

**PSYCHOSOCIAL ASSESSMENT IN POINT-IN-TIME SURVEYS: RATIONALE AND
AND DOMAINS of EVALUATION**

SPANISH LONG PAPER

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1.	Introduction.....	1
1.1.	Functions Instruments Serve	2
1.2.	Criteria Used to Select Instruments	3
2.	Objective and method	5
3.	Key Variables and Evaluation Techniques	5
	Sociodemographics	5
	Important Life Events	6
	Quality of life.....	7
	Health.....	8
	Social Support.....	11
	Areas	11
	Key information.....	11
	Services	12
	Functioning	13
	Other	14
4.	Selected Instruments	15
	Instruments measuring health.....	15
	Quality of life.....	19
	Functioning	20
	Satisfaction	20
5.	Referencias	22

1. Introduction

Homelessness is one of the most extreme problems caused by social exclusion facing today's society. It is closely associated with the loss of housing and lack of access to any available housing, exclusion from the workforce and labor market, feelings of loneliness and social abandonment, deterioration of mental and physical health, barriers that block access to social and health services, and difficulties in exercising citizen's rights like societal participation or the use of public spaces. Lastly homelessness seriously compromises personal dignity and a person's own identity. During the last two decades, a large number of studies have been conducted – between 1985 and 2003 PSYCinfo and Medline lists over 7000 references – on homelessness. These studies provide insight into the factors involved in the genesis, development and maintenance of the phenomenon, and also indicate which intervention tools effectively enhance the process of social re-integration of these people. The majority of these studies use of some form of evaluation or assessment instrument to study the homeless, usually of the point-in-time type. The objective of this work is to discuss some of the main conclusions

concerning the evaluation of this group based on a literature review of literally thousands of studies.

The authors of this article have already focused on some of the methodological issues important to study of the homeless, such as the analysis of sampling strategies and weighting procedures necessary to ensure that the data is representative (Marpsat and FirdioN, 2003). Unfortunately, using the criteria of employment of a rigorous sampling strategy as another criterion for the literature review would have greatly reduced the number of potential studies to examine. The present article focuses on the most important evaluation and assessment instruments employed in ALL kinds of homelessness. Many authors have cited a certain “instrument chaos” in the social sciences field in general and in the mental health area in particular (Froyd and Lambert, 1989; Ogles et al., 1990; Grundy et al., 1994; Vázquez, Muñoz, et al., 2000). The study of homelessness is no exception, and, in the more than 7000 studies on this topic found in the scientific literature, the number of different evaluation tools utilized by investigators falls in the hundreds; often times an instrument may only be used once (sometimes due to the fact that it is only useful to collect the information required for one concrete study). This confusion means that it is very complicated to study the instruments utilized to assess the homeless. Although the following work examines the instruments that are most often selected to study this population and those instruments that the authors believe are best adapted to the special peculiarities of the homeless population, in order to clarify some of this “chaos”, the first section discusses the functions that different evaluation instruments serve and the second section will go on to outline possible criteria that can help investigators in this field select the appropriate instruments to use in a given study.

1.1. Functions Instruments Serve

Evaluation instruments and techniques are used for:

Screening: Also known as detection techniques, tools in this category are important to epidemiological or exploratory studies but can be used in other cases. Screening instruments tend to be very short and easy to apply. Cut-off points should provide specific, sensitive-to-change criteria that make these instruments flexible and useful for evaluation needs that change over time. The downside of these tools is that they do not usually provide complete diagnostic information.

Determining a mental health diagnosis: There are general diagnostic instruments that allow professionals to classify symptoms into different categories of mental disorders, and there are more specific instruments that permit the diagnoses of concrete disorders. Advancement in these types of evaluation tools began in 1980 with the publication of the DSM-III (1980) (APA, 1987), and continued with the CIE-10 (WHO, 1992) and the DSM-IV-TR (APA, 2000). The more similar an instrument’s criteria are to the diagnostic classifications, the more valid, specific, and sensitive to therapeutic change it will be.

Measuring outcome-based results: Recently a new generation of instruments has been receiving a great deal of attention. These tools typically measure quality of life, overall health and psychosocial functioning and are usually derived from other well-known instruments by selecting the elements and variables that will best reflect the changes produced by the intervention or the impact of the intervention of the subject’s life. The psychometric properties of these evaluations should be highly sensitive to change while maintaining adequate reliability and validity.

Obtaining exploratory information: Often times (and many times too often), the investigator focuses on the personal history of one subject and obtains a large quantity of information about him/her. Techniques in this exploratory category do not have a specific aim;

instead they are general tools used to find out about the broad range of activities that span all sectors of a subject's life. When an investigator is not concerned about quantifying specific problems or collecting precise information, these tools can help paint an overall picture of all aspects of the subject's life. When working with these instruments it is especially important to consider the reliability of the measure.

Carrying out administration tasks: This category includes tools that help manage the evaluation and/or control of programs that provide attention to specific groups. As one of a series of techniques, evaluation instruments can be used to obtain statistics and information helpful in the creation, planning, and/or adaptation of program services and resources.

1.2. Criteria Used to Select Instruments

When attempting to study a specific area in a homelessness study, it is best to utilize protocols already established by the scientific community that were designed and approved to evaluate each variable or group of variables. Unfortunately, often times professional, academic, economic or social interests make it difficult to reach a scientific consensus regarding a particular instrument and the instrument in question remains unpublished and relatively unknown until much later on (if at all). In the area of physical and mental health, however, investigators have put forth more effort to obtain a certain level of scientific consensus (Hargreaves et al., 1998; Meyer et al., 2001; NIAAA, 2001; Rush et al., 2000; Strupp et al., 1997), yet these proposals are far from definite.

Culture has a great deal of influence on the design and adaptation of an instrument. A particular country may have its own measurement tool (developed within its own cultural context) to evaluate a certain variable. Other times one of the many instruments originating in an Anglo-Saxon community is adapted to a particular language and culture. Both of these instances make reaching scientific consensus more complicated. Until the types of evaluation instruments currently being used by investigators all over the world are proposed and accepted by the scientific community as a whole, professionals in the field will continue to need some type of guide to help them search for, identify and select measurement instruments to evaluate the variable(s) in each case.

