agreement on the changes to be made to the reconciled translation.

- Cognitive Debriefing: the test of the target language translation established in the light of the backward translation, is usually carried out on five patients suffering from the condition being investigated and native target language speakers. However, due to the complex nature of schizophrenia and the effect that this condition has on patients who suffer from it, it was decided to recruit three healthy subjects and two subjects suffering from schizophrenia. This form of recruitment allowed for a more subjective assessment of the clarity, appropriateness and acceptability of the translated questionnaire, which was followed by integration of the results into the reconciled translation.

- An international harmonization meeting during which the translations, modified according to the outcome of the cognitive debriefing, were compared to all the other translations as well as the original in order to ensure conceptual equivalence throughout all versions.

- Establishment of a final version in the target languages according to the outcome of international harmonization.

- Revision of the lay-out to facilitate completion of the questionnaire. This was done in collaboration with Janssen Research Foundation and submitted to Marion Becker for approval.

Introduction to Coding and Scoring

This section provides an overview of the general steps to accomplish before coding, data entering and scoring the QoL questionnaires covered in this manual.

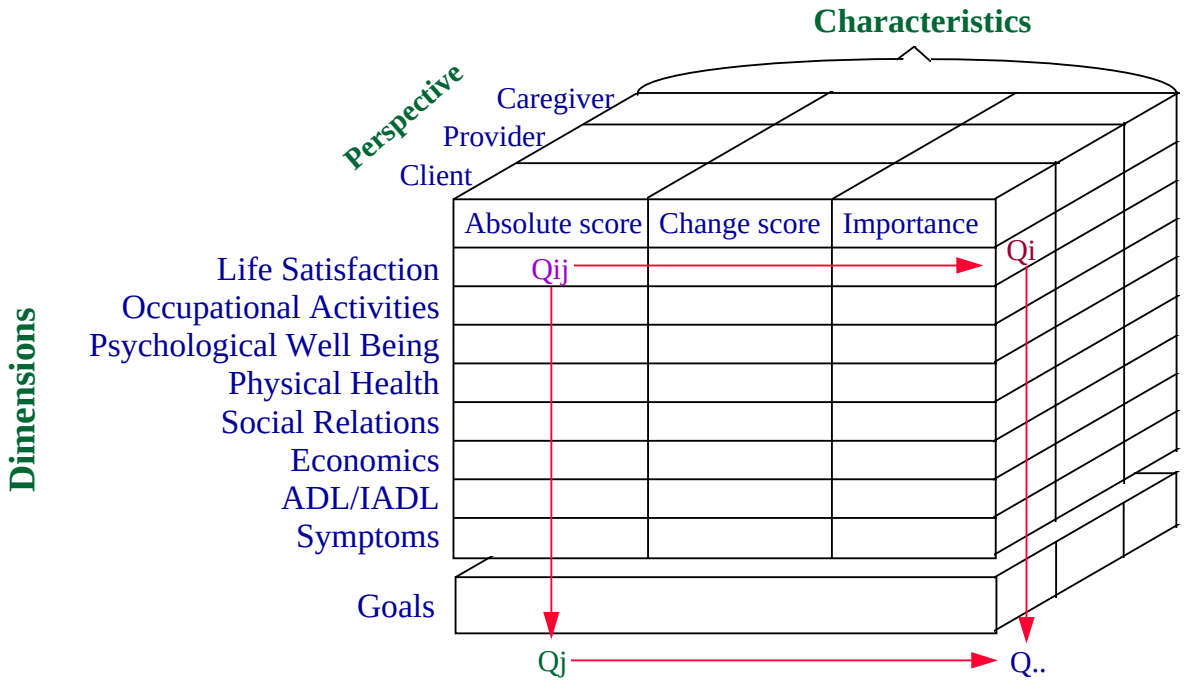
Whenever possible the questionnaire completion process should be supervised. Clients should be assisted to complete the self-report, self administered information requested and the questionnaires should be reviewed for completeness when they are returned. If the questionnaire has been administered as an interview, the client's choices and goals should be recorded verbatim and the interviewer should not influence the responders answer.

Performing Scoring Checks. Determine the completeness of the scale scoring. In general, we recommend that scale scores not be calculated if half or more of the scale items are missing. Compute raw scale scores according to the calculations provided in the coding and scoring directions for the scale used. Coding books are available from the principle investigator upon request. Outcome scores and information can be used in a variety of ways. On the following pages, we provide examples of ways to display and use the data for individual and clinical use. We continue to work on the development of optimal ways to format the data.

In collaboration with Alvan R. Feinstein, MD, we have developed a taxonomy for evaluating the goals domain. This taxonomy which appears on page 7 is used to categorize the goals. The taxonomic number can be used to analyze goals by responder type (i.e. client, clinician or caregiver) and across clinical settings.

Wisconsin Quality of Life Index

Multi-Dimensional Conceptual Model for Evaluating Quality of Life



Qij = Evalutaion of a particular dimension with respect to a particular characteristic.
Qi = Evaluation of dimension across characteristics.
Qj = Evaluation across dimensions.
Q.. = Evaluation of Quality of Life as a whole (perceived QoL)

Example of Individual Level Data Presentation
Looking at Client's Quality of Life from Client and Provider Perspectives

Examples of Client Questionnaire Aggregate Data Presentation

for Use in Clinical and Program Evaluation

Aggregate Data for Assertive Community Treatment Program					
	Mean	Std. Dev.	Minimum	Maximum	N
General Satisfaction	1.00	1.12	-1.78	2.89	59
Occupational Activities	.76	1.66	-3.00	3.00	58
Activities of Daily Living	1.84	1.03	-1.67	3.00	57
Psychological Well-Being	.38	1.45	-2.70	3.00	59
Symptoms/Outlook	1.45	1.11	-1.50	3.00	51
Physical Health	.38	1.45	-2.70	3.00	59
Social Relations / Support	1.15	1.26	-2.60	3.00	58
Money	.10	1.68	-3.00	3.00	57
Quality of Life Score	.75	.96	-1.28	2.33	47
Weighted Quality of Life Score	.70	.98	-1.31	2.41	43

Aggregate Data for Self-Help Day Program					
	Mean	Std. Dev.	Minimum	Maximum	N
General Satisfaction	.78	1.19	-2.00	3.00	48
Occupational Activities	.66	1.47	-1.67	3.00	45
Activities of Daily Living	2.12	.78	.00	3.00	43
Psychological Well-Being	.47	1.30	-1.95	3.00	46
Symptoms/Outlook	1.55	.97	-.30	3.00	46
Physical Health	-.14	1.59	-3.00	3.00	46
Social Relations / Support	.84	1.44	-2.17	3.00	49
Money	-.14	1.69	-3.00	3.00	39
Quality of Life Score	.80	.85	-.71	2.33	29
Weighted Quality of Life Score	.77	.84	-.71	2.33	28

Data can also be presented in aggregate form and used to compare the outcome of clients in different programs or to compare outcomes of different populations. For example, the above data provides a basis of comparison for outcomes between two programs. The top table contains data from a Program for Assertive Community Treatment (PACT) and the bottom table contains data from a self-help day program. The W-QLI project team has begun to investigate a number of questions using the W-QLI to examine outcomes for different populations including persons with and without co-occurring serious substance abuse problems and persons with and without hope for the future.

Outline of Categories: Taxonomy of Treatment Goals for Improvement of Persons with Schizophrenia Proposed by Clients, Clinicians, and Families

1. Control of Disease

1.1 Manifestation of Illness

1.1.1. Cardinal Manifestations of Schizophrenia
- 1.1.1.1 Thought Disorders
- 1.1.1.2 Auditory Hallucinations

1.1.2. Mental Stability
- 1.1.2.1. Achieve Mental Stability
- 1.1.2.2. Maintain Stability

1.1.3. General Manifestations
- 1.1.3.1. Aggression & Anxiety
- 1.1.3.2. General Mental Health
- 1.1.3.3. "Be on Level Keel"

1.1.4. Co-morbidity
- 1.1.4.1. Alcoholism
- 1.1.4.2. Substance Abuse

1.2 Therapy

1.2.1 Regulation of Medication
1.2.2. Compliance
1.2.3. Other (e.g. day treatment)

1.3 Side Effects of Therapy

1.3.1. Tardive Dyskinesia
1.3.2. Parkinsonism

2. Personal Status

2.1 Self Care

2.1.1. ADL
2.1.2. Other (e.g. coping skills)
2.1.3. Gain or lose weight

2.2 Independence

2.2.1. Domiciliary Issues
- 2.2.1.1. Deinstitutionalization
- 2.2.1.1. Domiciliary Independence

2.2.2. Finances
2.2.3. Occupation
2.2.4. Education
2.2.5. General Function

2.3 Sense of Well Being

2.3.1. "Improve Self-Esteem"
2.3.2. "Be Happier"

3. Interpersonal Status

3.1 Family Relationships
- 3.1.1. Parent(s)
- 3.1.2. Spouse
- 3.1.2. Child(ren)

3.2 Non-Family Relationships
- 3.2.1. Personal Relationships and Friends
- 3.2.2. Relationships at Work

3.3. Social Functioning
- 3.3.1. Social Interaction
- 3.3.2. Social Independence

4. Cargiver Relief

4.1 Less Dependence on Parent(s)
4.2 Less Dependence on Spouse/Partner
4.3 Less Dependence on Paid Providers

5. Other Treatment Goals

5.1 "A Place of Healing"
5.2 "Maintaining Hope for Future"

WISCONSIN QUALITY OF LIFE INDEX

CLIENT QUESTIONNAIRE

CONCEPTUAL FRAMEWORK

The Wisconsin Quality of Life Index (W-QLI) Client Questionnaire is a comprehensive multi-dimensional measurement tool that reflects the personal priorities and goals of individual mental health clients. On the basis of previous research, our clinical experience, and recommendations from an advisory board convened to develop the index, we defined QoL as made up of the following nine domains: 1) general life satisfaction, 2) activities and occupations, 3) psychological well-being, 4) physical health, 5) social relations/support, 6) economics, 7) activities of daily living, 8) symptoms, and 9) goal attainment. Each domain can be individually weighted depending on its relative importance to the patient. While this instrument can be used by itself, it is meant to be used in conjunction with two other instruments that measure patient QoL from the provider and caregiver perspectives. The Wisconsin Quality of Life Index Client Questionnaire was designed to be self-administered though clients can be assisted if necessary.

DOMAINS

General Satisfaction Level

This domain measures the client's overall life satisfaction about a broad array of issues such as satisfaction with their living environment, housing, food, clothing, and mental health services. Each indicator is also rated for importance, and the score for each item is determined by multiplying each patient's satisfaction response with the importance response.

Activities and Occupations

These questions focus on the client's day-to-day activities related to work, school or day programming. Other items in this domain relate to client's capacity to work in his/her usual manner and how satisfied they are with the way they spend their time.

Psychological Well-Being

Among other things, this domain uses the well-validated Bradburn Affect Balance Scale (ABS) to measure the client's sense of emotional well-being[3]. The ABS is a widely used and well validated scale that has been used by other researchers attempting to operationalize and study psychological well-being. The ABS includes separate assessments of negative and positive affect. This domain also includes a global question asking the client to rate their overall mental health during the past four weeks.

Symptoms/Outlook

Questions in this domain focus on client's mental health and subjective assessments of how his/her mental health symptoms affect their QoL and functional abilities. This domain also contains two questions that assess client's propensity toward harming themselves or others.

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[3] See *The structure of psychological well-being,*by N.M. Brandburn, 1969, Chicago: Aldine.

Physical Health
This domain measures the client's perceptions about his/her physical health. For example, the client is asked to rate his/her physical health during the past four weeks on a 5 point scale from poor to excellent. Another question asks respondents about how satisfied they are with their physical health.

Social Relations/Support
These questions measure the client's social relations and social skills -- an area considered essential to the determination of clients' QoL. The domain includes the International Pilot Study of Schizophrenia (IPSS) outcomes scale related to frequency and type of social contact. In addition, clients are asked to rate the amount of support they experience from their relationships and also their satisfaction with social relations.

Money
This section focuses on the economic aspects of the client's QoL. Domain questions ask about the adequacy of client's financial support and about his/her satisfaction with the amount of control he/she has over those financial resources. These indicators are also rated for importance by the client. This domain also includes a question asking the client how often lack of money prevents him/her from doing what he/she wants to do.

Activities of Daily Living (ADL)
This domain measures the client's functional status in accomplishing independent living tasks such as preparing meals, doing laundry, running errands or practicing adequate personal hygiene.

Goal Attainment
This section focuses on the client's personal mental health treatment goals. Clients are asked to specify three of the most important goals he/she hopes to accomplish as part of their treatment. Goals are ranked both in terms of their relative importance to the client as well as the extent to which the responder feels each goal has been achieved.

