EFFECTS OF THERAPY
ON QUALITY OF LIFE OF CLIENTS
AT AN ALTERNATIVE COMMUNITY MENTAL HEALTH AGENCY

BY

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A THESIS

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CHAPTER I

INTRODUCTION

Rapidly escalating costs of mental health services makes it important to determine their true effectiveness. As a labor intensive service, mental health care costs are tied to the rising costs of living. The gap between available funding, on the one hand, and costs of service delivery, on the other, continues to widen, leaving more and more individuals without needed services.

One possible remedy for this situation lies in the provision of "traditional" services using "non-traditional" delivery systems. Creative use of available resources may make it possible to provide services to indigent people in ways which will make minimal demands on the taxpayer.

The present study represents an effort to evaluate the ability of a non-traditional agency to provide useful services to a client population which would ordinarily be cared for by a government-funded (city, county, state or federal) agency. The study examines the effects of therapy on the quality of life of clients receiving services at an alternative community mental health agency in an attempt to determine whether quality mental health services can be provided at minimal cost to the client or taxpayer. The agency in the study may present a model for a new type of mental health service delivery as well as a model for the training of psychiatric nurses and other mental health professionals. It is staffed by volunteer professional counselors and graduate students who receive ongoing weekly training sessions and contact with fellow professionals in exchange for their services.

The instrument chosen to measure quality of life was the Oregon Quality of Life Questionnaire (OQLQ), developed by Brodsky, Bigelow, and others (1980) at the Oregon State Division of Mental Health. It has been used to evaluate mental health services in mental health agencies in Oregon. Maslow's Theory of Needs (1943) formed the conceptual base for instrument development. The conceptual base for the instrument is compatible with Martha Rogers' holistic nursing theory, as it deals with the needs and abilities of an individual participating in his/her environment.

Conceptual Framework

It is not the purpose of this research to demonstrate that the program under study provides better services than other, more traditional agencies (although this may, indeed, be true). Rather, the study is to investigate whether or not adequate services, at least comparable to those in traditionally funded agencies, can be provided by volunteer professional counselors and advanced graduate students.

Variables

The independent variable in this study is the mental health services (therapy) provided at Aslan House Counseling Center, an alternative community mental health agency, located in Eugene, Oregon. The agency provides traditional mental health treatment to persons most of whom can be diagnosed as having psychoneurotic disorders.

The dependent variable is the quality of life of clients at Aslan House, as defined by the Oregon Quality of Life Questionnaire. There has been increasing emphasis over the past two decades in the community mental health literature on evaluation of community mental health programs (Stewart, 1979). An active program for the evaluation of mental health

services has been developed over the past four years in the State of Oregon by Brodsky, Bigelow, and others at the Oregon State Mental Health Division (1980). The Oregon Quality of Life Questionnaire (OQLQ) was developed to assess adjustment from both individual and social points of view.

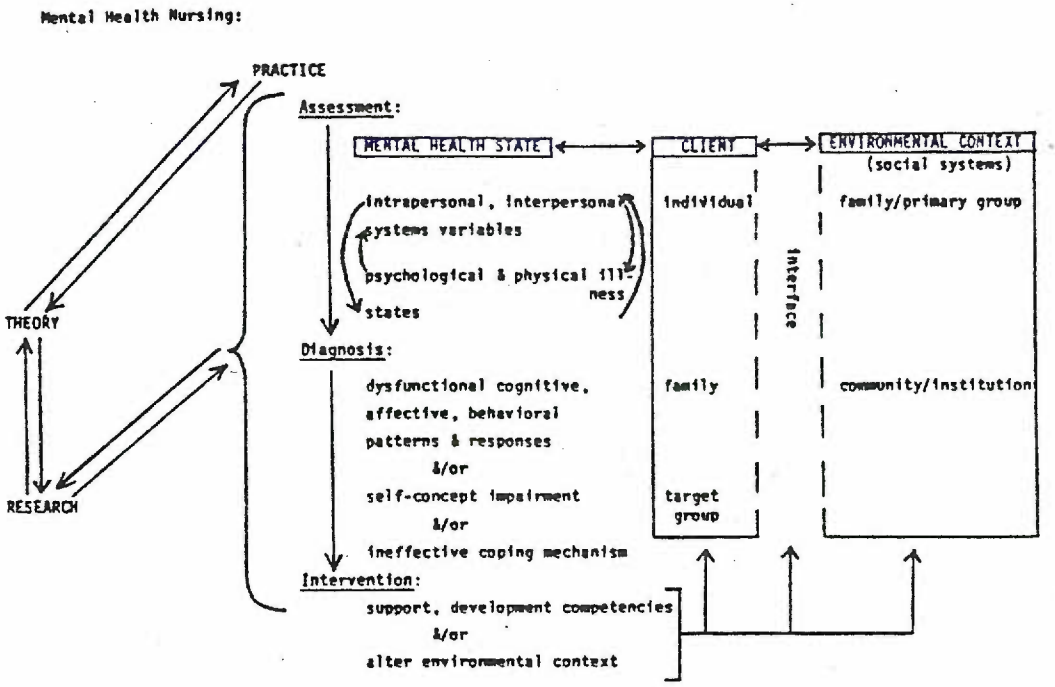
The conceptual framework used by Brodsky and Bigelow for the OQLQ is developed around Maslow's theory of a hierarchy of needs (Maslow, 1943). Campbell's "domains" idea (1976) has been incorporated by Brodsky and Bigelow along with the emphasis on personal relationships that was stressed by Bateson (1972) and by Dalkey (1972). The individual is seen as embedded in his environment, and each human being has two broad characteristics which are considered in the Oregon Quality of Life Questionnaire: needs and abilities.

The conceptualization on which the evaluation instrument is based is compatible with Martha Roger's nursing theory (Rogers, 1971). Maslow's Theory of Motivation is consistant with nursing theory, especially Rogers', which is concerned with promoting optimal health for the individual, the family, the community, and society. Since psychiatric nurses practice in a variety of settings, and frequently are a part of an interdisciplinary team, a comprehensive framework is necessary for doing nursing research. The theory provided by Rogers and the conceptual framework for the OQLQ are comprehensive, and are concerned with individuals participating within the environment.

Psychiatric nusing has no single conceptual framework at this time. However, the psychiatric-mental health nursing department at the Oregon Health Sciences University is in the process of developing one, a rough draft of which is shown in Figure 1. As can be seen, the concepts mentioned in this framework are also present in the OQLQ conceptual base.

FIGURE 1

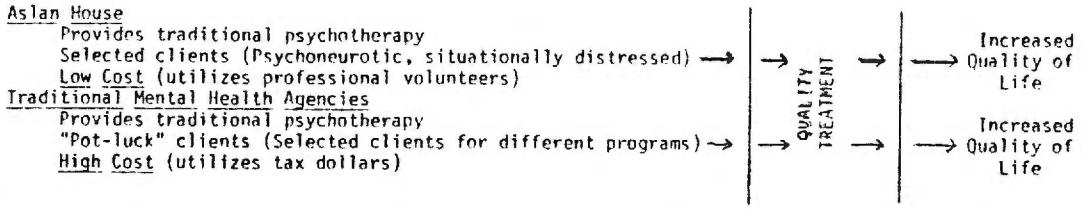
Conceptual Framework of Psychiatric Nursing



The question of whether or not counseling and psychotherapy are, in fact, at all effective in changing a client's quality of life is, of course, one which has received extensive research attention over the last three decades. It is clearly beyond the scope of the present study to address this question in any definitive way. The investigator has, however, attempted to investigate the efficacy of the agency under consideration in bringing about measurable change in clients' life situation, and compares client satisfaction in this agency with client satisfaction in more traditional settings. (The reader is referred to Figure 2 for a schematic presentation of the conceptual framework for the present study).

FIGURE 2

Conceptual Framework for this Study



Hypotheses

Hypothesis 1: The Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more as Aslan House will be higher than their OQLQ scores after just one session at the agency.

Hypothesis 2: The Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more at Aslan House will be higher than the OQLQ scores of other clients who have had just one session of treatment at the agency.

Hypothesis 3: Clients who have received therapy for a period of 60 days or more at Aslan House will report on the OQLQ that the agency has been at least as helpful as clients' reports about other agencies in Oregon which have participated in OQLQ studies.

The purpose of this study is two fold: (1) to determine the effects of therapy on the quality of life of the clients at an alternative community mental health agency, and (2) to compare the clients' perceptions of the helpfulness of the services provided at the agency with clients'

perceptions of the helpfulness of other mental health agencies in the State of Oregon.

Review of Literature

Before the broad objectives of this study can be attained, a survey of existing literature pertinent to the problem must be made. The following section briefly defines mental health services with a short discussion of some literature related to the effectiveness of treatment. Then some exploration is made first of the research describing the growth of agencies providing traditional mental health services, then the research outlining the development of "alternative" means of providing such services, and finally the literature assessing the usefulness of various sorts of volunteer programs. There will also be some exploration of the research that investigates general problems of program evaluation. The section will conclude with a look at the delineation and rationale of the evaluation instrument used in this present research.

Mental Health Services

Before investigating the growth of mental health services, a clear definition of those services should be given. The service provided at the alternative mental health agency in the present study is counseling/psychotherapy. While many experts maintain that there are consistent and important differences between counseling and psychotherapy, other practitioners report that "counselors" and "therapists" (as well as psychiatric nurses and social workers) carry out essentially the same functions (Hahn & MacLean, 1955; Patterson, 1974: Phillips, 1977: Tyler, 1961 & 1969). Therefore the terms "counseling" and "therapy" are used interchangeably in this study.

There are many theories of psychotherapy not all of which are congruent. However, according to Jerome D. Frank (1961), all psychotherapies are "attempts to heal through persuasion." Rachman (1971) says that psychotherapy is "interpretive therapy and not the support, reassurance, encouragement, guidance, and sympathetic listening" which has often been defined as psychotherapy. There has been increasing disagreement about what is to be included in the perimeters of psychotherapy and little consensus about what is to be excluded from its progressively elasticized boundaries (Parloff, 1980).

For the purposes of this study, mental health services are defined as psychotherapy/counseling which is designed not only to restore normal functions, but also to help an individual develop his maximum potential.

Effectiveness of Treatment

Extensive research on the effects of therapy was provoked by Eysenck when he reported his conclusions in 1952 that "psychotherapy makes no difference in the condition of individuals" (Eysenck, 1952). Many clinicians set out to prove that their particular type of therapy, certain theoretical variables, or therapist or client variables made a significant difference in the outcome of therapy (Goldstein, 1962; Gottschalk & Auerbach, 1966; Kilmann, et al, 1979; Rachman 1971; Strupp, 1973).

Although this controversy continues to exist, the preponderent evidence suggests that psychotherapy does indeed make a difference. The Senate Finance Committee recently heard testimony that in over 90 percent of nearly 700 published and unpublished controlled studies of treatment effectiveness, the treated group was more improved than the untreated group (Parloff, 1980). Schoolar and Gaitz state: "We would not get

involved as to what techniques work better - - the variables are so confounding that it is doubtful that we will receive any clear answers. The rights of the recipients of services will have to be more clearly recognized" (Schoolar & Gaitz, 1975).

A recent National Institute of Mental Health (NIMH) task force report concluded that most forms of psychotherapy are effective with about two-thirds of nonpsychotic patients. The report asserts that "concern for positive mental health, along with concern for the conquest of mental illness, is at the core of our interests." The report also found that researchers formerly paid little attention to the psychoneuroses, which are probably the most prevalent form of mental disorder. Recommendations were made for new conceptual methods of mental health service delivery "on information and programs that help foster emotional well-being and self-realization even among those of our citizens who suffer no clearly defined pathology" (NIMH Report, 1975).

The Federal government has actively supported psychotherapy research for the past 35 years. With the development of community mental health centers in the mid 1960's, the government role shifted to support research efforts which were directed "toward achieving clear evidence of the efficacy, safety, and possibly cost-effectiveness of psychosocial treatments" (Parloff, 1980).

Growth of Agencies Providing Mental Health Services

Following the definition of mental health services and discussion of the effectiveness of those services, it is appropriate to briefly discuss the trend toward providing psychotherapy services in the community. It has been almost a half century since Herbert Hoover campaigned for the presidency promising "a car in every garage and a chicken in every pot."

More recently the focus of the American public has shifted from a concentration on being materially well-off to a concern with a sense of psychological and emotional well-being. Yankelovich (1981) has estimated from studies in recent years that as many as eighty percent of all adult Americans are seeking self-fulfillment.

Emphasis has also shifted from providing psychiatric services in institutions to providing mental health services in the community. Along with the shift in the focus of the setting has been a increasing demand of Americans for the provision of mental health services and an accountability of the effectiveness of such services (Tulipan & Cutting, 1972).

As a result of Federal legislation which began with the Mental Health Study Act of 1955 and the Community Mental Health Center Act of 1963, over 750 community mental health centers have been established in an attempt to meet the needs of the American people (Langsley, 1980). These centers were originally referred to as "alternatives to institutionalization." Mental health centers with certain government fundings were required by the Community Mental Health Centers Act of 1963 to offer a wide range of services including: inpatient care, outpatient care, emergency services, partial hospitalization, and consultation and education. Ultimately, five additional services were also to be provided: diagnostic services, rehabilitation services, pre-care and after-care services, training, and research and evaluation (Bloom, 1977).

The community mental health centers have now become "traditional" in that they are defined as those public and private agencies which represent the established mental health services delivery system. This established system includes county hospitals and clinics, community mental health centers, and private practitioners and hospitals.

Alternative Agencies. In contrast to the traditional agencies, alternative facilities are here defined as private, independent agencies which primarily utilize volunteers (who are not necessarily professionally trained), and which are supported by donations and/or a small fee for services. Most alternative facilities are usually located in old houses or store fronts. They are seen as free and independent, and are not subject to regulations and restrictions of any agency other than usually a board of directors. Other characteristics described by Glasscote, et al (1975) include ready availability and anonymity.

Most alternative mental health agencies do not provide the wide range of services required by traditional government funded agencies. They usually provide free or low cost services of a specialized nature such as crisis centers, hot lines, shelters, and church-supported counseling centers. There is controversy in the psychiatric community about specialized versus generalized services (Panzetta, 1971), but the fact remains that there is a high demand for specialized alternative services that are free or low cost to the client.

Alternative agencies were established in the late 1960's as a result of increased use and abuse of drugs by young people. At that time, there was an "anti-establishment" movement, and the alternative agencies provided specialized services to individuals who were not utilizing services in traditional settings. Hot-lines, runaway houses, and free medical clinics were developed primarily to meet the needs of counter-culture young people whose numbers are now diminishing. The original philosophy of the free medical clinics was that health care was a right and that medical institutions should recognize a culturally pluralistic consumer population. A major issue was freedom from "bureaucratic tangles" and

a freedom to relate to the entire individual (Glasscote, et al, 1975).

Since 1967 there have been about 3000 alternative community mental health facilities established (Glasscote, et al, 1975). With decreasing funds to traditional community mental health centers and the inevitable decrease in services, the alternative systems began to be utilized by a wide range of clients. The fact that so many alternate services have been developed indicates that the American tradition of volunteering to help others in need is very strong in this country. In addition, the fact that so many thousands of individuals are utilizing the services indicates that there is a need for alternative services.

