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National nstitute for
Mental Health in England

OUTCOMES COMPENDIUM

helping you select the right tools for best mental health care practice in your field

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The role of the clinical practice group, chaired by Albert Persaud and Simon Pearson, has been pivotal in the development of the compendium.[1] The work was undertaken by Professor Kamaldeep Bhui and Drs Bernadette Khoshaba and Sokratis Dinos, under the guidance of the practice group, and with the input of key consultees including the Royal College of Psychiatrists, Royal College of Nursing, and the British Psychological Society. The work would not have been possible without the active support and generous comments of the practice group and consultees. The practice group included national and international experts and practitioners, service providers, carers and partner organisations. By using the findings of a literature review, the practice group identified the final shortlist of tools that are included in the compendium on the basis that these are acceptable and useful as a starting point.

1 *The opinion received from Central Office for Research Ethics Committees (COREC) deemed this work to be service/therapy evaluation and should not be managed as research, therefore not requiring ethical review by a NHS Research Ethics Committee or approval from the NHS R&D office, but in the work of the practice group, participating trusts should manage ethical issues within their ethical governance framework*

FOREWORD

There are many reasons for measuring outcomes routinely in the provision of mental health care. Drivers such as System Reform, Lord Darzi's report "High Quality Care for All" and service development provide clear stimuli and direction. But perhaps the most important reason is that it is the right thing to do in order to provide good treatment and care which can continually improve. Reflective practice requires us to get better at measuring the things that matter so that progress for individuals who use services (as well as the service provision itself) can be properly understood.

However, it is well recognised that implementing outcome measurement into regular practice can be a difficult process. A process arguably made more difficult by the growing number of instruments that have been developed which can lead some people to feel overwhelmed and uncertain where to start. Internet searching may make finding a tool an easier process, but often the right supporting information is more difficult to access or interpret. This is where we hope this document will help.

The Outcomes Compendium has been developed to provide information on many available measurement tools, their properties and their use. Compiled by a team led by Professor Kamaldeep Bhui (with the support of an expert practice group) it is a resource which can help clinicians and their teams determine which of the widely available instruments best meet the needs of their service users.

It is not intended to be an exhaustive or "recommended" list. There may well be instruments that do not appear here which some may favour or choose. But the intention is that this will provide a helpful starting point in outcome measurement for many teams and services as they try to understand and improve what they do.

I hope it succeeds in this aim and helps keep mental health provision in this country at the forefront of service improvement. But future success will depend on adapting over time and our intention is to ensure that this resource evolves in accordance with technical and practice developments as well as learning from the experience of those who use it.

Dr Hugh Griffiths

Deputy National Director for Mental Health, Department of Health

BACKGROUND

INTRODUCTION

The full evaluation of an individual's mental health status or the effectiveness of services requires the measurement of a wide array of social, clinical and economic variables including those measuring function and emotional well being and quality of life (Tansella 2001).

Defining mental health and measuring mental health outcomes has been the focus of academics and mental health professionals from a number of disciplines from psychiatry and psychology to anthropology and sociology. The drive for the development of valid mental health measures has been for diagnostic assessment in the absence of pathological and organic tests of mental disorder.

There will always be a debate over how to best measure health and well being, especially when such measurements can be used to sanction specific treatments, ration others, and assess performance of services and benefits of public spend. Mental health is measured not only with instruments that gauge symptoms and assign diagnoses, but also by quality of life, social functioning and social inclusion, and self-reported perceptions of health status and recovery from illness.

These more general measures of well being and functioning are complementary to biological measures of health status, and symptom and diagnostic measures that have been used conventionally. States of health and well being may be influenced by social contact, inclusion, and by psychological and pharmacological interventions.

In medical practice, especially for the treatment of physical illnesses, the 'biomedical' model emphasises measures of disease presence and progress, often using biological, physiological and clinician rated outcomes. In mental health care, such physiological measures are not found, and so assessment of complaints, speech, symptoms, and 'clinical phenomena' are the foundations of assessing the presence or absence of mental illness.

Measures of quality of life are popular in mental health settings as indeed are measures of recovery. Quality of life as a measure of outcome redirects attention towards consideration of the impact of the condition and its treatment on an individual's emotional, social and physical functioning and lifestyle. More recently, mental health service users assert the need for recovery measures which sustain optimism but also assign greater importance to self reported states of health and well being. Although these do not always map onto professional notions of illness, service users have consistently proposed that such measures warrant greater attention in care delivery than more conventional and professionally accepted ones.

Generally, 'outcome' is a term often used to mean the positive changes, benefits, learning or other effects that result from the work that clinicians do. Adopting outcome measurement will help establish which interventions and services are desirable and cost effective. Traditionally, the primary goal of outcome assessment has been to detect clinically important changes in some aspect of an individual's condition.

Thus, there are many views of what represents an appropriate or a useful outcome. Some of these views are professionally driven, or related to the specific service area or illness for which the outcome is designed. Whichever outcomes are adopted their use needs to be demonstrably ethical, and the measures need to show some characteristics that make the information they yield of relevance and value in making decisions about health care. The measures should usually be reliable (adequate for achieving measurement objective), valid, (achieving measurement objective) and sensitive to change whether at two different time points or during the course of an illness or recovery process. In the development of the compendium, it was evident that these properties are not always as highly valued by clinicians and service users compared with researchers and academics.

All stakeholders agree that measuring outcomes is useful, especially where services offer complex interventions including social, psychological, and pharmacological components. These are often delivered through newly formed and innovative teams that improve early access to interventions for psychosis, engagement with services, and the delivery of psychological treatments. There are many ways in which outcome information can inform care practices and there are many different types of measurement tools to assess clinical symptom improvement rather than recovery. The variety of tools and methods of using instruments, and the contrasts between the priorities of different stakeholders makes it difficult for policy makers, clinicians, and service users to agree on a single set of instruments that might be recommended for routine use.

The establishment of electronic clinical records and the aspiration to ensure outcomes are to be found in electronic service user records mandates a process to identify a set of measurement tools that are widely accepted as being useful, reliable, valid, and that lend themselves to routine use without the restrictions of copyright, training and cost issues.

This publication presents a compendium of outcome measures that can be used across mental health services. The compendium provides a basket of candidate instruments with their advantages and disadvantages clearly laid out so that stakeholders can make an informed choice in their early encounters with outcome measurement and its implementation.

THE OBJECTIVES

This compendium is primarily designed for clinicians engaged in service delivery and development, who wish to gauge clinical effectiveness and recovery, in a balanced, culturally appropriate, ethical and respectful manner. It is designed for clinicians who perhaps are not expert in the area of outcome measurement, and who wish to be guided about the scope of instruments, and find out which instruments might be appropriate for particular forms of outcome measurement. The compendium is also aimed at service users who might want to learn about different measures, and their properties, advantages and disadvantages.

The compendium does not attempt to include all instruments for all disease areas or for any specific disease area, or for all domains of activity. It is not disease specific but includes instruments selected by a process of balancing clinicians', service users', service providers' and researchers' desired requirements of outcome measures. Therefore, the identified outcome measures do not comprise a compulsory set of instruments, or an exclusive set of instruments that cannot be bettered by others in specific circumstances. It does not preclude the use of other measures or instruments that are not mentioned. The compendium does not list all instruments ever used, or present a systematic review or list of instruments for all service areas.

The methodology used to develop the compendium identified key instruments across a broad range of service areas and illness specificity, so it should be used to assist those new to outcome measurement to make informed choices based on characteristics that are relevant to their area of work. We hope that it will provide a starting point for most practitioners in the routine use of instruments in outcome measurement.

The compendium provides guidance about the available tools for measuring outcomes routinely in adult mental health services. Adolescent mental health services instruments were not included as these have already identified and established through Child and Adolescent Mental Health Services (CAMHS) Outcome Research Consortium (CORC). Four instruments were identified, namely the Strengths and Difficulties Questionnaire (SDQ), Commission for Health Improvement (CHI) Experience of Service Questionnaire (ESQ), The Children's Global Assessment Scale (CGAS), Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) *http://www.corc.uk.net/* (accessed June 2008). Similarly, the principles and guidance for best practice in managing risk tools have not been included but the Department of Health publication can be viewed by visiting the following link: *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511*

THE CHALLENGES

Each academic discipline has its own ways of carrying out outcome measurement with its own criteria of quality or validity. The same might be said of clinicians, researchers, service users, service developers, Department of Health policy makers and regulators. Each of these stakeholders has a particular emphasis on the sort of outcome sought to fulfil its role and responsibilities. Centrally routine data can be required by commissioners and funding agencies, but routinely collected outcome measures in clinical practice are also now encouraged to assess clinical effectiveness, clinical governance, and the appropriate use of public monies.

There is also a large body of work on developing outcome measures to assess the experience of recovery from illness in terms of a return to functioning and sustained or revitalised identity as a person who has recovered from the impacts of developing and surviving an illness.

Outcome measures are also used to assess public health needs, health-economic benefits and to assist with the allocation of resources, and to secure the efficacy and effectiveness of specific interventions in clinical trials, for example, the management of the risk of violence, self harm, suicide and homicide.

Each of these requirements makes distinct demands on the properties of an outcome measure, its sensitivity to change, its domains of importance, and its application and conceptual basis. The notion of producing a single compendium of outcomes across these diverse areas of activity, and indeed even in the clinical domain where distinct illnesses might be better assessed by 'disease specific measures', is challenging. The challenge is in part to produce a compendium that is used regularly and is accessible rather than a heavily referenced academic text that is not used in services.

There are an enormous number and variety of clinical outcome measures in current use in clinical practice and research, particularly in relation to adult mental health. One study found that in published studies of psychotherapy outcome over a five-year period, 1430 separate measures were used, 851 of these being used only in one study (Froyd, Lambert and Froyd, 1996). In the UK, it has been noted that four recently published trials assessing counselling in primary care did not share a single measure in common (King et al., 2000). How can all this knowledge be made available in practice?

DEPARTMENT OF HEALTH PILOT STUDY

The Department of Health (DH) signalled its commitment to measuring outcomes in the Mental Health National Service Framework. In 2002 DH initiated a pilot of outcome measurement in England *(http://www.outcomemeasures.csip.org.uk/about.html)* testing four instruments in four sites: Health of Nation Outcome Scale (HoNoS), Functional assessment of the Care Environment (FACE), Carers & Users Expectations of Service (CUES) and Manchester Short Assessment of Quality of Life (MANSA) (*See Appendix 1*).

This pilot study attempted to understand the practical issues involved in using routine outcome measurement, identifying challenges and implementation issues. In brief, the impact of the pilot study was difficult to determine in the time allocated to this project. The small amount of data that was generated supported the approach of encouraging practitioners' individual assessments tailored to the clinical issues that required monitoring. Global measures offered little value if used once but over time proved to be more useful. Overall, valuable lessons were learnt about implementation and staff engagement (National Institute for Mental Health in England, 2002). The main points of this report are summarised in *Appendix 1*.

IMPLEMENTING OUTCOME MEASUREMENT INTO SERVICES

Some accounts provided by stakeholders about using outcome measures in their clinical service are detailed in *Appendix 2*.

The accounts reflect not only using outcome measures in relation to best practice, but one in particular highlights the challenges and dilemmas when implementing outcome measurement in practice. Recommendations for some instruments have been listed, irrespective of whether we have scored them highly or included them in the compendium. In addition, comments and recommendations were put forward by practice group members that certain instruments such as the Health of the Nation Outcomes Scales (HoNOS) and the Mental Health Recovery Star should be included as these measures were popular and were being used in assessing outcomes.

