A number of research groups have been advancing the conceptualization and measurement of quality of life in the mental health field for more than a decade (Lannon, 1980; Lehman, 1983, 1988; Lehman, Ward, & Linn, 1982; Mercier, 1987; Zautra, Beier, & Coppel, 1977;). The concept has both subjective and objective components. The subjective component is frequently referred to as "well-being," "life satisfaction," and "happiness" (Bradburn, 1969). The objective component is less clearly described but of great importance.

Quality of Life Theory

I and my colleagues have developed and applied a concept and measure of quality of life as a mental health service outcome (Barron, 1984; Bigelow, & Beiser, 1978; Bigelow, Brodsky, Steward, & Olson, 1982; Bigelow, McFarland, Gareau, & Young, in press; Bigelow, & Hooper, 1977; Bigelow, & Young, in press; Field, & Yegge, 1982; Hammaker, 1983). Our concept of quality of life is drawn largely from need (Maslow, 1954) and role (Sarbin & Allen, 1968) theories. Quality of life, as we view it, consists of the fulfillment of needs and the meeting of demands which society places upon its members. Needs are met through opportunities presented by the social environment. Demands are met through the exercise of basic psychological abilities—cognition, affect, perception, and motor. For example, a work role demands concentration and stress tolerance while it provides opportunities for meeting self-esteem, social affiliation, and basic needs.

Demands and opportunities are tailored to the average person's abilities and needs, e.g., competitive employment is designed for people who can consistently tolerate stress eight hours per day. Abilities which have been impaired by mental illness deprive a person of the satisfaction of his/her needs by rendering the person uncompetitive in the normal opportunity structure. Mental health services reduce barriers to meeting clients' needs—excessive demands, restricted opportunities, or impairment of ability. If the service succeeds, people with mental disabilities enjoy an improved quality of life, even without eradication of disabilities. Our Quality of Life Interview is designed to evaluate these successes.

The Quality of Life Interview

We had previously experienced difficulties with highly structured interviews such as the Oregon Quality of Life Questionnaire, self-report version (Bigelow, Brodsky, Stewart, & Olson,
1982), when we interviewed clients with chronic mental illness. Chronic mental illness causes
difficulties in understanding reality, abstract thinking, choosing, and interpersonal processes.

Therefore, we designed a procedure which used a less structured interview and decreased
demands upon the interviewee to choose among response alternatives. At the same time, we
constructed our instrument to discriminate within the range of functioning, resources, and special
problems experienced by individuals with chronic mental illness. Ratings are based on
information gained from the client during a semi-structured interview, the interviewer's own
observations, and clinical judgment. Additional information may be sought from family,
clinicians, and landlords. The interviewer then uses his/her own judgment to decide on the appro-
priate rating for each item.

Domains covered by the interview are housing, self and home maintenance, finances,
employment, psychiatric medications, physical health, the meaningful use of time, psychological
distress, psychological well-being, and interpersonal functioning. Satisfaction of need and
performance are assessed within domains. Service items pertaining to the domains are included
to facilitate evaluation of the service program.

The objectives of the project reported here were to (1) test the feasibility of an interview
designed to enhance rapport and increase the validity of responses, (2) test the centrality of
quality of life domains to the lives of persons with chronic mental illness, (3) test the
appropriateness and sensitivity of items and response scales, and (4) determine the inter-rater
reliability of the interview.

Methodology

A prototype of this instrument was used successfully in an evaluation of a case management
program (Bigelow & Young, in press). The prototype was based on our previous, extensively
tested, self-report instrument measuring most of the same aspects of quality of life (Bigelow,
Brodsky, Stewart, & Olson, 1982). The latter, itself, was developed from the well-researched
Denver Community Mental Health Questionnaire (Ciarlo & Reihman, 1977). The instrument and
procedures were further developed by a team of clinicians and a researcher in three months of
interviewing representative clients, detailed discussion of the results, and revision. This lengthy
development process resulted in an instrument with good face validity and many of the bugs
worked out before the reliability test reported here.

Interviews were conducted with six clients with chronic mental disability to quantify
inter-rater reliability. These six clients were selected from caseloads of three direct service
agencies in a three-county metropolitan area. The clients were stable at the time of the interview.
Six experienced raters participated in each interview. Interviews took place in clients' homes.
One rater conducted the interview, the remainder asked additional questions at the end.

Results

There were 36 scores for each item, to which two measures of reliability were applied. The
percentage of agreements across raters (a flexible but insensitive measure) was calculated for
each item. Cronbach's alpha were calculated for the 86 items having at least ordinal response scales. Alpha is a sensitive measure of the consistency among judges (who are, in this analysis, analogous to six items on a multi-item scale).

The interviewer rating method appeared to improve rapport with severely impaired clients and, furthermore, elicited important information about clients' quality of life which the clients, themselves, did not seem to fully and accurately report. Obvious lack of self-awareness was superseded by interviewer judgement and client ambivalence about choosing response alternatives was avoided.

Raters agreed on between 58% and 100% of their 36 judgements for each of the 146 items in the QOL Interview. More than half the items elicited greater than 90% agreement among judges. Of the 86 items with at least ordinal scales, 56 items had Cronbach's alpha greater than .70 and more than half were above .80.

The least agreement indicated by Cronbach's alpha was found for items concerned with keeping up with housework (.32), keeping up with shopping and errands (.49), satisfaction with own room (.53), tangible social support (.63), adequate medication (.65), and informational support (.68).

Conclusions

Evaluations of community support programs for people with chronic mental illness are usually conducted with limited resources and under conditions unfavorable to precise measurement and sound research design. The Quality of Life Interview (Interviewer Rating Version) has characteristics that render it useful for program evaluation under such conditions. Inter-rater reliability was generally good, despite the very small sample used in this study. The items, procedures, and quality of life concept have good face validity (that is, credibility and acceptance among experienced practitioners). The interview can be readily administered (by clinicians or others having significant experience with the target population). It can also be easily scored and used in reports. Furthermore, the interview (in prototype and current form) has been used successfully in several program evaluations (Barron, 1984; Bigelow, McFarland, Gareau, & Young, in press; Bigelow & Young, in press).

The Quality of Life Interview (Interviewer Rating Version) is among a number of outcome instruments (Ciarlo, Brown, Edwards, Kiresuk, & Newman, 1986; Lehman, 1988) suitable for evaluation of mental health programs. Although these instruments are adequate for the purpose of program evaluation, there is still a great deal of room for research on quality of life and for more precisely measuring the quality of life of persons with mental illness.

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REFERENCES