In order to guide investigators in their search for appropriate evaluation instruments, there are three kinds of criteria to consider:

- **Practical criteria:** This category includes brevity, ease of application, time required to administer, and cost-effectiveness. Obviously the best, most cost-effective instruments in this category are the most brief and simplest possible (proportionate to the amount of information needed), the least time consuming (in order to increase the number of participants), and the easiest to apply (and for the interviewer/administrator to learn).
- **Usefulness criteria:** In order to ensure that the information obtained by the instrument is descriptive and relevant to the objective at hand, when selecting an instrument it is important to consider the subject of the evaluation, in this case the homeless, and all of their unique characteristics. It is also important to remember that the interviewer or administrator must be well trained in order for the instrument to provide useful, effective results. The best instruments in this category are ones that are easily understood by lay people, specifically the homeless, and can be easily administered and interpreted by non-professional evaluation interviewers.
- **Psychometric properties:** Instrument quality can be optimized by comparing and contrasting information previously obtained in other studies studying the same variables or

employing the same instrument (ITC, 2001; APA, 1999). The psychometric quality must be high: reliable, valid and sensitive to change as the intervention progress with minimal reactivity. The most important types of psychometric properties and their basic types are listed in Table 1.

Table 1. Psychometric properties of evaluation instruments

Psychometric Property	Type / Concept	Calculation
Reliability (consistency and stability of the instrument)		
	Parallel forms	Correlation Coefficient
	Two halves	Correlation Coefficient
	Test – retest	Correlation Coefficient
	Inter-observer agreement	Correlation Coefficient Kappa
Validity (to what degree does the instrument measures what it is supposed to measure)		
	<i>Content</i>	Multivariate analysis Correlation with other measures of the same variable
	<i>Criteria</i>	
	Sensitivity Specificity Predictive power	Sensitivity coefficient Specificity coefficient Positive Predictive Power (PPP) and Negative Predictive Power (PPN)
	<i>Predictive</i>	Correlation with the criteria Experimental tests
	<i>Construct</i>	
	Convergent / discriminant	Multiple trait matrix / Multiple method Correlation with similar and different measures
	Experimental	Experimental tests
Homogeneity (internal coherence of the instrument)		
	Integration of reliability and content validity	Cronbach's Alpha coefficient
Normativity (availability of normative tables for each population)		
	Adjustment of the instrument to the population	Corrective and interpretive tables with normative data

Depending on the investigation's objective, certain properties become more important than others. In addition, one evaluation instrument can serve many functions within a single investigation, and, as the purpose of its use changes, the important psychometric properties should change as well. However, all this makes it very difficult to determine which instruments are better or worse in quality. Instrument quality depends on the function they serve in each case, when in the study they are used, and especially how the instrument's results collected at a given point in time will be interpreted.

Because of all the different criteria relating to the identification and employment of psychological evaluation or assessment instruments, many international organizations have

developed standards to ensure that these criteria are followed with utmost rigor. Such organizations include a group of North American professional and scientific associations (APA, AERA, NCME, 1999) and the *International Tests Commission* (ITC, 2001) in Europe.

Before beginning the search for an instrument, the investigator must determine exactly what aspects or variables will be studied. When attempting to understand a complex phenomenon like homelessness and determine possible solutions, it is essential to investigate the variables deemed relevant to homelessness in a scientifically sound manner.

2. Objective and method

This revision article is based on a literature review of articles found in Medline, PSYCinfo and Sociological Abstracts databases. Homelessness articles published after December 1984 were reviewed with the aim of identifying the specific variables or key information most often studied by investigators in this field and the aspects proven to be most relevant to homelessness. Once the instruments utilized most in point-in-time studies were determined, a search was conducted by instrument. Because of the immense number of published works on this theme in the last two decades, this revision attempts to:

- 1) Determine what investigators over the past two decades have studied about homeless and how they have conducted evaluations of this group
- 2) Provide specific examples of studies and the details of some of the best instruments currently employed in this field, and
- 3) Synthesize this information to orient other investigators towards the important variables or key aspects of the study of homelessness and specify instruments to use in future studies

3. Key Variables and Evaluation Techniques

The literature review identified many variables often studied and key pieces of information often collected in studies of the homeless. They can be classified into the following aspects: sociodemographics, important life events, quality of life, health, social support, services, functioning, and other. Each aspect is explained in detail in the following sections and each section includes a discussion about the most common forms of evaluation of the key information and/or variables in that area.

Sociodemographics

Table 2. Key information and instruments: Sociodemographics

SOCIODEMOGRAPHIC DATA	
Areas	Key information
<i>General</i>	Age Gender Education Ethnicity or race Birthplace Marital status
<i>Housing situation</i>	Age of abandonment of the family home Number of days in the street Housing history Quality of current housing Current type of housing
<i>Employment situation</i>	Work history Current employment situation Employment stability (ex. duration of current employment)

	Longest period of employment Income: quantity, type and source of income
<i>Standardized instruments</i>	Personal History Form (Barrow, Hellman, Lovell et al., 1985)

Collecting sociodemographic data provides a description of the basic characteristics of the participants in any given study. Some general types of this information are important to determine for any participant group, such as gender, age, marital status, education, birthplace, and ethnicity, race or cultural reference group.

Other information is of special interest to investigators studying this particular group called the homeless. It is important, for example, to learn more specifically about their housing situation. The absence of a home, which is more than a physical house or shelter with a roof, - Cabrera, 2000-, is the fundamental characteristic of this group. Although many different definitions of “homeless” exist and there is a lack of agreement as to which is the most appropriate, all of the definitions refer to a person’s housing situation. They emphasize the temporary or permanent absence of stable housing (but they do not reduce homelessness to this simple description). It comes as no surprise that most studies in the literature review collected key information about the subjects’ housing situation and the condition of this housing. It is not sufficient to simply have a roof over one’s head; the housing must be adequate, or meet certain habitability standards that allow them to maintain personal dignity according to the criteria set by the society in which they live.

Collecting key information regarding employment and economic resources is equally important in a homelessness study. Observations in these areas have shed light on the correlation between suffering an unemployment crisis and social exclusion phenomena. Long-term unemployment, awful working conditions, and the growing difficulties that unqualified people have re-incorporating into the workforce are also correlated with social exclusion, especially among the homeless (Castel, 2000). Data on these aspects were usually collected using questions specially formulated for a given study. They tended to be answered directly by the person and related to his/her current employment situation and income, as well as information about his/her employment stability and history.

Sociodemographic data in general is usually collected at the beginning of an evaluation and is typically included in standardized instruments that evaluate other areas. Some examples include the Composite International Diagnostic Interview (CIDI; OMS, 1993) which evaluates the presence of mental disorders and the Addiction Severity Index (ASI; McLellan, Luborsky, Woody et al., 1980) which evaluates substance abuse problems.