Other Analyses of Interest in the W-QLI Client Questionnaire
The W-QLI Client Questionnaire contains a number of items that do not load in any specific domains in the total QoL score but which are valuable in both an applied or theoretical context. Examples include:

Alcohol & Other Drugs
These questions can be used in clinical and program evaluations to stratify populations based on whether or not they use alcohol or drugs and the extent to which clients perceive their drug or alcohol use to be a problem in their lives. These questions allow clinicians and program evaluators to examine differences in QoL and program effectiveness for clients with and without AODA problems. These questions can also be used to compare the degree to which there is congruence between client and provider about whether AODA issues are a problem in the client's life.

Hope
This question (Q5) provides the opportunity to examine the role of hope in overall QoL and how treatment outcomes vary depending on differing levels of hope.

Locus of Control

This question (Q6) provides the opportunity to examine how differences in clients' sense of control impacts treatment outcomes and overall life quality.

Internal Consistency for Domains in Client Questionnaire	
Domains	**Cronbach's Alpha**
Social Relations / Support	.7585
Money / Economics	.6854
Activities of Daily Living	.6697
Occupational Activities	.9343
Psychological Well Being	.7938
Symptoms	.7707
Physical Health	.7446
Life Satisfaction	.8250

Wisconsin Quality of Life Client Questionnaire

Wisconsin Quality of Life Associates
University of Wisconsin - Madison

Your Name:_____ ID #: _____

Date of Completion: ___/___/___ Location: _____

Directions: We are interested in your views and feelings. The questions in this booklet ask for your opinions about the quality of your life. When you answer each question please indicate the response which most closely reflects your opinion.

You are the person who knows best how you feel about these questions. If you would like someone to help you in filling out this questionnaire, and a friend or family member is not available, please contact a staff member to assist you.

Note: if this form was filled out by someone other than you, please

indicate who helped: _____

Relationship to you: _____

BACKGROUND INFORMATION

What is your date of birth? _____

You are? __ Male __ Female

What is your highest school grade completed: _____

What is your current relationship/marital status?

- ☐ Single/Never Married
- ☐ Married
- ☐ Divorced
- ☐ Committed relationship
- ☐ Separated
- ☐ Spouse deceased

How many times have you been married?_ _____

What is the source of your income? (Check all that apply)

- ☐ Paid employment
- ☐ Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)
- ☐ Veterans disability or pension benefits
- ☐ General assistance
- ☐ AFDC
- ☐ Unemployment compensation
- ☐ Retirement, investment or savings
- ☐ Alimony or child support
- ☐ Money shared by your spouse/partner
- ☐ Money from your family
- ☐ Other source: _____

What is your racial/ethnic background? (Check all that apply)

- ☐ American Indian/Native American
- ☐ Asian
- ☐ African American
- ☐ Hispanic/Latino
- ☐ White
- ☐ Other, specify: _____

During the past four weeks, you lived: (Check all that apply)

- ☐ alone
- ☐ with roommate/friend
- ☐ with children
- ☐ with parents
- ☐ with significant other/spouse
- ☐ with other, please specify: _____

Who would you like to live with? (Check all that apply)

- ☐ alone
- ☐ friend/roommate
- ☐ with children
- ☐ with parents
- ☐ with significant other/spouse
- ☐ with other, please specify: _____

During the past four weeks, you lived primarily: (Check one)

- ☐ in an apartment/home
- ☐ in a boarding home
- ☐ in an group home or halfway house
- ☐ homeless
- ☐ at school/college
- ☐ in an institution (i.e. hospital or nursing home)
- ☐ in jail/prison
- ☐ other, please specify:_____

Where would you like to live? (Choose one)

- ☐ in an apartment/home
- ☐ in a boarding home
- ☐ in an group home or halfway house
- ☐ at school/college
- ☐ in an institution (i.e. hospital or nursing home)
- ☐ in jail/prison

 homeless other, please specify:_____

SATISFACTION LEVEL							
	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the way you spend your time?							
How satisfied or dissatisfied are you when you are alone?							
How satisfied or dissatisfied are you with your housing?							
How satisfied or dissatisfied are you with your neighborhood as a place to live in?							
How satisfied or dissatisfied are you with the food you eat?							
How satisfied or dissatisfied are you with the clothing you wear?							
How satisfied or dissatisfied are you with the mental health services you use?							
How satisfied or dissatisfied are you with your access to transportation?							
How satisfied or dissatisfied are you with your sex life?							
How satisfied or dissatisfied are you with your personal safety?							

We have asked how satisfied you are with different parts of your life. Now we would like to know how important each of these aspects of your life are.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important to you is the way you spend your time?					
How important is it to feel comfortable when alone?					

How important is your housing?	□	□	□	□	□
How important is your neighborhood as a place to live in?	□	□	□	□	□
How important to you is the food you eat?	□	□	□	□	□
How important to you is the clothing you wear?	□	□	□	□	□
How important to you are the mental health services you use?	□	□	□	□	□
How important to you is your access to transportation?	□	□	□	□	□
How important to you is your sex life?	□	□	□	□	□
How important to you is your personal safety?	□	□	□	□	□

ACTIVITIES AND OCCUPATIONS

During the **past four weeks**, you have: (Check one)

- □ been working/studying or doing housework in your usual manner
- □ been working/studying or doing housework but less often
- □ stopped working/studying or doing housework

About how many hours a week do you work or go to school? Hours per week = _____

What is your main activity? (Check one).

- □ Paid employment
- □ Volunteer or unpaid work
- □ School
- □ Treatment/rehabilitation program
- □ Craft/leisure time/hobbies
- □ No structured activity
- □ Other, Please Specify _____

How satisfied or dissatisfied are you with the main activitity that you do? (Check one)

□ Very dissatisfied	□ Moderately dissatisfied	□ A little dissatisfied	□ Neither satisfied or dissatisfied	□ A little satisfied	□ Moderately satisfied	□ Very satisfied

Do you feel that you are engaged in activities: (Choose one)

- □ Less than you would like
- □ More than you would like
- □ As much as you want

What would you like to have as your main activity?

- □ Paid employment
- □ Volunteer or unpaid work
- □ School
- □ Treatment/rehabilitation program
- □ Craft/leisure time/hobbies
- □ No structured activity
- □ Other, Please Specify _____

PSYCHOLOGICAL WELL-BEING

Now we would like to know how you feel about things in your life. For each of the following questions, check the boxes that best describe how you have felt in the **past four weeks**.

YES	NO	

□	□	Pleased about having accomplished something?
□	□	Very lonely or remote from other people?
□	□	Bored?
□	□	That things went your way?
□	□	So restless that you couldn't sit long in a chair?
□	□	Proud because someone complimented you on something you had done?
□	□	Upset because someone criticized you?
□	□	Particularly excited or interested in something?
□	□	Depressed or very unhappy?
□	□	On top of the world?

In the **past four weeks**, would you say that your mental health has been:

□ Poor □ Fair □ Good □ Very Good □ Excellent

SYMPTOMS/OUTLOOK

During the **past four weeks**, you have: (Check one)

□ generally felt calm and positive in outlook

□ been having some periods of anxiety or depression

□ generally been confused, frightened, anxious or depressed

.....

There are many aspects of emotional distress including feelings of depression, anxiety, hearing voices, etc. In the **past four weeks**, how much distress have these symptoms caused you?: (Check one)

□ Not at all □ A little □ Some □ A moderate amount □ A lot

In the **past four weeks**:	Never	Occa-sionally	Frequen tly	Most of the time	Constan tly
How much has feelings of depression, anxiety, etc. interfered with your daily life?	□	□	□	□	□
Have you felt like killing yourself?	□	□	□	□	□
Have you felt like harming others?	□	□	□	□	□

PHYSICAL HEALTH

In the **past four weeks**, you would best describe your physical health as:

□ Poor □ Fair □ Good □ Very Good □ Excellent

.....

How do you feel about your physical health? (Check one)

□ Very dissatisf ied	□ Moderat ely dissatisf ied	□ A little dissatisf ied	□ Neither satisfied or dissatisf ied	□ A little satisfied	□ Moderat ely satisfied	□ Very satisfied

.....

How important to you is your physical health? (Check one)

Not at all important	Slightly important	Moderately important	Very important	Extremely important

Are you currently taking psychiatric medications? Yes No (If no, go to next page)

If you are currently taking psychiatric medications, do you take them as prescribed? (Check one)

Never Sometimes Always
Very infrequently Quite often

If you are currently taking psychiatric medications, do you have side effects from them?

None Slight Mild Moderate Severe

If you take medications for mental health problems, do you feel the medication helps control your symptoms?

Not at all Some A fair amount Quite a bit Eliminates all symptoms

How do you feel about taking your psychiatric medications?

Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied

ALCOHOL & OTHER DRUGS

Over the **past four weeks**, have you drank any alcohol?

Yes No

If yes, on how many days have you had any alcohol to drink?_____
(number of days)

What do you think about your alcohol use? (Check one)

It is a big problem Not a problem It helps a lot
It is a minor problem It helps a little

Over the **past four weeks**, have you used any street drugs (cocaine, marijuana, heroin, speed, LSD, etc.)?

Yes No

If yes, on how many days have you used any street drugs? _____
(number of days)

What do you think about your drug use? (Check one)

It is a big problem Not a problem It helps a lot
It is a minor problem It helps a little

SOCIAL RELATIONS / SUPPORT

	Very dissatisfied	Moderately dissatisf	A little dissatisfied	Neither satisfied or dissatisf	A little satisfied	Moderately satisfied	Very satisfied

		ied		ied			
How satisfied or dissatisfied are you with the number of friends you have? **No friends**							
How satisfied or dissatisfied are you with how you get along with your friends?							
How satisfied or dissatisfied are you with your relationship with your family? **No family**							
If you live with others, how satisfied or dissatisfied are you with the people you live? **Live alone**							
How satisfied or dissatisfied are you with how you get along with other people?							
How many people do you count as your friends?	none	1-2	3-5	over 5			

IMPORTANCE LEVEL					
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important is it to have an adequate number of friends?					
How important is it to get along with your friends?					
How important are family relationships?					
If you live with others, how important are the people with whom you live?					
How important is it to get along with others?					

During the **past four weeks**, you have (check one):

- been having good relationships with others and receiving support from family and friends
- been receiving only moderate support from family and friends
- had infrequent support from family and friends or only when absolutely necessary

MONEY

Are you paid for working or attending school? □ Yes □ No

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How do you feel about the amount of money you have?	□	□	□	□	□	□	□
How satisfied are you about the amount of control you have over your money?	□	□	□	□	□	□	□

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important to you is money?	□	□	□	□	□
How important is it to you to have control over your money?	□	□	□	□	□

How often does lack of money keep you from doing what you want to do?

□ Never □ Sometimes □ Frequently □ Almost always

ACTIVITIES OF DAILY LIVING

Below are activities that you may have participated in recently. Please check YES or NO to indicate whether you have done the activity in the **past four weeks**.

	YES	NO		YES	NO
Gone to a restaurant or coffee shop	□	□	Gone shopping	□	□
Gone for a ride in a bus or car	□	□	Prepared a meal	□	□
Cleaned the room/apartment/home	□	□	Done the laundry	□	□

During the **past four weeks** you:

□ have been able to do most things on your own (such as shopping, getting around town, etc.)

□ have needed some help in getting things done

□ have had trouble getting tasks done, even with help

In the **past four weeks**, how often have you had any problems with personal grooming (e.g. taking showers, brushing your teeth)? □ Never □ Sometimes □ Frequently □ Almost always

GOAL ATTAINMENT

What did you hope to accomplish as a result of your mental health treatment? Please write below up to 3 goals:

Goal 1: _____

How important is this goal to you? Please check the box below to indicate how important this goal is to you. *(NR = No Response)*

Not at all important	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	**Extremely Important**	☐ NR

To what extent have you achieved this goal? Please check the box below to indicate the extent to which you have achieved this goal.

Not at all achieved	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	**Completely achieved**	☐ NR

Goal 2: _____

How important is this goal to you?

Not at all important	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	**Extremely Important**	☐ NR

To what extent have you achieved this goal?

Not at all achieved	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	**Completely achieved**	☐ NR

Goal 3: _____

How important is this goal to you?

Not at all important	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	**Extremely Important**	☐ NR

To what extent have you achieved this goal?

Not at all achieved	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	**Completely achieved**	☐ NR

Below are activities that you may have participated in recently. Please check Yes or No to indicate whether you have done the activity in the **past four weeks**.

