Italian version of the "Specific Level of Functioning"

Versione italiana della "Specific Level of Functioning"

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Summary

Objectives

The assessment of real-life functioning presents complex challenges from variability in the operational definition of functional outcome to problems in identifying optimum information sources. In this context, there are still few satisfactorily reliable instruments for the assessment of functional outcomes that are practical in terms of time involved, and most real-life functional outcome scales seem to be largely redundant with each other when utilised simultaneously. The Validation of Everyday Real-World Outcomes (VALERO) Study selected six functional outcome scales from a much larger group of candidate scales as most suitable for current use. The Specific Levels of Functioning (SLOF) Scale was one of these and was considered to be a hybrid scale rating multiple functional domain. This scale has been translated into Italian by our group, and the translation is presented herein.

Methods

In the context of the multicentre study of the Italian Network for Research on Psychoses, the SLOF was translated in Italian by two psychiatrists and then back-translated. A formal assessment of semantic equivalence, debriefing of conventional sample and final review by experts were carried out. The operational equivalence was taken into account, which preserves the original features.

Results

The Italian version of the SLOF is a 43-item multidimensional behavioural survey comprising six subscales: (1) physical functioning, (2) personal care skills, (3) interpersonal relationships, (4) social acceptability, (5) activities of community living and (6) work skills. It is administered in person to the caseworker or caregiver of a schizophrenic patient or a patient-administered scale completed with verbal instructions from the examiner to rate its own performance. The scale does not include items relevant to psychiatric symptomatology or cognitive dysfunctions, but assesses the patient's current functioning and observable behaviour, as opposed to inferred mental or emotional states, and focuses on a person's skills, assets, and abilities rather than deficits that once served as the central paradigm guiding assessment and intervention for persons with disabilities.

Conclusions

Ratings on individual items of the SLOF may be used to capture the current state of overall functioning while showing specific areas of therapeutic and rehabilitative need. Moreover, the SLOF has direct applications in research on patient outcomes and evaluation of programmes.

Introduction

Despite significant advances in pharmacological and psychological treatments, patients with schizophrenia show impairment in everyday functioning, with deficiencies in social, cognitive and real-life activities, including independent living, productive activities and social relationships, that are detectable at the time of the first episode of illness and commonly observed in patients through the course of illness, even among patients who respond to antipsychotics and have only residual psychotic symptoms [1-3]. The assessment of real-life functioning presents complex challenges from variability in the operational definition of functional outcome to problems in identifying optimum information sources [4]. Indeed, many different strategies have been proposed to assess real-life functioning, including self-report interviews, proxy reports, informant interviews [4], direct observations by trained clinicians [5], and performance-based measures, which assess functional capacity ("what the individual can do under optimal conditions") [6]. However, reports of real-life outcomes vary across informants and contain elements of error or shortcomings [4]. It has been suggested that self-reports should be accepted at face value even if they reflect patients' delusional beliefs [7] and have limitations such as inaccurate estimations [8]. Other investigators have highlighted the potential for psychotic symptoms, mood states, disorganised thinking, lack of insight, and neurocognitive deficits to limit the usefulness of the self-report methodology in severely ill schizophrenia patients. Furthermore, it has been suggested that these measures

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may not adequately reflect the effects of various interventions [9]. However, studies have shown that patient self-reports of everyday functioning in schizophrenia often do not converge with objective evidence or the reports of others [10 11]. Self-reports of functioning therefore appear problematic, and alternative assessment methods may be required. However, many patients have no caregivers to provide information, and variance in their reports can be influenced by the amount of contact with the subject and situation specificity of the observation. High contact clinicians appear to generate ratings of everyday functioning that are more closely linked to patients' ability scores than friends or relative informants [12]. Both types of direct assessment (direct observation versus analogue assessment) have advantages and limitations. Real-life observations are necessarily individualised and non-standardised as well as costly and potentially reactive (presence of an observer may alter the environment and resulting behaviours). To this end, performance-based measures of functional capacity have been developed. However, they are valid to the extent that they measure the relevant skills accurately, but other factors may influence real-life outcomes, such as financial resources, motivation and symptoms of the illness may limit the extent to which skills that are present in the behavioural repertoire are actually performed in real-life settings [13].