Furthermore, routine outcome measures are being proposed to be part of a minimum data set and some practitioners are already being encouraged to use outcomes routinely. For example, the Improving Access to Psychological Therapies (IAPT) programme has an agreed minimum data set (DH, 2007). It also responds to service user's requests for more personalised services based around their individuals needs. The evidence based outcomes framework in IAPT services was agreed a priori. On completion of the early version of the compendium it was reassuring, and a form of face validity, that all of the IAPT instruments were included in the compendium.

METHODS - BUILDING THE COMPENDIUM

AN OVERVIEW

We developed a mixed methods approach to identify outcome measures that are of value in mental health care. Outcome measures are sometimes called instruments or tools, but are usually based on questionnaires, either self completed or administered by a clinician or researchers. The process we undertook to identify a core set of outcome measures to support clinicians in the routine implementation of outcome measurement in the practice included:

- a literature review to identify the most popular and evidenced outcome measures (*see Figure 1*)
- developing a system for scoring these in terms of psychometric properties
- a system for identifying a short list of instruments that were identified to be of clinical value or were recommended by service users, irrespective of their psychometric properties
- a system for consulting experts, identifying key omissions, strengthening the compendium with further recommended outcome measures that did not feature in the literature or the practice group's recommendations. This was done in partnership with the Department of Health practice group.

The compendium includes:

- guidance on selecting an outcome measure suitable for one's own purpose (we recommend compendium users read with care the methods by which we selected the outcome measures to avoid any assumptions about the properties, quality checks, and to avoid copyright violations, and to ensure training requirements are not overlooked)
- an outline of the characteristics that were profiled for each instrument
- guidance on table contents and how they may be used
- summary tables of outcome measures, that provide an easy access method to assess the presence of absence of specific characteristics.

BUILDING THE EVIDENCE BASED COMPENDIUM

The purpose of the compendium is to list the best known and most widely used instruments that might be a valuable starting point, and not to restrict use of more less well known or specialist instruments.

We carried out a literature review to identify key instruments used to measure mental health outcomes. The search strategy was constructed to identify published papers from journal databases on outcome measures in mental health. The detailed methods taken in the literature search and to reduce the large number of identified instruments to a workable and evidence based short list of outcome measures are given in *Appendix 3*.

Short listing outcome measures for inclusion in the compendium

Anyone using an outcome measure will need to be clear about the reasons for collecting outcome measures and which particular aspects of settings or characteristics are of interest. For example, if the purpose is to look at the effectiveness of a service in relation to other similar services, then it will be vital to use an instrument that is being used by other such services and where benchmarking data are available.

If the purpose is to audit particular aspects of a service, then the measure selected will need to address the relevant aspects (e.g. user satisfaction, symptomatic improvement, social integration, quality of life). In other words, the content of the measure needs to be appropriate to the purpose for which data is being collected.

Each user of the compendium will need to ensure there is clarity about their intentions, and which outcomes are to be measured over which time frame, and which types of conditions or symptoms or processes are to be assessed, and for which profile of service users. There is considerable evidence that outcome evaluations may vary significantly between different groups (e.g. users and clinicians; see the discussion of these issues in Lambert and Hill, 1994).

Please refer to *Appendix 3* for details of how the evidence was used and criteria applied in selecting appropriate outcome measures as recommended by Fitzpatrick et al (1998).

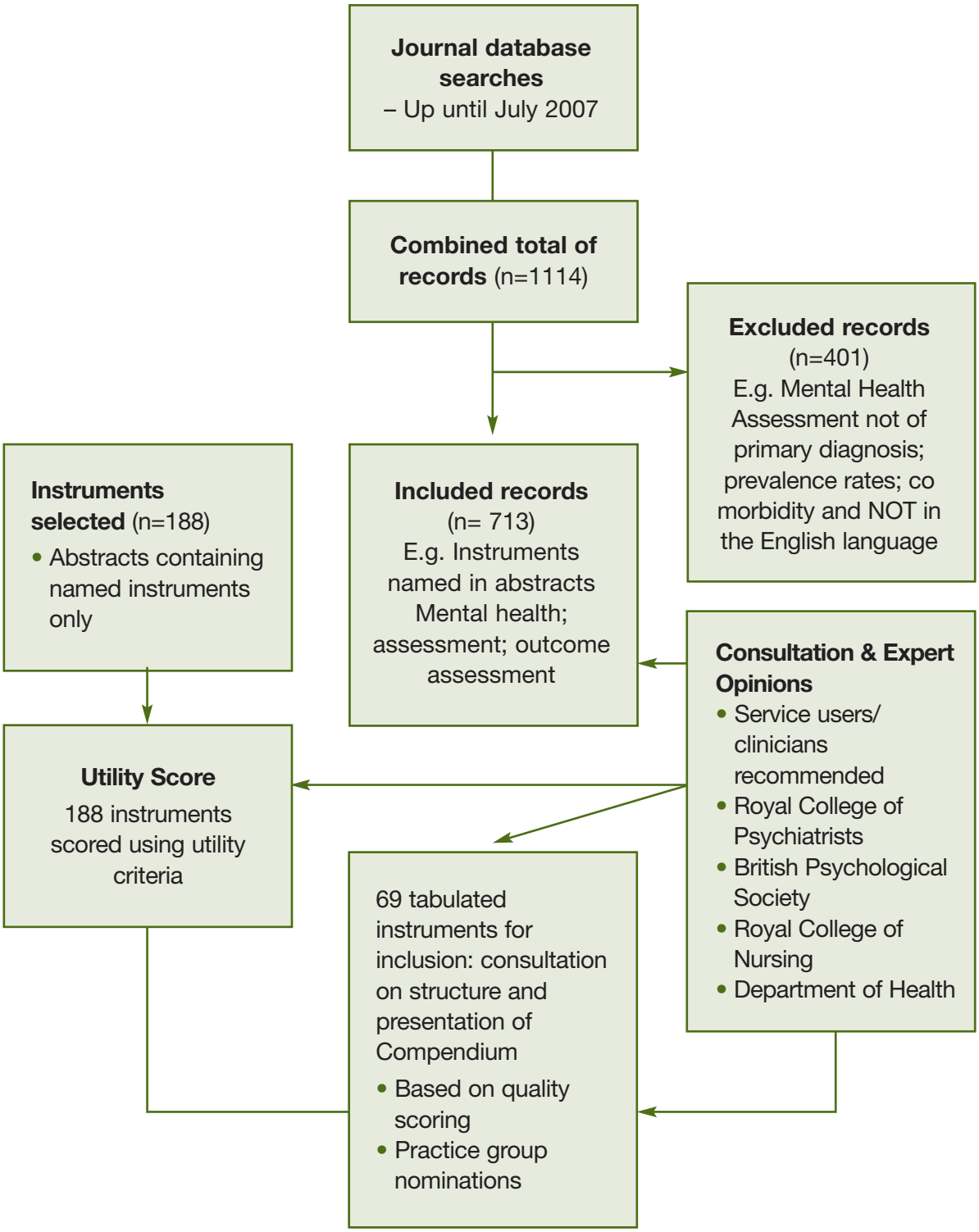
These criteria and the importance and relevance of an outcome measure to stakeholders were used to give a quality score to each outcome measure. This was based on psychometrics, stakeholder priorities, the evidence base and availability of the measure. The quality score was a composition of these characteristics and was assigned a numerical value. This scoring system (*Appendix 3c: Figure 2*), shows the characteristics that were assigned a score and the rules for assigning scores. These final characteristics were established following joint agreement with the outcome practice group members.
This schema was validated by piloting the preliminary scoring system on 15 measures. The stakeholder opinions were not scored but classified as meeting the practice group's requirements as 'of no use', 'some use' or 'very useful' (*third column of Figure 2 in Appendix 3c*).

Selecting outcome measures for the compendium

We identified 188 instruments and scored them on quality. The quality scores for instruments ranged from 0-11 (out of a potential 16 maximum score) and were split into three by using the 33rd and 66th percentiles as thresholds; low (0-1.9); medium (2-7) and high (7.1-11). High quality scores were those with a value of higher than seven. Thus, any instrument scoring higher than 7 was retained as the selected instrument with best quality. On this basis a total of 27 instruments were identified as having the best quality from the original 188 instruments.

Quality scores were not applied in order to select specific instruments from the 37 instruments that had been recommended by the users from the practice group or other stakeholders. From these 37 instruments 17 had been identified in our initial search. Therefore, the user instruments may not necessarily meet the quality score threshold that we have proposed, but their characteristics are presented so that users of the compendium can make informed selections of instruments. A final list of 69 instruments is now included (*see Table 1*). These include instruments we scored highly, instruments recommended by the practice group, and instruments proposed by the Royal Colleges of Psychiatry and Nursing and also the British Psychological Society.

Figure 1 *How we chose literature for the outcome measures review*



RESULTS - THE COMPENDIUM OF OUTCOME MEASURES

The results section reports on the description of the tables included in the compendium. The actual compendium is presented in *appendix 4* (p. 25). This can be used as a stand alone document.

GUIDANCE FOR THE TABULATIONS IN THE COMPENDIUM

This compendium, set out in *appendix 4* (p. 25), contains four main tables of outcome measures that can be recommended on the basis of our quality scoring system or on the basis of recommendation by service users, and providers or other stakeholders.

The compendium offers guidance on the different ways in which the instruments are tabulated to guide users of the compendium. The compendium consists of tabulations of the instruments for easy reference organising the instruments by service settings in which they are used (*Table 1*), and by the characteristics and properties on which we scored them (*Table 2*). These tabulations simplify the descriptions found in the literature and put forward by experts and practice group members, but the tabulations are not intended to restrict the use of the instruments for other conditions, in different service settings, or to prevent innovation in selecting other alternative or additional complementary instruments that are considered appropriate. *Table 3* includes the 69 short listed instruments and represents information in more detail. *Table 4* is an alphabetical listing of all 188 instruments retrieved from our literature search and Practice Group Member nominations, and also shows whether they were recommended by the practice group or on the basis of quality scores.

CONCLUSIONS

A gap exists between theory and empirical research. Pressure to use outcome measures in routine clinical practice is increasing (Department of Health and Aged Care, 1999). However, the majority of mental health professionals do not routinely measure service users' care needs and outcomes in a standardised way (Gilbody, 2002).

Consequently, we need to decide what is to be measured and the agreed concepts need to be defined and translated into observable form. Outcome instruments are the basic tools of health service evaluation and must be designed to suit their purpose. No single system of outcome measurement will ever be able to capture the full complexity of the issues to be addressed but we hope this compendium will be actively used by clinicians and service users to improve benefits to service users and to improve the quality and coherence of our systems of care. Service users and carers should in future be able to influence improvement and further development. As the compendium is a fluid document it will need to be updated at intervals with evidence based practice and case studies, as service practices emerge. The Compendium should be updated on a regular basis so that it becomes an active and up to date resource for mental health outcome measurement.

ACKNOWLEDGEMENTS

Commissioned by NIHME, the Practice Outcome Group's Lead Simon Pearson and Project Manager Margaret Oates both provided excellent support in facilitating requests and discussions and keeping the dialogue going amongst the Practice Group members and ourselves. The Outcomes Practice Group members have pledged their support to the development of the Compendium. Discussions and actions agreed at both of these meetings have been expressed within the Activities and Progress to date section of this interim report.