	YES	NO		YES	NO
Gone for a walk	☐	☐	Gone to a social group	☐	☐
Gone to a movie or play	☐	☐	Read a magazine or newspaper	☐	☐
Watched TV	☐	☐	Gone to church, synagogue, mosque	☐	☐
Played cards	☐	☐	Listened to a radio	☐	☐
Played a sport	☐	☐	Gone to a library	☐	☐

Please check the box below to indicate how you feel about your quality of life during the **past four weeks.**
Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

LOWEST QUALITY	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	**HIGHEST QUALITY**

If your quality of life is less than you hope for, how hopeful are you that you will eventually achieve your desired quality of life? (Check one)

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very

How much control do you feel you have over the important areas of your life? (Check one)

 None Some A moderate amount A great amount

How important are each of the following factors in determining your quality of life?	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Work, school or other occupational activities					
Your feelings about yourself					
Your physical health					
Friends, family, people you spend time with					
Having enough money					
Ability to take care of yourself					
Your mental health					
Other, please specify:					

Is there anything else you would like us to know?

This is the end of the questionnaire. Thank you for giving your opinion and sharing your responses with us. If you have any questions about this questionnaire, please call or write Marion Becker, Ph.D., University of South Florida, Department of Community Mental Health, 13301 Bruce B. Downs Blvd., MHC 1423, Tampa, Florida 33612-3899 Telephone: (813)974-7188 Fax: (813)974-6469 E-Mail: .becker@fmhi.usf.edu

WISCONSIN QUALITY OF LIFE INDEX (W-QLI)
PROVIDER QUESTIONNAIRE

CONCEPTUAL FRAMEWORK

The Wisconsin Quality of Life Index (W-QLI) Provider Questionnaire is a comprehensive multi-dimensional measurement tool that reflects the clinician's perspective on the client's QoL and functional status. On the basis of previous research, our clinical experience, and recommendations from an advisory board convened to develop the index, we provide eight domains for clinicians to evaluate their clients. These include: 1) occupational activities, 2) psychological well being, 3) physical health, 4) social relations/support, 5) economics, 6) activities of daily living, 7) symptoms/outlook, and 8) goal attainment. In calculating the total QoL score, each domain can be individually weighted depending on how important the clinician thinks the domain is to the client. This instrument is especially helpful for discovering whether the clinician and client are in concordance about treatment goals and the relative importance of different QoL domains. While this instrument can be used by itself, it is designed to be used in conjunction with another instrument that measures the client's QoL from his/her perspective. There is a third form in the Wisconsin Quality of Life Index which measures the client's QoL from a family member or significant other's point of view. The Caregiver Questionnaire of the Wisconsin Quality of Life Index can also be used to assess attitudes from family and friends toward the assistance they provide to clients and is further described on page 28.

DOMAINS

Occupational Activities
This domain focuses on the client's capacity for performing day-to-day activities related to work or other structured activities. Other questions in this domain relate to patients' capacity to work in their usual manner and the extent to which the clinician believes the client is capable for employment.

Psychological Health
These questions ask about the clinician's overall rating of the client's psychological health.

Physical Health
This domain measures client's physical health from the clinician's point of view. Questions ask about the client's overall physical health as well as side effects from any antipsychotic medications.

Social Relations/Support
Questions in this section ask the clinician to measure the client's social relations and social skills, including experiences with friends, family and other social interaction in the community.

Economics
These questions asks the clinician to rate the client's satisfaction with the amount of money he/she has and the degree to which financial limitations restrain the client from doing what he/she wants.

Activities of Daily Living (ADL)
This domain measures the client's functional status in accomplishing independent living tasks such as maintaining a healthy diet, self-administering medications, following a budget and practicing adequate personal hygiene from the clinician's perspective.

Symptoms / Outlook
This section uses the 24-item Brief Psychiatric Rating Scale (BPRS) developed by Overall and Gorgam to measure clients' level of symtomatology.

Goal Attainment
This section contains questions that ask about the clinician's mental health treatment goals for their client. Clinicians are asked to specify the three most important mental health treatment goals for the client. Goals are ranked both in terms of their relative importance to the clinician as well as the extent to which the responder feels that the listed treatment goals have been achieved.

Other Analyses of Interest in the W-QLI Provider Questionnaire

The W-QLI Provider Questionnaire contains a number of items that do not load in any specific domains in the total QoL score but which are valuable in both an applied or theoretical context. Examples include but are not limited to:

Alcohol & Other Drugs

These questions can be used in clinical and program evaluations to stratify populations based on whether or not they use alcohol or drugs and the extent to which clinicians perceive that drug or alcohol use is a problem in their clients' lives. These questions allow clinicians and program evaluators to examine differences in QoL and program effectiveness for clients with and without AODA problems. These questions can also be used to compare the degree to which there is congruence between clinician and client about whether AODA issues are a problem in the clients' life.

Medication

There are a number of questions which can be used to measure how medication effectiveness, side effects and compliance can affect treatment outcomes at the individual and group level. For example, question (X3) provides the opportunity to examine the role of medicine compliance in QoL and how treatment outcomes vary depending on differing levels of compliance.

Internal Consistency for Domains in Provider Questionnaire	
Domain	**Cronbach's Alpha**
Activities of Daily Living	.8371
Money / Economics	.6907
Social Relations / Support	.6994
Symptoms	.8536

Wisconsin Quality of Life Provider Questionnaire

Wisconsin Quality of Life Associates
University of Wisconsin - Madison

Client Name: _____ Client ID #: _____

Date of Completion ___/___/___ Location: _____

Name of person filling out this form. _____
(First Initial) (Last Name)

THIS INSTRUMENT IS NOT FOR
CIRCULATION OR CITATION

BACKGROUND INFORMATION

What is your client's date of birth? _____

What is your client's sex? □ Male □ Female

OCCUPATIONAL ACTIVITIES

During the **past four weeks**, this person has: (Check one)

- □ been working/studying or doing housework in their usual manner
- □ been working/studying or doing housework but less often than they did before
- □ stopped working/studying or doing housework

What sort of work is this person generally capable of (even if unemployed, retired, or doing unpaid domestic duties)? (Check one)

- □ Capable of independent full-time work
- □ Capable of work only if given special support
- □ Capable of independent part-time work
- □ Totally incapable of work

PSYCHOLOGICAL HEALTH

In the **past four weeks**, would you say that this person's overall psychological health has been: (Check one)

□ Poor □ Fair □ Good □ Very Good □ Excellent

PHYSICAL HEALTH

During the **past four weeks**, this person has: (Check one)

- □ been feeling well or great most of the time
- □ been lacking energy or not feeling well more than just occasionally
- □ been feeling ill or poorly most of the time

Does this person have any significant medical illness or physical impairments other than mental illness?

□ No □ Yes - specify _____

How much of a physical problem do you think this person has from antipsychotic medication side effects?

□ Severe □ Moderate □ Mild □ Slight □ None

SOCIAL RELATIONS / SUPPORT

During the **past four weeks**, this person has: (Check one)

- □ been having good relationships with others and receiving support from family and friends
- □ been receiving only moderate support from family and friends
- □ had infrequent support from family and friends or only when absolutely necessary

Does this person attend any social organization (e.g., church, club or interest group but excluding psychiatric therapy groups)? (Check one)

 Frequently Occasionally Rarely Never

Does this person generally make and keep up friendships? (Check one)

 Friendships made and kept up well Friendships made and kept up with considerable difficulty

 Friendships made and kept up with some difficulty Few friendships made and none kept up

How would you describe the quality of this person's relationship with his/her family? (Check one)

 None/has no relationship Fair Very good

 Poor Good Excellent

ECONOMICS

Is this person paid for working or attending school? Yes No

How does this person feel about the amount of money s/he has? (Check one)

 Very dissatisfied Neither satisfied nor dissatisfied Very satisfied

 Moderately dissatisfied A little satisfied

 A little dissatisfied Moderately satisfied

How important to this person is money? (Check one)

 Not at all important moderately important Extremely important

 Slightly important Very important

How often does lack of money keep this person from doing what s/he wants to do? (Check one)

 Never Sometimes Frequently Almost always

ACTIVITIES OF DAILY LIVING

During the **past four weeks** this person has: (Check one)

 been able to do most things on their own (such as shopping, getting around town, etc.)

 been needing some help in getting things done

 been having trouble getting tasks done, even with help

Does this person generally have any difficulty with initiating and/or responding to conversation?	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty
Is this person generally well groomed (e.g., neatly dressed, hair combed?	Well groomed	Moderately well	Poorly groomed	Extremely poorly

	□	groomed □	□	groomed □
Does this person generally neglect his/her physical health?	No neglect □	Slight neglect □	Moderate neglect □	Extreme neglect □
Does this person generally maintain an adequate diet?	No problem □	Slight problem □	Moderate problem □	Extreme problem □
Does this person generally look after and take his/her own prescribed medication (or attend to prescribed injections on time) without reminding? □ No Meds	Reliable with medication □	Slightly unreliable □	Moderately unreliable □	Extremely unreliable □
Is this person generally inactive (e.g., spends most of the time sitting or standing around doing nothing)?	Appropriately active □	Slightly inactive □	Moderately inactive □	Extremely inactive □
Does this person generally have definite interests (e.g., hobbies, sports, activities) in which s/he is involved regularly?	Considerable involvement □	Moderate involvement □	Some involvement □	Not involved at all □
Can this person generally prepare (if needed) his/her own food or meals?	Quite capable of preparing □	Slight limitations □	Moderate limitations □	Totally incapable of preparing □
Can this person generally budget (if needed) to live within his/her own means?	Quite capable of budgeting □	Slight limitations □	Moderate limitations □	Totally incapable of budgeting □
Does this person have habits or behaviors that people find offensive?	Not at all □	Rarely □	Occasionally □	Often □

SYMPTOMS/OUTLOOK

During the **past four weeks**, this person has:

- □ generally felt calm and positive in outlook
- □ been having some periods of anxiety or depression
- □ generally been confused, frightened, anxious or depressed

Does this person behave dangerously because of confusion or preoccupation (e.g., ignoring traffic when crossing the road)?

□ Not at all □ Rarely □ Occasionally □ Often

Please complete the following 24-item version of the Brief Psychiatric Rating Scale. The scale should be completed to reflect the person's current condition. Using the scale value below, enter the number in the box that best describes the person's present condition.

No Problem **1**	Very Mild **2**	Mild **3**	Moderate **4**	Moderately Severe **5**	Severe **6**	Extremely Severe **7**

	Somatic Concern - preoccupation with physical health, fear of physical illness			Disorientation - confusion regarding person, place or time
	Anxiety - worry, fear, over concern for present or future			Conceptual Disorganization - thought process confused, disconnected, disorganized, disrupted
	Depressive mood - sorrow, sadness, despondency, pessimism			Excitement - heightened emotional tone, increased reactivity, impulsivity
	Guilt feelings - self-blame, shame, remorse for past behavior			Motor Retardation - slowed, weakened movements or speech, reduced body tone
	Hostility - animosity, contempt, belligerence, disdain for others			Blunted Affect - reduced emotional tone, reduction in normal intensity of feelings, flatness
	Suspiciousness - mistrust, belief others harbor malicious or discriminatory intent			Tension - physical and motor manifestations or nervousness, hyperactivity
	Unusual Thought Content - unusual, odd, strange, bizarre thought content			Mannerisms and Posturing - peculiar, bizarre, unnatural motor behavior
	Grandiosity - exaggerated self-opinion, arro-gance, conviction of unusual power of abilities			Uncooperativeness - resistance, guardedness, rejection of authority
	Hallucinatory Behavior - perceptions without normal external stimulus correspondence			Bizarre Behavior - reports of odd, unusual, or psychotically criminal behavior
	Emotional Withdrawal-lack of spontaneous inter-action, isolation, deficiency in relating to others			Elated Mood - euphoria, optimism that is out of proportion to circumstances
	Suicidality - expressed desire, intent, or actual actions to harm or kill self			Motor Hyperactivity - frequent movements and/or rapid speech
	Self-Neglect - hygiene, appearance, or eating below social standards			Distractibility - speech and actions interrupted by minor external stimuli or hallucinations/delusions

GOAL ATTAINMENT

What are your goals for the mental health treatment of this person? Please list up to 3 goals:

Goal 1:

_____

_____

How important is this goal?

Not <u>at all</u> important	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10	**Extremely Important**

To what extent has this goal been achieved?

Not at all achieved	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10	**Completely achieved**

Goal 2:

_____

_____

How important is this goal?

Not <u>at all</u> important	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10	**Extremely Important**

To what extent has this goal been achieved?

Not at all achieved	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10	**Completely achieved**

Goal 3:

_____

_____

How important is this goal?

Not <u>at all</u> important	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10	**Extremely Important**

To what extent has this goal been achieved?

Not at all achieved	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10	**Completely achieved**

OTHER

Please check a box below to indicate your rating of this person's quality of life during the **<u>past four weeks.</u>**
Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

LOWEST	□	□	□	□	□	□	□	□	□	□
	HIGHEST									
QUALITY	1	2	3	4	5	6	7	8	9	10
	QUALITY									

How confident are you that your rating of the person's quality of life is accurate? (Check one)

 Not at all confident Very confident
 Quite confident Absolutely confident

What is this person's primary psychiatric diagnosis? _____

How effective do you think the antipsychotic medication is in treating this person's mental illness?