Overview of everyday real-life outcomes

In this context, research efforts are increasingly turning to the design, evaluation and improvement of relatively economical real-life measurement [14-16]. Moreover, given concerns about length and ease of administration, as well as burden to the subject for assessment batteries, a practical measure must be both cost efficient and require a modest amount of time to administer [14]. However, there are still few satisfactorily reliable instruments for the assessment of functional outcomes that are practical in terms of time involved, and most real-life functional outcome scales seem to be largely redundant with each other when utilised simultaneously. One upshot of this situation is the Validation of Everyday Real-World Outcomes in schizophrenia (VALERO Expert panel) initiative. This project represents a joint effort between researchers at Emory University and the University of California, San Diego. The goal of this initiative was to identify the functional rating scale or scales (or subscales from existing scales) (self-report and informant-based reports) most strongly related to performance-based measures of cognition and everyday living skills through a comprehensive evaluation of existing instruments [4]. Forty-eight experts were asked to nominate the scales that they think best measure everyday outcomes in schizophrenia. The outcomes may include social, vocational, independent living, self-care, or any combination of these. The scale characteristics, which were rated by the panellists and were similar to those deemed important in the MATRICS process, were: reliability (test-retest and interrater), convergence with performance-based measures of functional capacity and neurocognitive performance, sensitivity to treatment effects, usefulness for multiple informants (e.g., self, friend or relative, case manager, or prescriber), relationships with symptom measures, practicality and tolerability for people with low education levels, and convergence with other measures of real-life functional outcomes (including either other rating scales or achievement milestones). Among the 59 measures nominated, the investigators selected the 11 scales that were the most highly nominated, had the most published validity data regarding their psychometric qualities and best represented the domains of interest (social functioning, everyday living skills, or both these areas -"hybrid" scales). Scales were rated on a 9-point (1-9) scale, where scores of 1-3 were poor, 4-6 were fair to good and 7-9 were very good to superb.

The two scales that scored highest across the various criteria for each of the classes of scales (hybrid, social functioning, and everyday living skills) were selected for use in the first substudy of VALERO [4]. The scales selected were the Quality-of-Life Scale, Specific Levels of Functioning Scale, Social Behavior Schedule, Social Functioning Scale, Independent Living Skills Schedule, and Life Skills Profile. The overall results of this first substudy of VALERO show that all examined scales can be considered as somewhat useful in their current versions. Moreover, many of these scales lack critical data regarding reliability across investigators and relationship with neuropsychiatric and functional capacity performance. Ratings for usefulness across multiple raters were also quite low, partly because many of these scales do not have alternate forms that attempt to capture the differing perspectives of different raters. As an entirely effective measure of the real-life outcomes component of the functional outcomes construct has not yet been identified, some measures are likely to be suitable in the interim. Thus, comprehensive real-life functioning assessment, using self-report, informant report and interviewer best judgment across six different real-life functioning rating scales may be required to capture the complexity of functional outcome in schizophrenia [13]. However, a through description of these scales is beyond the scope of this paper, in which we focused on the Specific Level of Functioning.

The Specific Levels of Functioning (SLOF) Scale [17] is a 43-item multidimensional behavioural survey administered in person to the caseworker or caregiver of a schizophrenic patient, selected on the basis of his/her familiarity with that person or a patient-administered scale completed with verbal instructions from the examiner to rate its own performance. The scale does not include items

