



The Ohio Coordinating Center for Integrating Care Measurement Tool Resource List February 2010

The Ohio Coordinating Center for Integrating Care (OCCIC) was given the responsibility by Ohio Department of Mental Health to disseminate “examples of brief, efficient outcomes measures” to provider organizations. Please see the ODMH director’s memo “Outcomes Measures Reporting System” dated August 28, 2009, for details. This library is not intended nor shall it be construed to either abandon the use of existing outcomes measures or limit the scope of the tools that can be used by the providers. Behavioral health providers are encouraged to consider their accreditation, certification/licensure requirements, contract obligations, client population needs, strategic goals and any other relevant factors when implementing an outcome measurement system.

There are many resources for measuring the physical and behavioral health of people with mental illnesses. This document is a resource library of these screening and outcomes tools. The intent of this library is to make it easier for community behavioral health providers to find and use these tools.

Most (but not all) tools on this list conform to two of the following three criteria: widely used; relatively brief; and in the public domain.

It is recommended that you use, administer, or “score” these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool’s publisher or author.

As you look for screening or assessment tools, consider if appropriate, selecting tools that can be used in both behavioral health and primary care settings. The consistent use of screening and outcomes tools will facilitate continuity of care and improve communication across providers.

In addition to specific screening and outcomes tools, behavioral health providers who engage in pharmacological management (psychotropic medication prescription) should consider collecting (through administration or collection from an “outside” provider), a basic set of health and process indicators at the “person level.” The National Association of State Mental Health Directors recommended the use of health and process indicators in its Medical Directors Council Report, *Measurement of Health Status for People with Mental Illnesses*, published in 2008. The recommended indicators fall into three broad categories: history, clinical values for chronic disease monitoring, and process indicators for monitoring access and utilization.

The report also called for further discrete identification of indicators and use, while identifying specific indicators for immediate collection in the three categories:

- a. History/Screening
 - i. Family History and Personal History
 1. Diabetes
 2. Hypertension
 3. Cardiovascular Disease
 - ii. Substance abuse and tobacco use
- b. Clinical Values
 - i. Glucose/HgA1C
 - ii. BP
 - iii. BMI
 - iv. Lipid Profile
- c. Utilization/Process
 - i. Access of primary and specialty care
 - ii. Utilization of primary and specialty care

For more information about health indicators, screening and outcomes tools please contact Jonas Thom at the Ohio Coordinating Center for Integrating Care at 513-458-6733 or jthom@healthfoundation.org .

Over the next year, ODMH will be collecting feedback about the use of the tools included in this resource library from consumers, providers and families and considering additional categories, such as outcomes for trauma, outcomes and screening tools for individuals with mental illnesses involved in the criminal justice system, and physical health indicators for children. Please direct comments to Kraig Knudsen, Kraig.Knudsen@mh.ohio.gov

Finally, the following Ohio Coordinating Centers of Excellence deserve recognition and thanks for their critical feedback and input in the development of this resource library: The Center for Evidence Based Practices, The Center for Innovative Practices, The Cluster-Based Planning Alliance CCOE, The Criminal Justice CCOE, The Mental Illness/Developmental Disability CCOE and The Wellness Management and Recovery CCOE.



The Ohio Coordinating Center for Integrating Care

Measurement Tool Resource List

Adult Behavioral Health Outcomes and Screening Tools

Adult Behavioral Health Outcome Tools

General

DUKE

Measure of Functional Health Status

The DUKE Health Profile is a 17 item self-reported, self-administered measure of functional health status intended as a brief measure of health outcome after medical and health interventions in primary care setting with adult ambulatory patients. According to Rush, et. al, the major strengths of the DUKE are the fact that it takes only 5 minutes, its broad conceptualizations of health and functioning, and the substantial validity and reliability of the data. Rush also notes that it is valuable because of the availability of normative data including means and standard deviations. It is not useful for differentiating among severely ill or very impaired patients. In addition, it is not useful for measuring change over time except on its Self-Esteem and Mental Health Scales, where it has demonstrated a high sensitivity to change in status.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Available from the Department of Community and Family Medicine, Duke University, <http://healthmeasures.mc.duke.edu>. A user's guide costs \$35.00.

Copyrighted by Duke University.

Psychosis

BASIS-24

Measure of Mental Health Treatment Outcome from Patient's Perspective

According to Rush, et. al. (2008), the Behavior and Symptom Identification Scale (BASIS-32 and Basis-24) was designed to be a brief but comprehensive measure of mental health treatment from the patient's perspective. The revision, BASIS-24 covers behavioral and functioning areas in addition to psychiatric symptoms. The scale is a broad-based measure of general functioning that allow for the evaluation of change over the course of treatment. BASIS includes the major symptoms and problems that bring people to inpatient treatment. It can be administered through structured interviews, patient self-reporting, telephone interviews, and mailed self-report questionnaires. The self-reporting version takes 5 to 20 minutes and the structured interview takes from 15 to 20 minutes to administer. Rush notes, that "A major strength of this measure is its applicability to a wide range of people receiving mental health treatment." It is simple and brief and can be administered by nonprofessional personnel. It is appropriate for adults and adolescents.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright: McLean Hospital Corporation.

A license is available from McLean Hospital, www.basissurvey.org

BPRS: Brief Psychiatric Rating Scale

Assessment of Change of Severity of Psychopathology

According to Rush, et. al. (2008), the Brief Psychiatric Rating Scale (BPRS) is “a clinician-rated tool designed to assess change in severity of psychopathology.” The items cover a broad range of symptoms that are common in psychotic disorders as well as those found in severe mood disorders, especially those with psychotic features. The BPRS includes 18 items; an earlier and less frequently used version had 16 of these items. A 24 item version is available from Ventura, Green, Shaner & Liberman (1993). It takes from 20 to 30 minutes to administer the BPRS, depending on the familiarity with the patient and on patient cooperation. Rush, et. al., notes, in the clinical setting, the BPRS is most appropriately used as a global measure of response to treatment interventions in patients with moderate to severe psychotic disorders. Its primary advantage is that it provides a simple and efficient review and summary of a broad range of clinically relevant psychopathology. The tool does not cover all areas of potential interest to the clinician. It is also not diagnostic of a particular disorder. Finally, it is less able to assess change in patients with relatively mild levels of psychopathology. The BPRS is to be used by clinicians experienced in the evaluation and treatment of psychotic disorders. Clinicians should review the administration instructions provided in key references. BPRS is appropriate for use with adults with mild intellectual disability with adapted administration (Kellett et al., 2004). Items are read to the individual and response choices are presented visually.

Sources:

Ventura, Green, Shaner & Liberman (1993), Training and quality assurance with the brief psychiatric rating scale: "The drift buster", *International Journal of Methods in Psychiatric Research*, 3 (1993)

Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Kellett, S., Beail, N., Newman, D. W., & Hawes, A. (2004). The factor structure of the Brief Symptom Inventory: Intellectual disability evidence. *Clinical Psychology and Psychotherapy*, 11, 275-281.

In the public domain.

Available on the CD-ROM accompanying the *Handbook of Psychiatric Measures* (2nd ed.) 18 item instrument, and from Ventura, Green, Shaner & Liberman (1993), 24 item instrument.

NOTE: It is recommended that you use, administer, or “score” these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool’s publisher or author.

Functioning

Global Assessment of Functioning (GAF)

The **Global Assessment of Functioning (GAF)** is a numeric scale (1 through 100) used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological functioning of adults. The Global Assessment of Functioning (GAF) scale was introduced as a measure of global severity of illness in the Diagnostic and Statistical Manual of Mental Disorders version III-R first published in 1987. The scale is presented and described in the DSM-IV-TR on page 32. Children and adolescents under the age of 18 are evaluated on the Children's Global Assessment Scale, or C-GAS.

Sheehan Disability Scale

Measurement of Impairment Due to Panic, Anxiety, Phobic, or Depressive Symptoms.

The Sheehan Disability Scale is designed to measure the extent to which three major sectors in the patient's life (work, social life, family life) are impaired by panic, anxiety, phobic, or depressive symptoms. It is a 5-item self-reporting or clinician-reporting instrument. According to Rush, et. al. (2008), the scale is a short, simple, and cost-effective measure of disability and functional impairment that can be quickly administered and scored without disrupting the flow of routine care. It appears to be susceptible to change with treatment. The Sheehan Scale is not intended to be used for diagnostic purposes. Nevertheless, it may be a useful supplement to a diagnostic mental health assessment. In primary care practices elevated scores on this instrument may serve as a warning to indicate the need for a detailed, diagnostically oriented mental health assessment. Rush notes that a significant disadvantage is that the three areas queried are highly inter-correlated. Another disadvantage is that for patients that are not working the work item is not applicable.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright, David V. Sheehan, 1983-2008, All Rights reserved. Reproduce with permission only.