The alternative agency in the present study provides a relatively new type of mental health service delivery. Although it cannot be viewed as an alternate service in the same sense as the previously mentioned "alternatives", it differs in important respects from traditional mental health services, in that it uses professional volunteers to provide service and it is not supported by taxes. With the development of the network of alternate services, it becomes more and more difficult to differentiate particular community mental health services as being "traditional" or "alternate" services. Many gaps in mental health services were identified by the American Psychiatric Association in a recent publication (1975). For the purposes of this study, the agency is defined as an alternative agency which fills a gap between traditional facilities and the private sector, on the one hand, and the original alternative facilities which provide mental health services, on the other.

Volunteer Programs. According to Webster's dictionary, a volunteer is "one who enters into or offers himself for a service of his own free will," or, "one who renders a service. . voluntarily, without valuable

consideration. ." (Webster, 1981). While most mental health "volunteers" are not professionally trained, it is clear that this definition does not exclude any donor of services, regardless of professional expertise.

Americans at all levels of society are the greatest providers of volunteer services in the world. People have volunteered their services in hospitals since 1752 (Lucas, 1975). Volunteerism has been an integral part of the American tradition in health services, education, corrections, rehabilitation, and the various phases of community service work. There are more than 115,000 voluntary health and welfare organizations that receive contributions from the general public (Hardy & Cull, 1973). Hardy and Cull state: "Voluntary health agencies are a formulation of sporadic and widespread expression of altruism on the part of the American people. They have been organized to meet the specific needs of a group or groups of individuals concerned about overlooked or inadequately managed conditions in the field of health." Many official health agencies have been stimulated by volunteer activities which have been catalysts of many official programs to meet needs in research or patient care.

As government supported programs have cut-backs in funding, it is necessary to develop concepts of self-help, community support systems, and natural helping networks (Pilisuk, 1980). Pilisuk states: "We are all our brothers' keeper in a society as interdependent as ours has grown." Recently, President Reagan has suggested that an increase in volunteerism would ensure that needed services will continue. The spirit of volunteerism accounts for the fact that over 3000 alternate services have been developed. Unlike Aslan House, most alternate services are staffed by small numbers of volunteers who work long hours and are mainly non-professional. Some agencies, including Aslan House, allow graduate

students to work for academic credit.

As examples of other studies which have evaluated volunteer-staffed agencies, one may refer to Glasscote, et al (1975), and to Hollinger and Tubesing (1979). While the agencies evaluated in these studies were staffed primarily by non-professionals, the volunteer (i.e., donated services) aspect provides a clear parallel to the Aslan House method of mental health service delivery.

The establishment of large numbers of "alternative" or voluntary mental health facilities indicates that the traditional agencies have been unable to meet the needs of all of the people adequately. Some of the difficulty that the traditional settings are having in mental health service delivery may be due to a lack of agreement about the concepts underlying the methods of psychological rehabilitation. The dominant conceptual model used in traditional settings is the disease model described by Parsons in 1951 (Arluke, et al, 1979). Now the trend is toward a wellness model which considers social and environmental factors as potential causes of mental disorder (Holahan, et al, 1979). While there is currently a trend toward the wellness model, it is not widely used or accepted in traditional settings.

Research related to low socio-economic level as one of the primary stressors to mental health and quality of life indicates that there are hundreds of thousands of Americans who do not receive mental health services because of low income (Dohrenwend & Dohrenwend, 1974; Reissman, et al, 1964). The literature of psychology also indicates that the inability to receive needed services (because of low income) is contributory to emotional mal-adaptation (Hollingshead & Redlich, 1958; Klein, 1977). As the economy of the United States tightens, and as the citizens demand

the right to have their needs met, it becomes clear that established methods of mental health service delivery are inadequate. One of the demands of the public is to have professional assistance with problems of living (Lazare, 1975). In the community where the present study took place, Aslan House attempts to fill this need.

Since the nature and purpose of alternative community mental health agencies varies widely, conclusions about the effectiveness of services need to be made on the basis of research done at individual facilities. Funding of alternative facilities is usually more precarious than funding of traditional facilities, services are usually more specialized, and characteristics of the staff may be unique to each agency. The lack of solid funding may also limit the numbers of alternative facilities that have had studies done to determine the effectiveness of their services.

Program Evaluation

Blackwell and Bolman (1977) have articulated some of the problems inherent in program evaluation. They state: "The community mental health center is a relatively new concept in a field in which there is ambiguity about value, standards, and methods." They propose a multilevel, multi-focus approach to evaluation in which goal attainment can be evaluated simultaneously from multiple perspectives. Numbers of researchers have attempted in various ways to incorporate such suggestions in their program evaluations (Holahan, 1979; Kilburg, 1977; Kiresuk & Sherman, 1968).

Other authors have emphasized the importance of program evaluation to ensure that quality of care is sufficient to meet the needs of the population served (Bloom, 1977; Caplan, 1961; Kraus & Howard, 1976; Levy, Herzog, & Slotkin, 1968; Mechanic, 1980; Raeburn & Seymour, 1979; Stewart, 1979).

For the purposes of this review, the general problems facing such evaluations can be summarized as follows:

Because it is field based, rather than laboratory based, program evaluation research is seldom amenable to strict experimental control. This leads to problems in establishing the kinds of conditions necessary to meet the assumptions of traditional experimental designs. Paramount here, and of greatest relevance to the present study, are issues related to sampling, internal validity, and external validity.

Sampling. Ethical and practical considerations preclude both truly random sampling and random assignment of subjects to "treatment" and "no treatment" groups in most program evaluation studies. Rather, convenience samples or post hoc samples are used to take advantage of available data and/or subjects. While this practice violates the assumptions of formal research design, it often appears to present the only available compromise between the needs of the agency and the needs of the researcher. Because of this weakness, statistical "significance" must be viewed with some reservation. While the present study will report such "significant" outcomes, the reader is cautioned that these results should be replicated in similar studies before they can be regarded as firm grounds for theoretical or practical decision-making.

Internal validity. Small, non-random samples often create problems of internal validity. In order to account for effects of all possible causal variables, the Solomon four-group design is a preferred approach; few evaluation studies, however, can follow such an elegant format. Thus, much evaluation research leaves moot the question of how much of the observed changes are the results of pre-testing influences, of concurrent changes in client situation, or of Hawthorne effect (Moursund, 1973).

The present study uses a mixed, quasi-experimental design which, while it cannot deal with all of these problems, does provide some clues as to possible factors affecting observed changes (See "Methods" and "Discussion" sections).

External validity. The fundamental question here is, "Can the observed changes be confidently predicted in groups beyond those actually examined?" - that is, how far can these results be generalized? Again, small, non-random samples inevitably lead to doubts about generalizability. Given the necessary violations of experimental design assumptions, the reader's best strategy is to look to the actual magnitude of differences between comparison groups. If these differences are of practical (as distinguished from statistical) significance they are worthy of attention in the form of follow-up and replication studies.

Purpose. One of the prime purposes of program evaluation is to provide feed-back about the impact of the program to the agency, the consumers, and the community (Newman & Rinkus, 1978; Oetting, 1977). This feed-back is crucial to program planning and to the decision making process (Pharis, 1976). A close working relationship and open channels of communication between the researcher and the staff of the program being evaluated has been found to result in refined programming, increased staff effectiveness, and improved feed-back to the community (Borg & Gall, 1979; Hinkle, Cole, & Oetting, 1968; Moursund, 1973; Siegel & Goodman, 1976; Smith, Kaplan & Amidjaya, 1980). Again, strict attention to formal experimental design principles is often in conflict with this kind of ongoing communication. Formative research is not the same as summative research - the former changes in mid-stream, in response to agency needs; the latter deals with what has been done. In the present study, results were shared

with the agency only after data-collection was complete. While this resulted in the loss of some of the potential advantages of information sharing, it avoided contamination or confounding of variables due to experimenter or treatment-deliverer bias.

Evaluation Instrument Development

An active program for the evaluation of mental health services has been developed over the past three and one half years in the State of Oregon by Brodsky, Bigelow, and others at the Oregon State Mental Health Division (1980). Conceptualization of the Oregon Quality of Life Questionnaire (OQLQ) is an outgrowth of the trends evidenced in some national studies done over the past 24 years, along with some ideas taken from role and exchange theories, as well as Maslow's theory of needs. The concept of quality of life includes and integrates all the features of one's life which are found to be satisfying and desireable.

"Quality of life" was first studied in 1951 by Gurin, Veroff, and Feld of the Survey Research Center of the Institute for Social Research. The study mainly focused on distress and various forms of "worry", with one question which asked the respondent to report how "happy" he was (Gurin, Veroff, & Feld, 1960). A number of studies followed that were similarly concerned with the epidemiology of mental health, but not necessarily related to quality of life. Related studies were concerned with happiness, particularly, Norman Bradburn's research in 1961 which used positive and negative affect as the basic measure of well-being (Bradburn, 1969).

A study done by Hadley Cantril used, as the critical measure, the point at which an individual placed himself on a scale between an imagined "the best life" and "the worst life." His emphasis was on aspirations,

needs and satisfactions, as opposed to Bradburn's emphasis on affective states (Cantril, 1965). Cantril's study and the previous studies had addressed life as a whole rather than addressing specific areas of life.

Campbell, et al, did a study which focused on 12 critical "domains" of life, such as jobs, housing, and marital status. The study examined the relationship of the various domains to each other and their respective contributions to the overall quality of life in terms of the satisfaction of needs (Campbell, Converse, & Rodgers, 1976). Bateson (1972) and Dalkey (1972) argued that quality of life is not defined by physical variables, such as "domains" of life. Instead, they used personal relationships as their point of reference. They proposed that people's concerns lie mainly in the patterns and setting of their personal relationships.

Although the conceptual framework used by Brodsky and Bigelow for the OQLQ is developed mainly around Maslow's theory of needs, Campbell's "domains" idea has also been incorporated, along with the emphasis on personal relationships that was stressed by Bateson and by Dalkey. The individual is seen as embedded in his environment, and each human being has two broad characteristics which are considered in the Oregon Quality of Life Questionnaire: needs and abilities. Role and exchange theories are used by the authors in describing the adjustment of individuals to their environments. Adjustment is viewed as: (1) the general happiness or satisfaction of one's needs, and (2) the performance or actualization of one's abilities. Quality of Life is a concept of simultaneous individual need satisfaction and acceptable performance within one's environment.

The four broad areas of adjustment which are examined on the OQLQ

are related to role expectations: intrapersonal roles, interpersonal roles, productivity roles, and civic roles. When expectations are met in each area in a satisfactory way, the individual is considered to have made a high quality of adjustment to life (Brodsky & Bigelow, 1980).

The conceptualization of the OQLQ is compatible with Martha Rogers' nursing theory, and makes the OQLQ a useful tool for doing nursing research. The outcome variable - quality of life, or satisfaction and performance in social roles, is used to assess impact of treatment in the present study. Results of this study are compared with other studies in the state of Oregon that have used the OQLQ.

In summary, the conceptualization of quality of life has progressed over the past 24 years from assessment of general distress and "worry", to general happiness related to positive and negative affect, to an emphasis on aspirations and needs in general and specific areas of life, and most recently to a concept of satisfaction of needs and performance within a social environment. Bigelow and Brodsky have provided an operational definition of Quality of Life which can be used to measure the effectiveness of psychotherapy in various treatment models. The concept of quality of life on which the Oregon Quality of Life Questionnaire was based is also used in the present research project.

CHAPTER 2

METHODS

Setting

The agency evaluated in the present research project is Aslan House Counseling Center, in Eugene, Oregon. The study is concerned with adults who seek and receive treatment on an appointment basis at the agency, which is staffed by volunteer professional counselors, University of Oregon advanced graduate students in counseling, psychology, and Oregon Health Sciences University graduate psychiatric nursing students.

Staff. Aslan House has a staff of 14 to 17 part-time workers, each providing an average of about three service-delivery hours per week. The composition of the staff fluctuates from time to time since practicum students make a six month commitment to the agency, and other obligations of the professional counselors impinge upon their ability to volunteer their services over long periods of time. However, there are usually 10 to 12 counselors, 2 to 3 intake workers, several receptionists, and the director of counseling. Length of time that staff members have been in association with Aslan House ranges up to four years; six of the members have been with Aslan House for one and one half years or more, and 90 percent have volunteered their services for over six months.

The director of Aslan House has a Ph.D. degree in School Psychology, is a licensed psychologist in the State of Oregon, and is also a faculty member at the University of Oregon in the educational/psychology department. The counselors either have Master's degrees, or are advanced doctoral or master's degree candidates in counseling, psychiatric nursing, psychology, or social work. Intake workers are not academically trained, but receive ongoing training and supervision at Aslan House, as do all

other counseling staff. There is a high degree of cohesiveness and enthusiasm among the staff members, and concern with delivering a high level quality of service to clients. There is also an atmosphere of interest in continuing to learn new information and to improve professional skills.

While the present study does not address the question of why skilled professionals continue to be willing to donate their services in this fashion, it may be instructive to speculate that training and growth opportunities, as well as the contact with fellow professionals, are an acceptable exchange to the counselors for their services to clients. The community in which the agency is located may be unique in that there is a surplus of professionally trained counselors. Many of the professional counselors at the agency also have private practices, and find the opportunity to discuss professional issues to be a valuable one.

Funding Base. The policy of Aslan House is to provide no-charge treatment for up to six sessions; a modest sliding-fee schedule is used for subsequent therapy sessions (See Appendix B, page74). Since the cost is minimal, the agency serves people who would not be able to secure counseling from private practitioners in the community. The traditional mental health agency in the community has had funding cutbacks, and is increasingly unable to provide growth-oriented counseling to adults who are not pathologically or chronically disabled due to functional disorders. (The private sector in the community charges fees that make their services inaccessible to persons who do not have financial resources or insurance to pay for therapy).

Clients. The client population may be different from traditional mental health centers and other alternative mental health centers in

that there is no crisis service offered, there are no facilities for children, and clients whose primary presenting problem is substance abuse or severe chronic psychiatric disability are referred to other agencies in the community. Clients range in age from 19-60, with women comprising about 75 percent of the client population. The most frequent presenting problems are interpersonal and/or intrapersonal adjustment difficulties. Diagnoses of the majority of clients include what has been formerly catagorized as the psychoneurotic and situational adjustment disorders. Using the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) (APA Publication, 1980), which is being used by most mental health professionals, the diagnoses would include: affective, anxiety, adjustment, and personality disorders. Approximately 30 to 40 clients are seen each week.

Clients are referred to the agency by private and public agencies in the community as well as by individuals who are familiar with the service. The largest number of referrals comes from the traditional community mental health center in the community. Attempts are made to arrange an intake interview within a week or two after a client calls for an appointment. The intake interview is a screening process to determine whether the client meets the criteria of the agency and if the agency can meet the needs of the client.

When the intake counselor determines in the intake interview that the services at the agency will meet the needs of the client, and the client agrees, the client's name is put on a waiting list for assignment to a professional counselor or advanced practicum student. The length of time that a client has to wait to begin treatment varies with the availability of the counselors. An attempt is made to keep the waiting

period as short as possible, but as the demand for service has increased, the waiting period has also increased to several weeks or more at times.