relevant to psychiatric symptomatology or cognitive dysfunctions, but assesses the patient's current functioning and observable behaviour, as opposed to inferred mental or emotional states, and focuses on a person's skills, assets, and abilities rather than deficits that once served as the central paradigm guiding assessment and intervention for persons with disabilities. It comprises six subscales: (1) physical functioning, (2) personal care skills, (3) interpersonal relationships, (4) social acceptability, (5) activities of community living and (6) work skills. The work skills domain comprises behaviours important for vocational performance, but is not a rating of behaviour during employment. The latter would not be feasible, since the majority of patients with schizophrenia are unemployed; therefore, the proxy measure of work skills from the SLOF is used. Lastly, the SLOF also includes an open-ended question asking the informant if there are any other areas of functioning not covered by the instrument that may be important in assessing functioning in this patient. Each of the questions in the above domains is rated on a 5-point Likert scale. Scores on the instrument range from 43 to 215. The higher the total score, the better the overall functioning of the patient. According to the original version of the SLOF, the time frame covered by the survey is the past week. Each informant is asked to rank how well they know the patient on a 5-point Likert scale ranging from "not well at all" to "very well." Ratings on individual items of the SLOF may be used to capture the current state of overall functioning while showing specific areas of therapeutic and rehabilitative need, i.e. to identify goals in planning treatment for clients, to develop special intervention or skill-training programs, or to assign clients with similar or complementary strengths and needs to existing programmes. An adaptation of the SLOF is to allow patients to rate themselves on each item, while staff make independent judgments. Patients and staff then share their ratings, discuss discrepancies and negotiate a mutually acceptable set of functionally oriented goals for the plan. This process also could serve as a form of quality assurance, allowing patients and staff to obtain potentially valuable feedback about the patients' self-perceptions and help staff to gauge better the accuracy of their judgments [17]. Lastly, the SLOF has direct applications in research on patient outcome and programme evaluation.

SLOF: psychometric features

The SLOF was found to be a reliable and valid scale, with a good construct validity and internal consistency, as well as a stable factor structure.

In the context of a multicentre study of the Italian Network for Research on Psychoses, Mucci et al. [18] explored the construct validity, internal consistency and factor structure of the Italian version of the SLOF. The Italian version of the SLOF [18] is derived from the original SLOF, and has also demonstrated good psychometric properties, maintaining the same factorial structure as the original [17] in a much larger (n=895) and more homogenous (community sample) sample. The six factors identified (Activities, Interpersonal relationships, Work skills, Personal care skills, Social acceptability, and Physical functioning) explained 57.1% of the item variance, comparable to the one reported in the original study for community sample (58%). The variance explained by each factor was respectively 30.7%, 7.7%, 6.2%, 5.0%, 4.2% and 3.3% (expressed as percentage of the total variance, these figures correspond to 53.8%, 13.5%, 10.8%, 8.7%, 7.3% and 5.8%, respectively). The factor order is equivalent between the study by Mucci et al. [18] and the original one, as the Social acceptability and Physical functioning factors explain the lowest amount of variance. The inter-rater reliability for each of the six domains has shown a good to excellent agreement among raters, being higher in the community than in the hospital samples. Moreover, the authors of the scale recommend that to foster the SLOF inter-rater reliability, assessments should be performed by an informant who knows "well" the client's skills and behaviour. Thus, in case of hospitalised patients, he/she should not be assessed immediately following entry into an agency, but only after staff have interacted with him or her several times and observed the individual in many situations and circumstances [17].

SLOF: Italian translation

In the context of the multicentre study of the Italian Network for Research on Psychoses the instrument was translated in Italian (two independent translations of the scale were made by two psychiatrists; PR and AM, experienced in this area, fluent in English, and able to identify the concept covered by each of the original items) and then back-translated, according to the method proposed by Herdman et al. [19]. A formal assessment of semantic equivalence, a debriefing of conventional sample and a final review by experts were carried out. The operational equivalence was taken into account, which preserves the original features. For this purpose, we kept the same number of fields, same statements and same option of scoring and qualification.

This is the first comprehensive English language report on the development of the Italian version of the SLOF.

In Appendix A the Italian translation of the SLOF is presented.

Conflict of interest

None.

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APPENDIX A
Specific level of functioning assessment and physical health inventory

INFORMAZIONI SUL VALUTATORE
Nome del valutatore:

_____

(per cortesia in stampatello)

Posizione accademica del valutatore:

_____

Data in cui è stato compilato il questionario:

_____

INFORMAZIONI SUL SOGGETTO
Nome del soggetto:

_____

Data di nascita: _____

Sesso: ☐ Maschio ☐ Femmina

Indirizzo: _____

_____

Questa persona è in grado di parlare, leggere e comprendere l'italiano? ☐ Sì ☐ No

In caso di risposta negativa, quale lingua o adattamenti la persona solitamente richiede?

