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Research paper

Validity of a common quality of life measurement in homeless individuals with bipolar disorder and schizophrenia ☆

V. Girard [a,b], A. Tinland [a,b], M. Boucekine [a], S. Loubière [a], C. Lancon [a,b], L. Boyer [a,c,*], P. Auquier [a,c], French Housing First Study Group

[a] Aix-Marseille Univ., EA 3279 Research Unit, 13385 Marseille, France
[b] Department of Psychiatry, Sainte-Marguerite University Hospital, Marseille, France
[c] Department of Public Health, University Hospital, Marseille, France

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ABSTRACT

Objective: To provide new evidence regarding the validity, reliability, sensitivity to change and acceptability of a schizophrenia (SCZ) quality of life measurement (S-QoL 18) in homeless people with bipolar disorder (BPD).

Methods: This multi-centre prospective study was conducted in the following 4 French cities: Lille, Marseille, Paris and Toulouse. In addition to the S-QoL 18, data on sociodemographic information, disease severity using the Modified Colorado Symptom Index (MCSI), recovery using the Recovery Assessment Scale (RAS) and QoL using the Short-Form Health Survey (SF-36) were collected. The S-QoL 18 was tested for construct validity, reliability, external validity, sensitivity to change and acceptability.

Results: In total, 216 homeless patients with BPD participated in this study. The eight-factor structure of the S-QoL 18 was confirmed by confirmatory factor analysis (RMSEA=0.058, CFI=0.98, TLI=0.966). The scalability was satisfactory, with INFIT statistics within an acceptable range (from 0.77 to 1.20). The internal consistency (from 0.43 to 0.76) and reliability coefficients (Cronbach's alpha from 0.65 to 0.86) were satisfactory for all dimensions. The external validity testing revealed that the S-QoL 18 dimension scores were significantly correlated with the MCSI, the RAS and the SF-36 scores. The percentage of missing data for the dimensions ($<15\%$) and sensitivity to change were satisfactory.

Conclusions: These results demonstrate adequate acceptability and psychometric properties of the S-QoL 18 among homeless patients with BPD. The S-QoL 18 can be a common instrument for measuring QoL in homeless people with SCZ and BD.

1. Introduction

Schizophrenia (SCZ) and bipolar disorder (BPD) are highly prevalent in homeless populations (Fazel et al., 2008). An accurate and appropriate assessment of quality of life (QoL) is critical in determining the efficacy of treatment and, more globally, of medico-social programmes and policies in this population (Auquier et al., 2013). Indeed, although reducing the severity of symptoms is an important goal, it is also well recognised that reducing symptoms does not indicate that all of the facets these individuals consider important in their life have been managed (Awad and Voruganti, 2012; Bobes et al., 2005; Boyer et al., 2013). QoL provides unique information concerning the emotional and social experiences of individuals, which are not available in traditional assessments (Faget-Agius et al., 2016). In recent works, QoL has been reported to be an independent predictor of long-term symptomatic remission, functional recovery and disability (Boyer et al., 2012; Lambert et al., 2010). However, QoL measures have been rarely validated with homeless populations. The limited access to care of homeless explains that they are not well represented in validation studies conducted in health care settings. Moreover, the lack of insurance coverage of homeless does not allow them to participate to studies in some countries. The extent to which QoL measurement remains relevant and valid for homeless patients is a crucial issue that has been insufficiently examined.

A plethora of QoL instruments is now available in psychiatry

☆ Collaborators: T. Apostolidis, P. Birmes, T. Bossetti, R. Bouloudnine, B. Combes, J. Debieve, B. Falissard, T. Greacen, C. Laval, P. Le Cardinal, J. Mantovani, D. Moreau, J. Naudin, P. Rhunter, and B. Videau.

* Correspondence to: Aix-Marseille Univ., EA 3279 – Public Health, Chronic Diseases and Quality of Life – Research Unit, 13284 Marseille, France.

E-mail address: laurent.boyer@univ-amu.fr (L. Boyer).

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(Boyer et al., 2013). The majority of them are disease-specific instruments, as they better assess the concerns and expectations of patients and consequently have a better sensitivity to change than generic instruments (Awad and Voruganti, 2012; Cramer et al., 2000). This property is of the utmost importance for clinical follow-up and for the evaluation of interventional studies in homeless individuals with SCZ and BPD (Fitzpatrick et al., 1992). However, one disadvantage of these disease-specific instruments is their lack of common metrics that provide a transnosographic assessment (Awad, 2015). First, the distinction between SCZ/BPD is probably not the most relevant for clinicians in their choice of management and treatment of homeless people with severe mental disorders (Girard et al., 2010, 2012). Second, the use of a common health outcome applicable to homeless people with SCZ and BPD is necessary to guide policy decisions. Lastly, the scope of disease-specific instruments has been shaped and constrained by "official" classifications (Craddock and Owen, 2007) and, in particular, the "Kraepelinian dichotomy" (Kraepelin, 1919). Historically, BPD and SCZ have been considered two distinct nosological entities, and this vision continues to influence clinical practice, research and public perceptions of mental illness (Craddock and Owen, 2010). However, the validity of maintaining such a distinction between SCZ and BPD has been called into question (e.g., phenomenological, biological and genetic overlap and shared pathogenesis and risk factors) (Arango et al., 2014; Craddock and Owen, 2005, 2007), suggesting a dimensional approach of the psychosis spectrum (Peralta and Cuesta, 2008; Reininghaus et al., 2016). For all these reasons, it appears important to propose a common QoL instrument that can be used indiscriminately in homeless patients with SCZ and BPD while preserving the advantages of disease-specific instruments over generic ones (e.g., higher relevance to the concerns and experiences of patients, better sensitivity to change).