 Not at all effective Mildly effective Extremely effective
 Slightly effective Moderately effective

In the **past four weeks**, did this person take his/her antipsychotic medications as prescribed?

 No medications prescribed (*if no medication skip the next question*)
 None of the time Sometimes Always *(if always, skip next question)*
 Very infrequently Quite often

In the **past four weeks**, how much assistance did this person receive to take his/her prescribed medication?

 Received considerable assistance Received no assistance
 Received minor assistance/supervision Don't know

Does this person use alcohol or other drugs?

 Not at all *(skip next question)* Rarely Occasionally Often

To what extent does this person's alcohol or other drug use concern you?

 Not at all Slightly Moderately A lot

Does this person get into trouble with the police?

 Not at all Rarely Occasionally Often Don't know

Which of the following factors do you think are most important in maintaining your client's quality of life?	Not important	Slightly important	Moderately important	Very important	Extremely important
Work, school or other occupational activities					
Feelings about him/herself					
His/her physical health					
Friends, family, people s/he spends time with					
Having enough money					

Ability to take care of him/herself	□	□	□	□	□
Mental health	□	□	□	□	□
Other, please specify	□	□	□	□	□

Is there anything else we should know about this client?

This is the end of the questionnaire. Thank you for giving your opinion and sharing your responses with us. If you have any questions about this questionnaire, please call or write Marion Becker, Ph.D., University of South Florida, Department of Community Mental Health, 13301 Bruce B. Downs Blvd., MHC 1423, Tampa, Florida 33612-3899 Telephone: (813)974-7188 Fax: (813)974-6469 E-Mail: .becker@fmhi.usf.edu

WISCONSIN QUALITY OF LIFE INDEX
CAREGIVER QUESTIONNAIRE

CONCEPTUAL FRAMEWORK

The Wisconsin Quality of Life Index (W-QLI) Caregiver Questionnaire is a comprehensive multi-dimensional measurement tool that reflects the perspective of the client's primary caregiver. On the basis of previous research, our clinical experience, and recommendations from an advisory board convened to develop the index, we used four scales in the caregiver questionnaire: 1) services, 2) family assistance, 3) life activities and goals, and 4) the QoL uniscale. The first three scales can be individually weighted depending on their relative importance to the patient. In addition, there are a number of open-ended questions which give the caregiver the opportunity to share their opinion about what the most important factors are for improving treatment outcomes for the client. This instrument is meant to be used in conjunction with two other instruments that measure patient QoL from the client and clinician perspectives. This instrument is particularly useful for examining discrepancies between client and caregiver and between caregiver and provider in terms of assessing client's treatment goals and overall QoL. This survey is also helpful for assessing family burden. The Wisconsin Quality of Life Index Caregiver Questionnaire was designed to be self-administered though respondents can be assisted if necessary.

DOMAINS

Services

These questions ask about the degree to which the caregiver believes he/she is working in cooperation with the mental health provider.

Family Assistance

Questions in this domain focus on the amount of daily assistance (ADL) required by the client from family or significant others and asks caregivers about their feelings in relation to providing the needed assistance. Elicited information can be used to measure the client's need for caregiver assistance, to monitor changes in the level of assistance required, as well as assessing caregivers' feelings about providing that assistance.

Life Activities and Goals
This domain can be used in two ways. Each part (activity, daily living, health, support and outlook) can be scored individually and compared with client and provider responses to the same items. The scale can also be averaged for a total score.

Goal Attainment
This section focuses on the caregiver's perspective on the most important treatment goals for the client, and their evaluation about whether those goals are being achieved. Caregivers are asked to specify the three most important goals for the client's improvement with treatment. Goals are ranked both in terms of their relative importance to the client as well as the extent to which the responder believes the client's goals have been achieved.

Other Analyses of Interest in The Caregiver Questionnaire
The Caregiver Quality of Life Questionnaire contains a number of items that do not load in any specific domains but which are valuable in both an applied or theoretical context. Examples of these include:

Contact
These variables (C1-C12) can be used to examine the relationship between client's contact with caregiver(s) and treatment outcomes.

Hope
Question (Q5) provides the opportunity to examine the role of caregiver hope in improving the client's QoL and how treatment outcomes and family burden measures vary depending on differing levels of caregiver hope.

Locus of Control
This question (Q6) provides the opportunity to examine the congruence between caregiver and client about client's locus of control - the degree of control which the client has over the important areas of his/her life.

Wisconsin Quality of Life Caregiver Questionnaire

Wisconsin Quality of Life Associates
University of Wisconsin - Madison

Interview Information:

Your Name: _____ ID#: _____

Date of Completion: __/__/__ Age: _____ Sex: _____

Relationship to Client: _____

Directions:

We are interested in learning about how mental health treatment, including medication, affect the Quality of Life of your family member, friend or neighbor. We also want to know about your experience as a family member, friend or neighbor of someone with mental illness. We are interested in your views and feelings. Please indicate the response which most closely reflects your opinion.

THIS INSTRUMENT IS NOT FOR
CIRCULATION OR CITATION

BACKGROUND INFORMATION

1. Please list members residing in your household:

Name (First names only)	Relationship to client
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Do you have a job at the present time? □ Yes □ No (if no, please skip to #5)

3. How many hours a week do you work or go to school? _____ hours per week

4. What is your occupation? _____

5a. Who was your relative/friend/neighbor living with when he/she first became ill? (Check all that apply)

- □ alone
- □ friend/roommate
- □ with children
- □ with parents
- □ with significant other/spouse
- □ other, please specify; _____

5b. Where was you neighbor/relative friend living when he/she first became ill? (Check one)

- □ in an apartment/home
- □ in a boarding home
- □ in an group home or halfway house
- □ homeless
- □ at school/college
- □ in an institution (i.e. hospital or nursing home)
- □ in jail/prison
- □ other, please specify:_____

6. How old was your relative/friend/neighbor when he/she first became ill? _____years

7a. Who is your relative/friend/neighbor living with now? (Check one)

- alone
- friend/roommate
- with children
- with parents
- with significant other/spouse
- other, please specify; _____

7b. Where is you relative/friend/neighbor living now? (Check one)

- in an apartment/home
- in a boarding home
- in an group home or halfway house
- homeless
- at school/college
- in an institution (i.e. hospital or nursing home)
- in jail/prison
- other, please specify:_____

8. When was the last time the patient spent more than 7 consecutive overnights in your household?

 Currently
 Within the past month
 Within the past six months
 Within the past year
 Longer than a year ago

9. In the time that you have been involved with the patient, how many times has he/she been hospitalized? None _____ # times

10. What services has the patient received during the **past 6 months?** Don't know
Please check all that apply.

Community Support Program/
Assertive Case Management with Regular Community Outreach .....
Job/Vocational Training.....
Individual Psychiatrist Appointments.....
Medication Group .....
Case Management.....
Individual Therapy other than Case Manager.....
Groups including Living Skills, Social, Recreational, and Therapy groups.....
Day Treatment .....
General Medical Health .....
Housing Support .....
Any Other Services? .....
Please Specify:_____

SERVICES

11. People are often required to talk with mental health professionals in trying to help their relative/friend/neighbor with mental illness. To what extent do the following statements reflect experiences you have had in getting treatment for your relative/friend/neighbor?

For each statement below, please tell us whether you **strongly agree, agree, have no opinion, disagree, strongly disagree** with it or **don't know.** Under each statement please check the corresponding box that best reflects your feelings.

a. The health care professionals that I have dealt with feel that I can play an important role in the treatment process.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Don't Know/ Doesn't Apply

b. The health care professionals that I have dealt with have given me as much information as I have needed.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Don't Know/ Doesn't Apply

c. I am comfortable questioning health care professionals about advice they give me.

□ Most of the time □ Some of the time □ No Opinion □ Rarely □ Never □ Don't Know/ Doesn't Apply

d. I would like to have more say than I do now about the services and medication my relative/friend/neighbor receives.

□ Strongly Agree □ Agree □ No Opinion □ Disagree □ Strongly Disagree □ Don't Know/ Doesn't Apply

e. Sometimes I feel that the health care professionals that I work with do not understand the problems people face in caring for a person with a mental illness.

□ Strongly Agree □ Agree □ No Opinion □ Disagree □ Strongly Disagree □ Don't Know/ Doesn't Apply

f. I often wish that I knew more about mental illness when I talk with health care professionals.

□ Strongly Agree □ Agree □ No Opinion □ Disagree □ Strongly Disagree □ Don't Know/ Doesn't Apply

g. I am comfortable in getting a second opinion when I have questions about advice I get from a health care professional.

□ Strongly Agree □ Agree □ No Opinion □ Disagree □ Strongly Disagree □ Don't Know/ Doesn't Apply

12. In general, how many contacts does your relative/friend/neighbor have with members of your household? Please fill in the blanks as appropriate.

Patient resides with you. □ Yes □ No

If Yes, patient has spent _____ overnights away.

I and other members of my household and the client have seen each other ___times in the past month

I and other members of my household and the client have talked on the telephone __times in the past month.

I and other members of my household and the client have corresponded in the past month.

□ Yes □ No

No contact in the past two months □ Yes □ No

Other, please specify: _____

13. In the **past six months** have you or any other member of your household had any meetings, any visits or phone calls **to** or **from** individuals who are treating the patient? (Doctors, Social workers, Psychologists, Counselors, Welfare workers).

If **Yes**, please complete the following information:

	Number	Agencies involved
Personal Visits	_____	_____
Phone Contacts	_____	_____

Other: _____ _____

Were any of these contacts of any help to you?

□ Yes □ No, please specify why not:_____
_____

If no, i.e., you haven't had contact, would you like to have had contact with any of these people?

□ Yes □ No

FAMILY ASSISTANCE

14. Family and friends often take on responsibilities to provide care and support for a person with mental illness. During the **past four weeks** how much support or supervision did you give to your relative/friend/neighbor in dealing with these particular problems/difficulties shown below and how did you feel about giving this support?

a. **Maintaining personal hygiene** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

b. **Taking prescribed medication** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

c. **Preparing meals** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

d. **Getting up and getting dressed** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfled □ Accepted □ Dissatisfied

e. **Doing household chores** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfled □ Accepted □ Dissatisfied

f. **Managing money** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

g. **Shopping for food, clothing, etc.** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

h. **Making use of leisure time** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

15. During the past four weeks, how much support or supervision did you give to help the patient control (overcome) the particular behaviors shown below?

a. **Socially embarrassing behavior** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

b. **Attention-seeking behavior** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

c. **Inappropriate sexual behavior** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

d. **Threatening or violent behavior** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

e. **Talk or threats of suicide** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

f. **Disturbing behavior at night** □ None □ Little □ Some □ Much
How did you feel about giving such support? □ Satisfied □ Accepted □ Dissatisfied

16. What is the hardest part in giving support to your relative/friend/neighbor? Please list the three hardest things to you, in order from most difficult to least difficult.
1. _____
2. _____
3. _____

17. Are there things that you enjoy about supporting your relative/friend/neighbor? Please explain:
_____
_____
_____

LIFE ACTIVITIES AND GOALS

Now we are interested in knowing about your relative/friend/neighbor's abilities during the **past four weeks.**

18. ACTIVITY During the **past four weeks**, my relative/friend/neighbor has:
□ not been working or studying and/or going out at all
□ been working or studying; but requiring assistance or a reduction in hours worked
□ been working or studying in usual manner

19. DAILY LIVING During the **past four weeks,** my relative/friend/neighbor has:
□ not been managing personal care and/or not leaving home or institution at all
□ been requiring assistance for daily activities and transport, but performing very light tasks
□ been self-reliant in daily tasks; using public transport or driving

20. HEALTH During the **past four weeks,** my relative/friend/neighbor has:
□ been feeling ill or poorly most of the time
□ been lacking energy or not feeling well more than just occasionally
□ been feeling well or great most of the time

21. SUPPORT During the **past four weeks,** my relative/friend/neighbor has:
□ had infrequent support from family and friends or only when absolutely necessary
□ been receiving only moderate support from family and friends
□ been having good relationships with others and receiving support from family and friends

22. OUTLOOK During the **past four weeks,** my relative/friend/neighbor has:
□ been seriously confused, frightened, or consistently anxious and depressed
□ been having some periods of anxiety or depression because not fully in control of personal circumstances
□ felt calm and positive in outlook and been accepting of personal circumstances

23. From your perspective, what do you think are the important treatment goals for your relative/friend/neighbor?

Goal 1:

_____

_____

How important is this goal to your relative/friend/neighbor?

Not <u>at all</u>	□	□	□	□	□	□	□	□	□	□
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent has your relative/friend/neighbor achieved this goal?

Not at all	□	□	□	□	□	□	□	□	□	□
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

Goal 2:

_____

_____

How important is this goal to your relative/friend/neighbor?