Framework for Therapy. The treatment model used at Aslan House is a blend of traditional psychotherapeutic approaches. The weekly inservice training conducted by the director provides a common theoretical framework of Gestalt and Transactional Analysis methods from which the staff operates. However, the staff size permits sharing of the variety of backgrounds of the counselors, and other theoretical approaches are also incorporated such as analytic, dynamic, social learning, systems, Adlerian, humanistic, Rogerian, and existential. Treatment is coordinated with individual client's physicians when a client is taking medication, or if a need for medication is indicated. Coordination with, and referral to other community resources is also done when needed. This model provides a multidimensional approach to psychotherapy which is delivered by an interdisciplinary staff.

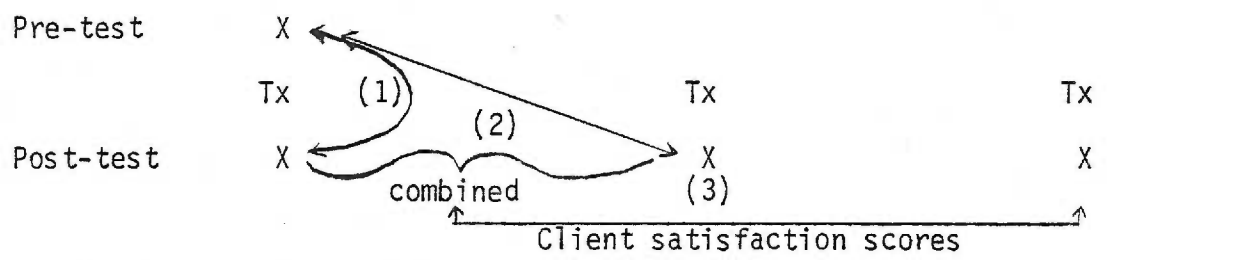
Aslan House probably does not differ from other agencies (in terms of the quality of direct, one-to-one counseling offered) any more than other agencies differ among each other. It is true that staff morale and commitment are high, but they are high in many other counseling centers. It is true that the counseling staff at Aslan House train together and thus share a theoretical framework, but other agency staffs operate in similar fashion. What may be unique about Aslan House is that it provides professional (rather than student or minimally trained volunteer) counseling services to a low income population at minimal cost to either clients or taxpayer. It is for this reason that an evaluation of the program is of interest: it provides a partial answer to the question of whether low cost quality services are possible.

Design

Traditional pre-post designs have an inherent threat to external validity in that pre-testing alone may significantly affect post-treatment scores. Alternatively, non-repeated-measures designs must assume, but cannot verify, actual changes in the clients being evaluated. For these reasons, the present study utilizes a combination of repeated measures and comparison group designs:

1. Pre-treatment versus post-treatment (repeated measures)
2. Pre-treatment versus post-treatment (with no pre-treatment measurement)
3. Post-treatment satisfaction scores at Aslan House versus post-treatment satisfaction scores at other Oregon Mental Health agencies.

The design can be illustrated by the following diagram:



The first hypothesis deals with the repeated measures (matched) group, and the second hypothesis deals with the pre- and post-treatment scores of separate samples. The third hypothesis compares Aslan House and statewide clients' perceptions of the helpfulness of services in their respective programs.

Procedure

Clients used in the study were selected from the client population of the agency. The criteria for selection required that each subject meet the requirements for treatment at the agency and had contracted for a period of therapeutic intervention. Subjects meeting criterian

requirements were added until the requisite number for each sample group had been reached.

Initial sample. A sample of 13 clients who began therapy sessions at Aslan House between February, 1981 and July, 1981 were interviewed using the Oregon Quality of Life Questionnaire.

Each client in this initial sample was contacted by the investigator after the assigned counselor had seen the client for the first time and established a treatment contract. The counselor assigned to the client told the client about the evaluation study, and asked if the client was willing to be contacted by the investigator. If the client agreed, the counselor gave the client's name to the investigator who contacted the client by phone, and explained the purposes of the study. If the client agreed to participate, an interview was arranged at a mutually convenient time and place. The investigator ascertained that the client understood his/her involvement in the study, and obtained the signature of the client on the Consent form. The interview then began.

After a period of at least 60 days, the investigator determined which clients from the pre-treatment measurement group had remained in treatment. Those eight clients who met the criteria for the study were then contacted by the investigator, and a second interview was arranged if the client agreed to participate again. A convenient time and place were set up and the client signed the consent form for the second interview before proceeding with the interview. This group of eight was used to test the first hypothesis of the study.

Post-treatment-only group. Seventeen clients who had received therapy sessions for a period of at least 60 days within the previous year and who agreed to participate were selected to become part of this group.

Those who were still in treatment and those who had received the most recent treatment were contacted first, to enlist their participation in the study.

The post-treatment group was told of the study by his/her counselor if the client was still in treatment. Then a phone call to the client was made by the investigator, and the procedure used with the initial sample group was followed. The clients who had been in treatment for at least 60 days within the past year and who had terminated from treatment were contacted by phone by their counselor, followed by a phone call by the investigator, and the preceeding procedure was followed.

The pre-treatment scores of the 13 initial sample clients who participated in the OQLQ interviews between February and July, 1981 were compared with the post-treatment scores of this post-treatment-only group of 17 clients who were interviewed in the same time period. This comprised the separate samples group, and the data were used to test the second hypothesis.

Other Oregon Mental Health Agencies group. Data collected from 293 clients in other mental health agencies in Oregon were used for this comparison group of satisfaction scores. The data are available in The Oregon Program Impact Monitoring System: Final Report and are reported in aggregate form (Brodsky, Bigelow, et al, 1980).

Comparison of clients' perceptions of the helpfulness of the therapy received at Aslan House was made with client's perceptions of the helpfulness of therapy received at other agencies in Oregon. The post-treatment scores of the eight clients in the matched group and the 17 clients in the post-treatment-only group at Aslan House were compared with post-treatment scores of clients at other mental health agencies in Oregon to

test the third hypothesis which deals with clients' perceptions of the helpfulness of the therapy received.

Instrument

The data in the study were collected by administration of the Oregon Quality of Life Questionnaire (OQLQ) developed in Oregon in 1978 by Brodsky, Bigelow, and others. The questionnaire includes measure of functioning in four broad areas of adjustment: personal, interpersonal, productive, and civic. It also contains specific questions relating to program impact and client satisfaction with the services. The instrument is based on the concept that mental health is the degree of adjustment between an individual's needs and her/his performance within the environment. When a person receives services from a "helping agency", improvements in these areas are expected. The OQLQ is used to measure the effects of treatment in different groups.

The OQLQ is a self-report instrument administered by trained interviewers in the form of questions with fixed alternative responses, and takes approximately one hour to complete. Questions are asked about each area in a standard way and responses are presented, chosen, and recorded in a uniform fashion. A strict uniformity in interviewing style is crucial to the usefulness of the resulting data. Data gathered in a standard way can be used to compare the improvements realized by different groups of clients (Brodsky & Bigelow, 1980).

For the past three and one half years the OQLQ has been administered to clients in various mental health programs in the state of Oregon. Data have also been collected on a normal sample when the instrument was standardized in 1978. Retrospective, self-reports were chosen by the developers of the OQLQ for three reasons: (1) clients' opinions are important,

(2) clients are in a position to observe change which we cannot adequately measure as this time, and (3) the retrospective measure does not depend upon assumptions about the comparability of intake and follow-up groups (Brodsky, Bigelow, et al, 1980).

Psychometric properties. The psychometric properties of the Oregon Quality of Life Questionnaire are reported by Brodsky and Bigelow (1980). The assessment of the psychometric properties of the OQLQ is necessarily colored by the purpose of the instrument: it was designed to be used only for the assessment of groups and group differences. This is in contrast to most other instruments of psychological measurement which attempt the appraisal and comparison of individuals. The OQLQ instrument is in the process of being refined, and an examination of the psychometric aspects is necessary in the further development of the tool.

The primary strength of the OQLQ is face validity. The strongest and most straightforward scales of the instrument are: Psychological Distress, Psychological Well-Being, Affective Status, Independence, Social Support, and Meaningful Use of Time. Most of the scales have internal consistency as measured by Cronbach's Alpha, a variant split-half technique (Bigelow & Olson, 1981). Validity has been established by various tests which have determined that the instrument fulfills expectations for its performance (Brodsky & Bigelow, 1981).

Interviewers. The investigator and one other person conducted the interviews for this study. The investigator was trained by using the Program Impact Monitoring System (PIMS) Project training manual designed for this purpose by the developers of the OQLQ (Brodsky, Bigelow, et al, 1980), and by viewing a videotape of a standardized interview at the Oregon State Mental Division. The investigator trained the other

interviewer with the use of the training manual and several hours of role-playing sessions to ensure that the interviews would be carried out in a consistent manner.

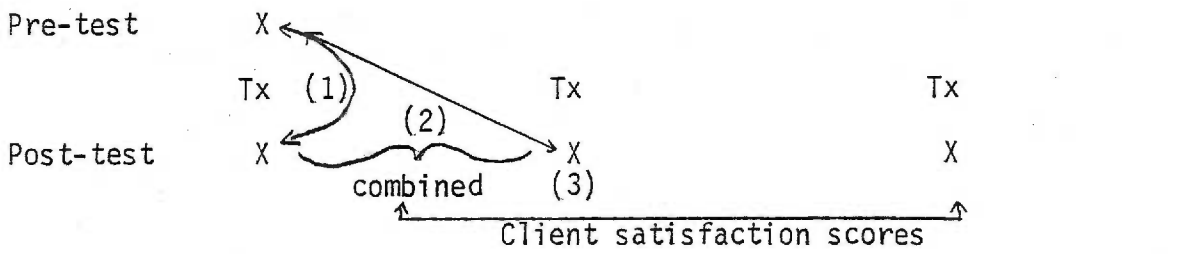
Due to the small sample size and the low budget of the study, it was not feasible to gather formal inter-rater reliability data. However, the two interviewers had worked closely together over the previous eight months, and have quite similar interviewing styles, so the assumption is made that the interviews were all conducted in a consistent manner.

CHAPTER 3

RESULTS

In this chapter, comparability of the samples, hypotheses about mental health services at Aslan House, and data analysis are presented. Sampling procedures are examined to determine to what extent the results may be biased by selection of subjects. Indications of selective biasing are examined in a comparison of the demographic characteristics of pre-post and post-treatment-only groups. Differences between the Aslan House clinical groups and the statewide sample are noted.

For the convenience of the reader, a restatement of the overall design and main hypotheses is repeated:



1. Pre-treatment versus post-treatment (repeated measures)
2. Pre-treatment versus post-treatment (with no pre-treatment measurement)
3. Post-treatment satisfaction scores at Aslan House versus post-treatment satisfaction scores at other Oregon Mental Health agencies.

Hypothesis 1: The Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more at Aslan House will be higher than their OQLQ scores after just one session at the agency.

Hypothesis 2: The Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more at Aslan House will be higher than

the OQLQ scores of other clients who have had just one session of treatment at the agency.

Hypothesis 3: Clients who have received therapy for a period of 60 days or more at Aslan House will report on the OQLQ that the agency has been at least as helpful as clients' reports about other agencies in Oregon which have participated in OQLQ studies.

Comparison of Samples

Overall, the demographic characteristics of the Aslan House and the statewide samples were quite comparable. The major difference lay in the percent of females, with 84% and 77% of the two Aslan samples, respectively, being female, while only 59% of the statewide sample were female. Slightly more of the statewide sample than the Aslan sample clients lived alone; more of the Aslan post-treatment group (53%) lived with a partner than in either the Aslan pre-treatment group (39%) or the statewide sample (37%). The Aslan post-treatment sample also had more clients living in single family dwellings (94%) than did the pre-treatment sample (69%) or the statewide sample (77%). The nature of the research design created a 100% "open status" classification for the pre-treatment sample; the post-treatment sample contained nearly 50% still open cases, while 73% of the statewide cases were still considered open. Finally, in terms of hours of services at time of testing, the Aslan post-treatment group had received 16.4 hours while the statewide clients had received 11.25 hours. These data are reported more fully in Table 1.

TABLE 1

Demographic Characteristics of Samples

	Aslan House (Pre-treatment)	Aslan House (Post-treatment)	Statewide (Post-treatment)
Number of Clients	13	17	293
Average Age	29.4	33.2	34.5
Percent Females	84.6	76.5	59.0
Percent White	100.0	100.0	96.9
Social Living Situation			
% Alone	15.4	17.7	22.3
% With Partner	38.5	52.9	37.0
% All Others	46.2	29.4	40.7
Physical Living Situation			
% Single Family Dwelling	69.2	94.1	77.4
% Apartment	30.8	5.9	16.6
% All Others	0	0	6.1
Treatment Status			
% Open	100.0	47.1	73.1
% Closed	0	52.9	26.8
Average Amount of Services Received (hours)	1.0	16.4	11.25

Aslan House Samples. The clients in the post-only group of 17 clients were an average of 3.8 years older than the average of the pre-treatment group of 13 clients. Seventy-six and one-half percent of the post-only group were female, compared with 84.6 percent of the pre- group. Ninety-four percent of the post-only group lived in single family dwellings, and 69.2 percent of the pre-treatment group resided in single family dwellings.

The average monthly income of the post-only group was $638.76, compared with $655.77 average monthly income of the pre-treatment group.

The matched group of eight had 25 percent who were still actively involved in treatment at the time of the post-test interview, with an average of 84.5 days between time of termination and time of the interview for the other 75 percent. The post-only group had 47.06 percent who were actively involved in treatment, with an average of 42.22 days since termination for the other 52.94 percent. The total matched group and post-only group sample had 40 percent still actively involved in treatment, with an average of 59.13 days between termination and time of interview for the remaining 60 percent.

For the purposes of this study, the demographic characteristics of the Aslan House pre-treatment group are comparable to the characteristics of the post-only group on several variables. The retrospective nature of the OQLQ does not depend on strict control of demographic variables, and the demographic characteristics are presented simply to show that the samples are indeed comparable.

Tests of Hypotheses

Both variations of the basic evaluation design were used in this study: (1) pre-treatment versus post-treatment (repeated measures) and (2) pre-treatment versus post-treatment (with no pre-treatment measurement). The first hypothesis deals with the repeated measures group and the second hypothesis deals with the pre- and post-test scores of separate samples. The third hypothesis compares Aslan House and statewide clients' perceptions of the helpfulness of services in their respective programs.

Significance. As can be seen from Tables 2, 3, and 5, levels of

statistical significance varied from less than .01 to greater than .20. All significance levels are, of course, subject to the restrictions discussed in the section on "Program Evaluation". For the purposes of the present discussion, reference will be made to levels at or less than .10 as "significant", while levels between .10 and .20 will be treated as a trend or pattern of differences (Isaac & Michael, 1979; Minim, 1977).

Hypothesis 1: The Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more at Aslan House will be higher than their OQLQ scores after just one session at the agency. Because the goals of treatment at Aslan House are primarily concerned with the first six scales on the OQLQ instrument, t-tests were done only on those first six scales for the pre-post, same sample group of eight clients.