APPENDICES

APPENDIX ONE

Main points of the Fonagy Report (2002)

This pilot study attempted to understand the practical issues involved in using routine outcome measurement, identifying challenges and implementation issues. Valuable lessons were learnt about implementation and staff engagement as briefly illustrated by the main points below:

Impact of the Outcome Pilot

- pilot site impact; difficult to determine significant long term positive effects
- direct client care choice of outcome measure meant that identifying any measurable impact upon client care was difficult
- care delivery process; as there was a relatively low level of data capture, staff did not reach a competency level which would demonstrate significant time savings
- choice of outcome ,measure; staff considered that the choice of the measure should be based upon whether it is likely or not to be clinically informative, whether it would inform clinical audit and whether the effort needed to collect the model was proportionate to the benefit derived, either at an individual service user or service perspective

Implementation – staff identified twelve main themes that must be addressed and employed to promote compliance. These were:

- the role of key decision makers
- costs with outcome measurement
  – timescales
  – training
- IT systems and infrastructure
- cultural issues
- perceived benefits
  – developing local protocols for implementation
  – service user/carer issues
  – engaging staff.

APPENDIX TWO

Detailed accounts provided by stakeholders using outcome measures in their clinical service

Overview of outcome measures implementation in practice

Repeated outcome measurement will give a picture of how a particular service user's condition is improving over time. As a consequence, the tool or tools must be used at the entry into the service at repeated intervals during the service delivery, and at exit from the service.

By their nature, assessment tools will probably be filled in by care co-ordinators but the findings of the tools will have to be fed back to the team in detail, and especially to the responsible lead clinician, so that the findings become an important part of the clinical decision making in the team. So training of appropriate staff, indeed of whole teams, will be necessary for the implementation of outcome measurement in services.

In some cases, the outcome measurement tools will in a sense dictate what the service shall attempt to accomplish and how the service must be structured. For example, the adoption of Comprehensive Assessment of at Risk Mental States (CAARMS) by a team which is attempting to detect psychosis early will mean that the team must check for all the parameters listed in this tool at such intervals while the service user is using services. Hence, organisations such as the Health Care Commission and the Independent regulator of NHS Foundation Trusts (MONITOR) insist in their checks of trusts that appropriate use of outcome measurements is being practiced and that an adequate resource of manpower within the teams is in place so that the outcome measurement can be carried out effectively.

Finally, and most importantly, outcome measurement must be seen as a key element in the functioning of services, and the measures must be seen as a central part of the work of services, informing decision making about the care of individual services and the functioning and design of the services themselves.

Mark Agius *Luton and Bedford Trust & Member of Outcomes Practice Group*

Instruments used in practice at the Acorn Therapy Unit

A review of services in the Southampton Older People's Mental Health (OPMH) service in 2005 led to the amalgamation of day hospitals into one smaller unit. The clinicians planning the new operation decided to turn a threat into a major opportunity for creative change.

They started by agreeing core principles for the new operation: every decision about change would have to satisfy these core principles. Two of the most prominent principles were the need for evidence and the need for outcome measurement. As far as possible, every treatment programme would be based on the best evidence available for efficacy. Every user's response to the treatment would be judged by a number of baseline and outcome measures.

Since there is clear evidence supporting cognitive behavioural therapy (CBT) for functional mental illness, CBT group therapy is offered to people for a range of difficulties for three days per week. They routinely measure outcomes using the Beck Anxiety and Depression Inventories, as well as the Geriatric Depression Scale.

Service users who need enhanced longer term treatment receive the Clinical Outcomes in Routine Evaluation (CORE) and Hospital Anxiety & Depression Scale (HADS) are used. Service users with dementia are offered treatment two days per week. Cognitive Stimulation Therapy, as recommended by the National Institute for Health and Clinical Excellence (NICE) is a standard feature. Adapted CBT for anxiety and depression in dementia are also offered. Routine outcome measures include the HADS, Zarit Burden Interview, Quality of Life in Alzheimer's Dementia (Qol AD) measure and the Barthel Activities of Daily Living Index.

In addition to this core treatment programme based on best evidence, the unit has also introduced highly innovative programmes where evidence is still evolving. For example, they offer dementia psycho-education groups for carers simultaneously with a parallel group for care receivers. They want to ensure that patients have seamless access to all forms of advice and treatment for dementia, so they are setting up shared processes with the local memory clinic and this will include shared baseline and outcome measures.

They are also supporting partner organisations, for example by offering a regular programme of training to day centre staff. Because they believe that 360 degree feedback is useful not only for clinicians, or units like this as a whole, they have installed a rolling programme of surveys capturing the views of users, their carers and also those of clinicians referring to the unit. The unit also publishes aggregated service user outcomes (objective measures), as well as survey results (subjective measures), in its annual report. They believe in being fully transparent in their operation, and fully accountable for their results

Barbara Rothwell and Paul Hopper, *Hampshire Partnership NHS Trust, Acorn Therapy Unit, Southampton*

Using Clinical Outcomes in Routine Evaluation (CORE 10)

We have used the Clinical Outcomes in Routine Evaluation (CORE 10) since its inception and find it to be a robust and useful tool for a number of reasons. Its brevity allows it to be used as a repeated measure, in a way that is not really possible with the 34 item OM. The incorporation of the measure into the CORE-Net system facilitates this regular or even session by session measurement, tracking progress in a way that has never before been practical. We have found that our awareness of a user's progress or lack of progress is heightened, and thus we can begin to alter what we offer in response to this emerging information. For example if someone makes significant changes in their general level of psychological distress in a short number of sessions, we might reflect on this and agree with the user that we have achieved our task ahead of time and end the work. On the other hand we might notice that things are not changing as we expected and refocus the work or extend contact to deal with the issues behind this pattern. Overall I think that the use of the CORE-10 in this way contributes to an improvement in the overall quality of the service offered as we become more responsive to what the user is telling us. This finding is of course in line with Mike Lambert and colleagues work using a similar process. Managerially, CORE-10 is helpful in that it provides a screening for severity and risk. By regular measurement throughout the therapy we have a greater percentage of second measures, and can thus have greater confidence that our outcome data reflects performance.

Dr Geoff Mothersole, *Consultant Counselling Psychologist Professional Lead for Primary Care Mental Health, Sussex Partnership NHS Trust*

Mental Health Recovery Star

The following individual case study exemplifies the positive change resulting from using the Recovery Star.

'Before using the Star the help I received from the project was very responsive. If I was in crisis the staff would give me support and that was great, but when I wasn't in a crisis I was left alone. Because I was calm and settled, I didn't attract their attention but in fact a lot of the time I was very low. The Star made a massive difference to me because it showed me that there were things I could do to become the person I wanted to be – a more rounded person with a more rounded star. I had written myself off – I saw myself as a dead man walking, someone going nowhere. But the Star showed me that there were things that I could do and goals I could achieve. When you are ill the thought that you can be well seems very daunting but the Star breaks it down into baby steps and you start to feel: Yes, I can do this. That really built my confidence and gave me hope. The language is very plain and simple – there was no medical jargon for me to get my head around. Because it is so visual I could see where I was and where I was going which you just can't do with a traditional support plan. And whereas before it had felt like the

key-worker was telling me what to do, this felt like a joint process. For the first time it felt like they were seeing me as a person rather than as a problem and that really built my confidence. Now I am working as a support worker in a drop-in centre for people with mental health problems and we are about to start using the Star. Because the Star helped me so much I am really looking forward to using it with the service users here. In the role of key-worker it will help me to feel more professional in my work. It will bring a focus and direction to the conversations that I have and I will feel that I am taking part in someone's recovery rather than just keeping them calm and out of trouble. To any key-worker who is about to use the Star I would say it's great. The language is straightforward, it will help you build a better relationship with your service users and you will see tangible improvements for them. To any service user who might have the chance to use the Star I would say – go for it. It can change your life and make you realise that there is a world out there and you can be part of it.'

Judy Weleminsky – *Chief Executive Mental Health Providers Forum*
Sara Burns – *Triangle Consulting*

IAPT Pathfinder case study

The collection of sessional outcome data including clinical measures for depression (PHQ9) and anxiety (GAD7) is a defining characteristic for IAPT stepped care services. Throughout the Demonstration and Pathfinder programmes clinicians and services have shown it is important that patient outcome data is available in real time to support interventions, monitor progress, and feedback to patients.

Clinicians also use this outcome data to monitor caseloads for their professional development and clinical supervision. Systems can also be designed to flag areas of risk or concern based on clinical scores and session attendance.

The following provides a case study from an IAPT Pathfinder services

"RC was referred to the service for moderate depression and poor stress management. RC was experiencing pressure from work due to organisational restructuring and potential redundancy. He reported low mood and anxiety, and this was having a negative impact on his home life. He had noticed that he had become particularly sensitive to criticism at work, but also with his family. At assessment, RC scored 8 on the PHQ-9 and 9 on the GAD-7 indicating mild to moderate levels of depression and anxiety.

RC completed eight sessions of CCBT and was reviewed one month after the completion of the last session. Scores on the PHQ-9 and GAD-7 on discharge were 2 and 3 respectively. RC found it beneficial to reflect on sessional PHQ-9 and GAD-7 scores. His scores actually increased at the third and fourth sessions and both worker and RC were able to use this guide to identify triggers and stressors at that time, and this led to a plan of how to manage future triggers. RC was also reassured by his gradual reduction in scores and how this correlated to his progress."

APPENDIX THREE

Detailed Methodology of Building an Evidence Based Compendium

3a – Literature Review

The literature search was conducted using well established bibliographic electronic databases: Ovid Gateway for Medline and PsyINFO; this database includes material of relevance to psychologists and professionals in related fields such as psychiatry, Excerpta Medica abstract service (EMBASE), Citation Index for nursing and allied health literature (CINAHL), Social Science Citation Index (SSCI), Web of Knowledge (WoK).

The search period ran from the start date of each database until July 2007. Search terms consisted of exploding the following terms to include all subheadings; *mental health; psychiatry and mental disorders*. Additionally these terms, with truncation, were also used in combination with free text searching within the databases. Outcome terms used were *health status indicators; outcome assessment or measurement; quality of life;* all subheadings. We used a combination of these terms for free text searching with additional terms such as *index; score; scale; indices* and *monitor*.

Once again abbreviations of these terms were suffixed with truncation syntax to allow any possible extension of the term used in the free text searching. The search terms were modified to optimise the searches taking account of the structure of each database. Duplicates were removed, and the final list of published sources identified in full text version. We did not carry out a search of the unpublished 'grey literature'.

The initial combined search returned a total of 1114 hits. From 1114 records, 713 records were retained from reviewing the abstracts (*see Figure 1*). These records were retained as they included outcome assessment with one or more search term in relation to an area of mental health as the primary diagnoses; i.e. trials, routine practice; reviews; theory of mental health outcome assessment; instrument development; named instruments relating to mental health being of either the primary diagnosis or subject matter and written in the English Language.

The reasons for excluding 401 records/abstracts varied; the publications were about the education and debate articles and commentaries of outcome measurement and principles in practice not specific to the field of mental health; mental health not being of primary diagnosis; studies only of prevalence rates; co morbidity; non psychiatric services; medical diagnosis (e.g. TB, surgery, rheumatoid arthritis) and where the articles were not written in English.