Not <u>at all</u>	□	□	□	□	□	□	□	□	□	□
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent has your relative/friend/neighbor achieved this goal?

Not at all	□	□	□	□	□	□	□	□	□	□
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

Goal 3:

_____

_____

How important is this goal to your relative/friend/neighbor?

Not <u>at all</u>	□	□	□	□	□	□	□	□	□	□
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent has your relative/friend/neighbor achieved this goal?

Not at all	□	□	□	□	□	□	□	□	□	□
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

24. Please check a box below to indicate your rating of your relative/friend/neighbor's quality of life during the **past four weeks.**

Lowest quality means your relative/friend/neighbor's life is as bad as it could be.
Highest quality means your relative/friend/neighbor's life is the best it could be.

LOWEST QUALITY	□	□	□	□	□	□	□	□	□	□
HIGHEST QUALITY	1	2	3	4	5	6	7	8	9	10

If your relative/friend/neighbor's quality of life is less than he/she hoped for, how hopeful are **you** that he/she will eventually achieve his/her desired quality of life? (Check one)

□ Not at all □ Somewhat □ Moderately □ Very

How much control do **you** feel your relative/friend/neighbor has over the important areas of his/her life?

□ None □ Some □ A moderate amount □ A Great amount

25. How confident are you that your rating of your relative/friend/neighbor's quality of life is accurate? Please check the appropriate box.

□ Not at all Confident	□ Very Doubtful	□ Not very Confident	□ Quite Confident	□ Very Confident	□ Absolutely Confident

26. Which of the following factors do you think are most important in determining your relative/friend/ neighbor's quality of life?	Not important	Slightly important	Mildly important	Moderately important	Extremely important
Work, school or other occupational activities	□	□	□	□	□
Your relative/friend/neighbor's feelings about him/herself	□	□	□	□	□
Your relative/friend/neighbor's physical health	□	□	□	□	□
Friends, family, people your relative/ friend/neighbor spends time with	□	□	□	□	□
Having enough money	□	□	□	□	□
Your relative/friend/neighbor's ability to take care of him/herself	□	□	□	□	□
Mental health	□	□	□	□	□
Other, please specify:	□	□	□	□	□

27. Have there been any important factors which would influence your relative/friend/neighbor's quality of life (i.e., deaths in the family, serious physical illness, accidents)? Please briefly explain.

_____

_____

_____

28. Is there anything else you would like to tell us?

_____
_____
_____

29. What is the most important thing that now needs to be done for your relative/friend/neighbor?

_____
_____
_____

This is the end of the questionnaire. Thank you for giving your opinion and sharing your responses with us. If you have any questions about this questionnaire, please call or write Marion Becker, Ph.D., University of South Florida, Department of Community Mental Health, 13301 Bruce B. Downs Blvd., MHC 1423, Tampa, Florida 33612-3899 Telephone: (813)974-7188 Fax: (813)974-6469 E-Mail: .becker@fmhi.usf.edu

QUALITY OF LIFE INDEX FOR ADULTS QUESTIONNAIRE (A-QLI)

CONCEPTUAL FRAMEWORK

The Quality of Life Index for Older Adults (A-QLI) is a comprehensive multidimensional measurement tool that reflects the complexity of QoL outcomes in older adults. Outcome information is captured using a three dimensional strategy which measures the responders status, disability and personal evaluation on eight key domains. The instrument measures a full range of health and functional outcomes. Older adults are asked to report on their physical, emotional and social well-being, and to respond to questions about their mood, feelings, personal goals and preferences. In this way the A-QLI is able to capture the individual's values and desires for improvement. The instrument is balanced allowing for positive and negative outcomes. The A-QLI is designed to be self-administered. However, a scripted version has been constructed for use in a face-to-face or telephone interview and a parallel provider form has been developed. A description of the eight domains follows. The conceptual model for the A-QLI is found on page 41.

DOMAINS

Physical Health

This domain includes questions that measure the respondent's perceptions of their physical health and the capacity to perform a variety of physical activities which require energy and mobility such as climbing stairs or swimming.

Self Care

This section focuses on respondent's perceived ability to perform accustomed functions and activities of daily living including the standard late loss ADL's (i.e. eating, dressing, toileting) and higher functioning ADL's (laundry, using transportation, cooking) needed for community living.

Pain

Questions in this domain asks about the respondent's experience or degree of bodily pain and the individual's perception of the adequacy of pain control with medication.

Social Relations / Support

This domain examines respondent's degree of satisfaction or dissatisfaction with their social relations and support.

Psychological Well-Being

This domain ascertains the psychological state of the older adult as determined by a self-assessment of the respondent's internal condition. These questions ask about respondent's subjective sense of well-being that cannot be inferred from observable behavior alone.

Other Issues
Questions in this domain ask about respondent's degree of comfort with his/her spirituality, experienced contentment, meaning and purpose of one's life.

Individual Importance
This domain reflects the respondent's personal values and the relative importance of domains to the respondent.

Goal Attainment
Here the respondent is asked to list the three most important personal goals for improving his/her life and the extent to which each goal has been achieved.

Types of Assessment

- **Status**
- **Disability**
- **Personal Evaluation**

Quality of Life Index For Adults Questionnaire

Your Name: _____

Today's Date: ____/____/____

What is your date of birth? ____/____/____

Directions: We are interested in your views and feelings about your health status and the quality of your life. When you answer each question, please indicate the response which most closely reflects your opinion.

You are the person who knows best how you feel about these questions. If you would like someone to help you in filling out the questionnaire please indicate who helped:

_____
__

Relationship to you:_____

Thank you for completing this questionnaire.

THIS INSTRUMENT IS NOT FOR
CIRCULATION OR CITATION

BACKGROUND INFORMATION

This questionnaire asks for your views about your health status and quality of life. Please begin by providing the following information about yourself. Please check (3) the best answer.

.....

You are? _____ Male _____ Female

.....

What is your highest school grade completed: _____

.....

What is your current marital status? Please check (3) the most appropriate answer.

_____ Single/Never Married
_____ Married
_____ Divorced
_____ Separated
_____ Spouse deceased
_____ Living with partner (but not married)

.....

What is your racial/ethnic background? Please check (3) the most appropriate answer.

_____ American Indian/Native American
_____ Asian
_____ African American
_____ Hispanic/Latino
_____ White
_____ Other, specify: _____

.....

What is your religious affiliation? Please check (3) the most appropriate answer.

_____ Catholic
_____ Jewish
_____ Protestant
_____ Muslim
_____ Other specify: _____
_____ None

.....

Who do you currently live with? Please check (3) the most appropriate answer.

_____ Living alone
_____ Living with spouse and/or children
_____ Living with non-relative
Other, please explain:_____

.....

What is your current living arrangement? Please check (3) the most appropriate answer.

_____ Living in own home
_____ Living in an apartment
_____ Living in a board and care facility
_____ Living in an institution
_____ Living in an assisted living facility
_____ Other, please explain: _____

What is your primary source of money? Please check (3) all that apply.

_____ Savings, Interest Dividends
_____ Pensions
_____ Family and Friends
_____ Stocks and Bonds
_____ Social Security
_____ Annuity
_____ Veterans' Benefits
_____ Disability Insurance
_____ Job
Other, please specify:
_____

PHYSICAL HEALTH

The following questions refer to your health status. Please check (3) the most appropriate answer.

In general, would you say your physical health is:

_____ Poor _____ Fair _____ Good_____ Very Good _____ Excellent

Compared to one year ago, how would you rate your health in general **now**?

_____Much _____Somewhat _____ About the _____Somewhat _____ Much
Worse Worse Same Better Better

Please choose the answer that best describes how true or false the following statements are for you.

Compared to others my age, my health is as good as can be expected.

_____Definitely _____Mostly _____Not _____Mostly _____Definitely
False False Sure True True

I expect my health to get worse.

_____Definitely _____Mostly _____Not _____Mostly _____Definitely
True True Sure False False

Do you take medication for your health? _____Yes _____No

If yes, how many different medications do you take? _____
(Include all medications; over the counter, prescribed, herbal, etc.)

	YES	**NO**
Do you require help in taking your medications correctly?	_____	_____

Are you bothered by side effects from your medications? _____ _____

During the **past four weeks**, have your activities been limited in any of the following ways due to problems with your physical health?

	Yes, completely	**Yes, limited a lot**	**Yes, limited some**	**Yes, limited a little**	**No, not limited**
Limited the **kind** of activities you could do?	_____	_____	_____	_____	_____
Limited the **amount** of time you could do activities you would like to do?	_____	_____	_____	_____	_____
Limited you in **performing** self-care?	_____	_____	_____	_____	_____

The following questions are about activities you might do on a typical day. In the **past four weeks**, has your health limited you in any of the following activities?

	All Days	Most Days	Some Days	Few Days	No Days
Moderate Activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	_____	_____	_____	_____	_____
Lifting or carrying groceries.	_____	_____	_____	_____	_____
Climbing **several** flights of stairs.	_____	_____	_____	_____	_____
Climbing **one** flight of stairs.	_____	_____	_____	_____	_____
Bending, kneeling or stooping.	_____	_____	_____	_____	_____
Walking **several blocks**.	_____	_____	_____	_____	_____
Walking **one block**.	_____	_____	_____	_____	_____
Walking **short distances**. (e.g. around your house)	_____	_____	_____	_____	_____

SELF-CARE

These questons refer to self-care tasks. Please check (3) the most appropriate answer.

During the **past four weeks...**

	All Days	Most Days	Some Days	Few Days	No Days
Did you need help from another person to take a bath or shower?	____	____	____	____	____
Did you need help from another person to get dressed?	____	____	____	____	____
Did you need help from another person to use the toilet?	____	____	____	____	____
Did you need help from another person to eat?	____	____	____	____	____
Did you need help from another person to get in or out of bed?	____	____	____	____	____

These questions refer to other important self-care tasks. Please check (3) the most appropriate answer.

During the **past four weeks...**

	All Days	Most Days	Some Days	Few Days	No Days
Have you been able to go shopping for groceries without help?	____	____	____	____	____
Have you been able to prepare your own meals without help?	____	____	____	____	____
Have you been able to do your own housework without help?	____	____	____	____	____
Have you been able to do your own laundry without help?	____	____	____	____	____
Have you been able to use public transportation or drive your own car?	____	____	____	____	____

PAIN AND SYMPTOMS

How much pain have you had during the **past four weeks** (check one)?
____Very Severe _____ Severe _____Moderate _____Mild _____Very Mild
_____None

During the **past four weeks**, how much has pain interfered with your normal activities? (check one)
_____ Not at all _____Slightly _____Moderately _____Very much
_____Completely interferes

Do you take pain medication? _____Yes _____No

If yes: Is your pain controlled by the medication you take?

_____Not at all _____Some _____Moderately _____Quite a bit
_____Completely

Do you use other measures to control your pain? _____Yes _____No

If yes, what do you use? _____

_____

Overall, to what degree is your pain controlled?

_____Not at all _____Some _____Moderately _____Quite a bit
_____Completely

Given the degree to which your pain is controlled, do you think something more should be done to help control your pain? _____Yes _____No

SOCIAL RELATIONS / SUPPORT

	Very dissatisfied	**Somewhat dissatisfied**	**Neither satisfied nor dissatisfied**	**Somewhat satisfied**	**Very satisfied**
How satisfied or dissatisfied are you with your relationships with family or friends?	_____	_____	_____	_____	_____

_____No family or friends

How satisfied or dissatisfied are you with the amount of

support you receive from family and friends?	_____	_____	_____	_____	_____

During the **past four weeks**, did you feel that your family or friends would be around if you needed assistance?

_____ Always _____ Often _____ Sometimes _____ Seldom _____ Never

During the **past four weeks,** how often did you go to a religious activity (e.g. church, synagogue, etc.) or attend a community activity? _____ (number of times)

During the **past four weeks,** did your physical health limit your ability to socialize with family or friends?

_____ Always _____ Often _____ Sometimes _____ Seldom _____ Never

During the **past four weeks,** did your emotional health limit your ability to socialize with family or friends?

_____ Always _____ Often _____ Sometimes _____ Seldom _____ Never

PSYCHOLOGICAL WELL-BEING

These questions are about how you have felt during the **past four weeks**. How much of the time. . .

	All Days	**Most Days**	**Some Days**	**Few Days**	**No Days**
Did you feel full of pep?	_____	_____	_____	_____	_____
Have you been nervous?	_____	_____	_____	_____	_____
Did you feel down in the dumps?	_____	_____	_____	_____	_____
Have you felt peaceful and content?	_____	_____	_____	_____	_____
Did you feel your life had purpose?	_____	_____	_____	_____	_____
Have you felt hopeful about the future?	_____	_____	_____	_____	_____
Have you worried about dying?	_____	_____	_____	_____	_____
Did you feel life was worthwhile?	_____	_____	_____	_____	_____

Did you feel in control of your life? _____ _____ _____ _____ _____

During the **past four weeks,** have you experienced a major loss? _____ Yes
_____ No

Please indicate below if during the **past four weeks** your activities have been limited in any of the following ways due to emotional difficulties.