The instrument is available on the CD-ROM included with the *Handbook of Psychiatric Measures* (2nd ed.).

WHODAS II

Measure of Functioning and Disability

The World Health Organization Disability Assessment Schedule II (WHODAS II) is a measure of functioning and disability that is, according to Rush, et. al. (2008), “conceptually compatible with WHO’s recent revisions to the International Classification of Functioning, Disability, and Health (ICF).” It is a standardized, cross-cultural measurement of health status that provides a summary of functioning and disability that is reliable and valid across geographic regions, diagnostic groups, ages, and genders. Rush notes that it has been extensively tested and is being widely used in clinical and general population samples. The primary version of WHODAS II is a 36-item fully structured lay interviewer-administered assessment instrument. It takes about 20 minutes to administer; a 12-item version takes about 5 minutes. The measure does require some training to administer. It provides a profile of functioning across 6 activity domains, as well as a general disability score. It does not include symptoms or feelings of subjective well-being. It records and measures the patients’ own experiences of disability.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright: Copyright World Health Organization (WHO), 2010. All Rights Reserved. Users must receive written permission from World Health Organization to use WHODAS II by completing a form “Application for Use of the WHODAS II and Related Materials” and mailing it to World Health Organization, Classification, Assessment, and Epidemiology Team, Global Program on Evidence for Health Policy, Avenue Appia, Geneva 27, CH 1211 Switzerland

Manuals and instruments are available from WHO, www.who.int/icidh/whodas/index.html.

Adult Satisfaction/Recovery Indicators

Satisfaction Indicators

CPOSS: Charleston Psychiatric Outpatient Satisfaction Scale

Psychiatric Outpatient Satisfaction Survey

The Charleston Psychiatric Outpatient Satisfaction Survey (CPOSS) is a 16-item questionnaire designed for self-administration by psychiatric outpatients. There are 15 structured items and one open ended item. Of these 13 items explore patients' perceptions of staff attitudes, therapeutic components, amenities, and the physical environment of the clinical setting. Two are general satisfaction questions. The survey was designed to be given to patients by a receptionist. It can be completed in 2 to 5 minutes. According to Rush, et. al. (2008), the instrument is useful for assessing patient perception of care in general and VA outpatient settings. The brevity of the instrument imposes relatively little burden on respondents, increasing its utility and likely improving potential response rates.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright notice: The Charleston Psychiatric Outpatient Satisfaction Scale is copyrighted by Bartley C. Frueh, Ph.D. Permission has been granted to reproduce the scale on its website (<http://www.outcometracker.org/library/CPOSS.pdf>) for clinicians to use in their practice and for researchers to use in non-industry studies. For other uses of the scale, the owner of the copyright should be contacted.

Also, available on the CD-ROM included with the *Handbook of Psychiatric Measures* (2nd ed.).

CSQ-8: Client Satisfaction Questionnaire

Client Satisfaction with Treatment

The CSQ-8 is an 8-item questionnaire that is designed to measure client satisfaction with treatment and services. The questionnaire is easy to administer and score. The CSQ-8 is unidimensional and yields a homogeneous estimate of general satisfaction with services. It is scored by simply summing the individual item scores to produce a range of 8 to 32, with high scores indicating greater satisfaction. The CSQ-8 has been studied extensively and elicits the client's perspective on the value of services received.

Source

Reprinting with permission from C.C. Attkisson (1991).

The CSQ was developed by C.C. Attkisson et al. at the University of California, San Francisco, Department of Psychiatry. Use for non-profit research and evaluation purposes is permitted. All other uses by prior permission and user fee, without exception.

MHSIP: Mental health Statistics Improvement Program- Consumer Survey

The MHSIP Consumer Survey is a key component of the MHSIP Consumer Report Card. The survey has been adopted by several states and other entities for implementation since it became available in 1996. A number of different versions of the consumer survey have emerged as mental health system stakeholders tried to adapt the survey for local use. MHSIP Consumer Survey (version 1.1, Feb, 2000) consists of 28 items measuring four distinct domains of general satisfaction, access, quality/appropriateness and outcomes.

Copyright: Public domain.

Source: MHSIP surveys are available for public use free of charge and can be obtained on MHSIP website: <http://www.mhsip.org/surveylink.htm#mhsipapprovedsurveys>.

PSQ-II/III

Medical Patient Satisfaction Questionnaire

According to Rush, et. al. (2008), “The PSQ is a self-administered survey instrument that assesses patient satisfaction with medical care in general and with specific features of care.” Respondents are asked to rate medical care in general without reference to particular time frames or instances of care. The PSQ-II consists of 55 items that are combined in 18 subscales. It takes about 11 minutes to complete the 55-item PSQ-II. The modified 50-item PSQ-III takes about 10 minutes. Rush notes that the PSQ has been shown to be a reliable and well-validated measure of satisfaction with medical services in general. The PSQ may be used in broad comparisons of providers, as well as for purposes of quality improvement of specific aspects of care. Separate results for recipients of psychiatric services were not reported, but a subset of this population was included in the development and validation studies. Rush also points out that because of its length, use with more inclusive psychiatric populations may be a problem, as it may be for lower-income and less educated populations. The 6-item general satisfaction scale of the PSQ-III correlates very highly with the latent variable derived from the scale as a whole and could thus serve well if specific aspects of care are not being evaluated. Rush warns that the PSQ may have limited use for smaller entities that do not account for most or all of the services received by the respondents as the instrument measures general satisfaction rather than satisfaction with the particular provider.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

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The PSQ-III is available on the CD-ROM included with the *Handbook of Psychiatric Measures* (2nd ed.).

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Recovery Indicators

Mental Health Recovery Measure (MHRM)

Assessment of Recovery of Individuals with Serious Mental Illness.

The MHRM is a 30-item self-reported, self-administered instrument. It has been tested with adults diagnosed with a serious mental illness who are members of several ethnic/racial groups: African American, White, Hispanic, and mixed race. It has been tested for use in the criminal justice system inpatient settings, outpatient setting, peer-run programs, and residential service settings.

Copyright: The Mental Health Recovery Measure© (MHRM) is a copyrighted assessment instrument, but may be freely reproduced. Users are asked to preserve the author information and the funding acknowledgement on the document if it is reproduced. The MHRM© was developed with the help of mental health consumers by researchers at the University of Toledo, Department of Psychology. This research was supported through a grant from the Ohio Department of Mental Health, Office of Program Evaluation and Research. For further information, please contact Wesley A. Bullock, Ph.D. at (419) 530-2721 or email: wesley.bullock@utoledo.edu.

Peer Outcomes Protocol (POP)

Outcomes tool for measuring recovery indicators deemed important to persons in recovery, assessing Peer Support and Consumer Operated Services.

According to Campbell-Orde, et. al. (2005), “This instrument used empowerment theory and peer-support/self-help approaches that by definition are intended to promote recovery.” The POP is composed of seven modules: Demographics, Service Use, Employment, Community Life, Quality of Life, Well-Being, and Program Satisfaction. There are 241 Items in the tool, and it takes approximately one hour to complete. This protocol was developed as a project of the University of Illinois at Chicago, National Research and Training Center on Psychiatric Disability, directed by Judith A. Cook, Ph.D.

Source: Campbell-Orde, T., Garrett, E., & Leff, S. (Eds.) (2005) *Measuring the Promise of Recovery: A compendium of recovery and recovery-related instruments, Part II*. The Evaluation Center@HSRI: Cambridge, MA. <http://www.power2u.org/downloads/pn-55.pdf>

Copyright: University of Illinois at Chicago (2004).

Reciprocal Support Scale (RSS)

A scale to measure peer to peer/mutual support, comprised of 14 items. All items are rated using a 5 point Likert scale, and it takes approximately 20 minutes to complete.

Source: Campbell-Orde, T., Garrett, E., & Leff, S. (Eds.) (2005) *Measuring the Promise of Recovery: A compendium of recovery and recovery-related instruments, Part II*. The Evaluation Center@HSRI: Cambridge, MA. <http://www.power2u.org/downloads/pn-55.pdf>

Copyright: The Reciprocal Support Scale is not copyrighted and the instrument can be used freely. There is not a user's fee associated with the instrument.

Recovery Assessment Scale (RAS)

An outcome measure for mental health/ support program evaluation.

According to Campbell-Orde, et. al. (2005), based on a process recovery model, the scale attempts to assess aspects of recovery with a special focus on hope and self-determination. The RAS has 41 items, rated using a 5 point Likert Scale, and its 5 sub-scales include: Personal Confidence and Hope, Willingness to Ask for Help, Goal and Success Orientation, Reliance on Others, No Domination by Symptoms. This tool is used through individual interview, and takes approximately 20 minutes to complete.