Other times sociodemographic data can be collected utilizing systematic instruments specifically designed to obtain information of special interest to investigators in the field. The Personal History Form (Barrow, Hellman, Lovell et al., 1985) is an example of an assessment tool developed for the homeless and those with few economic resources which provides data concerning the areas discussed earlier such as housing situation, income, education, and work history and adds other aspects like family structure and important life events.

Important Life Events

Table 3. Key information and instruments: Important life events

IMPORTANT LIFE EVENTS	
Areas	Key information
<i>Childhood</i>	Sexual or physical abuse Abandonment Kicked out of the house Parent drug or alcohol abuse Parent mental disorders Kicked out of school

<i>Adulthood</i>	Aggression Robberies / assaults Domestic violence Sexual abuse History of prison term Serious problems with family with friends Psychiatric hospital stay Hospitalization for drugs or alcohol Lose of work History of prostitution
<i>Standardized instruments</i>	List of Threatening Experiences-Questionnaire (LTE-Q; Brugha y Cragg, 1990) References: (45), (85), Social Readjustment Rating Scale (Holmes y Rahe, 1967) Life Events Schedule (Sandler y Block, 1979)

In the last few years many studies have examined the relationship between Stressful Life Events (SLEs) and homelessness. These studies have found a higher occurrence of SLEs in the homeless. Some authors conclude certain SLEs may cause homelessness and others discuss SLEs that they believe may maintain the homeless' situation of social exclusion (e.g. Daly, 1994; North and Smith, 1992).

Under this area of SLEs, the literature review indicated that the homeless tended to come from dysfunctional homes with a history of physical and/or sexual abuse in childhood and parent substance abuse or mental illness. Different studies have shown the high prevalence of childhood aversive experiences among the homeless and these experiences have been identified as risk factors for homelessness (Koegel, Melamid and Burnam, 1995; Herman, Susser, Struening and Link, 1997).

The following SLEs that occur in adulthood have also been related to homelessness: suffering physical or sexual violence, having been robbed or attacked, having been in jail, and remaining on the streets without a home for a long period of time (e.g. Stein et al., 2002; Vázquez and Muñoz, 2001; Wong and Piliavi, 2001). Some investigators have become interested when the SLE occurred and the person's perception of the degree to which the event caused his/her current homelessness (Muñoz, Vázquez, Bermejo and Vázquez, 1999). Being homeless in and of itself can be considered to be a stressful event and increase one's vulnerability towards certain other SLEs, such as suffering physical or sexual abuse, whose indexes are already very high among this population (D'Ercole and Struening, 1990). Other conditions that frequently accompany homelessness, like the lack of social networks that would normally support or protect the homeless, drug or alcohol consumption, mental disorders and physical handicaps, can all increase their risk of victimization as well (Wenzel, Koegel y Gelberg, 2000).

A variety of instruments have been used to evaluate SLEs. In some cases investigators employ standardized instruments like the LTE-Q (Brugha), however in the majority of the studies the authors chose to modify the instrument in order to include more events. In other studies the authors made their own lists of events and tended to include the important events mentioned in Table 3.

Quality of life

Table 4. Key information and instruments: Quality of life

QUALITY OF LIFE	
Areas	Key information
<i>Objective</i>	Nutrition, dress, housing, health, education, security, hobbies, income, etc.
<i>Subjective</i>	Well-being determined by own perception of overall life, nutrition, dress, housing, etc.
<i>Standardized instruments</i>	Quality of Life Interview (Lehman, 1988). References: (39)

Quality of life is difficult to study because of conceptual confusions, lack of agreement regarding the instruments employed, and differences concerning the key information to indicate quality of life. In general quality of life refers to the global well-being of the person, well-being as determined by the person's objective living conditions and the subjective sense of well-being the person feels about those same conditions. A few decades ago, only objective aspects were considered important to the evaluation of quality of life. However, the definition of quality of life changed, first to incorporate subjective aspects and now to a definition in which the subjective evaluation is the fundamental characteristic. In 1994 the World Health Organization defined quality of life as "the personal perception of one's living situation within a cultural context surrounded by societal values and in relation to that person's own objectives, expectations, values and interests".

Objective well-being, then, instead of referring to quality of life, is now habitually called level of living because it examines socioeconomic indicators such as nutrition, dress, housing, health, basic necessities, education, hobbies and income that vary depending on the social context of the person's reference group. However, level of living objective indicators are insufficient without other subjective indicators concerning perceived well-being of these same living conditions (Bowling, 2001). Quality of life involves well-being, defined as the relationship between the objective living conditions and the subjective evaluation of them.

The living conditions of the homeless lack basic necessities like housing and often food; subjectively they would not be satisfied with their conditions. An evaluation instrument in this area must obtain information about objective level of living conditions and the person's personal opinion about them.

Because the concept of quality of life is not very clearly defined, many different assessment instruments can be employed to obtain information about it. The majority of the authors chose semi-structured interviews instead of questionnaires because some subjects may not be able to read or understand the questions on the task. In order to increase questionnaire comprehension, categorized graphic responses (i.e. sad, normal and happy faces) were used (Lehman et al., 1995). In some studies the authors did not use standardized instruments and developed the questions to be asked "ad hoc" (e.g. LaGory, Fitzpatrick and Ritchey, 2001).

Health

In the last two decades, many published studies describe the relationship between health and homelessness. They show the correlation between homelessness and physical problems, psychological problems, and substance use. For the people who already suffered from these problems, their homelessness makes them worse. And, if they are fortunate to be in good health at the time they become homeless, their situation, lack of basic necessities and access to services cause many negative consequences to their physical and mental health (e.g. Burg, 1994).

Instead of referring to health in general, there are three particular sub-categories to explore: physical health, mental health and substance use. As occurs with the general population, normally it is the lack of health, or negative impacts on health, that is evaluated (instead of positive health or the presence of physical and psychological resources).