	Yes, completely limited	**Yes, limited a lot**	**Yes, limited some**	**Yes, limited a little**	**No, not limited**
Limited the **kind** of activities you could do?	_____	_____	_____	_____	_____
Limited the **amount** of time you could do activities you would like to do?	_____	_____	_____	_____	_____
Limited you in **performing** self-care or attending social activities?	_____	_____	_____	_____	_____

Now we'd like to ask you about some other areas of your life. To what extent are you experiencing difficulty in the area of:

	All Days	**Most Days**	**Some Days**	**Few Days**	**No Days**
Managing day-to-day life (making decisions, handling money)?	_____	_____	_____	_____	_____
Getting enough sleep?	_____	_____	_____	_____	_____
Maintaining an adequate diet?	_____	_____	_____	_____	_____
Concentration, memory or confusion?	_____	_____	_____	_____	_____
Depression, hopelessness?	_____	_____	_____	_____	_____
Sexual activity?	_____	_____	_____	_____	_____
Mood swings?	_____	_____	_____	_____	_____
Drinking alcoholic beverages?	_____	_____	_____	_____	_____

Misusing drugs (including prescription drugs)?	_____	_____	_____	_____	_____

OTHER ISSUES

Please choose the answer that best describes how true or false the following statements are for you.

I spend time in activities that nourish my spiritual life.

_____Definitely	_____Mostly	_____Not	_____Mostly	_____Definitely
False	False	Sure	True	True

I am not interested in activities that nourish my spiritual life.

_____Definitely	_____Mostly	_____Not	_____Mostly	_____Definitely
False	False	Sure	True	True

I am satisfied with my spiritual life.

_____Definitely	_____Mostly	_____Not	_____Mostly	_____Definitely
False	False	Sure	True	True

I feel that I am treated with dignity and respect.

_____Definitely	_____Mostly	_____Not	_____Mostly	_____Definitely
False	False	Sure	True	True

	Very dissatisfied	**Somewhat dissatisfied**	**Neither satisfied or dissatisfied**	**Somewhat satisfied**	**Very satisfied**
How satisfied or dissatisfied are you with your living arrangements?	_____	_____	_____	_____	_____
How satisfied or dissatisfied are you with the amount of privacy that you have?	_____	_____	_____	_____	_____
How satisfied or dissatisfied are you with the choices you have (e.g. control over time and your daily activities)?	_____	_____	_____	_____	_____

Please check the box below to indicate how you feel about your quality of life during the **past four weeks.**
Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

LOWEST QUALITY	_____ **1**	_____ **2**	_____ **3**	_____ **4**	_____ **5**	_____ **6**	_____ **7**	_____ **8**	_____ **9**	_____ **10** **HIGHEST QUALITY**

You have answered questions about areas of your health and quality of life. These areas are listed below. **Please check (☐)** next to the **three most important areas** in which you would like to see improvement in your own life. Please read all areas before marking your selections.

Physical Health _____ Social Relations _____ Pain _____

Daily Activities _____ Social Support _____ Diet _____

Spirituality _____ Your Feelings _____ (mood/or mental health) Substance Use _____ (drugs/alcohol)

Self-Care _____

PERSONAL GOALS

Please list below the three most important personal goals that you have for improving your life.

Goal 1:

_____
_____

To what extent have you achieved this goal? Please check the box below to indicate the extent to which _____ you have achieved this goal.

Not at all achieved **Completely achieved**	_____ **1**	_____ **2**	_____ **3**	_____ **4**	_____ **5**	_____ **6**	_____ **7**	_____ **8**	_____ **9**	_____ **10**

Goal 2:

_____
_____

To what extent have you achieved this goal?

Not at all achieved	_____ **1**	_____ **2**	_____ **3**	_____ **4**	_____ **5**	_____ **6**	_____ **7**	_____ **8**	_____ **9**	_____ **10 Completely achieved**

Goal 3: _____

To what extent have you achieved this goal?

Not at all achieved	_____ **1**	_____ **2**	_____ **3**	_____ **4**	_____ **5**	_____ **6**	_____ **7**	_____ **8**	_____ **9**	_____ **10 Completely achieved**

QUALITY OF LIFE INDEX FOR ADULTS (A-QLI)
PROVIDER QUESTIONNAIRE

CONCEPTUAL FRAMEWORK

The Quality of Life Index for Adults (A-QLI) Provider Questionnaire is a parallel form to the A-QLI, which is optional in its use or can be used when clients are aphasic or otherwise unable to complete a form for themselves. It can be a very useful tool in clinical paractice primarily because it is easy to assume more concordance with clients than actually exists. Use of the Provider Questionnaire allows clinicians to understand the reality of the commonality or discordance that exists. The domains for the Quality of Life Index for Older Adults Provider Questionnaire closely parallel those of the client version with some differences and are as follows:

DOMAINS

Physical Health
This domain includes questions that ask the clinician to rate the person's physical health, including use of medications for health reasons. Other questions relate to the person's capacity to perform activies that might be done on a typical day.

Self Care
This section focuses on the clinician's perceived ability of the person to perform accustomed functions and activities of daily living including the standard late loss ADL's (i.e. eating, dressing, toileting) and higher functioning ADL's (laundry, using transportation, cooking) needed for community living.

Pain
Questions in this domain ask the clinician to rate the degree of pain the person may be in and the degree to which the pain has interfered with normal activities. Questions in this domain also inquire about use of pain medication and how adequate pain is controlled.

Social Relations / Support
These questions measure the client's social relations and support as seen by the clinician.

Psychological Well-Being
This domain reflects the psychological state of the older adult as determined by the clinician.

Goal Attainment
This section contains questions about the clinician's goals for improving the individual's QoL.

Quality of Life Index For Adults Provider Questionnaire

Client's Name:_____

Today's Date: ____/____/____

What is your client's date of birth? ____/____/____

Name of person filling out this form: _____

Thank you for completing this questionnaire.

PHYSICAL HEALTH

The following questions refer to your client's health status. Please check (3) the most appropriate answer.

In general, would you say your client's physical health is:

_____ Poor _____ Fair _____ Good_____ Very Good _____ Excellent

Compared to one year ago, how would you rate your client's health in general **now**?

_____Much _____Somewhat _____ About the _____Somewhat _____ Much
Worse Worse Same Better Better

Please choose the answer that best describes how true or false the following statements are for your client.

Compared to others the age of my client, his/her health is as good as can be expected.

_____Definitely _____Mostly _____Not _____Mostly _____Definitely
False False Sure True True

I expect this client's health to get worse.

_____Definitely _____Mostly _____Not _____Mostly _____Definitely
True True Sure False False

Does your client take medication for his/her health? _____Yes _____No

If yes, how many different medications does he/she take? _____
(Include all medications; over the counter, prescribed, herbal, etc.)

	YES	NO
Does your client require help in taking his/her medications correctly?	_____	_____
Is your client bothered by side effects from his/her medications?	_____	_____

During the **past four weeks**, have your client's activities been limited in any of the following ways due to problems with his/her physical health?

	Yes, completely	**Yes, limited a lot**	**Yes, limited some**	**Yes, limited a little**	**No, not limited**
Limited the **kind** of activities he/she could do?	_____	_____	_____	_____	_____
Limited the **amount** of time he/she could do other activities he/she would like to do?	_____	_____	_____	_____	_____
Limited him/her in **performing** self-care?	_____	_____	_____	_____	_____

The following questions are about activities your client might do on a typical day. In the **past four weeks**, has your client's health limited him/her in any of the following activities?

	All Days	Most Days	Some Days	Few Days	No Days
Moderate Activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	_____	_____	_____	_____	_____
Lifting or carrying groceries.	_____	_____	_____	_____	_____
Climbing **several** flights of stairs.	_____	_____	_____	_____	_____
Climbing **one** flight of stairs.	_____	_____	_____	_____	_____
Bending, kneeling or stooping.	_____	_____	_____	_____	_____
Walking **several blocks**.	_____	_____	_____	_____	_____
Walking **one block**.	_____	_____	_____	_____	_____
Walking **short distances**. (e.g. around his/her house)	_____	_____	_____	_____	_____

SELF-CARE

These questions refer to self-care tasks. Please check (3) the most appropriate answer.

During the **past four weeks...**

	All Days	Most Days	Some Days	Few Days	No Days
Did your client need help from another person to take a bath or shower?	____	____	____	____	____
Did your client need help from another person to get dressed?	____	____	____	____	____
Did your client need help from another person to use the toilet?	____	____	____	____	____
Did your client need help from another person to eat?	____	____	____	____	____
Did your client need help from another person to get in or out of bed?	____	____	____	____	____

These questions refer to household tasks. Please check (3) the most appropriate answer.

During the **past four weeks...**

	All Days	Most Days	Some Days	Few Days	No Days
Has your client been able to go shopping for groceries without help?	____	____	____	____	____
Has your client been able to prepare his/her own meals without help?	____	____	____	____	____
Has your client been able to do his/her own housework without help?	____	____	____	____	____
Has your client been able to do his/her own laundry without help?	____	____	____	____	____
Has your client been able to use public transportation or drive his/her own car?	____	____	____	____	____

PAIN AND SYMPTOMS

How much pain has your client had during the **past four weeks** (check one)?

____Very Severe _____ Severe _____Moderate _____Mild _____Very Mild
_____None

During the **past four weeks**, how much has pain interfered with your client's normal activities?

_____ Not at all _____Slightly _____Moderately _____Very much
_____Completely Interferes

Does your client take pain medication?_____Yes _____No

If yes: Is your client's pain controlled by the medication he/she takes?

_____Not at all _____Some _____Moderately _____Quite a bit
_____Completely

If your client's pain is not controlled by medication, how is it controlled?_____
_____

Pain can't be controlled ____

SOCIAL RELATIONS / SUPPORT

During the **past four weeks**, your client has: (Check one)

_____ been having good relationships with others and receiving support from family and friends

_____ been receiving only moderate support from family and friends

_____ had infrequent support from family and friends or only when absolutely necessary

How would you describe the quality of your client's relationship with his/her family? (Check one)

_____ None/has no relationship _____ Fair _____ Very good
_____ Poor _____ Good _____ Excellent

PSYCHOLOGICAL WELL-BEING

In the **past four weeks**, would you say that your client's overall psychological health has been:

_____ Poor _____ Fair _____ Good _____ Very Good _____ Excellent

During the **past four weeks**, your client has:

_____ generally felt calm and positive in outlook

_____ been having some periods of anxiety or depression

_____ generally been confused, frightened, anxious or depressed

During the **past four weeks,** has your client experienced a major loss? _____ Yes _____ No

Please indicate below if during the **past four weeks**, your client's activities have been limited in any of the following ways due to emotional difficulties.

	Yes, completely limited	**Yes, limited a lot**	**Yes, limited some**	**Yes, limited a little**	**No, not limited**
Limited the **kind** of activities your client could do?	_____	_____	_____	_____	_____
Limited the **amount** of time your client could do activities he/she would like to do?	_____	_____	_____	_____	_____
Limited your client in **performing** self-care or attend social activities?	_____	_____	_____	_____	_____

To what extent is your client experiencing difficulty in the area of:

	All Days	**Most Days**	**Some Days**	**Few Days**	**No Days**
Managing day-to-day life (making decisions, handling money)?	_____	_____	_____	_____	_____
Getting enough sleep?	_____	_____	_____	_____	_____
Maintaining an adequate diet?	_____	_____	_____	_____	_____
Concentration, memory or confusion?	_____	_____	_____	_____	_____
Depression, hopelessness?	_____	_____	_____	_____	_____
Sexual activity?	_____	_____	_____	_____	_____
Mood swings?	_____	_____	_____	_____	_____
Drinking alcoholic beverages?	_____	_____	_____	_____	_____
Misusing drugs (including prescription drugs)?	_____	_____	_____	_____	_____

Please check the box below to indicate your rating of this person's quality of life during the **past four weeks.**
Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

LOWEST QUALITY	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	☐ **6**	☐ **7**	☐ **8**	☐ **9**	☐ **10** **HIGHEST QUALITY**

PERSONAL GOALS

Please list below the three most important goals for improving this client's life.

Goal 1:

_____

_____

To what extent has this goal been acheived?

Not at all achieved	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	☐ **6**	☐ **7**	☐ **8**	☐ **9**	☐ **10** **Completely achieved**

Goal 2:

_____

_____

To what extent has this goal been achieved?

Not at all achieved	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	☐ **6**	☐ **7**	☐ **8**	☐ **9**	☐ **10** **Completely achieved**

Goal 3:

_____

_____

To what extent has this goal been achieved?