Table 2 presents the results of the t-tests which show that clients in the matched group are significantly improved at follow-up at the .10 level of significance. Tolerance of Stress, Basic Need Satisfaction, and Independence scales show the highest level of significance at .02, .01, and .02, respectively.

The Psychological Well-Being scale showed a significance level of just above .05, and the results of the Psychological Distress and the Interpersonal Interactions scales were well below the .10 level of significance. All mean score differences were in the predicted direction. Therefore, the statistical analysis supports the first hypothesis. (See Table 2).

TABLE 2

Comparison of Intake and Follow-up

Mean Scale Scores For

Same-Subjects Using t-Test

	Intake $\overline{X}$ (N=8)	Follow-up $\overline{X}$ (N=8)	t	p
Psychological Distress	39	48	1.927	<.10
Psychological Well-Being	43	50	2.338	<.10
Tolerance of Stress	28	45	3.116	<.02*
Basic Need Satisfaction	40	50	3.549	<.01*
Independence	46	53	3.367	<.02*
Interpersonal Interactions	46	53	1.955	<.10

* = Significant
df = 7

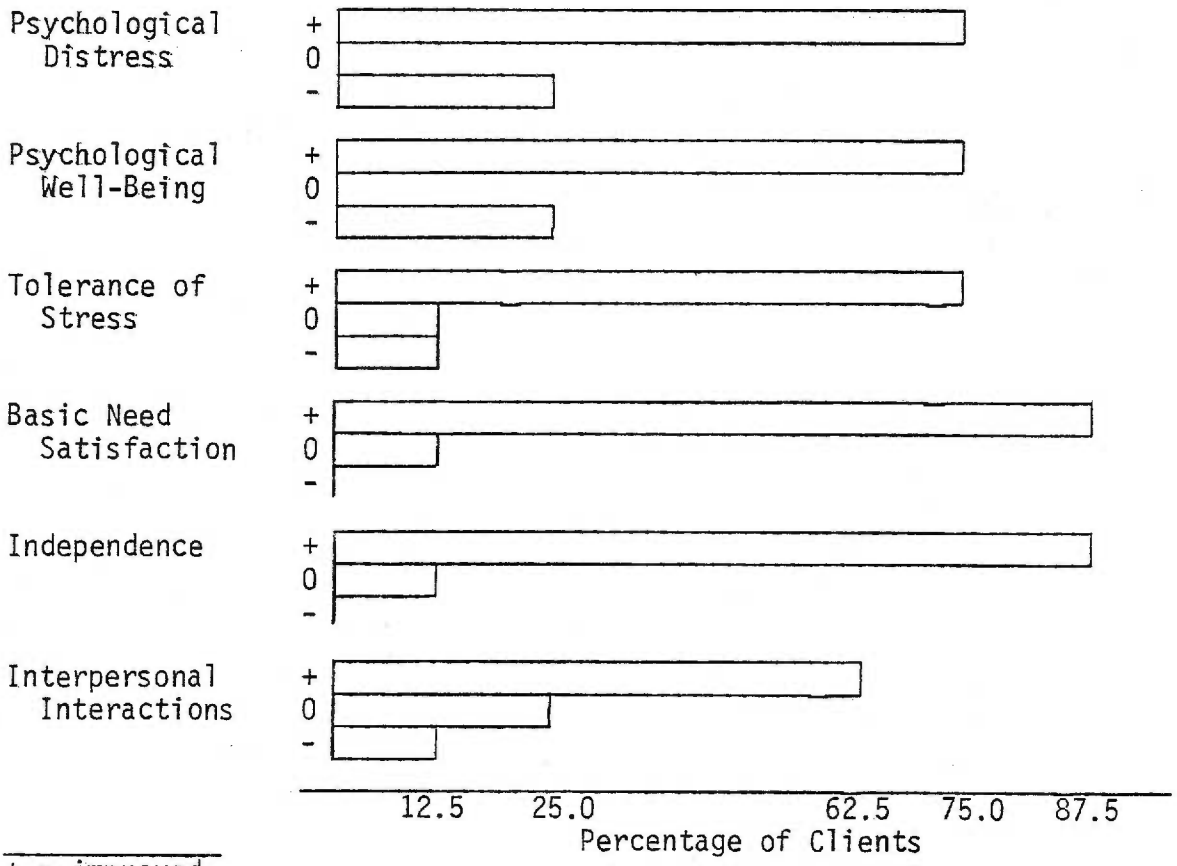
Note: The mean standardized scores of the OQLQ have a value of 50 for all scales. Scores below 50 indicate a less well adjusted score in comparison with the "normal" sample, and scores above 50 indicate a higher level of adjustment.

Descriptive statistics were also used to investigate the first hypothesis. The percentage of clients who changed on all scales from the intake interview to the follow-up interview are presented in Table A (Appendix A). This table shows that the greatest percentage of clients made improvements in scores on the OQLQ in all the areas which pertain to the treatment goals of Aslan House. Figure 3 is a graph which shows the improvements realized by the clients, as measured by the OQLQ, on the first six scales of the instrument.

FIGURE 3

Percent of Clients in Each Change Category

Matched Group



+ = improved
0 = no change
- = worsened
N = 8

The percent of clients who improved on the first six scales follows: Psychological Distress, 75%; Psychological Well-Being, 75%; Tolerance of Stress, 75%; Basic Need Satisfaction, 87.5%; Independence, 87.5%, and Interpersonal Interactions, 62.5%. Twenty-five percent scored lower at follow-up on the first two scales; 12½ percent worsened on the third and sixth scales.

Figure A (Appendix A) is a graph which shows the differences between the pre-test scores and the post-test scores of the matched group, with

a comparison between the groups and the standardized scores of the OQLQ. Post-treatment group mean scores are higher on all of the scales than the pre-treatment group mean scores.

Analysis of the differences between mean scores by use of a t test for correlated samples produced significance at the .10 level or less for the first six scales of the instrument. Inspection revealed that all of the post-test mean scores were higher than the pre-test mean scores in the matched group.

Hypothesis 2: The Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more at Aslan House will be higher than the OQLQ scores of other clients who have had just one session of treatment at the agency.

The independent samples t-test was used to test this hypothesis, since the clients in each sample were different and there was an unequal number of scores in the two groups. The retrospective measure does not depend on comparability of the groups, and the prediction is that post-treatment means will be higher than pre-treatment means.

Table 3 presents the results of the t-tests of the separate samples group. The Tolerance of Stress scale scores reached a significance level of near .05 and well below .10. Differences between sample means for the rest of the first six scale scores were in the predicted direction, but did not reach significant levels.

The Wilcoxen Sign Test for direction of mean differences across all scales yields a χ^2 of 4.16, $p < .05$ (Minim, 1977).

TABLE 3

Comparison of Intake and Follow-up Mean Scale Scores for Separate Subjects Using t-Test

	Intake $\bar{X}$ (N=13)	Follow-up $\bar{X}$ (N=17)	t	p
Psychological Distress	41	43	.559	>.20*
Psychological Well-Being	44	46	.654	>.20*
Tolerance of Stress	32	39	1.771	<.10
Basic Need Satisfaction	43	45	.632	>.20*
Independence	47	48	.404	>.20*
Interpersonal Interactions	47	48	.794	>.20*

* = Not statistically significant, the mean scores differ in the predicted direction.
df = 28

Table B (Appendix A) presents the mean standard scores of all the Aslan House clients in the pre-post matched group, the separate sample non-matched group, and the total number of clients who participated in the study at intake and at follow-up. Again, Aslan House clients had higher mean OQLQ scores at follow-up than at intake, except for the Social Support and Adjustment to Work at Home Scales in the non-matched group and the total sample, and the Adjustment to Work at Home scale in the matched group. No tests of statistical significance were carried out for these latter scale differences, since they are less directly related to the hypotheses under investigation.

The reader is also referred to Figure B (Appendix A), a graph

showing the relationship between separate sample post-treatment scores and the pre-treatment scores for all of the scales. The post-treatment scores on two scales were each one point lower than the pre-treatment scores, but still above the standardized scores of the normal sample; all other post-treatment scores were higher than the pre-treatment scores.

Hypothesis 3: Clients who have received therapy for a period of 60 days or more at Aslan House will report on the OQLQ that the agency has been at least as helpful as clients' reports about other agencies in Oregon which have participated in OQLQ studies. This hypothesis, it should be noted, is stated in null form. Rejection of this hypothesis in support of the superiority of Aslan House services would constitute support of the assertion that the alternative agency provides services "at least as helpful" as other agencies.

Data from Aslan House clients' and statewide clients' perceptions of the helpfulness of certain therapist attributes, and of the therapists, are summarized in Tables 4 and 5. Table 4 shows percentages of Aslan House and statewide samples perceiving the program elements as "harmful or very harmful", having "no effect", "helpful", or "very helpful". Table 5 presents the results of χ^2 tests of differences in these percentages. These tables can be seen on the following two pages.

TABLE 4

Aslan House and Statewide Samples

Client's Perceptions of the Helpfulness

of Program Elements

Item Description	Percent Harmful or Very Harmful	Percent No Effect	Percent Helpful	Percent Very Helpful	(N)
Therapist's Listening					
AH *	0	0	24.0	76.0	25
State *	.7	8.8	43.0	47.5	284
Therapist's Caring					
AH	0	4.0	20.0	76.0	25
State	.7	10.1	45.7	43.5	276
Therapist's Encouragement					
AH	0	4.0	20.0	76.0	25
State	.7	11.0	48.2	40.1	272
Information from Therapist					
AH	0	4.4	47.8	47.8	23
State	.4	18.4	49.2	32.0	256
Calming by Therapist					
AH	0	0	47.8	52.2	23
State	.8	19.2	52.8	27.0	250
Limit-setting by Therapist					
AH	5.0	10.0	50.0	35.0	20
State	1.0	28.8	49.0	21.2	208
Therapist					
AH	0	0	32.0	68.0	25
State	2.0	9.4	38.9	49.7	288

* AH = Aslan House
State = Statewide clinical sample. From Brodsky, Bigelow, et al, 1980.

TABLE 5

Aslan House and Statewide Samples

Client's Perceptions of the Helpfulness

of Program Elements Using Chi Square

	Aslan (N)	State (N)	χ^2	p
Therapist's Listening	25	284	7.889	<.05*
Therapist's Caring	25	276	9.78	<.05*
Therapist's Encouragement	25	272	12.069	<.01*
Information from Therapist	23	256	4.184	>.05
Calming by Therapist	23	250	10.245	<.01*
Limit-setting by Therapist	20	208	6.091	>.05
Therapist	25	288	4.69	>.05

* = Significant
df = 3

Four of the seven items showed statistically significant differences, with Aslan House clients perceiving their therapists' behavior more favorably. Differences on the other three items, while not statistically significant, reflected a similar trend. A Wilcoxen Sign Test over the pattern of responses on these seven scales yields a χ^2 of 24.14, significant (with one degree of freedom) at the .01 level.

Additional questions on the instrument dealt with clients' perceptions of program impact. Table C (Appendix A) presents the group mean scores of Aslan House clients and statewide clients on their perceptions of program impact. Both Aslan House and statewide clients tend to respond by saying that they were "improved" or "greatly improved" in all of the areas which

are addressed in the therapy program. The Aslan House clients reported the greatest improvement as a result of therapy in the areas of: psychological distress/well-being, tolerance of stress, independence, and spouse role. For statewide clients, greatest reported improvement showed in psychological distress/well-being, tolerance of stress, independence and spouse and parent roles. Although the pattern of client-reported impact is comparable in the Aslan House sample and the statewide sample, the group mean scores in 15 of 18 areas of client reported impact are larger in the Aslan House group. Individual differences on these items were not tested statistically, because only mean scores were available for the statewide sample. The Wilcoxen Sign Test, across all of these comparisons, yields a χ^2 of 6.7, significant at the .01 level (with one degree of freedom).

Table D (Appendix A) presents clients' perceptions of the helpfulness of non-program elements. These aspects are also outside the scope of the hypotheses, and therefore are not statistically treated. However, it is interesting to note that a large percentage of clients in both the Aslan House and statewide samples found the following elements helpful or very helpful: passing of time, keeping busy, being with people, and physical activity.

CHAPTER 4

DISCUSSION

The findings of this research study are interpreted in this chapter. The significance of the findings of this study and the relationship to previous research are discussed in relevance to the hypotheses. The chapter concludes with limitations of this type of research and of the present study, implications for nursing, and recommendations for future practice and research.

Interpretation and implications of the findings

The data indicate that the demographic characteristics of the Aslan House samples and the statewide samples are generally comparable. However, there is a much larger percentage of females in the Aslan House sample than in the statewide sample, which may suggest an admission bias or a self-selection bias in the Aslan House program. There are also more clients in the Aslan House sample who live in single family dwellings.

Although the level of significance in all of the t-test scores was below .10 for the matched group, three of the scale scores for the same-sample group reached significance levels of .02 and .01. Only one of the scores of the separate sample group reached a significance level of just over .05 using the t-test for independent samples. The rest of the scores failed to reach even the .20 level and were therefore clearly not significant. However, all the score differences were in the predicted direction. Given the methodological difficulties inherent in most program evaluations (see "Literature Review"), this degree of consistency is worth noting, and suggests the desireability of replicating the study at a future date.

The client samples, both Aslan House and in the statewide sample, were volunteers, so it is possible that there may have been a selection

bias. Since this bias operated in both Aslan House and statewide samples, it should not interfere with the investigation of Hypothesis 3. Hypotheses 1 and 2 are not immune to this criticism; self-selection may have biased the responses in favor of the program.

Recognizing the limitations of this study, nevertheless the findings support the hypothesis that the mental health services provided as Aslan House are at least as effective as mental health services provided in other mental health agencies in Oregon which have used the OQLQ to evaluate the services. (Since Hypothesis 3 was stated in null form, it cannot easily be rejected. See page (39) for discussion of this point). Follow-up scores on the OQLQ were higher in all areas for the Aslan House clients than were the pre-test scores. In relation to the main question of this study, it does appear that effective mental health services can be provided at minimal cost to the client or taxpayer.

The mental health services provided at Aslan House (psychotherapy/counseling) have been discussed in the Methods chapter. There has been no evidence to show that the services provided at the agency are any different from the services provided at other mental health agencies. Client populations and problems differ depending on the goals of programs, and the instrument used in the study was designed to measure the effectiveness of services in different programs (Brodsky, Bigelow, et al, 1980).

The conceptualization of the Quality of Life has been discussed in the Literature Review section. The Oregon Quality of Life Questionnaire (OQLQ) was developed to assess: 1) personal adjustment, 2) interpersonal adjustment, 3) adjustment to productivity, and 4) civic adjustment. Satisfactory adjustment in these areas indicate that an individual has a greater

degree of mental health than of emotional distress (Brodsky, Bigelow, et al, 1980). The instrument is lengthy and takes approximately one hour to complete. Some of the scales do not relate to specific program goals; on the other hand, the scales are not comprehensive enough to thoroughly assess improvements a given group of clients may have. Overall, the OQLQ is more comprehensive than other instruments that have been developed to measure quality of life and is in the process of being further refined. Although the instrument as it is provides only part of what is needed for a complete and systemic evaluation of program effects, it is probably the best available single measure of program effectiveness.