Table 5. Key information and instruments: Physical health, mental health and substance use

HEALTH	
Areas	Key information

<i>Physical health</i>	
	Mortality Risky behaviors Number of visits to the emergency room or times hospitalized Treatment follow-ups Medication usage Identification of specific physical illnesses Diet, eating habits Perception / satisfaction with health status General functioning
<i>Standardized instruments</i>	General Health Questionnaire (GHQ; Goldberg, 1972) References: (2), (6), (12), (14), (23), (30), (42), (63), (76), (78), (85), Medical Outcomes Survey Short-Form Health Survey (SF-36; Ware, et al., 1993). References: (4), (24), (37), (74), (76), (82),
<i>Mental health</i>	
	Diagnosed with a mental disorder Psychological symptoms and severity Psychiatric hospitalizations History of psychiatric treatment Distress Suicidal thoughts / Number of suicide attempts Suicide rate General functioning
<i>Standardized instruments</i>	Composite Internacional Diagnostic Interview (CIDI; OMS, 1993) References: (13), (34), (45), (55), (62), (71), Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, et al., 1995) References: (2), (4), (6), (10), (18), (25), (29), (54), (58), (60), (68), Diagnostic Interview Schedule (DIS) References: (17), (19), (20), (33), (46), (47), (61), (64), (66), (72), (75), Brief Psychiatric Rating Scale (BPRS; Overall y Gorham, 1988) References: (1), (7), (8), (23), (38), (41), (73), (83), Brief Symptom Inventory (BSI; Derogatis, 1993) References: (9), (21), (41), (43), (44), (50), Psychiatric Epidemiology Research Instrument (PERI; Dohrenwend et al, 1980). References: (40), (69), Positive and Negative Syndrome Scale (PANNS; Kay, Fiszbein y Opler, 1987) References: (10), (51), (52), Symptom Checklist 90 (SCL-90; Derogatis, 1994) References: (27), Center for Epidemiologic Studies Depression Scale (CES-D; Radloff y Lock, 1977) References: (15), (28), (35), (49), (56), (59), (68), (79), (81),
<i>Substance use</i>	
	Diagnosed with substance abuse disorders Blood analysis History of use / abuse (ex. age at first use) Amount consumed in a specific period Frequency of use Substance-use-related hospitalizations (total number and total time)
<i>Standardized instruments</i>	Addiction Severity Index (ASI; McLellan et al., 1980) References: (3), (16), (31), (55), (57), (84) Alcohol Dependence Scale (ADS; Skinner and Horn, 1984) References: (11), (16) Michigan Alcoholism Screening Test (MAST; Selzer, 1971) References: (9), (77), CAGE Alcohol Interview Schedule (Hayfield, McLeod y Hall, 1974) References: (20), (23), (34), (42), (43), (63), (64), (65),

Physical Health

Although most investigators chose to focus on mental health problems and substance abuse problems among the homeless, the relationship between homelessness and physical health

problems is clear (e.g. Wrigth y Weber, 1987). The dynamic can take any of the following forms.

- Sometimes a person's health problems occur before the person becomes homeless and may contribute to the person becoming homeless.
- Sometimes the living conditions associated with homelessness (i.e. inadequate nutrition, unsanitary conditions, and violence) make current problems worse or contribute to the appearance of new physical problems that did not exist before. Being homeless also complicates the person's ability to comply or continue with medical treatment for their problems.
- The difficulties accessing health services is another factor that plays a role in the homeless' chronic or worsening conditions. The homeless do not regularly see a doctor for preventative medicine and early detection of potential severe problems, which in turn may cause their health to deteriorate.

The studies reviewed that fell under this category aimed to detect medical problems. It was common for these studies attempt to obtain information on a wide range of health problems including hypertension, cardiac problems, respiratory problems, dental problems, etc. However, in the last few years investigators have turned their attention to specific diseases such as HIV/AIDS, tuberculosis, and sexually transmitted diseases, which have been found to be highly prevalent among the homeless (e.g. Wright, Rubin y Devine, 1998).

The identification of physical problems has been conducted using the following techniques:

- Asking questions, usually obtained from a list of health problems, of the subject about whether or not he/she suffers from a particular problem or illness, or
- Conducting a complete physical examination including blood pressure, heart rate, temperature, breathing, weight, height, and breast, skin, vision, hearing, and dental examinations (e.g. Harris, Mowbray y Solarz, 1944). This type of objective evaluation is not often used in homeless health studies.

The evaluation of specific physical problems has gone hand in hand with the assessment of at-risk health behaviors such as sharing needles, having unprotected sex, and using alcohol, tobacco or other drugs (e.g. Martinez, Gleghorn, Clements, et al., 1998).

Although the homeless' health conditions must be evaluated to learn more about the specific problems that affect, this objective information is not sufficient. Investigators in the field have acknowledged the need to take into account the person's own perceived health status. The person's opinion of his/her health may be more important than the physical objective measures when considering emotional and physical well-being. Different standardized instruments have been developed to subjectively evaluate general health and some of them, like the SF (Ware, Show, Kosinski et al., 1993), have been validated in the homeless population (SF-36: Wood, Hurlburt, Hough y Hofstetter, 1997; SF-12: Larson, 2002).

In addition to collecting this data on physical health, other studies have studied the mortality rate among the homeless and review hospital charts in order to obtain the relevant data.

Mental Health

The mental health problems of this population have been widely studied and results of studies in this area affirm the close relationship between these problems and homelessness.

People with mental disorders seem especially vulnerable to the processes of social exclusion because chronic mental disorders make getting a job, having a stable income, and maintaining a network of social support much more difficult.

Diagnostic instruments have advanced tremendously in this area in the last decade. Currently, structured interviews, questionnaires and scales are all available that either offer a DSM-IV (APA) or a CIE-10 (WHO) diagnosis – which are most often utilized in the area of mental health – or help the interviewer obtain information to assist them in reaching one. There are also general instruments that cover the most important pathologies and specific instruments adapted to each type of disorder. With the homeless population, the most utilized diagnostic instruments are the CIDI, which can be carried out by trained interviewers, and the SCID, which must be carried out by clinicians with experience.

Other instruments can be used to explore the symptoms of specific mental disorders that other studies have indicated are prevalent in the homeless, like psychotic illnesses and depression. Some of the instruments are validated for these populations, like the CES-D, the BPRS, or the BSI. Suicide is another aspect that has frequently been associated with homelessness. Information about suicidal thoughts and suicide attempts can be collected using questions asked of the person directly or instruments with a wider scope that incorporate this theme, like the GHQ (Goldberg, 1972). Complementary information concerning treatment history and psychiatric hospitalizations can also be collected by asking the subject directly, which is the technique most often utilized in studies of this nature. Some investigators later confirm the data by reviewing hospital records and charts. It is also possible to use second-hand information that comes directly from the professionals who interact with and treat the person.