Upon review of the 713 records, 188 individual instruments were mentioned within the abstracts. These instruments were entered onto an Excel spreadsheet in order to undertake some assessment of their usefulness or utility. Utility profiles were based on scoring of the psychometric properties of outcome measures that are

usually necessary before a measure is considered robust for individual or comparative use. However, the views of clinicians and service users, carers, and providers were not overlooked and included in the profile of usefulness.

3b – Evidence

There is considerable evidence that outcome evaluations may vary significantly between different groups (e.g. users and clinicians) (see the discussion of these issues in Lambert and Hill, 1994). Selecting the group to obtain information from needs to be driven by the decision about what aspect of outcome is essential to the agreed purpose. The measures should 'show respect for the complexity of psychological interventions and outcomes' (Berger, 1996: 36). Berger proposes a model in which outcome is a function of a number of variables to do with the individual, the condition that has to be dealt with, the treatment characteristics and the life and care context of the user. Attempts to assess outcomes will need to take account of this complexity.

Can the results from the outcome measures be presented in a form that will support clinical decision-making and communication? For example, will the results help inform decisions about whether a user needs services or what kinds of services might be needed? Even if the primary purpose is to obtain information to assist in service planning, it may be sensible to select measures that are also beneficial to clinicians and users as part of the clinical process so as to increase their involvement in the whole outcome implementation process.

If the measures are to be used across a range of services and thus provide the basis for benchmarking activity, then it is crucial that the measures used are compatible with a range of clinical theories and practices, rather than being relevant to only one theoretical approach.

Services need to bear in mind that it is inevitable that no system of outcome measurement will ever capture the full complexity of the issues to be addressed. All systems will have their flaws or areas of weakness. The options, therefore, are either not to try to measure outcomes at all or to implement the use of some measures, while taking into account the limitations of the information that they can provide.

There are some specific criteria relevant to ascertaining which particular measures may be of importance. Measures should be cost effective if used on a regular basis in a typical clinical situation, without undue burden to users or staff. Fitzpatrick et al (1998), refer to this as the 'feasibility' of measures; see also the discussion of these issues by Slade, Thornicroft and Glover (1999), who emphasise that feasibility is not a fixed property of a measure but is very much context-dependent.

3c – Criteria framework characteristics

A very helpful review of the criteria for selecting service user-based outcome measures can be found in Fitzpatrick et al (1998). The criteria used to select appropriate outcome measures should include:

- feasibility/application of instrument – easy to use in clinical practice
- psychometric properties – such as evidence of reliability and validity and be sensitive to detecting changes over time that is relevant to users and carers
- practical issues/considerations – reflect issues that are important to users
- evidence based – have relevant population norms and databases available, to enable comparisons between the findings.

We developed a framework for scoring instruments based on these criteria. This schema was arrived at after piloting the preliminary scoring system on 15 measures (*see Figure 2*).

Figure 2 *Quality Criteria Framework*

Main Area	* QM Scoring System	† User Ordinal Values
Evidence base (3 characteristics)		
☞ no evidence; ad hoc clinician's own	0	None
☞ some evidence i.e. experimentally and audit in UK	1	Some
☞ full – established cross cultural, benchmarking; reported norms	2 Max points 2	Very
Psychometric properties (7 characteristics)		
☞ validity	Yes = 1	As above
☞ reliability	No = 0	
☞ sensitivity for measuring change	Max points 7	
☞ cultural		
☞ translated versions		
☞ validation or culturally specific development		
☞ developed in cultural specific groups		
Availability of tool/measure (4 characteristics)		
☞ no training	Yes = 1	As above
☞ no costs for training	No = 0	
☞ no instrument copyright/ permissions required	Max points 4	
☞ no cost for use		

Main Area	* QM Scoring System	†User Ordinal Values
Practical Issues/considerations (3 characteristics)		
☛ easy to score and interpretation of scores	Yes = 1	As above
☛ no software required	No = 0	
☛ completed in ≤20 minutes	Max points 3	
Total	16	
Practice groups' members rating of feasibility/ application of instrument (7 characteristics)		
☛ areas of interest: scores influence practice		No use
☛ outcome (intervention; i.e. service or therapeutic)		Specific use
☛ clinical utility (ease and efficiency of use of an assessment, and the relevance and meaningfulness, clinically, of the information that it provides)		Definite use
☛ service development		
☛ positive feedback		
☛ appropriateness to field		
☛ acceptability		

* ***Queen Mary's instrument scoring:*** *A numerical value of 0, 1 or 2 (where applicable) was assigned for each of the above mentioned characteristics. The QM scoring was based on, and applied to four main area categories. These being; evidence based; psychometrics; availability of measure and practicality. From these numerical values, a utility score was applied on the initial 188 instruments identified through the literature searching of the journal databases. For example; under the main area of 'evidence based' if an instrument fulfilled the 'fully' met criteria it would receive a total score of '2'. This scoring was applied to each of the characteristics within the main area und subsequently totalled up. Potentially, each instrument could receive a possible total score of 16 from the above characteristics. Using this transparent and replicable approach, all instruments were assigned a score. These scores are not reported to avoid ranking of instruments by these scores which were used to select into the compendium and should not be used to guide instrument selection. However,* Table 4 *makes clear those selected on the basis of high quality scores and those selected on the basis of stakeholder recommendation for all 188 instruments.*

† ***Practice groups' ratings of instruments:*** *Practice group members were asked for their rating and feedback on the feasibility and application of instrument. Categorical responses were definitely useful; useful for specific purposes and of no use.*

APPENDIX FOUR

The Compendium of Outcome Measures

This compendium:

- does not attempt to include all instruments for all disease areas, or for all domains of activity
- does not comprise a compulsory set of instruments
- is not an exclusive set of instruments that cannot be bettered by others in specific circumstances and requirements
- does not list all instruments ever used, or present a systematic review or list of instruments for all service areas
- does not include adolescent mental health services instruments as they have already identified and established through Child and Adolescent Mental Health Services (CAMHS) Outcome Research Consortium (CORC)
- does not include Department of Health guidance for best practice in managing risk.

It is primarily designed:

- for clinicians engaged in service delivery and development
- to gauge clinical effectiveness and recovery, in a balanced, culturally appropriate, ethical and respectful manner
- for service users who might want to learn about different measures, and their properties, advantages and disadvantages.

The compendium includes four tables:

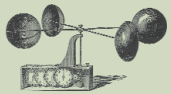
- Table 1 (*p.26*) detailing diagnostic/therapeutic areas in relation to what services they provide
- Table 2 (*p.36*) summarises each instrument by its evidence and availability.
- Table 3 (*p.41*) is a more detailed version of table 1 and 2. It gives further information about each instrument under characteristic column headings about instruments/outcome measures if someone wishes to actually use the tool
- Table 4 (*p.72*) is an alphabetical list of the instruments retrieved by literature searching and Practice Group recommendations.

Table 1 – Compendium outcome measures organised by diagnostic/therapeutic areas

Use this table if you do not use outcome measures routinely and are not aware of any existing measures used within your practice.

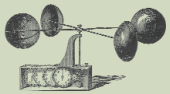
- This table is organised by diagnostic/therapeutic categories
- Instruments are listed only once. However, some instruments can fall under more than one area and are used in more than one diagnostic/therapeutic area. The classification is based on instrument use in the literature review and as informed by the practice group. Other headings might be added and one instrument may fit under other areas which are not indicated in this table. For example, Clinical Outcomes Routine Evaluation (CORE-10), Health of Nation Outcome Scale (HONOS), Camberwell Assessment of Needs (CANSAS), Functional assessment of the Care Environment (FACE) and Threshold Assessment Grid (TAG) are essentially global severity measures. They are not restricted to measuring 'Health Care Need' or 'Psychological Therapies' only as depicted in the table and that they can be used across more than one diagnostic/therapeutic category. Similarly the 'Mental Health Recovery Star' is included in 'Recovery' but is also highly relevant to social functioning.
- The literature search was not based on the above diagnostic/therapeutic areas and does not therefore provide an exhaustive list of all instruments used within these areas and should not be seen as a comprehensive or specialist list of instruments for these diagnostic/therapeutic areas.
- The 'practicality/application of instrument' column indicates whether the tool is self or practitioner completed and whether it is a 'condition-specific' or a 'generic' type of measure.





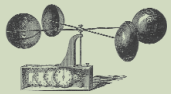

Type	Instrument	What it Measures	Practicalities
		Addictions	
Screening & Case Finding Measures	Addiction Severity Scale/Index	Substance Abuse only – Alcohol and Drug abuse and Gamblers Dependency	*Self & practitioner completed Condition-specific*
	Alcohol Use Disorder Identification Test (AUDIT)	Screening procedure in clinical settings is linked to a decision process that includes brief intervention with heavy drinkers, or referral to specialised treatment for patients who show evidence of more serious alcohol involvement.	*Self & practitioner completed Condition-specific*
Treatment Outcome Measure	The Severity Dependence Scale	Instrument developed to provide a brief, easily administered measure of the psychological aspects of dependence experienced by users of various types of illicit drugs.	*Self-completed Condition-specific*
	Maudsley Addiction Profile	Structured interview for treatment measuring problems in four domains: substance use, health risk, physical and psychological health, and personal/social functioning	*Practitioner-completed Generic*
		Adverse effects measures	
Assessment of abnormal involuntary movements	Abnormal Involuntary Movement Scale.	Assessment of abnormal involuntary movements associated with antipsychotic drugs, such as tardive dystonia and chronic akathisia, as well as 'spontaneous' motor disturbance related Scale	*Practitioner-completed Generic*
		Anxiety Disorders	
General anxiety	Fear Questionnaire	Screening instrument in community and general medical settings. To assess general distress of anxiety not specific	*Self-completed Condition-specific*
	GAD7	A brief scale to identify General Anxiety Disorder and to measure the severity of its symptoms. It can help with further assessment and possible treatment	*Self-completed Condition-specific*
	Health Anxiety Inventory (HAI)	There are four sections in the health anxiety inventory scored separately and is regarded as a treatment process measure. Ratings of avoidance and reassurance seeking are also included.	*Self-completed Condition-specific*





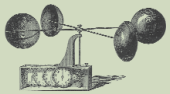

Type	Instrument	What it Measures	Practicalities
	Penn State Worry	A measure most frequently used to assess pathological worry in both clinical and non-clinical populations. The PSWQ is a 16-item inventory designed to capture the generality, excessiveness, and uncontrollability of pathological worry	*Self-completed* *Condition-specific*
	Beck Hopelessness Scale	Designed to measure negative attitudes about the future	*Self-completed* *Generic*
	Liewbotz social anxiety scale	To detect states of anxiety	*Practitioner-completed* *Condition-specific*
Obsessive Compulsive Disorder	Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)	The primary use of the Y-BOCS is in rating the severity of obsessive-compulsive disorder (OCD), with emphasis on its ability to reflect changes in severity during treatment	*Practitioner-completed* *Condition-specific*
	Obsessive Compulsive Inventory (OCI)	Rating the severity of obsessive-compulsive disorder	*Self-completed* *Condition-specific*
Panic Disorder & Agoraphobia	Mobility Inventory for Agoraphobia	Symptoms of agoraphobia	*Self-completed* *Condition-specific*
	Panic Rating scale	Monitoring symptom severity, process and outcome of care	*Self-completed* *Condition-specific*
Social Phobia	Social Phobia Inventory (SPIN)	Screening and diagnostic tool for social phobia presence or absence	*Self-completed* *Condition-specific*
Common Mental Disorders	General Health Questionnaire 12 (GHQ-12)	This self-administered questionnaire focuses on two major areas; the inability to carry out normal functions and the appearance of new and distressing phenomena	*Self-completed* *Generic*
Depression rating scale for General Psychiatric or	Amritsar Depression Inventory	Screening anxiety, depressive symptoms. Cultural Specific; used in Punjabi population and in primary care English and Punjab	*Self-completed* *Generic*