_____

(specificare)

Nelle pagine che seguono le sarà chiesto di formulare alcuni giudizi sulle capacità e abilità di questo individuo. Si prega di ricordare che le sue risposte dovrebbero riflettere ciò che è stato più caratteristico dell'individuo durante la scorsa settimana, il modo in cui l'individuo è stato per la maggior parte del tempo. Pertanto, la sua valutazione non si deve limitare solo a come stava l'individuo l'ultima volta in cui l'ha visto. Il suo punteggio si ripercuoterà sul servizio che questa persona riceverà, per cui è essenziale che si avvalga delle informazioni su come stava abitualmente l'individuo la settimana precedente.

Basi le sue risposte su come le persone di simili età, sesso e bagaglio culturale gestiscono queste attività nella normale vita quotidiana. Non usi il suo programma o struttura come unica base per il confronto. Siamo più interessati a come l'individuo si gestisce al di fuori del programma previsto per lui rispetto a come aderisce ad esso.

Utilizzi il buon senso. I seguenti item non sono tecnici o complessi, nel formulare la sua valutazione ricorra alle conoscenze in suo possesso.

Questa valutazione è stata adattata dalla *New Jersey Specific Level of Functioning* e della *New York Level of Care*.
Istruzioni: Verifichi quale numero meglio descrive il caratteristico livello di funzionamento del soggetto per ogni voce elencata sotto. Sia il più accurato possibile. Se non è sicuro rispetto ad un determinato punteggio, chieda a qualcuno che conosce il paziente o consulti la cartella clinica.

Segni un solo numero per ogni voce, controlli di aver contrassegnato tutte le voci.

CURA DI SÉ

A. Condizione fisica	Nessun problema	Crea problematiche, senza effetto sul funzionamento generale	Minimo effetto sul funzionamento generale	Limita in gran parte il funzionamento generale	Ostacola il funzionamento generale
1. VISTA	5	4	3	2	1
2. UDITO	5	4	3	2	1
3. COMPROMISSIONE DELL'ELOQUIO	5	4	3	2	1
4. DEAMBULAZIONE, USO DELLE GAMBE	5	4	3	2	1
5. UTILIZZO DI MANI E BRACCIA	5	4	3	2	1
B. Competenze nella cura di sé	**Totalmente autosufficiente**	**Necessita di un suggerimento verbale o di consigli**	**Necessita di un aiuto fisico o di assistenza**	**Necessita di un aiuto considerevole**	**Totalmente dipendente**
6. ANDARE ALLA TOILETTE *(usa correttamente la toilette, mantiene puliti sé e lo spazio)*	5	4	3	2	1
7. ALIMENTAZIONE *(utilizza gli utensili correttamente, abitudini alimentari)*	5	4	3	2	1
8. IGIENE PERSONALE *(corpo e denti, pulizia generale)*	5	4	3	2	1
9. VESTIRSI DA SOLI *(seleziona capi di abbigliamento adeguatamente; si veste autonomamente)*	5	4	3	2	1
10. CURA DELLA PROPRIA PERSONA *(capelli, trucco, aspetto generale)*	5	4	3	2	1
11. CURA DEI PROPRI BENI	5	4	3	2	1
12. CURA DEL PROPRIO SPAZIO VITALE	5	4	3	2	1

FUNZIONAMENTO SOCIALE

C. Relazioni interpersonali	Molto caratteristico di questa persona	Generalmente caratteristico di questa persona	Moderatamente caratteristico di questa persona	Generalmente atipico per questa persona	Molto atipico per questa persona
13. TOLLERA I CONTATTI CON GLI ALTRI *(non si allontana o respinge)*	5	4	3	2	1
14. STABILISCE I CONTATTI CON GLI ALTRI	5	4	3	2	1
15. COMUNICA IN MODO EFFICACE *(discorso e gestualità comprensibili e attinenti)*	5	4	3	2	1
16. PARTECIPA ALLE ATTIVITÀ SENZA SUGGERIMENTI	5	4	3	2	1
17. PARTECIPA A GRUPPI	5	4	3	2	1
18. ALLACCIA E MANTIENE LE AMICIZIE	5	4	3	2	1
19. CHIEDE AIUTO QUANDO NECESSITA	5	4	3	2	1
D. Accettabilità sociale	**Mai**	**Raramente**	**Qualche volta**	**Di frequente**	**Sempre**
20. ABUSI VERBALI	5	4	3	2	1
21. ABUSI FISICI	5	4	3	2	1
22. DISTRUGGE BENI	5	4	3	2	1
23. È AGGRESSIVO FISICAMENTE VERSO SE STESSO	5	4	3	2	1
24. HA PAURA, PIANGE, È APPICCICOSO	5	4	3	2	1
25. SI APPROPRIA DI BENI ALTRUI SENZA AUTORIZZAZIONE	5	4	3	2	1
26. REITERA I COMPORTAMENTI *(passi, oscillazioni, rumori, ecc.)*	5	4	3	2	1