Substance-Use-Related Problems

As the many articles over the last two decades indicate, homelessness is correlated with substance use, mainly of alcohol but also of harder drugs like cocaine and heroin (e.g. Koegel, Burnam y Farr, 1988; Fichter, 1997; Hwang, 2001). The problems related to substance use tend to be accompanied by other mental disorders, physical illnesses and legal problems (Farr, Koegel y Burnam, 1986) as well as high-risk behavior.

Depending on whether a study’s aim is to obtain a substance abuse mental disorder diagnosis or find out other data regarding substance use, there are different tools available. Some studies attempt to determine the frequency of these types of disorders in the homeless population. Investigators in this kind of study would need to use diagnostic questionnaires or interviews that encompass other mental disorders, like the SCID-I (First, Spitzer, Williams, et al., 1995) or the CIDI (OMS, 1993). However, many times the investigators want more information, for example the type of substance, history of use, quantity used and the severity of the problem, that helps to better quantify the problem in question. In this case, there are different standardized instruments available, some of which have been used repeatedly with the homeless, such as the ASI (McLellan, et al., 1980) and the Alcohol Dependence Scale (Skinner and Horn, 1984) and are known for their quality.

Social Support

Table 6. Key information and instruments: Social support

SOCIAL SUPPORT	
Areas	Key information
<i>Social network</i>	Perceived social support Number of close family and friends Frequency of contact with family and friends

	Interpersonal Support Evaluation List (ISEL) References: (5)
	Social Network Interview (SNI) References: (5)
	The Personal Assessment of Social Supports (PASS) References: (4),
	Social Network Index (Berkman, 1977). References: (9),
	Strong Tie Support Scale (Lin et al., 1986) References : (21), (35),
	Interpersonal Relationship Inventory (Tilden et al, 1990) References: (22),

As previously mentioned, beyond lack of housing, it is difficult to arrive at consensus regarding the characteristics of homelessness. Investigators often refer to their lack of social networks. For example, according to Cabrera (2000), homeless people are “not just people who lack a place to live, they also lack family and social ties, are in a situation of social exclusion and find themselves uprooted from society”. Loneliness and the lack of social contact with family, friends and the very social services designed to facilitate the process of societal re-integration is a second characteristic of the homeless (e.g. Solarz y Bogat, 1990). The deterioration of affective relationships with friends and relatives seem to be the beginning of a domino effect de-socialization process that results in the loss of social abilities and a decrease in positive attitudes, which make community re-incorporation even more difficult. At the same time, the gap between the homeless person and social services widens further as he/she loses contact with advocates and natural companions like family and friends.

Social ties are an important aspect to study in the homeless because of the role they play in creating and maintaining homelessness. In order to evaluate this aspect, often times quantitative data is obtained by describing the number and type of a person’s relationships: the number of friends and family, the frequency of contact and their availability in case of an emergency. Just as observed in the health aspect of homelessness, over time investigators have become interested in the individual’s own perception of his/her social network and the quality of the relationships. The size is important, but so is the person’s satisfaction with his/her network, the relationships that define it, as well as feelings of loneliness and the feeling of being able to count on another person in times of need.

To assess these key variables, the standardized instruments listed in Table 6 are normally used, although many studies have utilized “ad hoc” questions and still others have employed focus groups (Applewhite, 1998) as ways of obtaining pertinent information in this area.

Services

Table 7. Key information and instruments: Services

SERVICES	
Areas	Key information
<i>Use and accessibility of services</i>	Health services (number of hospitalization, number of emergency room visits, number of doctor visits in a given period of time) Services for the homeless Perceived barriers Satisfaction with services
<i>Standardized instruments</i>	
Satisfaction	Client Satisfaction Questionnaire (Larsen, Attkinson, Hargreaves et al., 1979)
In-take	The Homeless Engagement and Acceptance Scale (HEAS; Park., Tyrer, Elsworth, et al. 2002) References: (53),
Loyalty to model	DACTS (Teague, Bond, y Drake, 1998)

	References: (70), (80)
Environment	COPEs (Moss, 1996) Referentes: (32),

Studies show that accessing health services is very complicated for the homeless. Many times they cannot access normalized health services except for the emergency room. The homeless are the chronically ill, the difficult and unappreciative, those without family, those without an address to follow-up with them, and those who do not follow through with their appointments. They are dirty and hardly “ideal” patients. These details, combined with the lack of contact the homeless have with health services, make the homeless the group to receive the least medical attention within the developed world. Their high mortality rates (higher than any other group in the developed world) and an estimated life span of 20 years less than normal (Hibbs et al., 1994; Hwang, 2000) support this claim. Salit and colleagues (1998) compared the prevalence of illnesses requiring hospital admissions among the homeless and among others living in extreme poverty, and found significant differences between groups in the majority of the illnesses.

Regarding mental health services, the lack of assistance provided to the mentally-ill homeless is one of the most shameful problems in this field of investigation. Studies indicate that the homeless rarely come into contact with mental health services, and when they do they appear very sporadically. There is no coordination of their services and treatment follow-up is very difficult if not impossible. The obstacles that prevent access to mental health services are numerous and diverse, but can be placed into the following categories (Craig and Timms, 2000):

- Obstacles that originate from the person: Because the person suffers a handicapping mental disorder, many times they themselves are not conscious of their illness and they reject services. These actions can usually be justified by their history of institutionalization and previous treatment failures.
- Obstacles that come from poverty and social isolation: The homeless lack the social support necessary to help them make contact with needed services and to offer them continuous care and monitoring. Their poverty only adds to the difficulty of accessing mental health resources.
- Obstacles that originate from the services themselves: The services are managed according to effectiveness standards and cost-effective criteria, which means that the homeless population causes serious problems for them, including making initial contact, setting appointments for follow-up or hospitalizations, and providing treatment with a lack of family support and without a place to recuperate that meets minimum sanitary conditions.

Because of these barriers, service usage by the homeless and obstacles that hinder their access to services must be studied. Information has typically been collected in this area by asking about the (1) number of hospitalizations and length of stay and (2) number of emergency room and doctor visits during a given time. It is also important to study the use of services designed to specifically target the homeless and evaluate the frequency of use of these services as well as the user’s satisfaction with the service. In these cases the information can come directly from the homeless as well as from the staff at the service being studied.