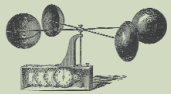

Type	Instrument	What it Measures	Practicalities
Community Populations	Beck Depression Inventory	A measure of the behavioural manifestations of depression in adolescents and adults. Designed to standardise the assessment of depression severity and monitor change over time or describe the illness.	*Self & practitioner completed Condition-specific*
	Centre for Epidemiological Studies Depression Scale	Used as a screening test and Outcome measure – Epidemiological studies of depression.	*Self-completed Generic*
General Psychiatric or Community Populations	Montgomery & Asberg Depression rating tool (MADRS)	Identifying presence and severity of depression	*Practitioner-completed Condition-specific*
	Profile of Mood States (POMS)	A measure of affective mood state fluctuation in a wide variety of populations including psychiatric outpatients, medical patients, and in sports psychology	*Self-completed Generic*
Depression Rating Scale	Edinburgh Postnatal Depression Scale (EPDS)	The Edinburgh Postnatal Depression Scale has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression	*Self-completed Condition-specific*
	Geriatric Depression Scale	The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults	*Self & practitioner completed Condition-specific*
	Hospital Anxiety and Depression Scale (HADS)	To detect states of anxiety and depression	*Self-completed Generic*
	Patient Health Questionnaire (PHQ9)	Used as diagnostic tool of depression and to assess severity of depression across all medical areas	*Self-completed Generic*
Bipolar disorder			
Symptoms of Depression & Mania	Internal State Scale	Rates manic and depressive symptoms	*Self-completed Condition-specific*





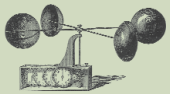

Type	Instrument	What it Measures	Practicalities
Eating disorders			
Assessment of binge eating	Eating Disorders Examination Questionnaire (EDE-Q)	For the assessment of binge eating, responses to probe questions concerning the amount of food consumed and the circumstances of eating are used to categorize episodes of overeating	*Self-completed* *Condition-specific*
Fatigue			
Symptom of fatigue scale	Chronic Fatigue Questionnaire	Used to indicate presence of fatigue	*Self-completed* *Condition-specific*
Forensic			
	Historical Clinical Risk 20	Adult & Forensic Psychiatry risk assessment and management tool. Direction of allocating resources	*Self-completed* *Generic*
Employment			
	Work and Social Adjustment Scale	A measure of general impairment This measure has been used in Department of Health to improve access to Psychological Therapies pilots	*Self completed* *Generic*
Health care and needs assessment			
General health care needs	*Camberwell Assessment of Needs (CANSAS)	Recommended for clinical use to identify need. The measure recognises the subjective nature of 'need' and emphasises the importance of gathering information from both the service user and staff carer.	*Self & practitioner completed* *Generic*
	Carers & Users Expectations of Service (CUES)	Service users' experiences of mental illness and its consequences. Ideally, this should happen in the context of individual care planning	*Self-completed* *Generic*





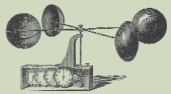

Type	Instrument	What it Measures	Practicalities
	*Functional Assessment of the Care Environment (FACE)	Assessment tools for health and social care which include measures of health and social functioning and disability.	*Practitioner-completed Generic*
	*Health of nations Outcome Scale (HONOS)	Intended to measure outcome, need and inform the provision of healthcare at a population level.	*Practitioner-completed Generic*
	*Threshold Assessment Grid (TAG)	To identify those people whose mental health problems are of sufficient severity to warrant access to secondary mental health services	*Practitioner-completed Generic*
Individual health care needs	Maslach Burnout Inventory	Designed to assess the three components of the burnout syndrome: emotional exhaustion, depersonalisation, and reduced personal accomplishment	*Self-completed Condition-specific*
Patient perceptions of care			
Patient perceptions of care measures	Illness Perception Questionnaire IPQ	Health illness perception tool across all diagnostic areas	*Self-completed Generic*
	Client Satisfaction Questionnaire	Satisfaction of treatment/evaluation programs – all areas of mental health	*Self-completed Generic*
	Patient Experience Questionnaire (PEQ) Part 1	Specifically developed for psychological services but could be used across other areas of mental health	*Self-completed Generic*
	Patient Experience Questionnaire (PEQ) Part 2	Specifically developed for psychological services but could be used across other areas of mental health	*Self-completed Generic*





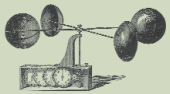

Type	Instrument	What it Measures	Practicalities
Personality disorders			
Diagnostic/Screening	Borderline Personality Disorder Severity Index (BPDSI),	Personality Disorders Symptom Severity	*Practitioner-completed Condition-specific*
	Zanarini scale for Borderline	Detecting presence or absence of Borderline Personality Disorder	*Practitioner-completed Condition-specific*
Post traumatic stress disorder			
Anxiety disorder	Impact of Events Scale	To measure the cognitive and emotional impact of traumatic events. It is an instrument that can be used for repeated measurement over a period of time	*Self-completed Condition-specific*
Psychological therapies			
Evaluation	*Clinical Outcomes Routine Evaluation (CORE) SEVERAL ANNEXES	The CORE system was designed to provide a routine outcome measuring system for psychological therapies, and some areas of psychiatry	*Self & practitioner completed Generic*
	Outcome Rating scale	Measuring change for a variety of therapeutic models and identifies clients at risk or null outcomes for therapy	*Self-completed Generic*
	Session Rating Scale	Reports on therapeutic fit related to therapeutic outcomes	*Self-completed Generic*
	The Barrett Lennard Inventory	Client change due to therapy	*Self-completed Generic*
	The Inventory Of Interpersonal Problems	To identify the most common interpersonal problems and enable the measurement of change due to intervention.	*Self-completed Generic*






Type	Instrument	What it Measures	Practicalities
Psychotic symptoms			
Assessment/Evaluation	Auditory Hallucination Rating Scale	Assesses distress, control and belief re origin of voices in addition to how client experiences voices. It is an 11 item checklist for auditory hallucinations	*Self-completed* *Condition-specific*
	Comprehensive Assessment of At Risk Mental States CAARMS	Identifying ultra high risk for psychotic disorders	*Practitioner-completed* *Generic*
	Positive and Negative Syndrome Scale (PANSS)	PANSS is a 30-item rating instrument evaluating the presence/absence and severity of positive, negative and general psychopathology of schizophrenia	*Practitioner-completed* *Generic*
	Psychotic Symptom Rating Scales: Delusions	Psychological assessment in the clinical setting, it is most appropriately used as a global measure of response to treatment interventions in patients with moderate to severe psychotic disorders	*Practitioner-completed* *Generic*
Quality of life and social functioning and wellbeing			
General Health Status	EuroQol 5-dimensions (EQ-5D)	A measure of health outcome. It provides a simple descriptive profile and a single index value for health status, and clinical utility	*Self-completed* *Generic*
	PSYCHLOPS	Used in Primary Care as Quality of Life measure	*Self-completed* *Generic*
	Short Form 36	The SF-36 is a multi-purpose short measure of quality of life developed by the Medical Outcomes Trust.	*Self-completed* *Generic*
	The How are you scale	Short self-report tool measuring wide range of aspects of a person's life, health and functioning.	*Self-completed* *Generic*
Special populations	Life Satisfaction Index	Measures general well-being or morale, in older people. It is designed to measure satisfaction or 'successful' ageing	*Self-completed* *Generic*






Type	Instrument	What it Measures	Practicalities
Recovery			
Evaluation	DREEM	A measure that helps services to learn about recovery and to assess the extent to which users of service judge that the services' staff, offerings and organisational climate support their recovery	*Self-completed* *Generic*
	*Mental Health Recovery Star	Measuring recovery from mental illness.	*Self-completed* *Generic*
	Ohio consumer assessment I & II	To measure how people change in treatment, and determine if the services they receive have an impact	*Self & Practitioner Completed* *Generic*
Service planning			
	World Health Organisation Short Disability Assessment Schedule (WHO DAS-S)	A measure of the level of disability across various conditions and interventions	*Self-completed* *Generic*
Social functioning and functioning disabilities			
Mental Health Status	Role Functioning Scale	Assessing improvement in psychosocial functioning among persons with severe and persistent mental illness after exposure to different clinical interventions	*Practitioner-completed* *Generic*
	Sheehan Disability Scale	To assess functional impairment across interrelated domains work/school, social and family life	*Self-completed* *Generic*
Mental Health – Treatment Effectiveness	Schwartz Outcome Scale	Quality of life – measures the effectiveness of mental health treatment across a wide range of mental health services and populations	*Self-completed* *Generic*

Type	Instrument	What it Measures	Practicalities
Mental Health Status-Social Functioning	Social Adaptation Self-Evaluation Scale	Successful social adjustment in community living, for people with depression. It was designed primarily to evaluate the effects of drug treatment and psychotherapy, but can be also used before and after occupational therapy.	*Self-completed* *Generic*
	Social Adjustment Scale	The Social Adjustment Scale is a self-report assessment of successful social adjustment in community living, for people with depression. It was designed primarily to evaluate the effects of drug treatment and psychotherapy, but can be also used before and after occupational therapy	*Self-completed* *Generic*
	Social Functioning Scale	The Social Functioning Scale (SFS) was constructed specifically to tap those areas of functioning that are crucial to the community maintenance of individuals with schizophrenia.	*Self-completed* *Generic*
	Social Summary Rating Scale	To assess social anxiety	*Self-completed* *Condition-specific*

*These instruments can be used across more than one service/diagnostic area

Table 2 – Compendium Outcome Measures: the characteristics on which they were scored for performance and availability

Use this table if you would like additional information about an instrument's psychometric properties and the evidence base supporting its use, and its availability. This table is constructed by listing the instruments in alphabetical order and by the characteristics that were scored are column headings

Column headings:

- evidence/availability of tool/measure
  - evidence based
  - training – training required
  - costs for training
  - copyright – permissions required
  - download available
  - cost for use

- practicality/Application of instrument
  - easy to score & interpret – does not require complicated calculations and the scores are meaningful
  - software required
  - complete ≤20 minutes

- an asterisk in any of the column subheadings indicates that the instrument has those properties.