Source: Campbell-Orde, T., Garrett, E., & Leff, S. (Eds.) (2005) *Measuring the Promise of Recovery: A compendium of recovery and recovery-related instruments, Part II*. The Evaluation Center@HSRI: Cambridge, MA. <http://www.power2u.org/downloads/pn-55.pdf>

Copyright: The Recovery Assessment Scale is not copyrighted and can be used freely. There is not a user's fee associated with the instrument.

Recovery Measurement Tool Version 4 (RMT)

A tool to measure individual specific "stages" of recovery, developed by an advisory group in Maine. The RMT is comprised of 91 items, rated using a 5 point Likert scale, that indicate the degree to which the respondent identifies with an item. The tool takes approximately 20 minutes to self-administer.

Source: Campbell-Orde, T., Garrett, E., & Leff, S. (Eds.) (2005) *Measuring the Promise of Recovery: A compendium of recovery and recovery-related instruments, Part II*. The Evaluation Center@HSRI: Cambridge, MA. <http://www.power2u.org/downloads/pn-55.pdf>

Copyright: The Recovery Measurement Tool Version 4 is not copyrighted and can be used freely. There is not a user's fee associated with the instrument; however the author requests data from the instrument's use. For more information contact: Ruth O. Ralph, Ph.D., Phone 207-934-0579, Email: ruth.ralph@maine.edu.

Relationships and Activities that Facilitate Recovery (RAFRS)

A tool to measure individual/subjective quality of life: rating specific elements deemed “important” to individual respondents. The RAFRS contains 18 items, rated on a Likert scale, plus 2 additional open-ended items. The administration is through interview, and takes approximately 5 minutes.

Source: Campbell-Orde, T., Garrett, E., & Leff, S. (Eds.) (2005) *Measuring the Promise of Recovery: A compendium of recovery and recovery-related instruments, Part II*. The Evaluation Center@HSRI: Cambridge, MA. <http://www.power2u.org/downloads/pn-55.pdf>

Copyright: The RAFRS is not copyrighted and can be used freely. There is not a user’s fee associated with the instrument.

Wellness Management and Recovery Scale: Client Self-Rating

According to Bullock et al., (2009), the *WMR Client Self-Rating* scale is a 20-item, self-report measure that was an adapted and expanded version of the Illness Management and Recovery (IMR) Client Self-Rating Scale (Mueser & Gingerich, 2005). The WMR Scale includes the 15 items on the IMR Scale and added five new items generated by the WMR CCOE that were designed to tap into additional content areas and program goals for the WMR program (e.g., tobacco use, healthy life-style choices, working collaboratively with mental health professionals, use of a wellness plan, and integration of recovery philosophy into ones life.) The WMR scale is designed to assess mental health consumers’ progress on those content areas targeted by the WMR curriculum. Participants respond to each item on a 5-point Likert scale, with response anchors varying dependent upon the item.

Source:

Bullock, W., Sage, J., Hupp, D., Ozbey, T., O’Rourke, M., Smith, M. K., Wesp, K., Wilcox, D., Rich, S., Pieples, G., Pesta, Z., Spiegelberg, J., & Garrity, J. (2009) From Illness to Wellness: An evaluation of Ohio’s Wellness Management and Recovery (WMR) Program in Community Mental Health and Consumer-Operated Services Agencies. *New Research in Mental Health*. Vol. 18, 312-321.

Mueser, K. T., & Gingerich, S. (2005). Illness Management and Recovery (IMR) Scales. In T. Campbell-Orde, J. Chamberlin, J. Carpenter, & H. S. Leff (Eds.). *Measuring the promise: A compendium of recovery measures* (pp. 124–132). The Evaluation Center @ Human Services Research Institute, Cambridge, MA.

Copyright: The WMR and IMR scales are not copyrighted and can be used freely. Users can obtain a copy of the scale through Ohio Coordinating Center of Excellence for Wellness Management and Recovery.

Contact: Kelly Wesp, Program Coordinator, Wellness Management and Recovery, 16 West Long Street, Columbus, Oh 43215.

Empowerment Indicators

MHLOC

Assessment of Patient Sense of Control of Health Care

According to its author, Kenneth Wallston, the Multidimensional Health Locus of Control (MHLOC or MHLC) is a self-administered questionnaire with 3 “forms” with 6 questions in 3 subscales asking patients to rate their level of agreement with a series of questions about the impact of the self, of others, and of chance on their level of health. Forms A and B are general health locus of control instruments. Form C is a condition-specific instrument in which the condition is inserted in the appropriate place in the questionnaire.

Source: Ken Wallston, Vanderbilt University School of Nursing,
<http://www.vanderbilt.edu/nursing/kwallston/mhlc scales.htm>

In the Public Domain, may be altered to suit the research needs of the user.

Quality of Life Indicators

CA-QOL

Quality of Life Scale

The California Quality of Life Survey is a self-administered instrument that measures QOL issues in 7 areas with an additional question on general life satisfaction asked both at the beginning and end of the survey. The instrument was adapted by the California Department of Mental Health from a QOL interview by Dr. Anthony Lehman.

Source: California Department of Mental Health,
<http://www.dmh.ca.gov/poqi/archive/docs/caqol.PDF>

Available at: <http://www.dmh.ca.gov/poqi/archive/docs/caqol.PDF>

Copyright: Public domain.

WHOQOL-BREF

Measure of Quality of Life

According to Rush, et. al. (2008), the World Health Organization Quality of Life Scale Brief (WHOQOL-BREF) is a 26-item scale intended to measure an individual's perception of quality of life issues including cultural, health, illness, socioeconomic, and environmental factors. It was developed simultaneously in 15 languages. The instrument explores four domains-physical, psychological, social relationships, and environment. Each of the domains explores 24 facets. It takes about 5 minutes to self-administer and about 15 to 20 minutes to be administered by an interviewer. Rush notes that the WHOQOL is particularly useful for cross-cultural or international collaborative research on quality of life. Although the theory and methodology underlying the measure are very strong, the WHOQOL has yet to be tested on many populations. It does exhibit some divergence from other QOL measures. Nevertheless the instrument has been reasonably well validated and has shown current usefulness and future promise.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyrighted, users must sign an agreement.

Available in the U.S. from Seattle Quality of Life Group, www.seaqolgroup.org.

Other Data

AHRQ Measures

Measurements of the Clinical Performance of Ambulatory Care

The federal Agency for Healthcare Research and Quality (AHRQ) in cooperation with the Ambulatory Care Quality Alliance (ACA) and other stakeholders agreed in early 2005 to develop a set of tools intended to measure the clinical performance of ambulatory care. The "Starter Set" consists of 8 areas measuring the percentage of patients receiving recommended treatment or screening. These included prevention measures; treatments for Coronary Artery Disease, Heart Disease, Diabetes, Asthma, and Depression; Prenatal Care; and Quality Measures Addressing Overuse or Misuse.

Source: *The Ambulatory Care Quality Alliance Recommended Starter Set: Clinical Performance Measures for Ambulatory Care*. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/aqastart.htm>

Available at The Ambulatory Care Quality Alliance, <http://www.ahrq.gov/qual/aqastart.pdf>

COM-T

The Consumer Outcomes Monitoring Tool (COM-T)

The Consumer Outcomes Monitoring Tool (COM-T) is a monthly checklist that quickly captures the SAMHSA National Outcomes Measures (NOMs) and EBP-specific outcomes and indicators. It is completed during treatment team (or supervision) utilizing all sources of information available. It was originally designed for Integrated Dual Disorders Treatment (IDDT) teams but is being piloted with all behavioral health recipients. The tool helps clinicians and supervisors review the current status of consumers to guide clinical decision-making regarding interventions/next steps while simultaneously collecting outcome information that can be tracked over time.

Source: Center for Evidence Based Practices at Case (CEBP)

Copyright: CEBP

Availability: Free use with proper citation of source

Adult Behavioral Health Assessment and Screening Tools

General

GHQ-12

General Health Questionnaire is a screening instrument to detect psychiatric disorders in community settings and non-psychiatric clinical settings, such as primary care or general practice. According to Rush, et. al. (2008), the General Health Questionnaire (GHQ) “was designed to screen for psychiatric distress related to general medical illness.” It is not a diagnostic tool, but rather one that may indicate the need for a formal psychiatric interview to determine a diagnosis. It is a paper-and-pencil self administered questionnaire. GHQ-12 is one of 4 official versions including 60-item, 30-item, and 28-item versions. Depending on the version used the GHQ takes 3 to 15 minutes to administer. Presumably, the GHQ-12 would fall at the lower end of this range. According to the publisher, the GHQ can be administered and scored by staff with minimal training. Rush notes, that the instrument “seems to be appropriate for all ages, including adolescents as young as 11 years.” However, women’s scores seem to decrease with age up to 65 years. Men’s scores appear to increase into middle age and then fall to age 65 or be unaffected by age. Scores for both men and women increase after age 75. There seems to be no undue effect due to class and gender. Its strength lies in its brevity and its acceptability across a wide range of clinical settings and cultures. The manual recommends that actual results be reported to the referring physician as specific results are more important than a general score.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright: GHQ-12 copyright © David Goldberg, 1978./ GHQ-28 copyright © David Goldberg and the Institute of Psychiatry, 1981./ GHQ-30 copyright © David Goldberg, 1978./ GHQ-60 copyright © David Goldberg and the Institute of Psychiatry, 1978.