Functioning

Table 8. Key information and instruments: Functioning

FUNCTIONING

Areas	Key information
<i>Psychosocial</i>	Ability to live a normal life, autonomy, ability to participate in social activities, ability to cope with difficulties and problem solve, etc.
<i>Neuropsychological</i>	Neuropsychological capacity (attention, memory, motor functioning, etc....)
<i>Instruments</i>	
<i>Psychosocial</i>	Global Assessment Functioning (APA, 1994) References: (38), (44),
	Brief Instrument Functioning Scale (BIFS; Sullivan, Dumenci, Burnam, y Koegel, 2001) References: (67).
<i>Neuropsychological</i>	Abbreviated Halstead-Reitan Test Battery References: (26),
	MMSE (Folstein, Folstein y McHugh, 1975) References: (2), (17), (23), (26),

All of the areas previously mentioned represent the multidimensional facets of homelessness. The homeless are not simply without a place to live, they suffer from physical and mental health problems and social isolation and have many SLE and obstacles that prevent them from accessing resources designed to assist them. As a logical result of this degree of social exclusion, studies have found the homeless to have deteriorated psychosocial functioning as well. The evaluation of this area centers on the daily functioning of the person, his/her abilities, and his/her quality of life (Thorncroft y Tansella, 1996) and is often used in studies who aim to determine the effectiveness of certain interventions.

The instruments measuring this aspect usually take into account: personal care, how the person relates to others, and his/her participation in social activities, etc. Some of the instruments used to assess functioning, like the Brief Instrument Functioning Scale (BFSI), have been validated for the homeless population (BFSI; Sullivan, Dumenci, Burnam, y Koegel, 2001).

In addition, some investigators have become interested in the neuropsychological function of the homeless. For this type of study, the Mini-mental State Exam (MMSE) is typically utilized to obtain neuropsychological data (MMSE; Folstein et al, 1975).

Other

The areas previously discussed in this article are the most widely investigated aspects in the study of homelessness over the last decades. However, a diverse other pieces of key information have also been assessed by these same studies and they are listed in Table 9.

Table 9. List of other non-categorized pieces of key information

NON-CATEGORIZED KEY INFORMATION	
Others	
	Necessities Self-esteem and self-image Citizen's rights Happiness in childhood Sexual orientation Intelligence and attention Locus of control Coping strategies Spirituality, religious beliefs and practices

4. Selected Instruments

This section of the article details some specific instruments with good psychometric qualities that are most often used with the homeless population to evaluate the different areas previously discussed. Perfect assessment tools do not exist – the investigator must select the instrument that best fits his/her goals, taking into account the objective of the study, the level of training of those who will use the instrument to assess the homeless, and all available resources.

INSTRUMENTS MEASURING HEALTH

MENTAL HEALTH

Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)

First, Spitzer, Williams et al., 1995

Purpose: This tool provides a DSM-IV diagnosis and collects information about: demographics, work history, psychiatric history and present problems, current treatments, and current level of functioning. The diagnosis falls into one of the following nine categories: affective disorders, psychotic symptoms, psychotic disorders, mood disorders, substance use disorders, anxiety disorders, somatoform disorders, eating disorders and adaptation disorders.

Description: This semi-structured interview must be administered by a clinician and can be used with psychiatric patients as well as the general, non-psychiatric population. The first part of the interview focuses on obtaining demographic data and a personal history of the person through yes-or-no questions and open-ended questions that the subject must answer in his own words. In the diagnostic portion of the interview, the clinician has a list of questions and must determine which are most appropriate to ask depending on the subject's response to the questions in a particular problem area. If the subject does not meet all the criteria for a certain diagnosis, the interviewer should ignore the rest of the questions pertaining to that disorder.

There are two versions of this instrument. The SCID-I is known as the investigative version because it has a wide variety of subtypes that allow the investigator to choose the one that best fits his/her objective. There are three different editions geared towards different subject groups: the SCID-I/NP, the SCID-I/P, and the SCID-I/P with a Brief Instrument for Psychotic Symptoms. The second version of this instrument is the SCID-CV, which is known as the clinical version, and only covers the most common diagnoses in the clinical practice. In a column at the right, the interviewer awards 1 point if the criteria or symptom is absent or false, 2 points if it is present but less than required (for example, a symptom that is present but not for a long enough time or of sufficient intensity for the diagnosis), or 3 points if the criteria or symptom is present (in all its intensity or duration) or true for the subject. The clinician develops his/her diagnostic opinion during the interview and at the end he/she simply adds up the points. The clinician should consult other sources for complementary information to confirm the diagnosis. Usually the diagnosis incorporates specific moments from the subject's past with what is happening at the present. The interview is designed to be conducted by experienced clinicians or those who receive extensive training. The interview takes at least one hour to administer (for subjects without a pathology) to two to three hours for subjects with a mental disorder.

Psychometric properties:

Reliability: For psychiatric patients: kappa = 0.61, for non-psychiatric patients: kappa = 0.37, for bipolar diagnosis: kappa = 0.84, for alcohol dependency or abuse: kappa = 0.75, for other drug dependency or abuse: kappa = 0.84, for anorexia nervosa: kappa = 0.72, for bulimia nervosa: kappa = 0.84, for dysthymia: kappa = 0.40, for agoraphobia without panic disorder: kappa = 0.43, and for social phobia: kappa = 0.47. The test-retest reliability is good for the DSM-III-R disorders in general, except for agoraphobia without panic disorder, obsessive-

compulsive disorder, and somatoform disorders. The reliability of the SCID-I, according to the DSM-IV criteria, has not yet been established.

Validity: More than 85% of the patients with a known psychotic disorder displayed the majority of their symptoms during the course of the interview.

Composite International Diagnostic Interview (CIDI)

World Health Organization (WHO), 1993

Purpose: This interview provides a diagnosis according to DSM-IV and CIE-10 criteria.

Description: This structured interview is clinically used, although it was originally designed for epidemiological and transcultural use. It adds on to the Diagnostic Interview Schedule (DIS) and allows for diagnosis based on the American Psychological Association's DSM-IV and the World Health Organization's CIE-10. The CIDI provides a better exploration of tobacco, alcohol and other drug use and includes a section that evaluates (1) the symptoms caused by withdrawal and drug overdose, (2) the periods of abstinence, (3) the length of dependency, and (4) the psychosocial consequences of dependency.

The CIDI includes the following sections:

- Section A: Demographic data
- Section B: Tobacco-use-related disorders
- Section C: Disassociate and somatoform disorders
- Section D: Phobias, panic and generalized anxiety disorders
- Section E: Depressive and dysthemic disorders
- Section F: Manic and bipolar disorders
- Section G: Schizophrenia and other psychotic disorders
- Section H: Eating disorders
- Section I: Alcohol-use-related disorders
- Section K: Obsessive-compulsive disorders
- Section L: Psychotropic drug-use-related disorders
- Section M: Organic mental disorders
- Section N: Sexual dysfunctions
- Section P: Interviewer's observations
- Section X: Interviewer's evaluation

Childhood disorders and personality disorders are not included in the interview.