Short listed instruments characterised by Evidence & Availability of tool

Assessment/tool	Evidence/availability						Practicality/application of instrument		
	Evidence Based	Training Required	Costs for training	Copyright produced with permission	Download available	Cost for use	Easy to score & interpret	Software required	Complete ≤20 minutes
Abnormal Involuntary Movement Scale				*	*		*		*
Addiction Severity Scale/ Index	*			*	*				
Alcohol Use Disorder Identification Test (AUDIT)	*	*			*		*		*
Amritsar Depression Inventory							*		*
Auditory Hallucination Rating Scale									
Beck Depression Inventory	*			*		*	*		*
Beck Hopeless-ness Scale	*			*		*	*		*
Borderline Personality Disorder Severity Index (BPDSI),	*			*					
Camberwell Assessment of Needs (CANSAS)				*		*	*		*
Carers & Users Expectations of Service (CUES)	*	*	*	*		*			
Centre for Epidemiological Studies Depression Scale				*	*		*		*
Chronic Fatigue Questionnaire	*			*			*		*
Client Satisfaction Questionnaire	*						*		*
Clinical Outcomes Routine Evaluation (CORE)	*	*	*	*	*		*		*
Comprehensive Assessment of At Risk Mental States (CAARMS)		*	*	*		*	*	*	

Assessment/tool	Evidence/availability						Practicality/application of instrument		
	Evidence Based	Training Required	Costs for training	Copyright produced with permission	Download available	Cost for use	Easy to score & interpret	Software required	Complete ≤20 minutes
DREEM	*	*		*	*		*		
Eating Disorders Examination Questionnaire (EDE-Q)		*	*	*		*			
Edinburgh Postnatal Depression Scale (EPDS)				*	*		*		*
EuroQol 5-dimensions (EQ-5D)	*			*	*		*		*
Fear Questionnaire	*			*			*		*
Functional Assessment of the Care Environment (FACE)	*	*		*		*	*		
GAD7	*			*	*		*		*
General Health Questionnaire 12 (GHQ-12)				*		*			
Geriatric Depression Scale				*	*		*		*
Health Anxiety Inventory (HAI)				*	*		*		*
Historical Clinical Risk 20	*	*	*	*		*	*		
HONOS (Health of Nations Outcomes Scale)	*	*	*	*			*		*
Hospital Anxiety and Depression Scale (HADS)				*			*		*
Illness Perception Questionnaire IPQ	*			*	*				*
Impact of Events Scale	*			*	*		*		*
Internal State Scale	*						*		*
Liewbotz Social Anxiety Scale				*	*				
Life Satisfaction Index				*	*		*		*
Maslach Burnout Inventory	*			*	*	*	*		*
Maudsley Addiction Profile				*	*		*		*
Mental Health Recovery Star		*	*	*	*				

Assessment/tool	Evidence/availability						Practicality/application of instrument		
	Evidence Based	Training Required	Costs for training	Copyright produced with permission	Download available	Cost for use	Easy to score & interpret	Software required	Complete ≤20 minutes
Mobility Inventory for Agoraphobia	*				*		*		*
Montgomery & Asberg Depression rating tool (MADRS)		*		*	*	*	*		
Obsessive Compulsive Inventory (OCI)	*						*		*
OHIO Consumer Assessment 1&2									
Outcome Rating scale	*			*	*		*		*
Panic Rating scale	*			*			*		*
Patient Experience Questionnaire (PEQ) Part 1	*			*	*		*		*
Patient Experience Questionnaire (PEQ) Part 2	*			*	*		*		*
Patient Health Questionnaire (PHQ9)				*	*		*		*
Penn State Worry	*			*			*		*
Positive and Negative Syndrome Scale (PANSS)		*		*	*	*	*		
Profile of Mood States (POMS)	*	*		*		*	*		*
Psychotic Symptom Rating Scales: Delusions		*		*					
PSYCHLOPS				*		*	*		*
Role Functioning Scale		*					*		*
Schwartz Outcome Scale	*			*			*		*
Session Rating Scale				*	*		*		*
Sheehan Disability Scale	*			*			*		*
Short Form 36	*			*		*			*
Social Adaptation Self-Evaluation Scale	*			*			*		*
Social Adjustment Scale	*			*			*		*
Social Functioning Scale	*			*			*		*

Assessment/tool	Evidence/availability						Practicality/application of instrument		
	Evidence Based	Training Required	Costs for training	Copyright produced with permission	Download available	Cost for use	Easy to score & interpret	Software required	Complete ≤20 minutes
Social Phobia Inventory (SPIN)	*			*	*		*		*
Social Summary Rating Scale				*			*		*
The Barrett Lennard Inventory				*		*			
The How Are You Scale	*			*		*	*		*
The Inventory of Interpersonal Problems	*			*			*		*
The Severity Dependence Scale				*	*		*		*
Threshold Assessment Grid (TAG)	*				*		*		*
World Health Organisation Short Disability Assessment Schedule (WHODAS-S)	*				*		*	*	*
Work and Social Adjustment Scale				*					
Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)	*	*	*	*	*				
Zanarini scale for Borderline		*	*	*		*			

Table 3 - Compendium Outcome Measures: detailed characteristics and performance information

The 69 short listed instruments, based on QM quality scored and Practice Group recommendations are contained in this table and are in alphabetical order. It is a more detailed version of table 2. The instrument can be looked up by name if you are familiar with using outcome measures. If you have pre-determined ideas of dimensions that should be reflected in selecting the tool of your choice, the table is divided up under column headings.

- Assessment/tool
  - The name of the instrument alphabetically listed and any related assessment/tool names.

- Area of Mental Health – What it measures
  - What areas and groups has the instrument been used in and general summary/information of the measure

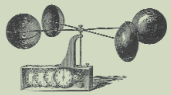
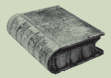
- Evidence based
  - The information provided under this heading contains National benchmarking data; Population norms or Audit data where available. The extent to which a particular outcome measure is currently being used can also be found in the 'evidence based' column (where information was available)

- Psychometric properties
  - Whether the instrument has been tested in relation to its reliability, validity, sensitivity to change and translated into several languages. NB most instruments had not been subjected to cultural diversity

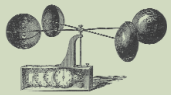
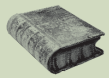
- Availability of tool/measure
  - How simple is it to acquire the tool? Is it free? Are there copyright issues?

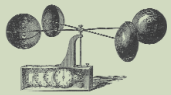
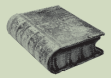
- Practicality/application of instrument
  - Whether the instrument is self or practitioner completed, time to complete and scoring tips

- These criteria are not mutually exclusive

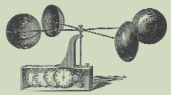
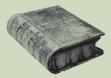





Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
Abnormal Involuntary Movement Scale. (AIMS) Related assessment/ tools: AMPS (see below).	Tardive dyskinesia (TD) is a side-effect of chronic antipsychotic medication. Substance Abuse – Psychotic; Schizophrenia side effects of these disorders, and functional impairment experiencing dyskinetic movement, usually as a consequence of antipsychotic treatment. Summary of Abnormal Involuntary AIMS is a 12-item instrument assessing abnormal involuntary movements associated with Movement antipsychotic drugs, 'spontaneous' motor disturbance related. Adolescent, Adult and Elderly.	None reported.	Reliability and validity.	**Copyright:** requires permissions The original reference for the AIMS is Guy W. ECDEU Assessment Manual for Psychopharmacology, revised ed. Washington, DC, US Department of Health, Education, and Welfare, 1976. Developers – World Health Organisation. Author to whom correspondence should be addressed at: Department of Psychiatry und Psychotherapy I, Johann-Wolfgang Goethe University, Heinrich-Hoffmann-Str. 10, 60528 Frankfurt/Main, Germany. Download available: *http://www.atlantapsychiatry.com/forms/AIMS.pdf*	**Practitioner-completed. 5-10 minutes to complete.** Instruction on how to score see: *http://psychservices.psychiatryonline.org/cgi/reprint/39/11/1172.pdf*
Addiction Severity Scale/Index Related assessment/ tools: ASI – baseline and follow up **Addiction Severity Index Lite. Comprehensive Adolescent Severity Inventory. Teen Addiction Severity Index.**	Substance Abuse only – Alcohol and Drug abuse and Gamblers Dependency. HIV/AIDS. Homeless. Prisoner. Pregnancy. Teens, Native Americans' Europeans.	Used by clinicians, administrators & policy makers. Used Internationally normative data (composite scores and background variables) are available for numerous populations including treated male and female alcohol, opiate, and cocaine abusers. Norms are also given on the basis of the type of treatment episode	Reliability, Validity, Sensitivity and Translation. Versions are available in several languages.	It is available in three different formats: pencil-and-paper self-administered, clinician interview, or computer-based. This instrument is in the public domain. It can be downloaded for free from the TRI web site. Treatment Research Institute 600 Public Ledger Building 150 South Independence Mall West Philadelphia, PA 19106 tel: 1-800-238-2433 (ASI Help Line) email: ASIHelpline@tresearch.org web: http://www.tresearch.org Administered by trained personnel	**Both self and practitioner completed. Approximately 50 minutes to 1 hour to administer.** It has been adapted for use in the NIDA CTN. A complete copy is available in NIAAA's "Assessing Alcohol Problems: A Guide for Clinicians and Researchers/2nd edition," p.248-253.

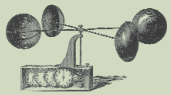
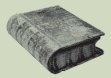
					
Tool	**What it Measures**	**Evidence Based**	**Psychometric Properties**	**Availability**	**Practicalities**
		(inpatient, partial hospitalisation, and outpatient substance abuse).			
Alcohol Use Disorder Identification (AUDIT).	Substance Misuse Services. Linked to a decision process that includes brief intervention with heavy drinkers, or referral to specialized treatment for patients who show evidence of more serious alcohol involvement. Populations include primary care, emergency room, surgery, and psychiatric patients; DWI offenders, criminals in court, jail and prison; enlisted men in the Armed Forces; workers encountered in employee assistance programs and industrial settings; and college students.	Full: Benchmarking data available.	Reliability and validity – Cost utility translated into numerous languages, including Japanese, French, Norwegian, Rumanian, Slavic, Spanish, and Swahili.	**Copyright:** Babor, Thomas F.; de la Fuente, J.R.;Saunders, J.; Grant, Marcus; World Health Organization *http://adai.washington.edu/instruments/pdf/AUDIT.pdf* (AUDIT) Core questionnaire can be reproduced without permission. Test and manual are free; The manual (175 KB) can be downloaded from: *http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf* and includes detailed administration guidelines Training module costs $75 and contains a videotape and manual.	Both self and practitioner completed. More than or equal to 2 minutes to administer. More than or equal to 5 minutes to complete.
Amritsar Depression Inventory.	Screening. Anxiety, depressive symptoms. Cultural Specific; used in Punjabi population and in primary care English and Punjab.	None reported.	Validity and reliability. Cultural specific. English and Punjabi.	Training is not required **No Copyright.** Please refer to source article. Developed by Punjabi Psychiatrists SINGH, G., VERMA, H.C., VERMA, R.S. & KAUR, H. (1974) A new depressive inventory. Indian Journal of Psychiatry, 161, 83-188.	Self-completed. Easy to score & interpret. No software required.