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K6

Measurement of Serious Psychological Distress

The Serious Psychological Distress Scale (K6) is a professionally administered 6-item scale developed to measure serious mental illness in adults 18 years and older using as few questions as possible. Answers are self-reported. According to Kessler, et. al. (2003), the brevity and accuracy of the K6 scale makes it an attractive screen for serious mental illness. As with all tools, it is recommended that it be administered by staff with training and supervision in use, scoring, and applicability.

Source:

Parks, J., Radke, A. Q., Mazade, N. A., & Mauer, B. (2008). *Measurement of Health Status for People with Serious Mental Illness*. Alexandria, VA: National Association of State Mental Health Program Directors.

http://www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf

Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., et al. (2003). Screening for Serious Mental Illness in the General Population. *Arch Gen Psychiatry*, 60(2), 184-189. <http://archpsyc.ama-assn.org/cgi/reprint/60/2/184>

Available in a number of publications including Parks, et. al., 2008., Public Domain

MHI5

Screening for the Occurrence and Extent of Psychological Distress During the Past Month.

MHI5 is a professionally administered 5-item version of the 38-item Mental Health Inventory intended to assess anxiety, calmness, depression, happiness, and behavioral or emotional control. Answers are self-reported. According to Rush, et. al. (2008), it is useful for detecting and differentiating between undiagnosed depression and anxiety disorders in primary care patients. It is easy to administer and interpret. It is not appropriate for use with children or psychiatric populations. As with all tools, it is recommended that it be administered by staff with training and supervision in use, scoring, and applicability.

Sources:

European Commission Health Indicators Monitoring Project, (2008), "European Health Indicators Monitoring Documentation Sheet: Mental Health Index (MHI-5)," ECHIM Project. http://www.healthindicators.org/healthindicators/object_document/o5742n29136.html

Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Available in a number of publications, including Rush, et. al., 2008 and from RAND Health Communications, www.rand.org/health

Public Domain with request for proper attribution for the scale.

Ohio Health History Form (OHHF)

Physical and Mental Health History Screening

The Ohio Health History Form (OHHF) is a multi-page (3 to 4 pages) self-reported, history form covering a broad range of physical and mental health issues.

Available from Ohio Department of Mental Health, SOQIC Standardized Electronic Forms, Health History Questionnaire, Form SQ-08-020, <http://www.mh.state.oh.us/what-we-do/promote/solutions-for-ohios-quality-improvement/ms-word-forms.shtml>

Instructions for filling out the form can be obtained at: SOQIC Forms User Manual, Section Four: <http://www.mh.state.oh.us/what-we-do/promote/solutions-for-ohios-quality-improvement/forms-user-manual.shtml>

Public Domain, “Each form is individually licensed so that anyone can use them.”

Depression

BDI-II (Fee Based)

Depression Screening

The Beck Depression Inventory (BDI-II) is a 21-question survey completed by the patient. The primary clinical use of BDI-II is to assess the severity of depressive symptoms in adult and adolescent patients with previously diagnosed depressive illness. It is also used to screen patients who may have depressive illness and who may require intervention. When used as a screening tool, the BDI should be followed up with a diagnostic instrument or a clinical interview. It was developed for adult and adolescent patients. According to Rush, et. al. (2008), the BDI is easy to use, uses simple language, and is easy to score. It takes 5 to 10 minutes to administer. It may take 15 minutes if administered orally. It is intended for use by licensed professionals only. According to Powell (2003), BDI was superior to the Zung when administered to adults with intellectual disability. An adapted administration should be utilized for adults with intellectual disabilities. Questions are read to the subject and bar graphs are used to represent the Likert response choices.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Powell, R. (2003). Psychometric properties of the Beck Depression Inventory and the Zung Self-Rating Depression Scale in adults with mental retardation. *Mental Retardation*, 41, 88-95. Copyrighted, available for sale from: <http://www.psychcorp.com/>,

<http://www.fpnotebook.com/Psych/Exam/BckDprsnInvntry.htm>

CES-D

Measurement of Depressive Symptoms in Community Samples.

The Center for Epidemiological Studies Depression Scale (CES-D) is a 20 item instrument that was developed to measure the symptoms of depression in community populations. The scale has also been used in many studies as a screen for the presence of depressive illness. The instrument takes about 5 minutes to complete. It is self-reported and professionally administered. According to Rush, et. al. (2008), validity studies indicate that it is not specific for depression and is more of a general measure of distress. Studies do not support its use in populations of individuals with undiagnosed conditions without a follow-up interview. Rush implies, but does not say, that the CES-D is intended for adult populations.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub, 506-508.

Copyright: The scale is in the public domain and appears in several publications including the *Handbook of Psychiatric Measures* (2nd ed.).

NOTE: It is recommended that you use, administer, or “score” these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool’s publisher or author.

PHQ-9

Depression Screening

The Patient Health Questionnaire is a 9-item self-administered instrument designed to screen for depression. The administration time is 5 minutes. There are alternative PHQ tools for somatic symptoms, and adolescents. Originally designed for Primary Care Physicians, it is now used in a variety of settings. As with all tools, it is recommended that it be administered by staff with training and supervision in use, scoring, and applicability.

Source: <http://impact-uw.org/tools/phq9.html>

Copyright, Pfizer Inc, 1999.

Anxiety

GAD-7

Screening for Anxiety

The Generalized Anxiety Disorder Scale (GAD-7) is a 7-item self-report questionnaire that has proved practical for use in screening for anxiety in primary care . Research indicates that it is a reliable and valid measure of anxiety in the general population. Data exists that the clinician can use to compare a subject's GAD-7 score with norms for the general population. Information about appropriate age groups for the use of GAD-7 was not found.

Source: Löwe B, Decker O, Müller S, Brähler E, Schellberg D, Herzog W, Herzberg PY., "Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population." *Med Care*. 2008 Mar;46(3):266-74.
<http://www.ncbi.nlm.nih.gov/pubmed/18388841>

Copyright: Pfizer, Inc. 1999

HADS

Screening for Mood Disorders in Medically Ill Patients

The Hospital Anxiety and Depression Scale (HADS) is a 14 item self-report instrument designed to screen for mood disorders in medically ill patients. According to Rush, et. al. (2008), it is appropriate for use in either hospital or community settings. It takes only a few moments to administer and is easy to use. It is appropriate for screening for depressive disorder in non-psychiatric patients. It is likely that it would be useful in primary care settings. Once depression is identified, other measures with more complete coverage should be administered. Use is not indicated for non-medically ill psychiatric patients.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

The HADS is copyrighted and available from nferNelson, www.nfer-nelson.co.uk.

HARS (HAM-A)

Measure of Overall Anxiety

According to Rush, et. al. (2008), the Hamilton Anxiety Rating Scale (HARS) or Hamilton Anxiety Scale (HAM-A) provides an overall measure of global anxiety, including psychic (cognitive) and somatic symptoms. It is clinician administered and consists of 14 items. It takes about 15 to 30 minutes to administer. It can be used to assess the severity of overall anxiety in patients who meet criteria for anxiety or depressive disorders and to monitor treatment outcome. The instrument does not distinguish symptoms of specific anxiety disorder and does not clearly distinguish anxiety from depression. Rush notes that the instrument is valid in both adults and adolescents, but points out that the scale is not valid as a screening tool. The BAI, a brief well-validated self-report questionnaire, also measures anxiety symptoms with minimal use of clinician time.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright: Public Domain

Trauma

CTQ

Screen for History of Abuse and Neglect

The Childhood Trauma Questionnaire (CTQ) is a 28-item self-report inventory designed to screen for a history of childhood or adolescent abuse and neglect. According to the Center for Psychological Studies at Nova Southeastern University, it is appropriate for use with patients 12 and above. It can be administered individually or in a group. It is appropriate for use (a) for rapid abuse-history taking for treatment planning, (b) to encourage disclosure of childhood abuse as part of clinical assessments, and (c) for use in epidemiological and correctional studies involving childhood abuse. It may have utility as a screening tool to identify individuals with a childhood history of abuse and neglect.