The interviewer reads each question followed by a group of responses that refer to a series of psychopathological symptoms specific to the diagnostic section being evaluated. If the subject does not understand a question, the interviewer should try to help him/her to understand by repeating the question and adding emphasis where indicated in the manual. If the subject still does not understand, only then can the interviewer rephrase the question in other terms. If a particular symptom is present, the interviewer must ask pre-established, systematic questions to determine the severity and possible origin of the symptom. If the symptom is clinically relevant, it will only be considered as part of the psychiatric diagnosis after a medical exam or after a subjective attribution to confirm that the symptom is not due to a physical illness or injury or the use of medications, alcohol or other drugs.

The most recent version of the CIDI is the CIDI-version 2.1. It provides DSM-IV and CIE-10 diagnoses, but is easier to administer. The interview can be completed in only one session of about 75 minutes and does not require the interviewer to consult other sources of information. Professionals who are not clinicians can conduct the interview. In this version, a computer uses diagnostic algorithms to arrive at a diagnosis. There are also fully computerized versions (the CIDI-Auto), a brief list of symptoms (the CIDI-Checklist), and an alternative version of the CIDI (the UM-CIDI).

Psychometric properties:

Reliability: The WHO has conducted a number of studies obtaining good test-retest reliability for the CIDI. The majority of the diagnoses have agreement indexes above 85%. The kappa statistics range from 0.52 for dysthymia to 0.84 for panic disorder. Inter-observer reliability for all diagnoses is 97%, with kappas above 0.90 in most of the cases (except summarization disorder where the kappa = 0.67).

Validity: The kappa index between the CIDI version 1.0 and the CIDI-DSM-III Checklist is 0.78, and between the CIDI version 1.0 and the CIDI-CIE-10 Checklist is 0.77. For anxiety disorders, the kappa index is 0.76 for the DSM-III-R diagnostic categories and 0.73 for the CIE-10 diagnostic categories. For depressive disorder, the kappa index is 0.84 and 0.78 respectively, and for substance-use-related disorders the kappa index is 0.83 for both the DSM-III-R and CIE-10 diagnostic categories.

HEALTH

Medical Outcomes Survey Short-Form General Health Survey (SF-36) Ware, 1993

Purpose: This survey provides a subjective measure of overall health.

Description: This is the abbreviated version of the instrument used in the Medical Outcomes Study (MOS) of the Project RAND Health Program. SF-36 detects positive and negative aspects of physical health and emotional well-being. Like its name suggests, it consists of 36 questions that evaluate eight generic health concepts that are not specific to a certain pathology, treatment group or age. The eight dimensions are: physical functioning, physical limitations, pain throughout the body, general health, vitality, social functioning, emotional limitations, and mental health limitations. It only requires five to ten minutes to administer, either in paper format or as a short interview. The overall lowest possible score on the survey is 0 (Very good health status) and the maximum score is 100 (Very bad health status). Using the averages scores on the eight dimensions, the each scale also provides a specific health indicator and together they form a comprehensive health profile. Although as of yet there are no precise definitions to help interpret the results, the general population average score is between 2 and 3, and increasing up to 30 for terminally ill patients with cancer or stroke victims. There are two even shorter versions, the SF-20 and the SF-12.

Psychometric Properties:

Reliability: Internal consistency: 0.62-0.94; Two-week test-retest reliability: 0.60-0.81.

Validity: Sample correlations with the Illness Impact Profile (0.78), with the Quality of Life Index EuroQol (0.48-0.60), with Nottingham's Health Profile (0.52 for the physical scale, 0.55 for pain, 0.67 for mental health and 0.68 for vitality).

The scales discriminate between types of levels of illness and are able to distinguish between people with chronic medical conditions and people who have medical problems combined with psychological ones. The instrument is sensitive to therapeutic change.

ALCOHOL-AND-OTHER-DRUG-USE-RELATED DISORDERS

Addiction Severity Index (ASI) McLellan, Luborsky, Woody et al., 1980

Purpose: The index provides a multi-dimensional evaluation of the problems presented by people with substance abuse disorders.

Description: This instrument is a semi-structured interview that covers seven basic areas: medical problems, employment situation, drug use, alcohol use, legal problems, family or social adaptation, and psychiatric disorders. It consists of 142 questions concerning the frequency,

intensity and duration of the problems in each of these seven areas both throughout the person's life and during the last month. Two kinds of information are gathered using this instrument: objective indicators of the severity of his/her problem and the person's own subjective evaluation of his/her situation. Each of the areas includes all types of questions: yes-or-no, multiple choice, open-ended, and 5-point rating scales (for example, the degree of annoyance or worry about the recent problems in that area). For each of the areas, the interviewer also gives his/her own estimation of the severity of the problem and need for treatment on a scale from 1 to 10. Normative data in various populations is available. It takes about 45 to 75 minutes to administer and the interviewer must be trained. There is a shorter version of this instrument that only covers problems in the last month.

Psychometric properties:

Reliability: Internal consistency: 0.62 (drug subscale) to 0.87 (for the alcohol and psychiatric disorders subscales); Test-retest reliability: 0.92.

Validity: Sample correlations with other alcohol use measures like the MAST is 0.58 (alcohol use subscale) and Beber's Quantitative Inventory of Behavior (Hayasida, 1981) is 0.87 (alcohol use subscale). Sample correlations with other variables like the number of prison sentences and the number of overdoses are 0.43 and 0.72 respectively. Correlations with Beck's Depression Inventory (BDI) and the 90 Symptoms Checklist (SCL-90) are 0.52 and 0.47 respectively. This instrument, the ASI, is not valid with adolescents so the T-ASI was designed for this population with good inter-observer reliability. The instrument is sensitive to therapeutic change.

CAGE Alcohol Interview Schedule

Hayfield, McLeod and Hall, 1974; Ewing, 1984.

Purpose: The interview evaluates possible cases of alcoholism within the general population.