Not at all achieved	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	☐ **6**	☐ **7**	☐ **8**	☐ **9**	☐ **10** **Completely achieved**

THE FAMILY
QUALITY OF LIFE INDEX
(F-QLI)

CONCEPTUAL FRAMEWORK

The Family Quality of Life Index (F-QLI) is a comprehensive multi-dimensional measurement tool that reflects the priorities and goals of families seeking counseling services. It is designed to be administered by social service agencies providing family preservation services. On the basis of previous research, our clinical experience, and recommendations from an advisory board convened to develop the instrument, we defined quality of family life as made up of the following seven domains: 1) life satisfaction, 2) activities of daily living, 3) physical health, 4) psychological well-being, 5) social relations, 6) alcohol and other drug abuse, and 7) goal attainment. Each domain can be individually weighted depending on its relative importance to the respondent. The goal attainment domain is helpful for both family members and the service provider in that it allows respondents to explicitly specify unique family goals in utilizing social services. Multiple respondents within the family can fill out the form so the service provider can assess differences between family members on perceptions about family QoL and counseling goals. The Family Quality of Life Index was designed to be self-administered though it can be administered verbally by the service provider when necessary. The independent domains of the F-QLI are briefly described below. Each domain can be scored separately and the separate domain scores can be added to produce the total quality of family life score. There is a parallel form for providers which can be used by professionals to assess clients' family QoL. The conceptual model for the F-QLI is found on page 62.

DOMAINS

Life-Satisfaction

These questions measure respondent's overall satisfaction about the quality of their family life. This domain includes a broad array of issues such as satisfaction with how the family spends time together, the housing they live in, personal safety, family routine and social services. Each indicator is rated for satisfaction with the item and for its importance. The score for each item is determined by multiplying each client's satisfaction response with the importance response.

Activities of Daily Living

This domain focuses on the family's day-to-day activities together. Questions in this domain ask about such things as how many meals a week the family eats together and satisfaction with family activities.

Physical Health

Questions in this domain inquire about the respondents physical health and functional capacity for accomplishing basic tasks.

Psychological Well-Being
Among other things, this domain uses the well-validated Bradburn Affect Balance Scale (ABS) to measure the respondent's sense of emotional well-being. The ABS is a widely used and well validated scale that has been used by other researchers attempting to operationalize and study psychological well-being. The ABS includes separate assessments of negative and positive affect. This domain also asks the respondent about coping ability and capacity to handle stress.

Social Relations
These questions measure respondent's satisfaction with how their family gets along with one another. Respondents are asked to rate the amount of support they experience from their relationships and their perceived satisfaction with their family's social relations.

Alcohol & Other Drugs
These questions ask about alcohol and other drug use and the extent to which family members' perceive their drug or alcohol use to be a problem in their lives. These questions allow clinicians and program evaluators to examine differences in quality of family life and program effectiveness for families with and without AODA problems.

Goal Attainment
This section focuses on family members' goals. Respondents are asked to specify the three most important goals they wish to accomplish as a result of the services to their family. Goals are ranked both in terms of their relative importance to the respondent as well as the extent to which the responder feels each goal has been achieved.

Other Analyses of Interest in The Family Quality of Life Index
The Family Quality of Life Index contains a number of items that do not load in any specific domains in the total family QoL score but which are valuable in both an applied and theoretical context. Examples of these include:

Hope
This question (Q5) provides the opportunity to examine the role of hope for improvement in family QoL and how family preservation outcomes vary depending on differing levels of hope.

Locus of Control
This question (Q6) provides the opportunity to examine how differences in respondents' sense of control over important areas of family life impacts treatment outcomes and overall quality of family life.

The Family Quality of Life Index

Your Name:_____

Date of Completion: ___/___/___

Directions: We are interested in your views and feelings. The questions in this booklet ask for your opinions about the quality of your family life. When you answer each question please indicate the response which most closely reflects your point of view.

For Office Use Only

Study Location: _____

Study ID: _____

Responsible Indvidual: _____

BACKGROUND INFORMATION

What is your date of birth?_____

.....

You are? __ Male __ Female

.....

What is your highest school grade completed: _____

.....

What is your current relationship/marital status?

- ☐ Single/Never Married
- ☐ Married
- ☐ Divorced
- ☐ Committed relationship
- ☐ Separated
- ☐ Spouse deceased

How many times have you been married? _____

.....

Please list members residing in your household:

Name (First names only)	Relationship to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is the source of your family's income? (Check all that apply)

- ☐ Paid employment
- ☐ Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)
- ☐ Veterans disability or pension benefits
- ☐ General assistance
- ☐ AFDC
- ☐ Unemployment compensation
- ☐ Retirement, investment or savings
- ☐ Alimony or child support
- ☐ Money shared by your spouse/partner
- ☐ Money from your family
- ☐ Other source: _____

.....

What is your racial/ethnic background? (Check all that apply)

- ☐ American Indian/Native American
- ☐ Asian
- ☐ African American
- ☐ Hispanic/Latino
- ☐ White
- ☐ Other, specify: _____

.....

During the past four weeks, you lived: (Check all that apply)

- ☐ alone
- ☐ with roommate/friend
- ☐ with children
- ☐ with parents
- ☐ with significant other/spouse
- ☐ with other, please specify: _____

Who would you like to live with? (Check all that apply)

- ☐ alone
- ☐ with parents
- ☐ friend/roommate
- ☐ with significant other/spouse
- ☐ with children
- ☐ with other, please specify: _____

During the past four weeks, you lived primarily: (Check one)

- ☐ in an apartment/home
- ☐ at school/college
- ☐ in a boarding home
- ☐ in an institution (i.e. hospital or nursing home)
- ☐ in a group home or halfway house
- ☐ in jail/prison
- ☐ homeless
- ☐ foster home
- ☐ other, please specify:_____

In regard to your housing, does your family:

☐ rent ☐ own ☐ have subsidized housing ☐ other, please specify: _____

How adequate is your housing? (Check one)

☐ Very inadequate	☐ Moderately inadequate	☐ A little inadequate	☐ Neither adequate nor inadequate	☐ A little adequate	☐ Moderately adequate	☐ Very adequate

Now we would like to ask you some questions about your satisfaction with aspects of your family life.

SATISFACTION LEVEL

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied nor dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the way you and your family spend time together?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with the activities you do with your family?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with the meals your family shares?	☐	☐	☐	☐	☐	☐	☐

□ Don't eat together							
How satisfied or dissatisfied are you with the food your family eats?	□	□	□	□	□	□	□
	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied nor dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you when you are alone?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with your family's housing?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with your neighborhood as a place for your family to live in?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with the safety of your neighborhood?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with your personal safety?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with the clothing your family wears?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with routines (i.e. time for bed, meals, school, work) in your family? **□ No routines**	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with the services your family uses?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with your family's access to transportation?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with your sex life? **□ Does not apply**	□	□	□	□	□	□	□

We have asked how satisfied you are with different parts of your family life. Now we would like to know how important each of these aspects of your family life are.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important to you is the way your family time is spent?	☐	☐	☐	☐	☐
How important to you are the activities you do with your family?	☐	☐	☐	☐	☐
	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important is sharing meals with your family?	☐	☐	☐	☐	☐
How important to you is the food your family eats?	☐	☐	☐	☐	☐
How important is it to feel comfortable when alone?	☐	☐	☐	☐	☐
How important is your family's housing?	☐	☐	☐	☐	☐
How important is your neighborhood as a place for your family to live in?	☐	☐	☐	☐	☐
How important is your neighborhood safety?	☐	☐	☐	☐	☐
How important is your personal safety?	☐	☐	☐	☐	☐
How important to you is the clothing your family wears?	☐	☐	☐	☐	☐
How important to you is it that your family have routines (i.e. time for bed, meals, school, work)?	☐	☐	☐	☐	☐
How important to you are the services your family uses?	☐	☐	☐	☐	☐
How important to you is your family's access to transportation?	☐	☐	☐	☐	☐
How important to you is your sex life?	☐	☐	☐	☐	☐

ACTIVITIES AND OCCUPATIONS

In the **past four weeks**, would you say that your family life has been:

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

.....

During the **past four weeks**, you have: (Check one)

- been working/studying or doing housework more than usual
- been working/studying or doing housework in your usual manner
- been working/studying or doing housework but less often
- stopped working/studying or doing housework

About how many hours a week do you work or go to school? Hours per week = _____

What is your occupation?

Do you work:? inside the home outside the home

.....

Below are activities that you may have participated in recently. Please check YES or NO to indicate whether you have done the activity in the **past four weeks**.

YES	NO		YES	NO	
		Gone for a walk			Gone to a social group
		Gone to a movie or play			Read a magazine or newspaper
		Watched TV			Gone to church, synagogue, mosque
		Played cards			Listened to a radio
		Played a sport			Gone to a library

How do you and your family spend time together? Please list the most frequent activities below.

1._____

2._____

3. _____

We spend no time together

.....

Do you feel that you are engaged in family activities: (Choose one)

Less than you would like More than you would like As much as you want

_____

How many meals in a week does your family eat together? _____

(number of meals)

.....

Overall, I feel close to my family.

Not at all	A little bit	Somewhat	Quite a bit	Very much
□	□	□	□	□

HEALTH AND WELL-BEING

Now we would like to know how you feel about things in your life. For each of the following questions, check the boxes that best describe how you have felt in the <u>past four weeks</u>.

YES	NO	
☐	☐	Pleased about having accomplished something?
☐	☐	Very lonely or remote from other people?
☐	☐	Bored?
☐	☐	That things went your way?
☐	☐	So restless that you couldn't sit long in a chair?
☐	☐	Proud because someone complimented you on something you had done?
☐	☐	Upset because someone criticized you?
☐	☐	Particularly excited or interested in something?
☐	☐	Depressed or very unhappy?
☐	☐	On top of the world?

In general, I am able to accomplish the things that I need to do.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

In general, I am able to cope with conflict and stress.

☐ All of the time ☐ Most of the time ☐ A good` bit of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

In the **<u>past four weeks</u>**, you would best describe your physical health as:

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

How do you feel about your physical health? (Check one)

☐ Very dissatisfied ☐ Moderately dissatisfied ☐ A little dissatisfied ☐ Neither satisfied nor dissatisfied ☐ A little satisfied ☐ Moderately satisfied ☐ Very satisfied

How important to you is your physical health? (Check one)

☐ Not at all important ☐ Slightly important ☐ Moderately important ☐ Very important ☐ Extremely important

Have you been prescribed medications?

 Yes No

If yes, please list all medications:

_____ _____
_____ _____
_____ _____

Do you take these medications as prescribed?

 Yes No

If you take medications for behavioral or mood problems, do you feel the medication helps?

 Not at all Some A fair amount Quite a bit Eliminates all symptoms

ALCOHOL & OTHER DRUGS

Over the **past four weeks**, have you drank any alcohol?

 Yes No

If yes, on how many days have you had any alcohol to drink? _____
(number of days)

On the days you drank, what was the average amount you consumed?_____
(number of drinks per day)

.....

Over the **past four weeks**, have you used any street drugs (cocaine, marijuana, heroin, speed, LSD, etc.)?

 Yes No

If yes, on how many days have you used any street drugs? _____
(number of days)

.....

Over the **past four weeks**, have you used tobacco?

 Yes No

If yes, on how many days have you used tobacco? _____
(number of days)

Now that we have asked you about your substance use please tell us about its effects on your life. Please check all the answers that apply and most closely reflect your situation.

SUBSTANCE USE

	Alcohol	Tobacco	Marijuana	Other Street Drugs	Prescription Drugs	Over the Counter	Caffeine
No use	☐	☐	☐	☐	☐	☐	☐
Use, but no problem	☐	☐	☐	☐	☐	☐	☐
Use, but it helps me	☐	☐	☐	☐	☐	☐	☐
Moderate problem	☐	☐	☐	☐	☐	☐	☐
Severe problem	☐	☐	☐	☐	☐	☐	☐
Extremely severe problem	☐	☐	☐	☐	☐	☐	☐

Has anyone ever spoken to you about your substance use?

☐ Yes ☐ No

If yes, did they consider your use as a problem?