Sources: Nova Southeastern University, Center for Psychological Studies,
<http://cps.nova.edu/~cpphelp/CTQ.html>

Bernstein, D. P., Fink, L., Handelsman, L., & Foote, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry*, 151 (8), 1132-1136.

Available from Pearson, PsychCorp,
<http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8102-339&Mode=summary>

Copyright: inquire with Pearson, PsychCorp.

PC-PTSD

Screen for Post-Traumatic Stress Syndrome in Veterans

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen PTSD in veterans at the Veterans Administration. Those screening positive should then be assessed with a structured interview for PTSD.

Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F.D., Sheikh, J. I. (2004). "The primary care PTSD screen (PC-PTSD): development and operating characteristics." *Primary Care Psychiatry*, 9, 9-14.
<http://www.ptsd.va.gov/professional/articles/article-pdf/id26676.pdf>

Available in: Prins, et. al. (2004)

Copyright: Public Domain

PCL-C

Screening for Post-Traumatic Stress Syndrome

According to the scoring guide for the PCL-C provided by the Department of Veterans Affairs, the PTSD Checklist – Civilian Version (PCL-C) is a standardized self-report rating scale for PTSD with 17 items that correspond to the key symptoms of PTSD. The PCL can be modified to fit specific time frames or events. PCL-M is for PTSD caused by military experiences.

Source: http://www.mirecc.va.gov/docs/visn6/3_PCL-C_CheckList_and_Scoring.pdf

Also available from: Weathers, F.W., Huska, J.A., Keane, T.M. PCL-C for DSM-IV. Boston: National Center for PTSD – Behavioral Science Division, 1991.

http://ctc.georgetown.edu/pdf/ptsdchecklistPCL_C.doc

Copyright: Public Domain.

Substance Use

Alcohol Use Disorders Identification Test (AUDIT)

Screening for Alcohol Consumption.

The Alcohol Use Disorders Identification Test (AUDIT), according to Rush, et. al. (2008), is useful for detecting broadly and diversely defined, clinically significant alcohol misuse that has not yet reached levels of harm associated with alcohol dependence. It has 10-item self-reporting self- or clinician administered instrument. It takes 2 to 3 minutes to administer this instrument and takes no training to administer or score. It also has an optional clinical screening module that requires a physical examination and blood test and includes two questions about traumatic injury, 5 findings from the physical exam, and results from the blood test. This module takes about 10 minutes to complete when incorporated into a medical evaluation. Only trained personnel should use this clinical module. Rush notes, that the AUDIT core questionnaire is easy to administer, performs well as a screening instrument and is one of the most widely used alcohol used disorders screening measures used in health care settings. It is useful across a wide range of setting and patient populations, including among those with severe mental illness. It also may flag individuals at an early stage of drinking who have avoided or failed to recognize significant alcohol-related problems, and permit earlier intervention.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright: the core questionnaire is copyrighted, but can be reproduced without permission.

The clinician-administered and self-report versions of the AUDIT are included on the CD-ROM included with the *Handbook of Psychiatric Measures* (2nd ed.).

CAGE-AID

Drug and Alcohol Abuse Screening

The original CAGE instrument screened solely for alcohol abuse, the addition of the phrase “or drug use” to the questions extended it to drug use as well (CAGE-AID). It is a 4-item self-reported and either self- or clinician administered instrument. It takes less than a minute to complete and can be used as a stand-alone tool or within questionnaires that cover health and lifestyle issues. It takes no special training to administer, score, or interpret. Rush, et. al. (2008) notes that the CAGE is one of the most widely used methods to screen for alcohol problems. It works well for detecting harmful lifetime drinking when individuals may have developed more severe alcohol use disorders. It is less useful in distinguishing individuals at an earlier stage of drinking. In addition, the CAGE has been found to perform less well among women, adolescents, and college students, because the severe problems queried by CAGE may be less indicative of problematic drinking in these populations. Rush, et. al. does not assess the value of CAGE-AID.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub, 444-445.

Copyright: Public Domain

National Outcomes Measure Survey (NOMs Survey)

The adult National Outcomes Measures Survey (NOMs) is a 19-item self-reported, self-administered survey asking about current and past use of alcohol, tobacco, cannabis, and other illegal drugs, and about attitudes toward the use of these substances. SAMHSA also has similar 25-item self-reported, self-administered instrument for adolescents age 12-17. The Ohio Department of Alcohol and Drug Addiction Services uses a 39-item self-reported, self-administered survey for children and adolescents 10 to 18+, that asks similar questions. All of the NOMs instruments collect demographic information on the respondents as well as drug and alcohol use and attitude data.

Copyright: Public domain.

Adult and Adolescent NOMs survey forms are available from the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration of the federal government. <https://www.pmrts.samhsa.gov/csams/tools/publictools.aspx?sp=5>

The ODADAS adolescent form is available at [http://www.odadas.state.oh.us/WebManager/UltimateEditorInclude/UserFiles/WebDocuments/Prevention/PA_\(NOMs_Insert\)_7-9-07cjb.pdf](http://www.odadas.state.oh.us/WebManager/UltimateEditorInclude/UserFiles/WebDocuments/Prevention/PA_(NOMs_Insert)_7-9-07cjb.pdf)

OHHF Tobacco Addendum

Initial Assessment

The Tobacco Addendum to the Ohio Health History form is a 15 items self-reporting, self administered instrument for the initial assessment of the level of motivation to quit tobacco use, the impact of tobacco use on the patient's health, and the level of use of alcohol, caffeine, and illicit drugs.

Source: Center for Evidence Based Practices at Case (CEBP)

Copyright: CEBP

Availability: Free use with proper citation of source

SOCRATES 8 A and D

Assessment of Readiness of Alcohol Abusers to Change

The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) is a self-reporting instrument designed to assess readiness for change in alcohol and illicit drug abusers. Administration takes 5 minutes. There are separate 19-item instruments for alcohol and for drugs. According to Rush, et. al. (2008), the SOCRATES 8A is an easy-to-use, reliable, and valid measure of readiness to change alcohol use and seems to work well in adult and adolescent populations. Adult norms are available. It may be useful to clinicians in targeting initial interventions to a patient's level of readiness to change. It also may be useful in measuring change in motivation over time as treatment proceeds and to guide treatment planning further. Rush notes that the clinical utility of the SOCRATES 8D instrument still needs to be established.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright: Public domain.

The instrument, scoring templates, and interpretation guidelines are available without cost from the Center for Alcoholism, Substance abuse, and Addictions (CASAA), University of New Mexico, <http://casaa.unm.edu/inst.html>. SOCRATES for alcohol use is available on the CD-ROM included with the *Handbook of Psychiatric Measures* (2nd ed.).

UNCOPE

The UNCOPE, a 6-item screening tool is used for identifying adults at risk for alcohol and drug abuse and addiction. The items provide a simple and quick means of identifying risk for abuse and dependence for alcohol and other drugs. A score of at least 2 is indicative of abuse; 4 or more is indicative of dependency. It was developed on clinical and corrections populations. UNCOPE was first reported by Hoffmann and colleagues in 1999. The UNCOPE questions are available free of charge for anyone to use.

Source: Hoffmann, N. G., Hunt, D. E., Rhodes, W. M., Riley, K. J. (2003). UNCOPE: A Brief Substance Dependence Screen for Use with Arrestees. *Journal of Drug Issues*, 33 (1), 29-44.

Social Support

Locus IV Subscale

Assessment of the Recovery Environment of Mental Health Patients

The Level of Care Utilization System, Recovery Subscale (LOCUS IV) measures the recovery environment of mental health patients. It is a clinician-completed instrument that rates the environment in two areas – level of stress in the recovery environment and level of support. Each area is broken down into 5 levels ranging from highly positive to highly negative. The 5 levels each have descriptors that may define the environment at that level. It is used to help assess the level of care that mental health patients may need. It is part of the larger 6 subscale LOCUS tools used to measure the level of care needed by mental health patients.

Copyright: American Association of Community Psychiatrists.

Availability: Contact Wesley Sowers, M.D., St. Francis Medical Center, CAS-2 East, 400 45th Street, Pittsburgh, PA, 15201, Phone 412-622-6717, Fax 412-622-6756, email: sowers@sfhs.edu

WMR Social Support Questionnaire

The *WMR Social Support Questionnaire (WMR SSQ)* is a seven item self-report questionnaire. The questionnaire is designed to measure both the quantity and quality of perceived social support. The WMR SSQ is adapted from two existing social support scales: the People in Your Life (PIYL) Scale (Marziali, 1987) and the three-item Social Support Questionnaire (SSQ3) (Sarason, Sarason, Shearin, & Pierce, 1987). The WMR SSQ was developed for the WMR project to evaluate whether participation in WMR increased the number of individuals in the participants' social support networks and level of satisfaction with this support.