In recent work, we have demonstrated the satisfactory acceptability and psychometric properties of a QoL measurement, the Schizophrenia-Quality of Life short-version questionnaire (S-QoL 18) (Auquier et al., 2003; Boyer et al., 2010), among homeless patients with SCZ (Auquier et al., 2013). In this new study, we hope to provide new data regarding the suitability of this QoL measure in homeless people with BPD and thus to propose a common instrument for homeless patients with SCZ and BPD. To this end, we assessed the validity, reliability, sensitivity to change and acceptability of the S-QoL 18 in a population of homeless patients with BPD.

2. Methods

2.1. Study design and population

This multi-centre prospective study was conducted in the following 4 large French cities: Lille, Marseille, Paris and Toulouse. The inclusion criteria were as follows: age over 18 years; absolutely homeless[1] or precariously housed[2]; diagnosis of BPD by a psychiatrist based on the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV-TR) criteria (APA, 2000); and the ability to speak French. The exclusion criterion was a reduced capacity to provide consent (Jeste and Saks, 2006). The patients were evaluated at baseline (t0), and a subsample was retested at 6 months to explore sensitivity to change (t1).

2.2. Procedure

Mobile mental health outreach teams recruited patients over a 12-month period (Girard et al., 2012). The evaluations were performed during face-to-face interviews by psychiatrists and research assistants in the offices of the mobile mental health outreach teams, which were located in the downtown area of each city. The patients completed the QoL questionnaire and other self-reported questionnaires independently or asked for assistance in completing all or part of the questionnaires.

2.3. Data collection

The following data were collected from the patients:

1. Sociodemographic information: gender, age and marital status.
2. Clinical characteristics: mental health was assessed using the Modified Colorado Symptom Index (MCSI), which has been validated in homeless individuals (Conrad et al., 2001). The MCSI contains 14 items that ask about how often in the past month an individual has experienced a variety of mental health symptoms, including loneliness, depression, anxiety, and paranoia. The index score for this scale is calculated by summing each response. Higher scores indicate a higher likelihood of mental health problems. Recovery was assessed using the Recovery Assessment Scale (RAS) (Corrigan et al., 2004), which measures various aspects of recovery from the perspective of the consumer, with a particular emphasis on hope and self-determination. This self-administered instrument has been validated in homeless individuals (Girard et al., 2015) and consists of 24 items that explore five domains, which are as follows: personal confidence and hope; willingness to ask for help; goal and success orientation; reliance on others; and lack of domination by symptoms. A higher score indicates better recovery.
3. Quality of life was assessed using the S-QoL 18 (Boyer et al., 2010) and the Medical Outcomes Study 36-item Short-Form Health Survey (SF-36) (Ware Jr. and Sherbourne, 1992) questionnaires. The S-QoL 18 is a self-administered, multidimensional questionnaire developed and validated for the specific assessment of quality of life in patients with SCZ (Auquier et al., 2003; Baumstarck et al., 2013; Boyer et al., 2010) and has been validated in homeless individuals with SCZ (Auquier et al., 2013) and in several languages (Boyer et al., 2010; Caqueo-Urizar et al., 2014; Chou et al., 2011). The S-QoL 18 consists of 18 items that describe 8 dimensions (Appendix): psychological well-being (PsW), self-esteem (SE), family relationships (RFa), relationships with friends (RFr), resilience (RE), physical well-being (PhW), autonomy (AU) and sentimental life (SL). From these items, a total score (index) is determined. The SF-36 is a self-administered generic questionnaire consisting of 36 items describing 8 dimensions that are as follows: Physical Functioning (PF); Social Functioning (SF); Role—Physical Problems (RPP); Role—Emotional Problems (REP); Mental Health (MH); Vitality (VIT); Bodily Pain (BP); and General Health (GH). Two composite scores are calculated, the physical composite score (PCS) and the mental composite score (MCS). The dimension, index and composite scores range from 0, indicating the lowest quality of life, to 100, indicating the highest quality of life.

2.4. Statistical analyses

Statistical analyses were performed to explore the internal structure, reliability, external validity, sensitivity to change and acceptability of the S-QoL 18. Descriptive statistics of the sample included frequencies and percentages of categorical variables and

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[1] Absolutely homeless: no fixed place to stay for at least the past 7 nights with little likelihood of finding a place in the upcoming month.

[2] Precariously housed: housed in single room occupancy, rooming house, or hotel/motel as a primary residence AND in the past year have a history of 2 or more episodes of being absolutely homeless OR one episode of being absolutely homeless for at least 4 weeks in the past year.