☐ Yes ☐ No

SOCIAL RELATIONS / SUPPORT

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied nor dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the number of friends your family has? ☐ **No friends**	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with how you and your family get along with friends?	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with your relationship with your children? ☐ **No children**	☐	☐	☐	☐	☐	☐	☐
How satisfied or dissatisfied are you with your relationship with your spouse/partner? ☐ **No spouse/partner**	☐	☐	☐	☐	☐	☐	☐

				Neither			

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	satisfied nor dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the way your family communicates with each other?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with how your family expresses caring for one another?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with how you get along with people outside of your family?	□	□	□	□	□	□	□
How satisfied or dissatisfied are you with the way your family resolves problems?	□	□	□	□	□	□	□
How many people outside of your family do you count as your friends?	□ none	□ 1-2	□ 3-5	□ over 5			

IMPORTANCE LEVEL

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important is it to have friends outside of the family?	□	□	□	□	□
How important is it to get along with friends?	□	□	□	□	□
How important is your relationship with your child/children?	□	□	□	□	□
How important is your relationship with your spouse?	□	□	□	□	□
How important is family communication?	□	□	□	□	□
How important is the expression of caring within the family?	□	□	□	□	□
How important is it for family members to get along?	□	□	□	□	□
How important to you is the way your family resolves problems?	□	□	□	□	□

During the **<u>past four weeks</u>**, you have (check one):

□ been having good relationships with others and receiving support from family and friends

□ been receiving only moderate support from family and friends

□ had infrequent support from family and friends or only when absolutely necessary

GOAL ATTAINMENT

What do you hope to accomplish as a result of the services to your family? Please write below up to 3 goals:

Goal 1:

_____

_____

How important is this goal to you? Please check the box below to indicate how important this goal is to you.

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent have you achieved this goal? Please check the box below to indicate the extent to which you have achieved this goal.

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

Goal 2:

_____

_____

How important is this goal to you?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent have you achieved this goal?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

Goal 3:

_____

_____

How important is this goal to you?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent have you achieved this goal?

Not at all achieved	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10 **Completely achieved**

Please check the box below to indicate how you feel about your family's quality of life during the **past four weeks.**

Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

LOWEST QUALITY	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10 **HIGHEST QUALITY**

If your family's quality of life is less than you hope for, how hopeful are you that you will eventually achieve your desired quality of life? (Check one)

□ Not at all □ Somewhat □ Moderately □ Very

How much control do you feel you have over the important areas of your family life? (Check one)

□ None □ Some □ A moderate amount □ A great amount

Has a child from your family ever been placed outside the home?

□ Yes □ No If yes, for how long?_____

Have you ever believed that your family would be better off if a child was placed outside the home?

□ Yes □ No

Do you think that it is possible that a child may be placed out of the home in the future?

□ Yes □ No

How important are each of the following factors in determining your family's quality of life?	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Family activities	□	□	□	□	□
Your feelings about the family	□	□	□	□	□
Your physical health	□	□	□	□	□
Friends, people you spend time with	□	□	□	□	□

outside of the family					
Ability to take care of yourself and your family	□	□	□	□	□
Your emotional health	□	□	□	□	□
Other, please specify:	□	□	□	□	□

Is there anything else you would like us to know?

This is the end of the questionnaire. Thank you for giving your opinion and sharing your responses with us. If you have any questions about this questionnaire, please call or write Marion Becker, Ph.D., University of South Florida, Department of Community Mental Health, 13301 Bruce B. Downs Blvd., MHC 1423, Tampa, Florida 33612-3899 Telephone: (813)974-7188 Fax: (813)974-6469 E-Mail: .becker@fmhi.usf.edu

THE FAMILY QUALITY OF LIFE INDEX (F-QLI)
PROVIDER QUESTIONNAIRE

CONCEPTUAL FRAMEWORK

The Family Quality of Life Index (F-QLI) Provider Questionnaire is a parallel form to the F-QLI, which is optional in its use. It can be a very useful tool in clinical practice primarily because it is easy for providers to assume more concordance with clients than actually exists. Use of the Provider form allows clinicians to understand the reality of the commonality or discordance that exists between providers and clients. The domains closely parallel those of the client version with some modifications and are as follows:

DOMAINS

Activities of Daily Living
This domain focuses on the family's day-to-day activities together. This domain also asks about the clinician's overall rating of the family's ability to spend time together.

Psychological Well-Being
These questions ask the clinician to rate the family's ability to accomplish things that need to be done and cope with stress and conflict.

Social Relations/Support
Questions in this section allow the clincian to rate the family's social relations. Questions ask about the family's experiences with each other, friends and involvement in social or community activities.

Money
These questions ask the clincian to evaluate the family's satisfaction and importance placed on money as well as the degree to which financial limitations may restrain families from doing what they want.

Alcohol & Other Drugs
These questions ask about alcohol and other drug use and the extent to which the provider perceives the use to be a problem. Evaluations can be made for more than one individual in the family by using supplemental Substance Use Forms. Additionally, these questions allow providers and program evaluators to examine differences in QoL and program effectiveness for clients with and without AODA problems. These questions can also be used to compare the degree to which their is congruence between clinician and client about whether AODA issues are a problem in a family's life.

Goal Attainment

This section contains questions that ask for the clinician's goals to improve the family's QoL. Clinicians are asked to specify the three most important goals for the family and rank them in terms of importance and extent to which the goal has been achieved.

The Family Quality of Life Provider Questionnaire

Client Name: _____

Date of Completion: ___/___/___

For Office Use Only

Study Location: _____

Study ID: _____

Responsible Individual: _____

You are: female _____ male _____

BACKGROUND INFORMATION

Please list the names and birth dates of all members of this family:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

.....

How adequate is this family's housing? (Check one)

□ Very inadequate	□ Moderately inadequate	□ A little inadequate	□ Neither adequate nor inadequate	□ A little adequate	□ Moderately adequate	□ Very adequate

What type of housing subsidy does this family receive: _____

_____

□ No subsidy

How many times has this family moved in the last year: _____

During the **past four weeks**, would you say that this client's family life has been:

□ Poor □ Fair □ Good □ Very Good □ Excellent

.....

During the **past four weeks**, this client has: (Check one)

- □ been working/studying or doing housework more than usual
- □ been working/studying or doing housework in your usual manner
- □ been working/studying or doing housework but less often
- □ stopped working/studying or doing housework

.....

During the past four weeks, this family has:

 been spending more time together than usual
 been spending as much time together as usual
 been spending time together but less often
 stopped spending time together

.....

Is this client engaged in family activities: (Choose one)

 Less than they should be More than they should be As often as they should

Does this family attend any social activities (e.g. church, club or interest group)?

 Frequently Occasionally Rarely Never

Does this family generally make and keep up friendships?

 Friendships made and kept up well Friendships made and kept up with considerable difficulty

 Friendships made and kept up with some difficulty Few friendships made and none kept up

How would you describe the quality of this family's relationship with each other?

 Poor Fair Good Very good Excellent

How does this family feel about the money they have?

 Very dissatisfied Neither satisfied nor dissatisfied Very satisfied
 Moderately dissatisfied A little satisfied
 A little dissatisfied Moderately satisfied

How important to this family is money?

 Not at all important Moderately important Extremely important
 Slightly important Very important

How often does lack of money keep this family from doing what they want to do?

 Never Sometimes Frequently Almost always

.....

HEALTH AND WELL-BEING

In general, this family is able to accomplish the things that they need to do.

Strongly agree	Agree	Disagree	Strongly disagree

In general, this family is able to cope with conflict and stress.

 All of the time Most of the time A good` bit of the Some of the time A little of the None of the time

time time

ALCOHOL & OTHER DRUGS

Does any member of this family use alcohol or other drugs?

□ Not at all *(skip next question)* □ Rarely □ Occasionally □ Often

Who in the family uses drugs? Please specify: _____

_____

To what extent does this use of alcohol or other drug use concern you?

□ Not at all □ Slightly □ Moderately □ A lot

SUBSTANCE USE

Please indicate the extent of your client's substance use and the individual being evaluated: _____.
(Supplemental Substance Use forms are available if more than one person is to be evaluated.)

	Alcohol	Tobacco	Marijuana	Other Street Drugs	Prescription Drugs	Over the Counter	Caffeine
No use	□	□	□	□	□	□	□
Use, but no problem	□	□	□	□	□	□	□
Use, but it helps	□	□	□	□	□	□	□
Moderate problem	□	□	□	□	□	□	□
Severe problem	□	□	□	□	□	□	□
Extremely severe problem	□	□	□	□	□	□	□

During the **past four weeks**, this family has (check one):

□ been having good relationships with others and receiving support from family and friends

□ been receiving only moderate support from family and friends

□ had infrequent support from family and friends or only when absolutely necessary

GOAL ATTAINMENT

What are your goals for this family? Please write below up to 3 goals:

Goal 1:

_____

_____

How important is this goal?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent has this goal been achieved?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

Goal 2:

_____

_____

How important is this goal?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent has this goal been achieved?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

Goal 3:

_____

_____

How important is this goal?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Extremely									
important	1	2	3	4	5	6	7	8	9	10
	Important									

To what extent has this goal been achieved?

Not at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Completely									
achieved	1	2	3	4	5	6	7	8	9	10
	achieved									

Please check the box below to indicate your rating of this family's quality of family life during the **past four weeks.**

Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

LOWEST	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ **HIGHEST**
QUALITY	1	2	3	4	5	6	7	8	9	10 **QUALITY**

How confident are you that your rating of this family's quality of family life is accurate? (Check one)

☐ Not at all confident ☐ Very confident

☐ Quite confident ☐ Absolutely confident

Has a child from this family ever been placed outside the home?

☐ Yes ☐ No If yes, for how long?_____

Which child/children was it? _____

Do you believe that this family would be better off if a child was placed outside the home?

☐ Yes ☐ No

If yes, which child/children are you referring to? _____

Is it possible that a child may be placed out of the home in the future?

☐ Yes ☐ No

How important are each of the following factors in determining your client's quality of family life?	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Family activities	☐	☐	☐	☐	☐
Feelings about the family	☐	☐	☐	☐	☐
Physical health of family	☐	☐	☐	☐	☐
Friends, people they spend time with outside of the family	☐	☐	☐	☐	☐

Ability to take care of themselves and the family	□	□	□	□	□
Emotional health	□	□	□	□	□
Other, please specify:	□	□	□	□	□

Is there anything else we should know about this client?

This is the end of the questionnaire. Thank you for giving your opinion and sharing your responses with us. If you have any questions about this questionnaire, please call or write Marion Becker, Ph.D., University of South Florida, Department of Community Mental Health, 13301 Bruce B. Downs Blvd., MHC 1423, Tampa, Florida 33612-3899 Telephone: (813)974-7188 Fax: (813)974-6469 E-Mail: .becker@fmhi.usf.edu

Wisconsin Quality of Life Index Agreement

We hereby grant the use of the Wisconsin Quality of Life Index (W-QLI) to the undersigned in the following terms:

The user is granted use of the W-QLI for clinical and research purposes on a royalty-free basis provided the unidentified data is shared with the developers of the index. This lease is for the sole use of the user identified below and the clinical research group to which s/he is affiliated.
The instrument or any translation thereof may not be used by any other entity or group without written permission from the Principal Investigator. Any other use of the W-QLI without the express written consent of the authors is prohibited.

The user agrees to provide the authors of the W-QLI a copy of the final data and demographic information which should be used for further development of the W-QLI.

AGREED this_____ day of_____19

_____
Signature of Collaborative User

_____
Printed Name of Collaborative User

Address: _____
_____
_____
_____
_____
Telephone: _____
Fax: _____
Email: _____

Study Title:
_____
_____

Anticipated Start and End dates: _____
Participants (anticipated number, demographics, where obtained)
_____
_____
_____
_____

_____

Marion Becker, Ph.D., Principal Investigator

_____

Ronald Diamond, M.D., Co-Investigator

A-QLI and F-QLI Agreement

We hereby grant the use of the Quality of Life Index for Adults (A-QLI) and/or The Family Quality of Life Index (F-QLI) to the undersigned in the following terms:

The user is granted use of the A-QLI and/or F-QLI for clinical and research purposes on a royalty-free basis provided the unidentified data is shared with the developers of the index. This lease is for the sole use of the user identified below and the clinical research group to which s/he is affiliated.
The instrument or any translation thereof may not be used by any other entity or group without written permission from the Principal Investigator. Any other use of the A-QLI and/or F-QLI without the express written consent of the authors is prohibited.

The user agrees to provide the authors of the A-QLI and F-QLI a copy of the final data and demographic information which should be used for further development of these instruments.

AGREED this_____ day of_____19

_____

Signature of Collaborative User

_____

Printed Name of Collaborative User

Address: _____
_____
_____
_____
_____

Telephone: _____
Fax: _____
Email: _____

Study Title:

_____
_____

Anticipated Start and End dates: _____
Participants (anticipated number, demographics, where obtained)
_____
_____
_____
_____

_____
Marion Becker, Ph.D., Principal Investigator

Requesting an Index

The instruments described in this manual are available on a royalty-free basis. Permission to use and reproduce the questionnaire is granted to individuals, organizations, and other investigators for their use upon receipt of the completed corresponding user's agreement found on either page 56 or 57. To help the developers monitor the use and application of the scales, users are requested to share information about their experiences and publications. In return, users will be assisted in the interpretation of the results and be notified of any advancement in the administration and scoring of the questionnaires.

Requests regarding the Quality of Life Questionnaires should be directed to:

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