COMPETENZE IN AMBITO COMUNITARIO					
E. Attività	**Totalmente autosufficiente**	**Necessita di suggerimenti o consigli verbali**	**Necessita di un aiuto fisico o di assistenza**	**Necessita di un aiuto sostanziale**	**Totalmente dipendente**
27. RESPONSABILITÀ DOMESTICHE *(pulizia della casa, cucinare, lavare vestiti, ecc.)*	5	4	3	2	1
28. ACQUISTI *(selezione di articoli, scelta di negozi, pagamento di cassa)*	5	4	3	2	1
29. GESTIONE DELLE PROPRIE FINANZE *(gestione del budget, pagamento delle bollette)*	5	4	3	2	1
30. USO DEL TELEFONO *(trovare il numero, digitare il numero, conversazione, ascolto)*	5	4	3	2	1
31.ALLONTANAMENTO DALLA PROPRIA ABITAZIONE SENZA PERDERSI	5	4	3	2	1
32. UTILIZZO DEI TRASPORTI PUBBLICI *(selezionare percorso, usare gli orari, pagare tariffe, effettuare i trasferimenti)*	5	4	3	2	1
33. IMPIEGO DEL TEMPO LIBERO *(letture, visite agli amici, ascoltare musica, ecc.)*	5	4	3	2	1
34. RICONOSCERE ED EVITARE PERICOLI COMUNI *(traffico, incendio, ecc.)*	5	4	3	2	1
35.AUTOMEDICAZIONE *(comprendere lo scopo, assumere come prescritto, riconoscere gli effetti collaterali)*	5	4	3	2	1
36. UTILIZZO DEI SERVIZI MEDICI E DI COMUNITÀ *(sapere a chi rivolgersi, come e quando usarli)*	5	4	3	2	1
37. LETTURA DI BASE, SCRITTURA E CALCOLO *(sufficiente per le necessità quotidiane)*	5	4	3	2	1
F. Capacità lavorative	**Molto caratteristico di questa persona**	**Generalmente caratteristico di questa persona**	**Moderatamente caratteristico di questa persona**	**Generalmente atipico per questa persona**	**Molto atipico per questa persona**
38. POSSIEDE COMPETENZE LAVORATIVE	5	4	3	2	1
39. LAVORA CON UNA SUPERVISIONE MINIMA	5	4	3	2	1
40. SOSTIENE GLI SFORZI LAVORATIVI *(non si distrae facilmente, è capace di lavorare sotto stress)*	5	4	3	2	1
41. SI PRESENTA AGLI APPUNTAMENTI PUNTUALE	5	4	3	2	1
42. SEGUE ACCURATAMENTE LE ISTRUZIONI VERBALI	5	4	3	2	1
43. COMPLETA I COMPITI ASSEGNATI	5	4	3	2	1

ALTRE INFORMAZIONI

44. In base alla conoscenza di questa persona, ci sono altre abilità o aree problematiche non contemplate da questo questionario e rilevanti ai fini della capacità di questa persona di operare in modo indipendente? Se è così, si prega di specificare.

_____
_____
_____
_____
_____

45. Quanto bene conosce le capacità e il comportamento della persona che ha appena valutato? (Barrare una casella)

MOLTO BENE		ABBASTANZA BENE		PER NULLA
5	4	3	2	1

46. Ha discusso questa valutazione con il soggetto? (Barrare una casella)	☐ Sì	☐ No
Se SÌ, l'individuo concorda generalmente con la valutazione? (Barrare una casella)	☐ Sì	☐ No

Se NO, si prega di commentare

_____
_____
_____
_____
_____

Firma del valutatore _____

STATO DI SALUTE FISICA

Istruzioni: Metta una X in tutte le caselle che descrivono il soggetto.