Source: Bullock, W., Sage, J., Hupp, D., Ozbey, T., O'Rourke, M., Smith, M. K., Wesp, K., Wilcox, D., Rich, S., Pieples, G., Pesta, Z., Spiegelberg, J., & Garrity, J. From Illness to Wellness: An evaluation of Ohio's Wellness Management and Recovery (WMR) Program in Community Mental Health and Consumer-Operated Services Agencies. *New Research in Mental Health* (2009). Vol. 18, 312-321.

Marziali, E.A. (1987). People in your life: Development of a social support measure for predicting psychotherapy outcome. *The Journal of Nervous and Mental Disease*, 175(6), 327-338.

Sarason, I.G., Sarason, B.R., Shearin, E.N., & Pierce, G.R. (1987). A brief measure of social support: Practical and theoretical implications. *Journal of Social and Personal Relationships*, 4, 497-510.

Copyright: Not copyrighted and can be used freely. Users can obtain a copy of the questionnaire through Ohio Coordinating Center of Excellence for Wellness Management and Recovery. Contact: Kelly Wesp, Program Coordinator, Wellness Management and Recovery, 16 West Long Street, Columbus, Oh 43215.

Child Behavioral Health Outcomes Tools

General

Child and Adolescent Functional Assessment Scale (CAFAS) (Fee Based)

Assessment of Needs for Services

The CAFAS includes 5 scales of the youth's functioning and 2 scales about caregiver resources. According to Rush, et. al. (2008), the five main scales reflect the youth's degree of impairment in the following domains: Role Performance, Thinking, Behavior Toward Others, Moods/Self Harm, and Substance Use. The two caregiver scales reflect the resources and ability to provide for the youth. It reflects the youth's functional status in the present and recent past to match needs with clinical services and to assess outcomes over time. A 2-page measure contains a list of behaviorally-oriented descriptors completed by the clinician. A structured interview is also available for administration by a lay interviewer asking questions of the parent or caregiver. It takes about 10 minutes to rate the 2-page CAFAS. It takes about 30 minutes to administer the structured interview. The scale was designed to rate impairment in children and adolescents referred for mental health services because of emotional, behavioral, substance use, psychiatric, or psychological problems. The CAFAS can be used at intake to link patient needs with available services and at follow-up to assess outcomes for youths with serious emotional issues. It is easily used by case managers and clinicians and is flexible. Rush cautions that the scale "is not specific enough to explore specific areas of dysfunction."

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyrighted, for permissions and to purchase: Kay Hodges, Ph.D., hodges@provide.net.

CFARS: The Children's Functional Assessment Rating Scale

The Children's Functional Assessment Rating Scale (CFARS) (John C. Ward, Jr., Ph.D. & Michael G. Dow, Ph.D., 1994, 1996, 1997, 1998) is a way of documenting and standardizing impressions from clinical evaluations or mental status exams that assess cognitive, social and role functioning.

Information on the scale is available from the author, Dr. John Ward at the University of South Florida. Use of the instrument requires taking a free training for certification. The instrument is free and in the public domain. <http://outcomes.fmhi.usf.edu/cfars.htm>

NOTE: It is recommended that you use, administer, or "score" these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool's publisher or author.

Children's Global Assessment Scale (CGAS)

CGAS is a widely used measure of the overall severity of disturbance in children. It is a unidimensional measure of social and psychiatric functioning for children ages 4-16 years. The CGAS is an adaptation of the Global Assessment of Functioning scale for adults and can be used as an indicator of need for clinical services, a marker for the impact of treatment, or a single index of impairment in epidemiological studies. The CGAS is a single rating scale with a range of scores from 1 to 100, designed primarily to be used by clinicians who are very knowledgeable about a child. The CGAS requires no administration time because it is based on prior clinical assessment. Reliability and validity have been reasonably well established in research settings. There are two versions of CGAS, a clinician and a nonclinician one.

Source: Shaffer D, Gould MS, Brasic J, et al. (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.

Copyright: No permission is required to use the CGAS. The scale is included in the *Archives of General Psychiatry* publication by Shaffer et al. (1983). However, use of training materials is highly recommended.

Contact: David Shaffer, M.D., Department of Child Psychiatry, College of Physicians and Surgeons, Columbia University, 1051 Riverside Drive, New York, NY 10032.

Depression

The Short Mood and Feelings Questionnaire (SMFQ)

A measure of childhood and adolescent depression

The Short Mood and Feelings Questionnaire (SMFQ) is a brief, easy-to-administer, self-report measure of childhood and adolescent depression, designed for the rapid evaluation of core depressive symptomatology. Studies of the SMFQ revealed substantial correlations between the SMFQ, The Children's Depression Inventory (CDI) and the Diagnostic Interview Schedule for Children (DISC) depression scale. The scale consists of 13 questions. Item responses are on a three point scale, where 0=not true, 1=Sometimes true, and 2=True. Use of the MFQ is free and available in the public domain at: <http://devepi.duhs.duke.edu/mfq.html>

Anxiety

Spence Children's Anxiety Scale (SCAS)

Anxiety severity screening tool

The Spence Children's Anxiety Scale (SCAS) assesses severity of anxiety symptoms in children. The scale assesses six domains of anxiety including generalized anxiety, panic/agoraphobia, social phobia, separation anxiety, obsessive compulsive disorder and physical injury fears. It is designed to be relatively easy and quick for children to complete, normally taking only around 10 minutes to answer the questions. The SCAS consists of 44 items; of which 38 reflect specific symptoms of anxiety and 6 relate to positive, filler items to reduce negative response bias. Of the 38 anxiety items, 6 reflect separation anxiety, 6 social phobia, 6 obsessive compulsive problems, 6 panic/3 agoraphobia, 6 generalized anxiety/overanxious symptoms and 5 items concern fears of physical injury. Items are rated on a 4 point scale involving never (0), sometimes (1), often (2), and always (3), the frequency with which they experience each symptom.

The SCAS is free and available in the public domain at:
http://www.scaswebsite.com/index.php?p=1_12

Child Behavioral Health Assessment and Screening Tools

General

CANS-MH

Screening Tool for Child and Adolescent Mental Illness

The Child and Adolescent Needs and Strengths (CANS) tool is a clinician-administered 6 domain instrument with a total of 45 questions. According to the California Evidence-Based Clearinghouse for Child Welfare, “the CANS-MH is a comprehensive assessment of psychological and social factors for use in treatment planning. Domains assessed include general symptomatology, risk behaviors, developmental functioning, personal/interpersonal functioning, and family functioning. The CANS-MH is intended to support case planning and evaluation of service systems.” The target population is children and adolescents with mental, emotional, or behavioral problems. It should be completed by mental health professionals. The publisher requires training and certification for users. It takes about 10 minutes to administer.

Source: The California Evidence-Based Clearinghouse for Child Welfare, Screening and Assessment Tools for Child Welfare: Child and Adolescent Needs and Strengths-Mental Health (CANS-MH), <http://www.cachildwelfareclearinghouse.org/assmt-cansmh>

Availability: The measure can be obtained free of charge from the [Praed Foundation](http://www.praedfoundation.org) but training and certification are required by the publisher, Praed Foundation, to use it, www.praedfoudnation.org

CASII: Child and Adolescent Service Intensity Instrument (Fee Based)

The CASII was developed by American Academy of Child and Adolescent Psychiatry’s (AACAP) Work Group on Community Systems of Care. The CASII is formerly called CALOCUS and it is a tool to determine the appropriate level of care placement for a child or adolescent. The instrument links a clinical assessment with standardized "levels of care" and has a method for matching the two. The method consists of quantifying the clinical severity and service needs on six dimensions (eight ratings) that are standardized using anchor points. The CASII can be used by a broad range of users with any child/adolescent in any setting regardless of diagnosis or the system with which the child is involved. According to AACAP, the instrument also considers three distinct types of disorders: psychiatric disorders, substance use disorders, or developmental disorders (including autism and mental retardation), and has the ability to integrate these as overlapping clinical issues. Once the dimensional ratings are done, the scores are combined to generate a level of care recommendation. The AACAP has developed a training manual for the CASII and strongly encourages training on the instrument.

Contact: For more information about the CASII or to arrange a training, please call or email Adriano Boccanelli at 202-966-7300, ext 133, aboccanelli@aacap.org.