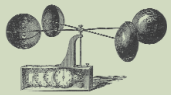
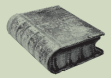




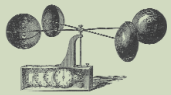
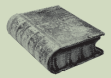

Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
Auditory Hallucination Rating Scale.	Assesses distress, control and belief re origin of voices in addition to how client experiences voices. The Auditory Hallucinations Rating Scale is an 11 item checklist for auditory hallucinations.	None reported.	No psychometric properties.	Training is not required. No associated costs. UNPUBLISHED INSTRUMENT By Haddock et 1994. Write to developer at Manchester University NO COPYRIGHT AS YET.	Self-completed. Less than or equal to 20minutes to complete. No software required to score.
Beck Depression Inventory.	Outcome evaluation. Depression Developed to measure the behavioural manifestations of depression in adolescents and adults. It was designed to standardize the assessment of depression severity in order to monitor change over time or to simply describe the illness.	Normative data available.	Reliability, validity, sensitivity and translation . All 4 Foreign language versions include Chinese, Dutch, Finnish, French, German, Korean, Swedish and Turkish.	A manual is included in the purchasing cost. Computer software is available for on-screen administration, for use with paper and pencil administration, or for input of data from a desktop scanner. Developer; Beck, Aaron T.; Ward, C.H.; Mendelson, M.; Mock, J.; Erbaugh, J. **Complete kit:** includes manual and 50 record forms £73.50 (£80.37 inc VAT). The BDI questionnaire is copyrighted and may be obtained from: *http://www.pearson-uk.com/SearchResults.aspx?Search=beck*.	Clinician-administered interview; Self-administered questionnaire.
Beck Hopelessness Scale.	Suicide predictor. Adult Psychiatry. Designed to measure negative attitudes about the future.	Normative data available – cross cultural group used.	Reliability and validity and sensitivity reported. Translated into Spanish.	Copyrighted instrument. Purchased from: **Complete kit:** includes manual and 25 record forms £73.50 (£80.37 inc VAT). **Publishers:** The Psychological Corporation Publishers *http://www.pearsonuk.com/SearchResults.aspx?Search=beck.* **Author:** A Beck	Self-completed. 5-10 minutes to complete. Easy to score with scoring template.

 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
Borderline Personality Disorder Severity Index (BPDSI).	Personality Disorders Symptom Severity. Psychiatric and non psychiatric patient samples. Screening instrument but used as an outcome measure.	Clinical Norms available.	Reliability and validity reported development. Dutch and English. Reliability And Validity Of The Borderline Personality Disorder Severity Index Journal of Personality Disorders, 17(1), 45-59, 2003 © *2003 The Guilford Press*. Sensitivity to change has been reported *http://ajp.psychiatryonline.org/cgi/reprint/159/12/2048.*	Copyright permissions required. **Authors:** Address correspondence to Arnoud Arntz, Department of Medical, Clinical and Experimental Psychology, Maastricht University, P.O. Box 616, NL-6200 MD Maastricht, the Netherlands; **email:** *Arnoud.Arntz@MP.Unimaas.nl.* An English version can be obtained from the first author.	**Practitioner-completed.** **Semi-structured interview.** Cut off scores were determined using formulas by Jacobson and Truax (1991). The dysfunctional cut-off score indicates where dysfunction (i.e. BPD pathology) starts. People above this score differs less than two SD from the BPD population.
Camberwell Assessment of Needs (CANSAS) Related assessment/tools: CAN AVON CANE.	Recommended for clinical use. Identify need. The measure recognizes the subjective nature of 'need' and emphasizes the importance of gathering information from both the service user and staff carer. The questionnaire was developed as a screening tool and offers the CNS. The identification of needs by the CAN was compared with measures of social, occupational and psychological functioning as assessed using the Global Assessment of Functioning (GAF) American Psychiatric Association 1994).	Although individual items showed poor correlation, comparison of aggregation scores showed a significant correlation. In one of the few studies to compare different needs assessment instruments in the same group of patients, Wiersma et al. (1998) reported that a user-based	Reliability and validity. Translated into several languages. The authors also reported that although the overall level of need identified by the two measures was similar, the types of needs identified were significantly different. i.e. Differing perspectives of users and professionals	**Training not required.** **Copyright:** Harcourt Assessment **Cost:** £75 Slade, M, Thornicroft, G, Loftus, L (1999) Camberwell Assessment of Need London: Gaskell.	**Both self and practitioner completed.** **15–30 minutes to complete.** **No software required.** **Easy to score.**

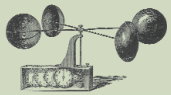
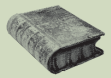
Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
		assessment of need (using the CAN) identified more unmet need than a professional-based assessment (using the Needs For Care Assessment Schedule).	with regard to need.		
Carers & Users Expectations of Service (CUES).	To improve communication in care planning: CUES provides a structure for service users to tell staff about their experiences of mental illness and its consequences. Ideally, this should happen in the context of individual care planning. Useful tool, for needs assessment, not an outcome measure instrument. Measures needs.	Local service development: at the service level CUES can bring the customer perspective to the quality improvement cycle. National bench-marking: Trusts can compare CUES returns from users of their services with those from other organisations.	Reliability and validity. Not tested in cultural populations.	**Instrument Crown Copyrighted:** Royal College of Psychiatrists **tel:** 020 7977 6655 *Enquiries@cru.rcpsych.ac.uk* Paul L Elliott, Anne Beevor, Gary Hogman, Bsc (Psych), Jon Hyslop, Bphil, Judith Lathlean, The British Journal of Psychiatry (2001) 179: 67-72. Training required. £1,300-1,600 plus VAT depending on caseload.	**Self-completed.**
Centre for Epidemiological Studies Depression Scale.	Depression – General Population. Used as a screening test. Outcome measure – Epidemiological studies of depression. Used also amongst cancer survivor populations. Young adults and adolescents & Older People. Non whites.	None reported.	Validity, reliability and sensitivity. Translated into Spanish.	**Copyright:** Centre for Epidemiologic Studies, National Institute of Mental Health; **Publisher:** West Publishing Company. **No associated costs.** **Training not required.** Questionnaire contained in the original reference at *http://apm.sagepub.com/cgi/content/*	**Self-completed.** **Less than or equal to 20minutes to complete.**

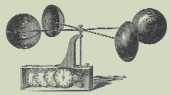
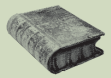
					
Tool	**What it Measures**	**Evidence Based**	**Psychometric Properties**	**Availability**	**Practicalities**
				abstract/1/3/385. **The CES-D Scale:** A Self-Report Depression Scale for Research in the General Population Lenore Sawyer Radloff Applied Psychological Measurement 1977; 1; 385.	
Chronic Fatigue Questionnaire.	Used to measure fatigue. Community and hospital settings.	RCT/normative data available on fatigue.	Reliability.	**Public domain produced with permission.** **Training not required.**	**Self-completed.** **Brief; Easy to score.** **No software required.**
Client Satisfaction Questionnaire. Related assessment/tools: CSQ-3, CSQ-4, CSQ-8, CSQ-31, CSQ-18A, CSQ-18B, CSQY.	All areas of mental health. To measure satisfaction with health and human services received by individuals and families. Adult, Adolescent and Paediatric. Generic.	Case study evaluations using CSQ 8 available – however measures single aspect of satisfaction and not OUTCOME of treatment.	Reliability and validity. Tested in different ethnic populations. Several languages.	**Copyright:** Product of University of California, San Francisco. Permission obtained from Dr. C.C. Attkisson (CSQ-8) at the UCSF Graduate Division, 200 West Milberry Union, 513 Parnassus Avenue, San Francisco, California 94143-0404 USA (FAX+1-415-). **Training not required.**	**Self-completed.** **Time to complete: Less than or equal to 20 minutes.** Can be scored and simply analysed using common statistical programmes such as SPSS, EPI INFO, spreadsheet or national data base management software such as Lotus 1-2-3, Excel, dBase, or Paradox.
Clinical Outcomes Routine Evaluation (CORE). Related assessment /tools: Several annexes including CORE OM	The CORE system was designed to provide a routine outcome measuring system for psychological therapies, and some areas of psychiatry. It also measures individual differences on entry into therapy and change. Adult.	Normative Data Available.	Reliability and validity. Translated in 11 languages: Albanian, Danish, Dutch, Greek, Gujarati, Italian, Icelandic, Norwegian,	**Training required.** **This instrument is copyrighted by the authors.** **CORE can be downloaded for free:** *http://www.coreims.co.uk/forms_mailer.php* However, user should contact CORE	**Both self and practitioner completed.** **15-30 minutes to complete.** CORE Systems provide optional software and

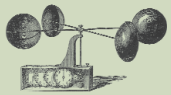
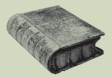
 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
(34 items), CORE 10,CORE GP.	The measure is brief and covers well being, problems/symptoms, life functioning and risk to self and others.		Portuguese, Slovak, Swedish.	systems if the tools are to be incorporated into existing service database systems where a license fee may be charged. Barkham M; Evans C; Margison F; McGrath G; Mellor-Clark J; Milne D; Connell J. The rationale for developing and implementing core outcome batteries for routine use in service settings and psychotherapy outcome research. J Mental Health 1998;7:35-47.	training/consultancy at an additional charge through CORE –PC and CORE-NET *http://www.coreims.co.uk/*
Comprehensive Assessment of At Risk Mental States (CAARMS).	Identifying ultra high risk for psychotic disorders. It is designed for repeated use over time, for example, monthly to 6 monthly. CAMHS. Young Adults.	None reported.	Reliability, validity Translated into French, Swedish and Japanese.	There are associated Copyright and training costs. Please see following website: *http://www.orygen.org.au/docs/RESEARCH/CAARMSposter(1).pdf* Developers: Yung, A. R., Yuen, H.P., McGorry, P.D., Phillips, L.J., Kelly, D., Dell-Olio, M, Francey, S., Cosgrave, E., Killackey, E., Stanford, C., Godfrey, K., & Buckby, J. (2005). Mapping the onset of psychosis: The Comprehensive Assessment of At Risk Mental States (CAARMS). Australian & New Zealand Journal of Psychiatry, 39, 964-971.	Practitioner-completed. More than or equal to 20 minutes to complete. Easy to score and interpret. Software required.
DREEM.	Mental health recovery. The primary goal of the DREEM is to create a sound, useful and comprehensive measure that helps services to learn about recovery and to	Analysed scores and reported as group data.	None reported.	Copyrighted. Training is required. If the tool is self administered by service user training is not required See following document:	Both self and practitioner completed. Less than or equal to 25 minutes to complete.

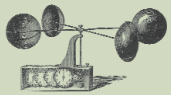
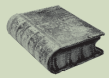





Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
	assess the extent to which users of service judge that the services' staff, offerings and organisational climate support their recovery.			*http://www.recoverydevon.co.uk/html/downloads/DREEM%20total%20dft4%20no%20tc.pdf* **Author:** Priscilla Ridgeway edited for UK use by Peirs Allott & Peter Higginson.	No software required. Easy to score and interpret.
Eating Disorders Examination Questionnaire (EDE-Q).	Eating Disorder Services. A 41-item measure adapted from the Eating Disorder Examination (EDE; a semi-structured investigator-based interview). For the assessment of binge eating, responses to probe questions concerning the amount of food consumed and the circumstances of eating are used to categorize episodes of overeating, based on the presence or absence of two features: loss of control over eating at the time of the episode and consumption of an "objectively large" amount of food.	None reported.	Excellent internal consistency and 2-week test-retest reliability. However, EDE-Q tends to yield higher estimates of objective bulimic episodes than EDE.	**EDE-Q needs no training; Training is required for EDE.** **The EDE and EDE-Q are copyright-protected.** Latest version available from Fairburn CM; Cooper Z. The Eating Disorder Examination. IN: Fairburn CG; Wilson GT (eds.). BINGE EATING: NATURE, ASSESSMENT AND TREATMENT (12th ed.). New York: Guilford Press, 1993, pp. 317-360. **Further details, contact:** Mara J. Catling, Administrator Centre for Research on Eating Disorders and Obesity University of Oxford Warneford Hospital Oxford OX3 7JX United Kingdom **fax:** +44 (0) 1865 226 244 *http://www.medicine.ox.ac.uk/credo/resourcesindex.html*	Self-completed. More than or equal to 20 minutes to complete.
Edinburgh Postnatal Depression Scale (EPDS).	Child Health Promotion. The Edinburgh Postnatal Depression Scale has been developed to assist primary care health professionals to detect mothers suffering from postnatal.	None reported.	Validated Cultural differences. Sensitivity and specificity. Several languages; Maltese, Chinese.	Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.	Self-completed. Less than or equal to 5minutes to complete. Easy to score.