Hypotheses

Hypothesis 1 states that the Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more at Aslan House will be higher than their OQLQ scores after just one session at the agency.

It is interesting to note in Table A (Appendix A) that a small percentage of clients were worse on some of the scores at the time of the post-test. This may indicate that the clients were reacting appropriately to the therapy situation. It is well known among clinicians that client's symptoms often become exaggerated during various stages of therapy. It may also indicate, of course, that treatment was actually harmful to these clients.

Both statistical tests and inspection of the data suggest that Aslan House clients experience an improved quality of life following treatment. This is consistent with other OQLQ studies, as well as with nation-wide studies of the effectiveness of psychotherapy (Brodsky, Bigelow, et al, 1980; Parloff, 1980).

Three of the t-tests with the matched group produced significant results (Refer to Table 2, page 35). The Tolerance of Stress Scale results produced a .02 level of significance. An example of this scale is an item which asks: "How much difficulty have you had handling feelings of depression? _____great difficulty, _____some difficulty, _____ no difficulty."

The second t-test which produced significant results at the .01 level was the Basic Need Satisfaction Scale. An example of an item in this scale is: "Can you get around town as you need (to work, shopping, medical appointment, visiting, etc.)? ___ can't get around at all, ___ with much difficulty, ___ with little difficulty, ___ with no difficulty."

The third significant result was on the Independence Scale with a .02 level of significance. An example of an Independence item is, "How confident are you in the decisions you make for yourself (what to buy, where to live, what to do, etc)? ___quite confident, ___confident, ___ little confidence, ___no confidence." All of these scales are in the Personal Adjustment group of scales, which is the main focus of the goals of treatment at Aslan House. The other two scales in this category produced results between the .05 and .10 level; while not "significant" from a conservative point of view, the results are consistent with the rest of the data.

Hypothesis 2 states that the Oregon Quality of Life Questionnaire scores of clients who have received therapy for a period of 60 days or more at Aslan House will be higher than the OQLQ scores of other clients who have had just one session of treatment at the agency.

There were no statistically significant t-test differences between

the two non-matched Aslan House samples; the hypothesis was not statistically supported by the t-tests. Again, however, all the differences were in the predicted direction. The likelihood of this happening by chance is less than .05; therefore, the total pattern of differences is statistically significant.

In terms of the whole OQLQ, including the scales not subjected to statistical analysis, the reader is referred to Table B (Appendix A). All of the post-treatment scores are higher than the pre-treatment scores in the non-matched group except for the Adjustment to Work-at-Home and Social Support Scales. The post-treatment scores of these two scales were slightly lower than the pre-treatment scores. Given the available data, it is not possible to say why these two scales alone failed to match the overall pattern of improvement.

Hypothesis 1 and Hypothesis 2 both deal with the effectiveness of therapy at Aslan House. Statistical analysis supports the hypotheses that clients are improved after treatment at the agency, as measured by the OQLQ. This is congruent with other studies of treatment effectiveness (Parloff, 1980), as well as with other program evaluation studies done in Oregon with the same instrument (Brodsky, Bigelow, et al, 1980).

Hypothesis 3: Clients who have received therapy for a period of 60 days or more at Aslan House will report on the OQLQ that the agency has been at least as helpful as clients' reports about other agencies in Oregon which have participated in OQLQ studies.

The data reported in the Results chapter support this hypothesis. Four of the seven items subjected to chi square tests yielded results at the .05 level or less. A Wilcoxen Sign Test over the pattern of responses yielded significance at the .01 level. Clients perceived the services

at the alternative mental health agency to be more helpful than did clients in other agencies which have used the same instrument to evaluate the programs.

The data reported in this preliminary study give acceptable support to the third hypothesis. Aslan House clients report that they found the services at the agency to be at least as helpful as the statewide clients' reports about the helpfulness of their agencies.

In summary, the results of this study suggest that effective mental health services can indeed be provided at minimal cost to client and/or taxpayer. It may be difficult to replicate the kind of service delivery that is provided at Aslan House. However, the positive results of this study may provide impetus to other psychiatric nurses and mental health care providers to make use of their own creative resources to discover new modes of service delivery. More research needs to be done about alternative methods of mental health service delivery, and a replication of this study at the same agency would strengthen the results.

Limitations

A major limitation of this study is the non-randomness of the samples. Volunteer clients are self-selected, and may well be more pleased with their treatment than those who do not choose to participate. Wagenaar (1981) addresses this problem, pointing out that most field research uses either a non-random sample or a convenience sample of a rather restricted population. The present evaluation study is of an exploratory nature, which does not mandate the use of a random sample, according to Wagenaar. The study deals with a small population in a single location. The possible volunteer bias was minimized by using an approach that made the potential interview as non-threatening as possible. The purpose of the study was

clearly stated to the potential subjects.

The instrument that was used for the present study is the Oregon Quality of Life Questionnaire (OQLQ), which is a self-report instrument administered by using an interview method. Three types of "response sets" are potentially present in self-report instruments: (1) acquiescence, or the set to respond "true", no matter what the content of the inventory item may be; (2) social desirability or the set to present oneself in a favorable light; and (3) the set to respond deviantly (Borg & Gall, 1979). Attempts were made to eliminate these response sets by using a skilled interview technique.

The interpersonal situation could also have the possibility of an experimenter bias. This variable was controlled by the use of a standardized interviewing technique which was used by the two interviewers. No client was interviewed by the same person with whom s/he had been involved in treatment.

Attempts were made to match pertinent variables, but some of the variables were difficult to manipulate. The samples were not completely homogeneous, so some relationships between variables may be obscure.

The Hawthorne effect may be present in studies that utilize same-subjects in pre- and post-tests. This is the tendancy of people to present themselves unfavorably in the pre-test and favorably in the post-test because of the knowledge that they are involved in a study. This effect was minimized in the present study because of the comparison of same and separate samples for the pre- and post-test.

Factors such as passage of time, or history, and maturation of clients have the potential of obscuring the results of treatment. These factors were minimized by selecting participants who were either still

in treatment, or who had finished treatment not more than four months prior to the interview.

The t-tests and chi square computations used in the present study are stringent statistical tests which have basic assumptions about their use. Additional research by some statisticians casts some doubt on the necessity of strict adherence to the assumptions when using the statistical techniques (Kerlinger, 1979).

The methodology of the study put some limits on the validity of the conclusions. Only some of the follow-up clients who participated in the pre-test are represented - those who were eligible and those who were willing to be interviewed. Attrition rate of the matched group was 36.48 percent. This is compared with a 50 percent attrition rate in the statewide samples. Eight of the thirteen clients who participated in the pre-test interview qualified for the post-test interview. Of the remaining five clients, one was not available to participate in the second interview, and four had terminated from treatment before the 60 day period had lapsed. Three of those four clients moved away from the area, and one terminated early because of physical health problems.

Although there are limitations to this type of research and to this study, it is nevertheless important for psychiatric nurses and other mental health professionals to evaluate the effectiveness of therapy programs. From a preliminary study such as the present one, hypotheses can be formed and methodology refined in future replication studies. This type of evaluation research also aids program directors in goal-setting and future planning.

Practical implications of this research for psychiatric nurses and other mental health professionals include this example of using creative

resources to provide psychotherapy for increasing numbers of the population who may otherwise go without needed services. Since the comprehensive framework for psychiatric nursing inclueds a multifaceted approach, it becomes necessary for the nurse practitioner to deliver therapy on many levels, and to use multidimensional measures of quality of care.

CHAPTER 5

SUMMARY AND RECOMMENDATIONS

Summary

The purpose of this study was to examine the effects of therapy on the quality of life of clients at an alternative community mental health agency in an attempt to determine whether effective mental health services can be provided at minimal cost to the client and/or taxpayer. The literature review provides an idea of the extensive research which has been done over the past three decades on the effectiveness of psychotherapy, and the growth and development of mental health programs. Eysenck's question (1952) about whether or not psychotherapy is effective has been answered in the affirmative by many outcome studies, and the government role has now shifted to support research efforts which are directed toward determining the efficacy, safeness, and cost-effectiveness of psychosocial treatments (Parloff, 1980).

It is evident that existing mental health services are increasingly unable to meet the demand of large numbers of people who seek therapy and who are financially unable to afford it. The demand of the public to receive quality mental health service is a challenge to psychiatric nurses and other mental health service providers.

Aslan House, the alternative community mental health agency in the present study, has attempted to meet the challenge by providing traditional psychotherapy within a setting which is staffed by volunteer professional counselors. Clients receive free therapy sessions for up to six sessions, and then a low sliding fee schedule is used for subsequent sessions.

The Oregon Quality of Life Questionnaire (OQLQ) was chosen as the instrument to be used in evaluating the therapy program at Aslan House. The OQLQ was developed by persons at the State of Oregon Mental Health Division, and has been used to evaluate the effectiveness of therapy in mental health agencies throughout the State (Bigelow & Olson, 1981). The conceptualization of the instrument is developed around Maslow's Theory of Needs, and provides a multidimensional tool for measuring effects of therapy. The Quality of Life concept is compatible with Martha Rogers' holistic nursing theory, as it deals with the needs and abilities of an individual participating in his/her environment.

Methods used in this study included both a same- and separate-sample pre-post test design. The subjects were administered the Oregon Quality of Life Questionnaire in an interview format at the beginning of therapy and after a period of 60 days or more of treatment at Aslan House. This design provided a comparison of pre-test scores with post-test scores. Post-test scores of Aslan House clients were also compared with post-test scores of clients at other agencies in Oregon which have participated in OQLQ studies, in order to compare the clients' perceptions of the helpfulness of the mental health services.

Hypothesis one, predicting higher OQLQ scores for clients following treatment than were obtained by these clients prior to treatment at Aslan House, was tested by means of t tests for correlated samples. Three of these t tests were significant at or below the .02 level; other mean differences were in the predicted direction. The hypothesis was supported.

Hypothesis two, predicting higher OQLQ scores in a group of Aslan House clients following treatment than in a separate group before treatment began, was tested by t tests for non-matched samples and by the

Wilcoxen sign test. None of the t tests were significant (although one closely approached significance at the .05 level); all the mean differences were in the predicted direction; the sign test indicates that this pattern is significant at the .05 level. The hypothesis was supported.

Hypothesis three, predicting Aslan House client satisfaction to be at least as great as client satisfaction of people seen in other OQLQ agencies, was tested by means of χ^2 and sign tests. Of the seven major target items, four sets of differences yielded statistically significant χ^2 (at or less than .05). Overall, the pattern of responses differed significantly from chance at the .05 level (Wilcoxen sign test). On an additional set of items, dealing with client perceptions of program impact, the pattern of differences between Aslan House and statewide clients was also significant ($\leq .01$, Wilcoxen sign test). The hypothesis was supported.

The results of this study may be questioned because of the methodology and the small sample size. However, all of the Aslan House clients reported that they were satisfied with the services they received, and that they would return to the agency if they needed furthur therapy in the future. OQLQ developers state that clients' reports are important and that clients are in a position to measure change that we cannot adequately measure at this time (Brodsky, Bigelow, et al, 1980).

The cost of service delivery in the tax supported mental health agency in this community is estimated to be approximately $75.00 per hour of therapy (Lane County Community Mental Health Program Annual Report, 1979-80). The private sector in the community charges the client fees ranging from $40.00 to $110.00 per hour of therapy. The agency in the present study charges clients an average of approximately $1.00 per therapy hour, with no taxpayer support. Effective mental health services can

indeed be provided at minimal cost to the taxpayer and/or client.

Recommendations

A replication of this study would strengthen the results. If another study is done at the same agency, it is recommended that attempts be made to conduct the post-test interview on all clients after the same length of time of treatment (60 days, 90 days, or 120 days). It is also recommended that the post-test interview be done not more than one week following termination of treatment in order to diminish maturation and history factors.

A random sample, rather than a convenience sample, would diminish any selection bias that may have occurred in this study. However, as discussed earlier, the use of random sampling in this kind of outcome evaluation can raise serious ethical questions. It might be more feasible simply to replicate with a larger sample; larger sample sizes would be more likely to produce reliable results.

The Oregon Quality of Life Questionnaire is lengthy and needs furthur refinement. Although the questions are interesting, some of the scales are not pertinent to program goals. It would be more useful to the program to have items on the questionnaire which are only related specifically to program goals. The items on the OQLQ which are related to Aslan House program goals need to be expanded and refined.

In order to provide a systemic evaluation of the Aslan House program, it is recommended that an evaluation be done of the training aspect of the program. This would provide a more comprehensive view of the range of services that are provided at the agency. A preliminary study of staff opinions about the agency has already been done by the investigator, and those results could be incorporated into a comprehensive evaluation of the

total agency (Carter, 1980).

Although a comprehensive program evaluation is complex, it will become more and more necessary for psychiatric nurse practitioners to have knowledge about this type of research. Nurses are increasingly assuming leadership roles in community mental health services and the development of programs, and need to provide clear evidence of quality of care.