Description: This test was designed to screen for alcohol abuse. The CAGE is a simple, short instrument that is easily and quickly administered. It consists of only four yes-or-no questions concerning the subject's (1) wish to cut down on his/her drinking, (2) annoyance at others' criticism of his/her drinking behavior, (3) guilty feelings associated with drinking, and (4) need for "eye-openers", or a drink to start off each morning. The interviewer should intersperse these questions throughout the interview with the subject and give 1 point for each affirmative response. Total score on the CAGE ranges from 0 to 4. A score of 2 or more is considered to be clinically significant and should alert the evaluator to possible problems related to alcohol abuse or a psychiatric diagnosis. The instrument is NOT used for diagnosis; it is an indicator – the more points a subject has, the higher the probability of alcoholism. The CAGE only takes about 1 minute to administer and does not require any special training on the part of the interviewer. The instrument has been adapted to evaluate drug use by simply substituting the word "alcohol" for the word for the particular drug in question.

Psychometric properties:

Validity: The instrument is highly sensitive (81%) and specific (97%) when used in hospitals, and is a little less sensitive and specific, 66% and 84% respectively, when used in other environments. The cutoff point of greater than or equal to 1 has high sensitivity (86-90%) and less specificity (52-93%) than a cutoff point of greater than or equal to 2, whose sensitivity ranges from 78-81% and specificity ranges from 76-96%. Sample correlation with the MALT is 0.42.

QUALITY OF LIFE

Quality of Life Interview (QOLI)

Lehman, 1988

Purpose: This interview measures objective and subjective quality of life in the chronic mentally ill.

Description: This structured interview requires previous training to administer. There are two versions of the QOLI: the complete version with 158 questions and the abbreviated version with 78 questions. The abbreviated version is most commonly used. Both versions take the form of a highly structured interview that centers on the subject's recent and current feelings of satisfaction, functional state, and access to resources. The QOLI evaluates eight basic areas: Residence, Family and social relationships, Hobbies, Everyday activities and functioning, Finances, Security and legal problems, Work and Health. Each question receives an objective and subjective score. The subjective score is awarded by the subject using a visual analog scale from 1 (terrible) to 7 (pleasant). The complete version takes 45 to 60 minutes to administer while the abbreviated version can be completed in 15 to 20 minutes. The instruments provides an objective indicator of quality of life, a subjective indicator of quality of life, and a measure of overall satisfaction with life.

Psychometric properties:

Reliability: Internal consistency of the complete version: 0.82-0.89 for the subjective scales and 0.61-0.80 for the objective scales; One-week test-retest reliability of the complete version: 0.72 for the subjective scales and 0.65 for the objective scales. The psychometric properties of the abbreviated version are very similar.

Validity: Sample correlations with Heinrichs and colleagues' Quality of Life Scale (QLS) is 0.38-0.75. The General Satisfaction with Life scale of the QOLI negatively correlates with depression (in a range of -0.17 to -0.56) and anxiety (in a range of -0.25 to -0.33). The instrument is sensitive to therapeutic change.

Satisfaction with Life Domains Scale (SLDS)

Baker and Intagliata, 1982

Purpose: The scale evaluates subjective satisfaction with life in four areas: security, belonging, stimulation and self-realization.

Description: The SLDS is an instrument administered by a clinician that consists of 15 questions asking the subject to use an 8-point visual analog scale to rate his/her current levels of satisfaction with different aspects of life, for example, home, neighborhood, family, finances, and free time activities. The visual scale shows faces that range from 8 points of maximum satisfaction (a beaming face) to 0 points of maximum dissatisfaction (a very sad face). The points are added together to determine an overall score for satisfaction with one's life – the higher the score, the higher one's satisfaction. The instrument only takes about 10 to 15 minutes to administer. The QOL Checklist is a modified version of this instrument that has been included in Corten and Mercier's (1994) Quavisup Rehab Set (a set of instruments grouped together for a special purpose) and asks the subject to also assess the importance he/she places on each of the aspects being evaluated.

Psychometric properties:

Reliability: Internal consistency: 0.84; Question-total score correlation: 0.47.

Validity: It demonstrates a relationship to other measures such as level of positive affect and availability and adequacy of social support. The instrument is sensitive to therapeutic change.

FUNCTIONING

WHO Short Disability Assessment Schedule (WHO DAS-S)

World Health Organization, 1992

Purpose: This instrument evaluates the psychosocial functioning of patients with mental disorders.

Description: The instrument is recommended by the WHO (who developed the CIE-10) for the evaluation of the difficulties resulting from the presence of physical or mental problems. The WHO DAS-S is the abbreviated version of the semi-structured interview The WHO Psychiatric Disability Assessment Schedule (WHO/DAS). It guides the clinician through the areas that need to be covered during the interview, including: personal care, occupation, family, living situation, and social functioning (the person's relationship with community members and participation in social activities). Based on the information he/she obtains, the clinician must evaluate the deterioration of the person on a 5-point visual analog scale where 0 is the absence of deterioration and 5 is greatly deteriorated according to specifically defined criteria. Besides evaluating the degree of deterioration in each area, the clinician must (1) identify the time period being evaluated as either current, last month, last year or other, (2) specify the total time during which the deterioration took place as either less than one year, more than a year, or unknown, and (3) list all of the resources available to the person. It can be administered by a clinician or by another health professional with the appropriate instrument-specific training.

Psychometric properties:

Reliability: The Interclass Correlation Coefficients range between 0.40 for the family/living category to 0.74 for the area of personal care. Half of the categories of specific handicaps have kappa values above 0.50 and the other half between 0.40 and 0.50.

Validity: The instrument has been shown to be a useful tool to evaluate change and predict results in senior citizens. It can discriminate between patients and the normal population.

SATISFACTION

Client Satisfaction Questionnaire -8 (CSQ-8)

Larsen, Attkisson, Hargreaves et al., 1979

Purpose: This questionnaire evaluates a person's satisfaction with general and mental health services through the following categories: type of service used, quality of the service, results and general satisfaction.

Description: The questionnaire is a self-administered instrument that includes eight questions evaluated on a 4-point Likert scale with specific cutoff points for each question. The questionnaire can also be group administered with people with severe mental disorders. The instrument also includes three open-ended questions asking the person what he/she liked most about the service, what he/she liked least and what he/she would like to change. The points are added together and the total score ranges from 8 to 32. Afterwards, the evaluator can calculate other measures like the average, standard deviation, and the total score for all of the people in one specific group. It takes 5 to 8 minutes to administer the questionnaire and there are many versions, including the CSQ-18, the CSQ-4 and the CSQ-3.

Psychometric properties:

Reliability: Internal consistency: 0.83-0.93. Average question to total correlation: 0.62-0.65. Average inter-question average: 0.44-0.47.
Validity: Correlation of the CSQ-8 with other measures of general satisfaction: 0.6-0.8.

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