Problema attuale di salute fisica dell'individuo
❑ Nessuno
❑ Arteriosclerosi cardiaca
❑ Ipertensione
❑ Altro disturbo circolatorio
❑ Gravi problemi respiratori
❑ Diabete
❑ Obesità
❑ Artrite
❑ Ulcera da decubito (piaghe da decubito)
❑ Crisi convulsive (epilessia)
❑ Disturbo gastro-intestinale
❑ Sindrome organica cerebrale
❑ Evento cerebrovascolare- Stroke
❑ Deficit visivi
❑ Cecità
❑ Compromissione dell'udito
❑ Compromissione del linguaggio
❑ Frattura
❑ Disturbo uro-genitale
❑ M. di Huntington
❑ M. di Alzheimer
❑ M. di Parkinson
❑ Discinesia tardiva
❑ Malattia neoplastica
❑ Altro

Sussidi (per la salute fisica) usati o richiesti dal singolo
❑ Nessuno
❑ Occhiali
❑ Protesi uditive
❑ Dentiera
❑ Altro

Procedure qualificate di cura richieste dall'individuo
❑ Nessuna
❑ Valutazione quotidiana segni vitali
❑ Trattamento insulinico
❑ Prevenzione delle piaghe da decubito
❑ Trattamento delle ulcere da decubito
❑ Gestione di catetere/stomia
❑ Mantenimento delle condizioni di asepsi mediante abbigliamento idoneo
❑ Fisioterapia
❑ Fisioterapia riabilitativa per l'incontinenza
❑ Irrigazione della lesione
❑ Aspirazione secrezioni
❑ Terapia inalatorie
❑ Nutrizione parenterale
❑ Nutrizione enterale
❑ Altro

Incontinenza urinaria
❑ Mai
❑ Meno di una volta al giorno
❑ Solo notturna
❑ 1-3 volte al giorno
❑ Più di 3 volte al giorno
❑ Uso del catetere

Incontinenza fecale
❑ Mai
❑ Meno di una volta al giorno
❑ Una volta al giorno
❑ Più di una volta al giorno
❑ Portatore di colonstomia

Quali delle seguenti opzioni descrive meglio la deambulazione dell'individuo
❑ Completamente indipendente
❑ Usa un bastone o un deambulatore
❑ Instabile
❑ Cammina solo con l'assistenza del personale

Uso della sedia a rotelle
❑ Indipendente
❑ Sta sulla sedia a rotelle o necessita di un supporto
❑ Deve essere spinto
❑ Sta a letto

Cura della propria persona

Fare il bagno:
❑ Completamente indipendente
❑ Ha bisogno di solleciti
❑ Ha bisogno di supervisione
❑ Ha bisogno di moderata assistenza fisica
❑ Ha bisogno di molta assistenza fisica
❑ Ha bisogno di una cura completa

Vestirsi:
❑ Completamente indipendente
❑ Ha bisogno di solleciti
❑ Ha bisogno di supervisione
❑ Ha bisogno di moderata assistenza fisica
❑ Ha bisogno di molta assistenza fisica
❑ Ha bisogno di una cura completa

Prepararsi:
❑ Completamente indipendente
❑ Ha bisogno di solleciti
❑ Ha bisogno di supervisione
❑ Ha bisogno di moderata assistenza fisica
❑ Ha bisogno di molta assistenza fisica
❑ Ha bisogno di una cura completa

Mangiare:
❑ Completamente indipendente
❑ Ha bisogno di solleciti
❑ Ha bisogno di supervisione
❑ Ha bisogno di moderata assistenza fisica
❑ Ha bisogno di molta assistenza fisica
❑ Ha bisogno di una cura completa

Usare il bagno:
❑ Completamente indipendente
❑ Ha bisogno di solleciti
❑ Ha bisogno di supervisione
❑ Ha bisogno di moderata assistenza fisica
❑ Ha bisogno di molta assistenza fisica
❑ Ha bisogno di una cura completa

Commenti:
(Specifichi e descriva le aree che richiedono una valutazione al fine di determinare il grado di assistenza che l'individuo necessita)
_____
_____
_____
_____

Firma del valutatore _____

Titolo accademico _____

Data di compilazione _____