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APPENDIX A

TABLE A

Aslan House

Percent of Clients in Each Change Catagory

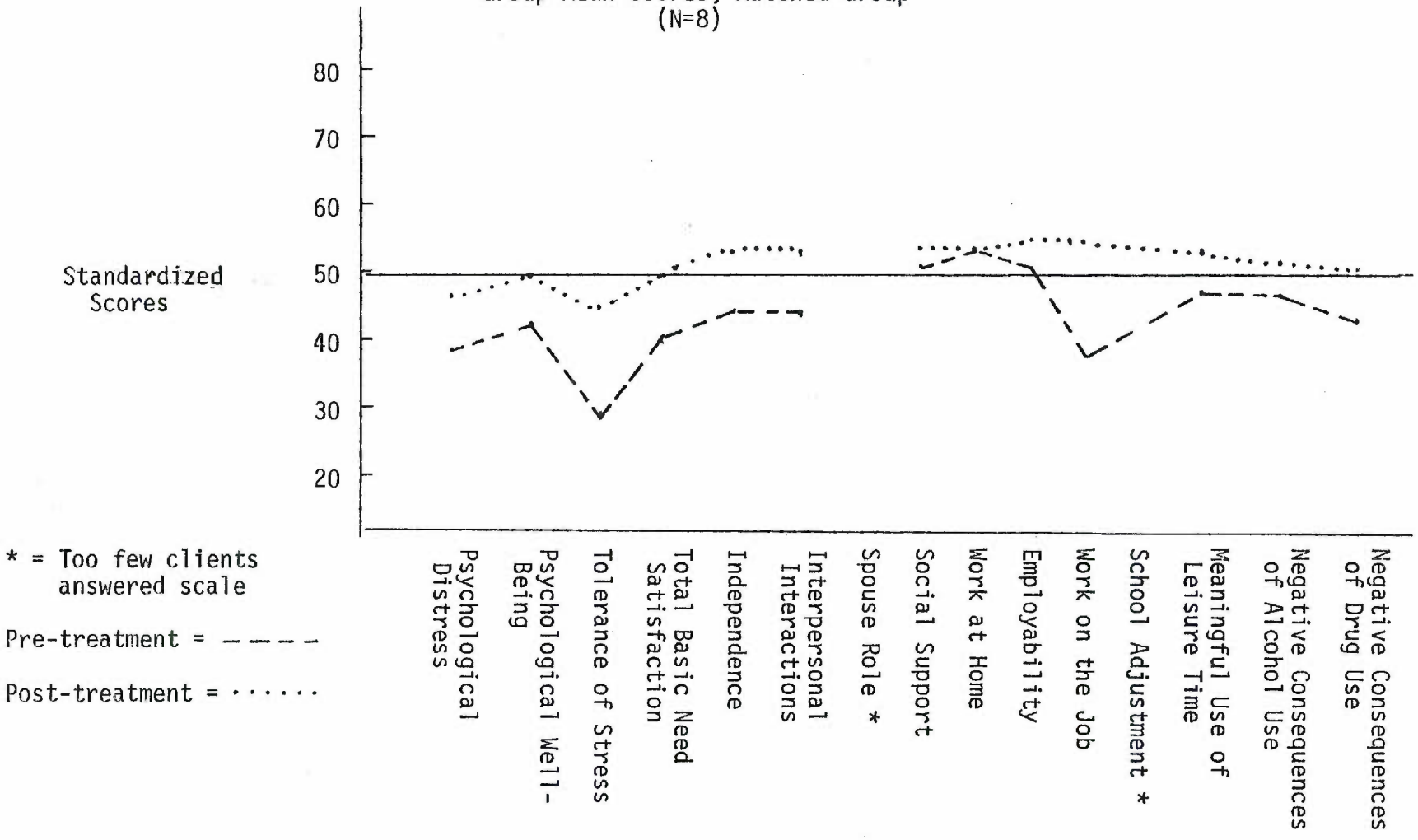
Matched Group

	Improved	Stayed Same	Worsened	N
Psychological Distress	75%	0	25%	8
Psychological Well-Being	75%	0	25%	8
Tolerance of Stress	75%	12.5%	12.5%	8
Total Basic Need Satisfaction	87.5%	12.5%	0	8
Independence	87.5%	12.5%	0	8
Interpersonal Interaction	62.5%	25%	12.5%	8
Spouse Role	-	-	-	*
Social Support	50%	12.5%	37.5%	8
Adjustment to Work-at-Home	25%	62.5%	12.5%	8
Employability	50%	37.5%	12.5%	8
Job Adjustment	-	-	-	*
School Adjustment	-	-	-	*
Meaningful Use of Leisure Time	50%	12.5%	37.5%	8
Negative Consequences of Alcohol Use	40%	60%	0	5
Negative Consequences of Drug Use	14%	86%	0	7

* = Too few clients answered scale

FIGURE A

Aslan House
Pre- and Post-Treatment
Group Mean Scores, Matched Group
(N=8)



* = Too few clients answered scale

Pre-treatment = — — — —

Post-treatment = · · · · · ·

TABLE B

Aslan House
Pre- and Post-Treatment Group Mean Scores

OQLQ Scales	Matched				Non-Matched				Total Sample			
	N	Pre-	N	Post-	N	Pre-	N	Post-	N	Pre-	N	Post-
Psychological Distress	8	39	8	48	13	41	17	43	13	41	25	44
Psychological Well-Being	8	43	8	50	13	44	17	46	13	44	25	48
Tolerance of Stress	8	28	8	45	13	32	17	39	13	32	25	41
Total Basic Need Satisfaction	8	40	8	50	13	43	17	45	13	43	25	46
Independence	8	46	8	53	13	47	17	48	13	47	25	50
Interpersonal Interactions	8	46	8	53	13	47	17	48	13	47	25	50
Spouse Role	*	-	*	-	4	36	9	44	4	36	11	42
Social Support	8	52	8	54	13	51	17	50	13	51	25	51
Adjustment to Work-at-Home	8	54	8	54	13	53	17	52	13	53	25	52
Employability	8	51	8	55	13	50	17	51	13	50	25	52
Job Adjustment	*	-	*	-	7	45	15	46	7	45	18	48
School Adjustment	*	-	*	-	*	-	*	-	*	-	*	-
Meaningful Use of Leisure Time	8	48	8	54	13	49	17	52	13	49	25	53
Negative Consequences of Alcohol Use	5	48	5	52	10	51	15	52	10	51	20	52
Negative Consequences of Drug Use	7	44	7	51	11	43	12	48	11	43	19	49

* = Too few clients answered scale.

FIGURE B

Aslan House
Pre- and Post-Treatment
Group Mean Scores, Non-Matched Group
Pre-test (N) = 13
Post-test (N) = 17

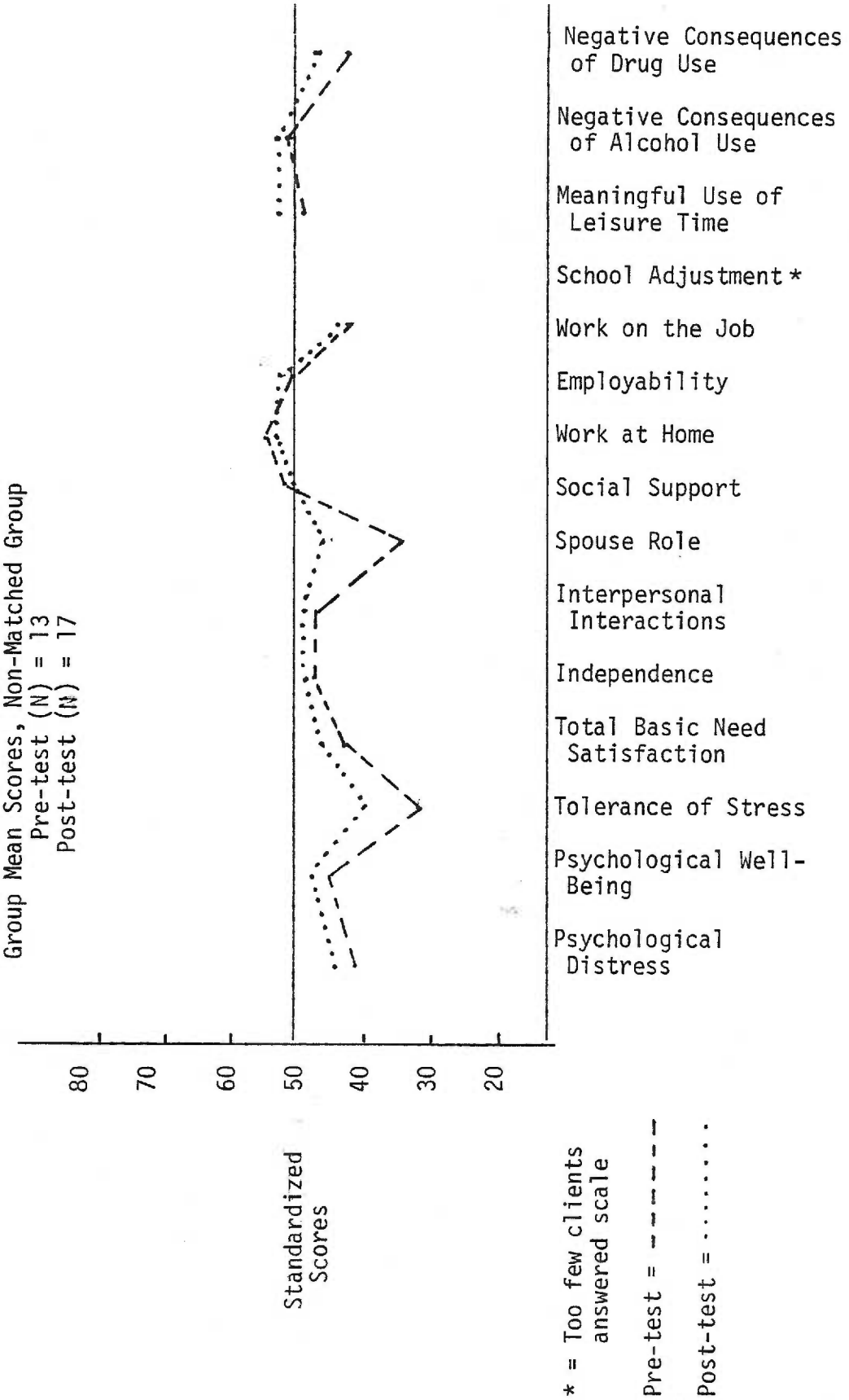


TABLE C

Aslan House and Statewide Samples
Client Perception of Program Impact
Group Mean Scores

	Aslan House		Statewide Sample *	
	N	$\bar{X}$	$\bar{X}$	N
Personal Adjustment				
Psychological Distress/ Well-Being	25	4.44	3.88	280
Tolerance of Stress	25	4.24	3.77	278
Living Situation	25	3.56	3.24	277
Adequacy of Income	25	3.40	3.06	277
Transportation	25	3.04	3.21	276
Medical Care	25	3.44	3.07	277
Independence	25	4.44	3.68	280
Interpersonal Adjustment				
Interpersonal Interactions	25	3.96	3.50	278
Close Friendships	25	3.76	3.25	256
Spouse Role	11	4.55	3.70	154
Parent Role	13	3.69	3.70	157
Social Support	25	3.56	3.30	277
Productivity				
Adjustment to Work-at-Home	25	3.56	3.23	271
Employability	25	3.44	3.23	242
Job Adjustment	18	3.78	3.22	147
Meaningful Use of Leisure Time	25	3.68	3.38	280
Civic Adjustment				
Legal Difficulties	**	--	3.30	98
Negative Consequences of Alcohol Use	11	3.18	3.42	166
Negative Consequences of Drug Use	8	3.50	3.11	167

Note: 5 = Greatly improved; 4 = Improved; 3 = No effect, 2 = Worse; 1 = Much worse.

* Statewide data from Brodsky, Bigelow, et al. The Oregon Program Impact Monitoring System Final Report. April, 1980.

** = Too few clients answered item.

TABLE D

Aslan House and Statewide Samples
Clients' Perceptions of the Helpfulness
of Non-Program Elements

	Percent Harmful or Very Harmful	Percent No Effect	Percent Helpful	Percent Very Helpful	(N)
Friends					
AH *	8.0	32.0	36.0	24.0	25
State *	8.5	42.8	29.5	19.1	572
Religious Associations					
AH	14.3	35.7	42.8	7.1	14
State	2.5	49.2	25.1	23.2	315
Other Counselors					
AH	-	-	-	-	**
State	6.0	22.6	35.9	35.5	217
Passing of Time					
AH	8.0	40.0	40.0	12.0	25
State	13.1	35.5	37.0	14.3	602
Keeping Busy					
AH	8.0	12.0	56.0	24.0	25
State	2.4	24.7	42.4	30.6	604
Being with People					
AH	0	20.0	64.0	16.0	25
State	5.7	26.5	43.3	24.6	601
Physical Activity					
AH	0	10.0	60.0	30.0	20
State	1.5	22.1	48.4	28.1	467
Family					
AH	36.4	22.7	31.8	9.1	22
State	11.5	33.0	33.2	22.3	584
Family Doctor					
AH	0	70.6	29.4	0	17
State	3.2	66.8	15.9	14.2	352

* AH = Aslan House
State = Statewide sample. From PIMS Data Base 12/3/80.
** Too few clients answered item.

APPENDIX B

Aslan House Fee Schedule

Monthly Net Income	Number of Dependents 0	1	2	3	4	5+
$0-$400	5.00	2.00	2.00	1.00	1.00	1.00
$401-$500	5.00	5.00	5.00	3.00	3.00	3.00
$501-$600	9.00	7.00	7.00	7.00	6.00	5.00
$601-$700	11.00	9.00	9.00	9.00	7.00	7.00
$701-$900	15.00	13.00	13.00	13.00	11.00	11.00
$901-$1100	17.00	16.00	16.00	16.00	15.00	15.00
$1101-$1300	21.00	19.00	19.00	19.00	17.00	17.00
$1301-$1500+	25.00	23.00	23.00	23.00	21.00	21.00

*This is the schedule for fees per session after the first six sessions, which are free.

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER
SCHOOL OF NURSING

I, _____, herewith agree to serve as a subject in the investigation named "Effects of Therapy on Quality of Life of Clients at an Alternative Community Mental Health Agency" by Carolyn A. Parson Carter, R.N., B.S. under the supervision of Florence Hardesty, R.N., Ph.D.

The investigation aims at determining the effectiveness of community mental health services. I agree to participate in an interview, which will take about an hour which will focus on:

How I am feeling.

How I am getting along with family and friends.

How work is going.

Whether I have had any recent contact with the law.

Whether, and how much, the services helped me.

I may benefit from the interview by becoming more aware of my social adjustment. All information obtained will be kept confidential. Code numbers will be assigned each subject to assure that answers will be anonymous. Data from all interviews will be reported as a group so that no single individual will be identified with specific answers.

I understand I may refuse to participate or withdraw from this study at any time without affecting my relationship with, or treatment at, Aslan House. Ms. Carter or Ms. _____ has offered to answer any questions I might have about participation in the study.

- -

I have read or listened to the above information regarding the interview and I am willing to proceed. I give my permission to allow the information gathered in this interview to be used for research purposes only.

Date _____ Signature _____

Witness _____

Oregon Quality of Life Questionnaire
Demographic Information

** The following information will be used for statistical purposes only.

AGE _____ SEX _____

MARITAL STATUS: (Check one)

Married ____ Single ____

Divorced ____ Single, living with partner ____

Widowed ____ Separated ____

NUMBER OF CHILDREN ____

NET INCOME PER MONTH _____

ETHNIC BACKGROUND _____

PLACE OF RESIDENCE: (Check one)

Eugene ____ Rural ____

Springfield ____ Other ____

HOW LONG HAVE YOU LIVED AT YOUR CURRENT RESIDENCE? _____

If less than one year, where was your previous residence? _____

TYPE OF DWELLING: (Check one)

House ____

Duplex ____ Other (please specify) _____

Apartment ____

ARE YOU BUYING _____ OR RENTING ____ YOUR HOME?

HAVE YOU BEEN IN THERAPY ANY PLACE ELSE SINCE COMING TO ASLAN HOUSE?

Yes ____ No ____

If yes, for how long? _____

HAVE YOU EVER BEEN IN THERAPY BEFORE COMING TO ASLAN HOUSE?

Yes ____ No ____

If yes, for how long? _____

Oregon Quality of Life Questionnaire (1980)

Department of Human Resources

These questions ask about how you have been feeling in the past week. Pleasant and unpleasant feelings of several different kinds are covered.