Copyright: The CASII is copyrighted by American Academy of Child and Adolescent Psychiatry and can be obtained for a small fee on the AACAP’s website:

http://www.aacap.org/cs/root/member_information/practice_information/casii

CBCL (Fee Based)

Screenings for Child and Adolescent Competencies and Behavioral/Emotional Problems

According to the publisher, the Child Behavior Checklist for Ages 6-18 (CBCL/6-18) obtains reports from parents, other close relatives, and/or guardians regarding children's competencies and behavioral/emotional problems. Parents provide information for 20 competence items covering their child's activities, social relations, and school performance. The CBCL/6-18 has 118 items that describe specific behavioral and emotional problems, plus two open-ended items for reporting additional problems." There is also a Child Behavior Checklist for 1½ to 5 year olds.

Source: Achenbach System of Empirically Based Assessment, "Child Behavior Checklist for Ages 6-18 (CBCL/6-18)," <http://www.aseba.org/products/cbcl6-18.html>

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CIS

Screening for Impairment

According to Rush, et. al. (2008), The Columbia Impairment Scale (CIS) is "a global measure of impairment of children that taps four major dimensions: interpersonal relations, psychopathology, job or schoolwork, and use of leisure time. It was developed to assess global impairment in community samples using lay interviewers. It also has potential for monitoring outcomes in clinical settings." It is a 13-item lay-administered structured questionnaire. There are 2 versions, one for the child and the other for the parent or caregiver. They take less than 5 minutes to administer. Rush notes that the instrument is a "potentially useful measure of impairment at entry into mental health care and at follow-up." It also may be "useful for children with relatively chronic medical conditions that include physical or mental limitations. The brevity and ease of administration of the CIS and the acceptability of its items facilitate incorporation of the CIS into either pediatric or psychiatric practice settings." Rush cautions that the CIS has not been tested for sensitivity to change after therapeutic intervention or differentiation among specific disorders. The CIS would benefit from further testing with multiple administrations over time to determine its usefulness as a measure of change in functioning.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

Copyright: No permission required.

Available from Hector R. Bird, M.D., Department of Child Psychiatry, New York State Psychiatric Institute, 1051 Riverside Dr. New York, NY, 10032, 212-543-2591.

NOTE: It is recommended that you use, administer, or "score" these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool's publisher or author.

Teen Screen

Initiative to Include Adolescent Mental Health Screening in a Variety of Youth Serving Institutions

Teen Screen National Center for Mental Health Checkups is an initiative of Columbia University, which, according to its brochure, is “working to increase youth access to regular mental health checkups and the early identification of mental illness. TeenScreen Schools and Communities is the National Center’s flagship program, offering mental health checkups to youth through more than 500 local sites in 43 U.S. states. TeenScreen Primary Care is working to make mental health checkups a routine part of adolescent health care through partnerships with providers in many communities. The National Center serves as a resource and ally for advocates and partners from the public and private sectors, non-profits and academic institutions.” Its goal is the early detection of mental disorders through the use of mental health checkups in adolescent health care, schools, and other youth serving settings.

Source: TeenScreen National Center for Mental Health Checkups,
<http://www.teenscreen.org/images/national%20center%20brochure.pdf>

Copyright: National Center for Mental Health Checkups at Columbia University.

Providers can sign up to receive free implementation materials at the following website:
<http://www.teenscreen.org/teenscreen-primary-care>

Anxiety

Screen for Child Anxiety Related Disorders (SCARED)

Anxiety Screening Tool

Screen for Child Anxiety Related Disorders (SCARED): The Screen for Child Anxiety Related Disorders was developed to assess anxiety symptoms in line with the dimensions of anxiety disorders in the DSM-IV. The scale assesses six domains of anxiety including generalized anxiety disorder, panic, social anxiety disorder, significant school avoidance, and separation anxiety disorder. A total score of equal to or greater than 25 indicates that presence of anxiety disorder. The measure consists of 41 items. Of the 41 items, 9 reflect generalized anxiety, 7 social anxiety, 4 school avoidance, 13 panic, and 8 separation anxiety. Item responses are on a three point scale (0= Not True, 1= Somewhat True, 2=Very True).

Copyright: Public domain. The SCARED is free and available in the public domain at:
<http://www.wpic.pitt.edu/research/>

Trauma

CANS Trauma

Assessment of Trauma in Children and Adolescents

The Trauma Module of the Child and Adolescent Needs and Strengths Scale – Comprehensive is a 17-item clinician administered tool assessing 3 domains: Characteristics of the Traumatic Experience (8 items), If the Child has been Sexually Abused (5 items), and Adjustment (4 items). According to the CANS website: “The CANS is a widely used tool that allows a system to remain focused on the shared vision at all levels of the system.” The website also notes that the CANS is easy to use and that it is aimed at monitoring outcomes and management systems. The items in the scale are matched to definitions “designed to translate easily into action levels” for both needs and strengths.

Source: The Praed Foundation, *About the CANS*,
<http://www.praedfoundation.org/About%20the%20CANS.html>

Copyright: The CANS is an open domain tool that is free to use. The copyright is held by the Praed Foundation in order to maintain its intellectual integrity. Training and certification is required for the use of the CANS.

Trauma Events Screening Inventory (TESI)

Trauma history

The Trauma Events Screening Inventory (TESI) outlines a child’s history of trauma. The TESI asks specific questions about trauma incidence, including: type, number of episodes, and developmental/chronological index (i.e., before age 6, before age 18, age 18 or later, in the past year) The TESI has thirteen questions about direct exposure to witnessing or experiencing illness/treatment, disasters, deaths of significant others by accident, illness, murder, or drivers under the influence of substances, family violence, community violence, and sexual assault or molestation. The scale consists of 13 items to which a respondent answers “Yes” or “No”. If the respondent answers yes, they are asked to elaborate regarding the specifics about the trauma (Child).

Copyright: The instrument is free and available to the public at:
http://stage.web.fordham.edu/images/academics/graduate_schools/gsss/catm%20-%20history%20of%20trauma%203.pdf

TSCC

Screening for Post-Traumatic Symptoms in Children and Adolescents.

The Trauma Symptom Checklist for Children (TSCC), according to John Briere, <http://www.johnbriere.com/tscc.htm>,

“evaluates posttraumatic symptomatology in children and adolescents (ages 8 to 16, with normative adjustments for 17 year-olds), including the effects of child abuse (sexual, physical, and psychological) and neglect, other interpersonal violence, witnessing trauma to others, major accidents, and disasters. The scale measures not only posttraumatic stress, but also other symptom clusters found in some traumatized children.”

Its 6 clinical scales include anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger. Briere notes that the TSCC is appropriate for children 8 years and older. It requires 10-20 minutes to complete for “all but the most traumatized or clinically impaired children, and can be scored and profiled in approximately 10 minutes.” There is a 44-item Alternate version of the TSCC (the TSCC-A) that does not contain Sexual Concerns items, for use in circumstances where sexual item content must be avoided. Briere also notes that research has shown it to be reliable and valid. “The validity scales appear to be useful, especially in identifying underreporting in traumatized children.” Normative data is available based on a population of greater than 3,000 nonclinical children across the United States.”

Source: Dr. John Briere, <http://www.johnbriere.com/tscc.htm>.

COPYRIGHT: Psychological Assessment Resources <http://www.parinc.com/>

Available from Psychological Assessment Resources <http://www.parinc.com/>.

UCLA PTSD Reaction Index

Childhood PTSD Screening Tool

The UCLA PTSD Reaction Index (RI) assesses childhood PTSD symptoms. The RI is a 22-item self-report instrument scored on a 1-5 point Likert scale with cutoff scores established for mild, moderate, severe, and very severe PTSD. Correlation with DSM-IV PTSD diagnosis was found to be .90 while inter-rater reliability was .87. The RI is commonly used assessment tool.

Copyright: National Center for Child Traumatic Stress, University of California at Los Angeles.

The instrument is free and available to the public at:

http://stage.web.fordham.edu/images/academics/graduate_schools/gsss/catm%20-%20exposure%20&%20symptom%20measures.pdf

Contact: Robert S. Pynoos, National Center for Child Traumatic Stress, 11150 W. Olympic Blvd., Suite 770, Los Angeles, CA 90064, 310-235-2633
rpynoos@mednet.ucla.edu

NOTE: It is recommended that you use, administer, or “score” these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool’s publisher or author.

Substance Use

Alcohol Expectancy Questionnaire-Adolescent Form (AEQ-A)

The AEQ-A is a 100-item, self-administered questionnaire. The questionnaire consists of seven subscales. The target population is adolescents and young adults ages 12 to 19. Time required for administration is 10 to 15 minutes. No training is required for administration.