In the past week, how often have you felt very restless, unable to sit still, or fidgety?	4 all the time 3 often 2 several times 1 none of the time	01-01 17
In the past week, how often have you enjoyed your leisure hours (evenings, days off, etc.)?	4 all the time 3 often 2 several times 1 none of the time	01-02 18
In the past week, how often have you felt preoccupied with your problems (can't think of anything else)?	4 all the time 3 often 2 several times 0 N/A 1 none of the time	01-03 19
In the past week, how often have you been pleased with something you did?	4 all the time 3 often 2 several times 1 none of the time	01-04 20
In the past week, how often have you felt unpleasantly different from everyone and everything around you?	4 all the time 3 often 2 several times 1 none of the time	01-05 21
In the past week, how often have you felt proud because you were complimented?	4 all the time 3 often 2 several times 1 none of the time	01-06 22
In the past week, how often have you felt fearful or afraid?	4 all the time 3 often 2 several times 1 none of the time	01-07 23
In the past week, how often have you felt that things were "going your way"?	4 all the time 3 often 2 several times 1 none of the time	01-08 24
In the past week, how often have you felt sad or depressed?	4 all the time 3 often 2 several times 1 none of the time	01-09 25
In the past week, how often have you felt excited about or interested in something?	4 all the time 3 often 2 several times 1 none of the time	01-10 26

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In the past week, how often have you felt angry?	4all the time 3often 2several times 1none of the time	01-11 27
In the past week, how often have you felt that life was going just about right for you?	4all the time 3often 2several times 1none of the time	01-12 28
In the past week, how often have you felt mixed-up or confused?	4all the time 3often 2several times 1none of the time	01-13 29
In the past week, how often have you felt tense (uptight)?	4all the time 3often 2several times 1none of the time	01-14 30
In the past week, how often have you felt good about decisions you've made?	4all the time 3often 2several times 1none of the time	01-15 31
In the past week, how often have you had trouble sleeping?	4all the time 3often 2several times 1none of the time	01-16 32
In the past week, how often have you felt like you've spent a worthwhile day?	4all the time 3often 2several times 1none of the time	01-17 33
In the past week, how often have you had trouble with poor appetite, or inability to eat?	4all the time 3often 2several times 1none of the time	01-18 34
In the past week, how often have you felt serene and calm?	4all the time 3often 2several times 1none of the time	01-19 35
In the past week, how often have you had trouble with indigestion?	4all the time 3often 2several times 1none of the time	01-20 36
In the past week, how often have you found yourself really looking forward to things?	4all the time 3often 2several times 1none of the time	01-21 37
In the past week, how often have you had trouble with fatigue?	4all the time 3often 2several times 1none of the time	01-22 38
Considering the feelings we've just talked about, did _____ make any difference in the way you feel?	5greatly improved it 4improved it 3no effect 2made it worse 1made it much worse	20-01 39

Everybody has unpleasant feelings sometimes: we wake up depressed, get upset or frustrated or frightened. These questions ask how much difficulty you have had recently in handling these unpleasant feelings.

How much difficulty have you had handling feelings of depression recently?	3 great difficulty 2 some difficulty 1 no difficulty 0 NA	02-01 40
How much difficulty have you had handling being upset recently?	3 great difficulty 2 some difficulty 1 no difficulty 0 NA	02-02 41
How much difficulty have you had handling frustration recently?	3 great difficulty 2 some difficulty 1 no difficulty 0 NA	02-03 42
How much difficulty have you had handling being frightened or shaken up recently?	3 great difficulty 2 some difficulty 1 no difficulty 0 NA	02-04 43
Has _____ made any difference in how you handle unpleasant feelings?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-02 44

These questions ask about your living situation, eating, income, transportation, and medical care. The purpose is to see if these needs are met to at least a minimum level of satisfaction. 45

How satisfied are you with your home--its state of repair, amount of room, furnishing, warmth, lighting, etc.?	4 very satisfied 3 satisfied 2 dissatisfied 1 very dissatisfied	03-01 46
How satisfied are you with your home, considering the amount of privacy, your neighbors, security, etc.?	4 very satisfied 3 satisfied 2 dissatisfied 1 very dissatisfied	03-02 47
Did _____ affect your living situation?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-03 48
This question asks about how well your income covers things you must have--food, medicine, clothing, etc. How adequate is your present income for your present needs?	4 very adequate 3 adequate 2 inadequate 1 very inadequate	03-03 49
Are you worried about your future income covering the things you must have?	4 terribly worried 3 quite worried 2 slightly worried 1 not at all worried	03-04 50
Did _____ affect the adequacy of your income?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-04 51
Can you get around town as you need for work, shopping, medical appointments, visiting, etc. ?	4 can't get around at all 3 with much difficulty 2 with little difficulty 1 with no difficulty	03-05 52

		4
Did _____ affect your ability to get around the community?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-06 53
In the last month, have you needed medical care? No=0 If yes, did you have difficulty getting medical care?	2 yes 1 no 0 NA	03-06 54
Do you have a regular or family doctor?	2 yes 1 no	03-07 55
Do you have medical insurance?	2 yes 1 no	03-08 56
Do you know where to get emergency medical help?	2 yes 1 no	03-09 57
Did _____ affect your medical care?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-07 58
These questions ask how you handle making decisions, dealing with conflict, asserting yourself, etc.		
In the last week, how did you find shopping, paying bills, preparing meals, and generally looking after your basic necessities?	4 very easy 3 fairly easy 2 rather difficult 1 very difficult	04-01 59
...and how enjoyable was it?	4 very enjoyable 3 fairly enjoyable 2 fairly unpleasant 1 very unpleasant	04-02 60
In the last week, how often did you go out socially?	4 more than 3 times 3 2 or 3 times 2 once 1 never	04-03 61
When you receive broken merchandise, poor service, or are overcharged, how hard is it for you to complain to the store, dealer or company?	4 can't do it at all 3 very hard 2 a little hard 1 not hard at all	04-04 62
When you want to join a conversation (e.g., at a party) how hesitant do you feel about doing so?	4 can't do it all 3 very hesitant 2 slightly hesitant 1 not at all hesitant	04-05 63
When you are treated unfairly by someone you know well, a family member or close friend, how difficult is it for you to tell them so?	4 can't do it at all 3 very difficult 2 slightly difficult 1 not difficult	04-06 64
How confident are you in the decisions you make for yourself (what to buy, where to live, what to do, etc.)?	4 quite confident 3 some confidence 2 little confidence 1 no confidence	04-07 65
How often do you put off making important decisions until it is <u>too late</u>?	4 always 3 often 2 occasionally 1 never	04-08 66
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		5
Did _____ affect your ability to make decisions, deal with conflict, and assert yourself?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-08 67
These questions ask how you have been getting along with people in the last week.		
In the past week, how many times have you spoken with neighbors?	4 more than 3 times 3 2 or 3 times 2 once 1 never	05-01 68
In the last week, how often have you spoken with people you saw at work or school or other daily activities?	4 more than 3 times 3 2 or 3 times 2 once 1 never	05-02 69
Do you feel that people avoid you?	4 all the time 3 often 2 occasionally 1 never	05-03 70
Do you feel that people are unkind to you?	4 all the time 3 often 2 occasionally 1 never	05-04 71
How comfortable do you feel being around people in general?	4 very uncomfortable 3 uncomfortable 2 comfortable 1 very comfortable	05-05 72
Last week, how often did you get to places where you could meet new people?	4 every day 3 several times 2 once 1 not at all	05-06 73
Did _____ affect how you get along with people?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-09 74
These questions ask how you have been getting along with your close friends.		
How easily do you make close friendships?	4 can't do it at all 3 with much difficulty 2 with a little difficulty 1 quite easily	06-01 75
Do you have any close friends?	2 yes 1 no	06-02 76
(If "yes")		
In the last week, how much of your free time did you spend with close friends talking or doing things together?	4 almost all 3 about half 2 very little 1 none	06-03 77
In the last month, how many times have you had contact by visit, phone, or mail with friends who live outside _____?	4 quite often 3 several times 2 once 1 not at all	06-04 78

		6
How much trouble have you had in your close friendships recently?	4 a great deal 3 quite a bit 2 a little 1 none	06-05 79
Did _____ make a difference in your close friendships?	5 greatly improved them 4 improved them 3 no effect 2 made them worse 1 made them much worse	20-10 80

These questions ask how you have been getting along with your family recently.

What is your marital situation now?	6 living together as married 5 married 4 separated 3 divorced 2 widowed 1 never married	07-01 81 & 82
How many people, not including yourself, live in the household with you between the ages of:	0-5 83 6-17 84 18-64 85 65+ 86	07-02
Are there any children living with you for whom you are responsible?	2 yes 1 no	07-03 87
In the last week, how much of your free time did you spend with the people with whom you live, talking or doing things together?	4 almost all 3 about half 2 very little 1 none	07-04 88
In the last month, how many times have you had contact by visit, phone, or mail with family members who do not live with you?	4 more than 3 times 3 2 or 3 times 2 once 1 not at all	07-05 89

(If married or living as married)

In the last week, how often have you gotten very angry with your spouse?	4 every day 3 often 2 once or twice 1 never	08-01 90
In the last week, how often did you go out of your way to be nice to your spouse?	4 all the time 3 often 2 several times 1 never	08-02 91
In the last month, how much have you enjoyed your spouse's company?	4 a great deal 3 quite a bit 2 a little 1 not at all	08-03 92
How well have you been getting along with your spouse recently?	4 very well 3 well 2 poorly 1 very poorly	08-04 93
Did _____ affect your relationship with your spouse?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-11 94

—(If living with and responsible for children)

How much have you been involved with your children's activities recently?	4 a great deal 3 a lot 2 a little 1 not at all	09-01 95
How much difficulty have you had meeting your children's demands for your attention recently?	4 a great deal 3 a lot 2 a little 1 none at all	09-02 96
In the last week, how many conversations did you have with your children?	4 more than 3 3 2 or 3 2 one 1 none	09-03 97
How much have your children annoyed you recently?	4 a great deal 3 a lot 2 a little 1 not at all	09-04 98
How much have you enjoyed your children's company recently?	4 a great deal 3 a lot 2 a little 1 not at all	09-05 99
Did _____ make any difference in the way you get along with your children? ____	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-12 100

There are some things we share with family and friends; some things we can count on them for. These questions ask about your family and friends, as you see them now.

When something nice happens to you, do you want to share the experience with your family?	4 always 3 often 2 sometimes 1 never	10-01 101
When something nice happens to you, do you want to share the experience with your friends?	4 always 3 often 2 sometimes 1 never	10-02 102
How much would your family be of help and support if you were sick, or moving, or having any other kind of problem?	4 a great deal 3 a lot 2 a little 1 none	10-03 103
How much would your friends be of help and support to you if you were sick, or moving, or having any other kind of problem?	4 a great deal 3 a lot 2 a little 1 none	10-04 104
How much would anyone in the community, other than family and friends, be of help and support to you if you were sick, or moving, or having any other kind of problem?	4 a great deal 3 a lot 2 a little 1 none	10-05 105
Did _____ affect the help and support you feel you can count on from family, friends, and others?	5 greatly increased it 4 increased it 3 no effect 2 made it worse 1 made it much worse	20-13 106

8

These questions are about your experience with work at home.

In the last week, how well have you kept up with your share of the housework (cleaning, laundry, errands)?	4 completely done 3 quite well 2 fairly well 1 not at all	11-01 107
How much of the household money management (paying the bills, budgeting) do you do?	4 all 3 most 2 a little 1 none	11-02 108
How much of the shopping for the household do you do (groceries, furnishings, supplies)?	4 all 3 most 2 a little 1 none	11-03 109
In the last month, how much time did you spend fixing or changing things connected with your car or home (repairs, redecorating, remodeling, yard work)?	4 several days 3 a day or so 2 an hour or so 1 none	11-04 110
About how many hours per day do you usually spend preparing meals?	4 more than 3 3 1 to 3 hours 2 an hour or less 1 none	11-05 111
Did _____ affect your work in the home?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-14 112

These questions concern looking for a job. Even if you are not looking for a job, the questions ask about how you would feel.

12-01
113

How good an impression do you feel you would make in a job interview?	4 very good 3 good 2 poor 1 very poor	12-02 114
How serious are any emotional problems you may have which would make it hard for you to find work?	4 very serious 3 pretty serious 2 slightly serious 0 NA 1 not at all serious	12-03 115
How comfortable do you feel going out to look for a job?	4 completely 3 quite 2 fairly 1 not at all	12-04 116
How hard is it for you to stick to a job when it becomes unpleasant or boring or stressful?	4 can't do it at all 3 very hard 2 a little hard 1 not at all hard	12-05 117
If you had a chance to get more job training, how willing would you be to get it?	4 not interested 3 slightly willing 2 fairly willing 1 very willing	12-06 118

		9
How comfortable do you feel working with co-workers?	4 not at all comfortable 3 fairly 2 quite 1 completely	12-07 119
The next two questions are a bit different. I'm going to ask you to list some things. Please name some of your hobbies and special interests.	4 more than 3 3 2 or 3 2 one 1 none	12-08 120
Please name some of the ways you know for finding a job.	4 more than 3 3 2 or 3 2 one 1 none	12-09 121
Did _____ make a difference in how easy it would be for you to get a job?	5 made it much easier 4 made it easier 3 no effect 2 made it harder 1 made it much harder	20-15 122
These questions ask about your work on the job.		
Are you employed?	4 full-time (35+ hours) 3 part-time (17-34 hours) 2 irregularly (≤16 hours) 1 not employed	13-01 123
—*(If employed)*		
In the last month, how much time did you miss from work?	4 several days 3 a day or two 2 an hour or so 1 none	13-02 124
In the last month, how much difficulty did you have in doing your work?	4 a great deal 3 quite a bit 2 a little 1 none	13-03 125
How did you feel about the quality of the work you did recently?	4 very good 3 good 2 bad 1 very bad	13-04 126
How much conflict have you had with people while you were working recently?	4 a great deal 3 quite a bit 2 a little 1 none	13-05 127
How interesting is your work?	4 very interesting 3 moderately interesting 2 slightly interesting 1 it's boring	13-06 128
In general, how much do you like your job?	4 really like it 3 like it 2 don't like it 1 hate it	13-07 129
In the last month, how many times did people complain about your work?	4 more than 3 times 3 2 or 3 times 2 once 1 not at all	13-08 130

In the past month, how many times did people say good things about your work?	4 more than 3 times 3 2 or 3 times 2 once 1 not at all	13-09 131
Did _____ affect the way your job went last month?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-16 132

These questions are about how things are going at school.

Are you enrolled in school, night classes, job training, etc.?	4 full-time (12+ hours) 3 half-time (6-11 hours) 2 less than ½ time (<6 hours) 1 no	14-01 133
How many hours did you spend last week in any informal studying, reading for job promotion, correspondence courses, home extension, etc.?	4 20+ hours 3 8-20 hours 2 1-7 hours 1 none	14-02 134

(If enrolled in school)

In the last week, how many classes have you missed from school?	4 all week 3 a day or so 2 one or two classes 1 none	14-03 135
In the last week, how well have you kept up with your school work?	4 completely 3 quite well 2 fairly well 1 not at all	14-04 136
How satisfied are you with the work you did for your classes last week?	4 very satisfied 3 quite 2 a little 1 not at all	14-05 137
In the last week, how many times have you had problems with people at school?	4 more than 3 times 3 2 or 3 times 2 once 1 none	14-06 138
In the last week, how interesting was your school work?	4 very interesting 3 moderately 2 slightly 1 not at all	14-07 139
In general, how much do you like being in school?	4 really like it 3 like it 2 don't like it 1 hate it	14-08 140
In the last week, how many times did anyone complain about your school work?	4 more than 3 times 3 2 or 3 times 2 once 1 not at all	14-09 141
In the last week, how many times did anyone say good things about your school work?	4 more than 3 times 3 2 or 3 times 2 once 1 not at all	14-10 142

11

Did _____ help you get into, or back into, or stay in, school?	2 yes 1 no	20-17 143
Did _____ affect the way school has gone for you?	5 greatly improved it 4 improved it 3 no effect 2 made it worse 1 made it much worse	20-18 144

These questions ask about some of the ways you spend your time when you are not working at home, on the job, or in school.