Copyright: The AEQ-A is copyrighted, free of charge and may be obtained through request in writing to the authors: Mark S. Goldman, Ph.D., Department of Psychology, BEH 339, University of South Florida, Tampa Florida 33620-8200 and Sandra A. Brown, Ph.D., 9500 Gilman Drive (0109) San Diego, CA 92093-0109.

CRAFFT (Adolescent Substance Abuse Screening Tool)

The CRAFFT is a behavioral health screening tool for use with children under the age of 21. It is recommended for use with adolescents by the American Academy of Pediatrics' Committee on Substance Abuse. The name, CRAFFT, is an acronym for key components in the questions: Car, Relax, Alone, Forget, Friends, Trouble. This tool is use for youth 14 and up. There is one form, consisting of six questions about behaviors relating to alcohol and drug use. The tool is usually self-administered by the youth, but could also be conducted as an interview. It takes less than five minutes to complete and a brief time for staff to score. The response categories are either "Yes" or "No" . "Yes" responses to two or more questions indicate that the youth is at risk. This tool is free and available online.

A pocket card with the CRAFFT questions is available for clinical use at: <http://www.ceasar-boston.org/about/CRAFFT%20Card%20Request%20Form.pdf>. All cards are printed on a bright red, laminated 4"x 5" card.

To request other translations, call the Center for Adolescent Substance Abuse Research (CeASAR) at 617-355-5433 or write to ceasar@childrens.harvard.edu

GAIN-Short Screener

Screening for Common Psychological, Behavioral, and Personal Problems

The Global Assessment of Individual Needs-Short Screener (GAIN-SS) is a self-reported 7-item scale that screens for common psychological, behavioral, and personal problems. According to the GAIN website, THE GAIN, “is a progressive and integrated series of measures designed to support a number of treatment practices, including initial screenings; brief interventions; referrals; standardized clinical assessments for diagnosis, placement, and treatment planning; monitoring of changes in clinical status, service utilization, and costs to society; and subgroup- and program-level needs assessment and evaluation.” The GAIN-SS manual states, “The 5-minute GAIN Short Screener (GAIN-SS) is designed primarily for three things. First, it serves as a screener in general populations to quickly and accurately identify clients (also known as patients, respondents, or research participants) whom the full 1.5 to 2-hour GAIN–Initial would identify as having one or more behavioral health disorders (e.g., internalizing or externalizing psychiatric disorders, substance use disorders, or crime or violence problems), which suggests the need for referral to some part of the behavioral health treatment system. Second, estimates of need from the GAIN-SS can be used as a common metric across multiple systems or remote staff (e.g., employee assistance program with multiple contractors) and as a denominator for quality assurance on the extent to which the rate of diagnoses/referrals are consistent with the estimated mix of problems from the GAIN-SS. Such measures of quality assurance can be used for one-on-one supervision or performance-based contracting. Third, it serves as a periodic measure of behavioral health change over time.”

Source: Chestnut Health Systems, Lighthouse Institute: Research and Training Division, GAIN Coordinating Center, <http://www.gaincc.org/>.

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Availability: Chestnut Health Systems, <http://www.chestnut.org/>

Physical Health Outcomes Tools

General

Maine MHSIP

Physical Health Questions in Survey of Mental Health Consumers

Maine recently added 7 physical health items to its Mental Health Consumer Satisfaction Survey. It drew these items from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) telephone survey that tracks health conditions and risk behaviors in the United States. Maine did this as part of its participation in the Mental Health Statistics Improvement Program. A number of states have followed Maine's lead. The MHSIP Survey itself is a 28 item self-reported consumer survey that can be self or interviewer administered.

Sources: Parks, J., Radke, A. Q., Mazade, N. A., & Mauer, B. (2008). *Measurement of Health Status for People with Serious Mental Illness*. Alexandria, VA: National Association of State Mental Health Program Directors.

http://www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf

Clinical Values

BMI: Weight/Height

Body Mass Index

Body Mass Index (BMI) is determined as follows: $\text{Weight in pounds} \div \text{Height in inches squared} \times 703 = \text{BMI}$

Adults:

BMI	Weight Status
Below 18.5	Underweight
18.5—24.9	Normal
25.0—29.9	Overweight
30.0 and Above	Obese

Children:

NOTE: It is recommended that you use, administer, or “score” these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool's publisher or author.

The calculations for children are the same, but assigning weight status depends on where they fall in the percentile range for children of their own age.

Weight Status Category	Percentile Range
Underweight	Less than the 5th percentile
Healthy weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	Equal to or greater than the 95th percentile

Source: Centers for Disease Control and Prevention,
<http://www.cdc.gov/healthyweight/assessing/bmi/index.html>

Hypertension/Blood Pressure

Classification of Blood Pressure (BP)*

Category	SBP mmHg	DBP mmHg
Normal	<120	<80
Pre-hypertension	120–139	80–89
Hypertension, Stage 1	140–159	90–99
Hypertension, Stage 2	≥160	≥100

Source: Joint National Committee on Prevention, D., Evaluation, and Treatment of High Blood Pressure., (2003). *Reference Card from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)* (No. NIH Publication No.03-5231). [Bethesda, MD]: U.S. Department of Health and Human Services, National Institutes of Health.
<http://www.nhlbi.nih.gov/guidelines/hypertension/phycard.pdf>

Blood Glucose/HgA1C

An HbA1c of 6% or less is normal. Those with diabetes, should try to keep their HbA1c level at or below 7%.

Source: Medline Plus Encyclopedia, “HbA1c,”
<http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm>

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Cholesterol/Lipid Profile

The total cholesterol values listed below are used to target therapy:

Desirable: Under 200 milligrams per deciliter (mg/dL)

Borderline high: 200 to 239 mg/dL

High risk: 240 mg/dL and higher

Lipid Profile – Normal Results:

LDL: 70 - 130 mg/dL (lower numbers are desired)

HDL: greater than 40 - 60 mg/dL (higher numbers are desired)

Total cholesterol: less than 200 mg/dL (lower numbers are desired)

Triglycerides: 10 - 150 mg/dL (lower numbers are desired)

VLDL: 2 - 38 mg/dL

Sources:

Medline Plus Encyclopedia, “Cholesterol Test,”
<http://www.nlm.nih.gov/medlineplus/ency/article/003492.htm>

Medline Plus Encyclopedia, “Coronary Risk Profile,”
<http://www.nlm.nih.gov/medlineplus/ency/article/003491.htm>

Other Outcome Measures

Primary Care Provider

Current Primary Care Provider

Physical Exam Within Last 12 Months

Current access and utilization of Primary Care

Physical Health Assessment and Screening Tools

General

SF-36/12/8

Assessment of Perceived Health Status

According to Rush, et. al. (2008), SF-36 is one of nine versions that assess perceived physical and mental health status and that range in length from 12 to 56 items taking from 2 to 14 minutes to complete as self-report forms. All versions can also be administered through a telephone or staff interview. Across a range of clinical and research settings the various SF questionnaires yield self-reports of behavioral functioning and perceived psychological well-being independent of age, disease, or specific treatment. Choice of length is determined by the trade-off between instrument length (and time) and measurement precision. SF-12 for example has 7 subscales and takes only 2 minutes to complete. The SF-36 assesses health concepts that represent basic human values relevant to general functional status and well-being and thus has the potential to serve an important function in everyday medical practice. Rush notes that extensive normative data is available for the general population of the U.S. and across various demographic subgroups.

Source: Rush, A. J., First, M. B., Blacker, D., & American Psychiatric Association. Task Force for the Handbook of Psychiatric Measures. (2008). *Handbook of Psychiatric Measures* (2nd ed.). Washington, DC: American Psychiatric Pub.

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NOTE: It is recommended that you use, administer, or “score” these tools within the scope of practice and receive appropriate training. It is also advised that you receive permission to use each tool from the tool’s publisher or author.

History

Ohio Health History Form (OHHF)

Physical and Mental Health History Screening

The Ohio Health History Form (OHHF) is a multi-page (3 to 4 pages) self-reported, history form covering a broad range of physical and mental health issues.

Available from Ohio Department of Mental Health, SOQIC Standardized Electronic Forms, Health History Questionnaire, Form SQ-08-020, <http://www.mh.state.oh.us/what-we-do/promote/solutions-for-ohios-quality-improvement/ms-word-forms.shtml>

Instructions for filling out the form can be obtained at: SOQIC Forms User Manual, Section Four: <http://www.mh.state.oh.us/what-we-do/promote/solutions-for-ohios-quality-improvement/forms-user-manual.shtml>

Copyright: Public Domain, “Each form is individually licensed so that anyone can use them.”

The Ohio Health History Form: History/screening for:

Personal and/or Family History of :

- Diabetes
- Hypertension
- Cardiovascular Disease
- Substance Use
- Tobacco Use

Medical Record

Current medication list

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