In the last week, how much time did you spend actively participating in recreation or sports?	4 20+ hours 3 8-20 hours 2 1-7 hours 1 none	15-01 145
In the last week, how much time did you spend on your hobbies, creative pursuits, or games?	4 20+ hours 3 8-20 hours 2 1-7 hours 1 none	15-02 146
Of the TV watching you did last week, how much time did you spend on really interesting programs?	4 20+ hours 3 8-20 hours 2 1-7 hours 1 none 0 NA	15-03 147
In the last week, how much time did you spend window shopping?	4 20+ hours 3 8-20 hours 2 1-7 hours 1 none	15-04 148
In the last week, how much time did you spend on volunteer work?	4 20+ hours 3 8-20 hours 2 1-7 hours 1 none	15-05 149
Not counting any time for which you were paid, how much time did you spend last week which you felt was boring and useless?	4 20+ hours 3 8-20 hours 2 1-7 hours 1 none	15-06 150
Regarding the activities we've just talked about, did _____ affect how you spend your free time?	5 made it much more satisfactory 4 made it more satisfactory 3 no effect 2 made it less satisfactory 1 made it much less satisfactory	20-19 151

The following questions are about legal problems you may have had in the last month.

16-01
152

In the last month, have you been arrested, cited or ticketed for a:

Traffic-related offense?	2 yes 1 no	16-02 153
Drug-related offense?	2 yes 1 no	16-03 154

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Alcohol-related offense?	2 yes 1 no	16-04 155
Violence-related offense?	2 yes 1 no	16-05 156
Theft-related offense?	2 yes 1 no	16-06 157
In the last month, have you been sued?	2 yes 1 no	16-07 158
In the last month, has there been a commitment hearing regarding your mental health?	2 yes 1 no	16-08 159
Did _____ affect any of your legal difficulties?	5 greatly reduced them 4 reduced them 3 no effect 2 increased them 1 greatly increased them 0 NA, No legal problems	20-20 160

These questions are about drinking alcoholic beverages.

In the last month, have you had any alcohol to drink like beer, wine or anything else?	2 yes 1 no	17-01 161

(If "yes")

People sometimes have problems with using alcohol. The following questions ask about problems you may have had with alcohol in the last month.

Have you had problems controlling your drinking?	4 very severe 3 a lot	2 a few 1 none		17-02 162
Problems controlling your behavior because of drinking?	4 very severe 3 a lot	2 a few 1 none		17-03 163
Problems with feelings like guilt, anger or depression because of drinking?	4 very severe 3 a lot	2 a few 1 none		17-04 164
Problems with your health because of drinking?	4 very severe 3 a lot	2 a few 1 none		17-05 165
Problems with your parents because of your drinking?	4 very severe 3 a lot	2 a few 1 none	0 NA, No contact with parents	17-06 166
Problems with your friends because of your drinking?	4 very severe 3 a lot	2 a few 1 none	0 NA	17-07 167
Problems with your spouse because of your drinking?	4 very severe 3 a lot	2 a few 1 none	0 NA	17-08 168
Problems with your children because of your drinking?	4 very severe 3 a lot	2 a few 1 none	0 NA	17-09 169
Problems with your job or school because of drinking?	4 very severe 3 a lot	2 a few 1 none	0 NA	17-10 170
Problems with any other activities because of drinking?	4 very severe 3 a lot	2 a few 1 none		17-11 171
Did _____ affect any problems you may have had with alcohol?	5 greatly reduced them 4 reduced them 3 no effect 2 increased them 1 greatly increased them		0 NA, No alcohol problems	20-21 172

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These questions are about drugs.

In the last month, have you used drugs or medications of any kind, including prescription, over-the-counter, or street drugs?	2 yes / 1 no	18-01 173

(If "yes")

People sometimes have problems with the use of drugs or medications. The following questions ask about problems you may have had with drugs in the last month.

Have you had problems controlling your use of drugs?	4 very severe / 3 a lot	2 a few / 1 none		18-02 174
Problems controlling your behavior because of drug use?	4 very severe / 3 a lot	2 a few / 1 none		18-03 175
Problems with feelings like guilt, anger or depression because of drugs?	4 very severe / 3 a lot	2 a few / 1 none		18-04 176
Problems with your health because of drug use?	4 very severe / 3 a lot	2 a few / 1 none		18-05 177
Problems with your parents because of your drug use?	4 very severe / 3 a lot	2 a few / 1 none	0 NA, no contact with parents	18-06 178
Problems with your friends because of your drug use?	4 very severe / 3 a lot	2 a few / 1 none	0 NA	18-07 179
Problems with your spouse because of your drug use?	4 very severe / 3 a lot	2 a few / 1 none	0 NA	18-08 180
Problems with your children because of your drug use?	4 very severe / 3 a lot	2 a few / 1 none	0 NA	18-09 181
Problems with your job or school because of drug use?	4 very severe / 3 a lot	2 a few / 1 none	0 NA	18-10 182
Problems with any other activities because of drug use?	4 very severe / 3 a lot	2 a few / 1 none		18-11 183
Did _____ affect any problems you you may have had with drug use?	5 greatly reduced them / 4 reduced them / 3 no effect / 2 increased them / 1 greatly increased them		0 NA, No drug problems	20-22 184

Some of the following opportunities exist where you live. These questions ask which you have used in the last month.

(YMCA, city pools, etc.)?	2 yes	1 no	185	19-01
Movie theatres, bowling alleys, and other entertainment?	2 yes	1 no	186	19-02
Churches?	2 yes	1 no	187	19-03
Social clubs?	2 yes	1 no	188	19-04
Community parks?	2 yes	1 no	189	19-05
Libraries?	2 yes	1 no	190	19-06
Museums?	2 yes	1 no	191	19-07
Welfare?	2 yes	1 no	192	19-08

			14	
Food stamps?	2 yes	1 no	193	19-09
Social Security?	2 yes	1 no	194	19-10
Public transportation (buses, etc.)?	2 yes	1 no	195	19-11
Salvation Army or other hostel and meal services?	2 yes	1 no	196	19-12
County health department?	2 yes	1 no	197	19-13
Family planning?	2 yes	1 no	198	19-14
Alcohol and drug abuse programs?	2 yes	1 no	199	19-15
Children's services?	2 yes	1 no	200	19-16
State hospital?	2 yes	1 no	201	19-17
Counseling/guidance services (doctor, church, etc.)?	2 yes	1 no	202	19-18
University health service (speech, hearing, etc.)?	2 yes	1 no	203	19-19
Single Parents' Club?	2 yes	1 no	204	19-20
Weight Watchers?	2 yes	1 no	205	19-21
Alcoholics Anonymous?	2 yes	1 no	206	19-22
Big Brother or other "buddy" programs? . . .	2 yes	1 no	207	19-23
Legal Aid?	2 yes	1 no	208	19-24
County Juvenile Department?	2 yes	1 no	209	19-25
Advocate groups (tenants' association, Consumers' Protection, Civil Liberties, Women's Rights, etc.)?	2 yes	1 no	210	19-26
Vocational Rehabilitation?	2 yes	1 no	211	19-27
Oregon State Employment Service?	2 yes	1 no	212	19-28
Manpower Development and Training?	2 yes	1 no	213	19-29
Sheltered Workshop?	2 yes	1 no	214	19-30
Private employment counseling/placement services?	2 yes	1 no	215	19-31
Community college?	2 yes	1 no	216	19-32
Night school?	2 yes	1 no	217	19-33
University classes?	2 yes	1 no	218	19-34
Continuing educaton?	2 yes	1 no	219	19-35
Business or vocational school?	2 yes	1 no	220	19-36
Public school?	2 yes	1 no	221	19-37
Experimental college?	2 yes	1 no	222	19-38
Special interest groups (e.g., science fiction society)?	2 yes	1 no	223	19-39
_____? . . .	2 yes	1 no	224	19-40
_____? . . .	2 yes	1 no	225	19-41
_____? . . .	2 yes	1 no	226	19-42
			227	20-62

Your counselor may have done some of the things listed below. These questions ask how helpful you feel these things were. 15

Did your counselor <u>listen</u> to you--just let you say what you felt? [No = 0] - Did listening have an effect [No = 3] - Was listening helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	21-01 228
Did your counselor seem to <u>care</u> about you and the things bothering you? [No = 0] - Did caring have an effect? [No = 3] - Was caring about you helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	21-02 229
Did your counselor <u>encourage</u> you? [No = 0] - Did encouraging you have an effect?[No = 3] - Was encouraging you helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	21-03 230
Did your counselor <u>tell you about things</u> (jobs, community services, how to relate to people, how one's mind works)? [No = 0] - Did telling you about things have an effect? [No = 3] - Was telling you helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	21-04 231
Did your counselor <u>attempt to calm your worries</u> or relieve your fears? [No = 0] - Did it have an effect? [No = 3] - Was it helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	21-05 232
Did your couselor <u>set limits</u> for you and help you keep them? [No = 0] - Did setting limits have an effect? [No = 3] - Was setting limits helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	21-06 233
- Did your counselor have an effect on your problem? [No = 3] - Was your counselor helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful	22-01 234
[If no friends, mark NA = 0] Did friends have an effect on your problem? [No = 3] - Was it helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	22-02 235
Did you receive medications supplied or prescribed by _____? [No = 0] - Did medications have an effect on your problem? [No = 3] - Were the medications helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	22-03 236
Do you have any religious associations? [No = 0] - Did religious associations effect your problem? [No = 3] - Were religious associations helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 0 NA 2 harmful 1 very harmful	22-04 237

Did you have a counselor in other programs or a private counselor? [No = 0] - Did other counselor(s) have an effect on your problem? - Were other counselor(s) helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful	0 NA	22-05 238
Would the passing of time have had an effect on your problem? [No = 3] - Would the passing of time have been helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful		22-06 239
Did you "drop in" to the program? [No = 0] - Did "dropping in" have an effect on your problem? [No=3] - Was "dropping in" helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful	0 NA	22-07 240
Did keeping busy have an effect on your problem? [No = 3] - Was keeping busy helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful		22-08 241
Did being with people have an effect on your problem? [No = 3] - Was being with people helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful		22-09 242
Did you do physical activity such as running, swimming, or walking? [No = 0] - Did the activity have any effect on your problem? [No=3] - Was the activity helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful	0 NA	22-10 243
[If no family, mark NA = 0] Did your family have an effect on your problem? [No = 3] - Was the effect helpful or harmful - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful	0 NA	22-11 244
Did you attend group therapy at _____? [No = 0] - Did the group meetings have an effect on your problem? [No = 3] - Was the effect helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful	0 NA	22-12 245
[If no family doctor, mark NA = 0] Did the family doctor have an effect on your problem? [No=3] - Was the effect helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 3 no effect 2 harmful 1 very harmful	0 NA	22-13 246
Was there anything else that had an effect on your problem? [No = 0. If yes, write it down.] - Was it helpful or harmful? - Helpful or Very Helpful? Harmful or Very Harmful?	5 very helpful 4 helpful 2 harmful 1 very harmful	0 NA	22-14 247

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These questions ask about the service you received at _____.

Did you have any difficulty finding out about _____?	2 yes 1 no	23-01 248
Did you have any difficulty getting into _____?	2 yes 1 no	23-02 249
When you came to the program, did the receptionist make you feel comfortable?	2 yes 1 no 0 N/A	23-03 250
Was the waiting room satisfactory--its comfort, privateness, quietness, etc.?	2 yes 1 no 0 N/A	23-04 251
Was your first contact with the program satisfactory (when you discussed why you had come, etc.)?	2 yes 1 no	23-05 252
Was your counselor's attitude toward you satisfactory?	2 yes 1 no	23-06 253
[If no medications, mark NA = 0. If yes, then ask:] Was the process of getting medications satisfactory?	2 yes 1 no 0 N/A	23-07 254
Was your counselor accessible to you--could you get to your counselor when you needed to?	2 yes 1 no	23-08 255
[If there was no individual counseling, mark NA = 0. If yes, ask:] Were the individual counseling sessions with your counselor satisfactory?	2 yes 1 no 0 N/A	23-09 256
[If there were no group sessions, mark NA = 0. If yes, ask:] Were the group sessions you had with counselors and other clients satisfactory?	2 yes 1 no 0 N/A	23-10 257

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Did you have any trouble with appointments because of distance or time of the appointment?	2 yes 1 no	23-11 258
Was the attitude of staff toward you, as a client, satisfactory?	2 yes 1 no	23-12 259
[If client is still participating in program, mark NA = 0. If not participating ask:] Was the decision to end your participation in the program made in a satisfactory way?	2 yes 1 no 0 N/A	23-13 260
Are you satisfied with the way you are (were) charged?	2 yes 1 no	23-14 261
Did you get the kind of service you wanted?	2 yes 1 no	23-15 262
If you were to seek help again, would you come back to _____?	2 yes 1 no	23-16 263
Do you have any comments, criticisms, or suggestions about _____?	2 yes 1 no	

AN ABSTRACT OF THE THESIS OF

CAROLYN A. PARSON CARTER

for the Master of Nursing

Date of receiving this degree: June 11, 1982

Title: Effects of Therapy on Quality of Life of Clients at an Alternative Community Mental Health Agency

Approved: [redacted]

(Florence F. Hardesty, R.N., PhD., N.P., Advisor)

This outcome study examined the effects of therapy on quality of life of clients at an alternative community mental health agency, (Aslan House Counseling Center, Eugene, Oregon), in an attempt to determine whether quality mental health services can be provided by volunteers and advanced practicum students.

The clients in the study were administered the Oregon Quality of Life Questionnaire using an interview format. The instrument has been developed in the State of Oregon at the Mental Health Division, and is being used to assess treatment impact in mental health programs in Oregon.

The program evaluation design included three comparisons: a repeated measures comparison, a non-matched pre- versus post-treatment comparison, and a comparison of post-treatment samples from the target agency and from other Oregon agencies. A sample of 13 clients were given a pre-test at the beginning of treatment, and 8 of those clients participated in a post-test after a period of at least 60 days of treatment, thus providing a matched group. Another sample of 17 clients were given the post-test-only after a period of 60 days or more of treatment, and the scores were

compared with the pre-test scores of the other 13 clients, providing a separate-sample comparison. The post-treatment data from both groups were compared with available data on client satisfaction of treatment from 288 clients at other mental health agencies in Oregon.

Statistical analysis yielded substantial support for the three major hypotheses of the study. Aslan House clients scored significantly higher following treatment than they did prior to treatment. The non-matched post-treatment group scored higher than the pre-treatment group. Also, the pattern of differences in perception of treatment helpfulness was significantly different from chance, with Aslan House clients scoring in the more positive direction.

Aslan House Counseling Center was chosen for evaluation because it offers mental health services at minimal cost to the client and/or taxpayer. If it could be demonstrated that these services are effective, resulting in positive changes in client quality of life and in a high level of consumer satisfaction, the agency may serve as a model for service delivery elsewhere in the country. The present study represents a first step in so demonstrating.