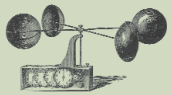
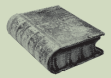
 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
				http://www.dbpeds.org/media/edinburghscale.pdf **Source:** Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-itemEdinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786. Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002,194-199.	
EuroQol 5-dimensions (EQ-5D).	All Areas of Health, Conditions and treatment effects. Generic Qol The EQ-5D is a standardised instrument for use as a measure of health outcome. It provides a simple descriptive profile and a single index value for health status, and clinical utility.	Benchmarking data available. Clinical utility.	Reliability, validity, sensitivity and translation. Translated into 60 other languages. EuroQol Group. EuroQol – a new facility for the measurement of health-related quality of life. Health Policy 1990;16:199-208.	Information about this instrument can be found at the EuroQol web site: *http://www.euroqol.org/*. It is in the public domain and may be used freely except in instances of commercial use. Without the prior written consent of the EuroQol Group Office, third parties are not permitted to i.e. use, reproduce, alter, amend, convert, translate, publish or make available in whatever way (digital, hard-copy etc.) the EQ-5D. Currently, consent will be given for free academic and clinical use of the EQ-5D. However, this policy is likely to change in 2009. To request copies of the EQ-5D, contact: EuroQol Group Executive Office, PO Box 4443, 3006 AK Rotterdam, The Netherlands **tel:** +31 10 408 1545 **fax:** +31 10 452 5303 **email:** *userinformationservice@ euroqol.org*	Self-completed. Less than or equal to 5 minutes to complete.

 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
Fear Questionnaire.	Agoraphobia and social phobia. Screening instrument in community and general medical settings. To assess general distress of anxiety not specific.	Normative data available.	Reliability and validity.	Training not required. **Developers:** I. M. Marks & A. Mathews, (1979) Brief standard self-rating for phobic patients. Behaviour Research and Therapy, 17, 263-267. Available from: Isaac marks, MD, Maudsley Hospital, IOP.	Self-completed. Less than or equal to 10 minutes to complete. No software required. Easy to score and interpret.
Functional assessment of the Care Environment (FACE).	Assessment and care planning tools for health and social care. Multidimensional measure of: Psychological well-being Activities of daily living Physical well-being Interpersonal relationships Social circumstances Impact on carers Risk. The FACE tools support the mental health minimum dataset and generate a HoNOS score.	Benchmarking data available. Initial research and validation of the approach was supported by the Department of Health over a 7-year period. Production of the FACE assessment toolsets involves review of existing literature and research findings. Tools are routinely updated in the light of new evidence and the practical experience of thousands of practitioners in social and health care feeding back through our user groups. We are currently	Reliability and validity. Central databases for purposes of research and validation.	Training required for form completion. Assessment and outcome measurement tools available for: - Screening/crisis settings - Generic use in secondary services - Rehabilitation/long-term mental illness - Older people's mental health services. Several toolkits available. Requires copyright permissions. Use of the Assessment and Outcome Package is free except for the software, but the clinician, team or organisation must register with CORE. FACE Recording & Measurement Systems, King John Chambers, 13-15 Bridlesmith Gate, Nottingham NG1 2GR. **tel:** 0115 950 8300, **fax:** 0115 911 0303. Further information on cost and software: *http://www.facecode.com/tools.html*	The FACE Outcomes software provides continual feedback to maintain data quality and provide real time benchmarking.

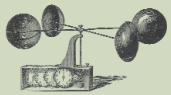
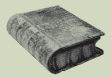
 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
		establishing a Scientific programme to ensure ongoing research and validation of FACE tools and to support further research using FACE data.		Clifford P.I. (1994 The FACE Project: Final report. Report to the Department of Health. London: England: University College London, Centre for Outcomes, Research and Effectiveness.	
GAD7	Generalised Anxiety disorder. The GAD-7 provides a reliable brief scale to identify General Anxiety Disorder and to measure the severity of its symptoms. Like PHQ9, the GAD7 is a 7-item anxiety module/subscale derived from the 60-item Patient Health Questionnaire (PHQ; a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders).	Cut off scores available. Tested in primary care sample.	Reliability and validity.	Instrument Free. Copied with Permission. See IAPT LINK: *http://www.mhchoice.csip.org.uk/silo/files/phq9-and-gad7-guidance-notes.pdf* Spitzer R, Kroenke K, Williams J. Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study. Journal of the American Medical Association 1999; 282: 1737-1744.	Self-completed. Less than or equal to 20 minutes to complete. No software required. Easy to score.
General Health Questionnaire 12 (GHQ-12). Related assessment/tools: GHQ-60, GHQ-30 & GHQ-28.	Psychiatric disorders. Clinical Psychologists Psychiatrists, Doctors and Researchers. Screens for non-psychotic disorders used in different settings and different cultures. Community & General Practice This self-administered questionnaire focuses on two major areas– the inability to carry out normal functions and the appearance of new and distressing phenomena.	None reported.	Reliability, validity and sensitivity. Translated into several languages.	Copyrighted. NFER Publishing Company, Darville House, 2 Oxford Road East, Windsor, SL4 1DF. Original version developed by: David Goldberg Authors of User Guide: David Goldberg and Paul Williams General Health Questionnaire: 12 (Pack of 100) at £36. This resource is only available to registered test users. To register please download and	Self-completed. Less than or equal to 20 minutes to complete.

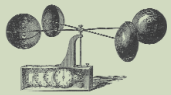
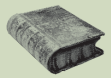

Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
				complete the registration form or contact directly at *information@gl-assessment.co.uk*	
Geriatric Depression Scale (GDS).	Older Peoples Psychiatry. The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings. It is a useful screening tool in the clinical setting to facilitate assessment of and monitor depression in older adults over time in all clinical settings. It does not assess suicide. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicide.	None reported.	Reliability and validity. The GDS was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria. Yesavage, et al. (1983). Development and validation of a geriatric depression Screening scale: A preliminary report. Journal of Psychiatric Research, 17, 37-49.	Permission is granted to reproduce, post, download, and/or distribute, this material in its entirety only for not-for-profit educational purposes only, provided that The Hartford Institute for Geriatric Nursing, College of Nursing, New York University is cited as the source. This material may be downloaded and/or distributed in electronic format, including PDA format. Available on the internet at *www.hartfordign.org* and/or www.GeroNurseOnline.org. E-mail notification of usage to: *hartford.ign@nyu.edu*.	Both self and practitioner completed. 5 -7 minutes to complete. The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued.
Health Anxiety Inventory (HAI).	Screening instrument of health anxiety should and sensitive across the full range of intensity (from mild concern to hypochondriasis). Differentiates people suffering from health anxiety from those who have actual physical illness but who are not excessively concerned about their health. Encompasses the full range of clinical symptoms characteristics of clinical hypochondriasis.	None reported.	Reliability, validity and sensitivity.	Training is not required. Instrument is free. Copy can be obtained from: Professor Paul M. Salkovskis, Department of Psychology, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF. available from: *http://psychology.iop.kcl.ac.uk/cadat/questionnaires/questionnaires_for_clinical_use.aspx.*	Self-completed. Brief. Easy to score and no software required.

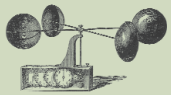
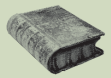

Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
Health of the Nation Outcome Scale (HoNos). Various Annexes. Related assessment/tools: HoNOS-ABI (Brain injury). HoNOSCA (Adolescent). HoNOS 65+ (Older Adult). HoNOS-LD (Learning Disabilities). HoNOS-MDO (Forensic).	Intended to measure outcome, need and inform the provision of healthcare at a population level. In 1993 the UK Department of Health commissioned the Royal College of Psychiatrists' Research Unit (CRU) to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'.	HoNOS has been accepted as part of the Mental Health Minimum Data Set (MHMDS) and implemented by April 2003.	Reliability and validity. Sensitivity in question as to quality of raters.	Training is required plus training costs. Freely available to National Health Service and non-profit organisations. Copyright in the Health of the Nation Outcome Scales (HoNOS) is owned by the Royal College of Psychiatrists. Commercial copying, renting, and adaptation are prohibited. Further information and downloads: *http://www.rcpsych.ac.uk/crtu/healthofthenation/workingageadults/training.aspx* Administrative costs for paper-based glossaries and score sheets. Wing J. Measuring mental health outcomes: a perspective from the Royal College of Psychiatrists. In: Delamonthe T, editor. Outcomes into clinical practice. London: BMJ Publishing; 1994. pp. 147-152.	Practitioner-completed over time. More than or equal to 20 minutes to complete.
Historical Clinical, Risk-20 HCR-20. Related assessment/ tools: Clinical Assessment of Behaviour and Conduct Disorder Scale.	Adult & Forensic Psychiatry. Risk assessment and management tool. Direction of allocating resources.	Scored highest in the evaluation of risk assessment tools for managing the risk of violence by the Risk Management Authority (2006).	Reliability and validity. Translated into several languages.	Training is required. Requires copyright permissions. Purchased from Website: *www.parinc.com* Psychological Assessment Resources, Inc. PO Box 998. Odessa. Florida 33556. USA. Manuals and Guides.	Self-completed. Easy to score and interpret with established cut off points. No software required.

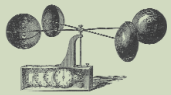
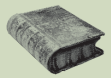




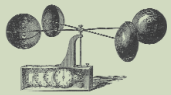
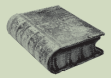

Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
Hospital Anxiety and Depression Scale (HADS).	Anxiety. Depression. To detect states of anxiety and depression. Primary Care. Screening. Used in population of malignant disease and most medical populations.	None reported.	Reliability, validity and sensitivity. Translated into several languages and cultural differences.	Training is not required. **Authors:** Snaith RP, Zigmond AS. Commercial use requires copyright permissions or purchase of the questionnaires, both which must be obtained from: NFER Nelson, The Chiswick Centre, 414 Chiswick High Road, London, W4 5TF **tel:** +44 (0) 20 8996 8445, **fax:** +44 (0)20 8996 3660 **email:** *international@nfer-nelson.co.uk* **Web:** *http://shop.nfer-nelson.co.uk/icat/hospitalanxietyanddepress*	Self-completed. Less than or equal to 10 minutes to complete. Easy to score. No software required.
Illness Perception Questionnaire IPQ. There are several different versions for a number of common illnesses.	Psychology assessment. Measures patients' ideas about an illness around five components: Identity, cause, time-line, consequences and cure/control.	Health illness perception tool across all diagnostic areas.	Reliability and validity. Several languages.	Training is not required. Tool must be referenced. Please see following website: *http://www.uib.no/ipq/html/citing.html* This scale is made available free to health psychology researchers. More are being added all the time. If using the IPQ-R cite the paper: Moss-Morris, R., Weinman, J., Petrie, K. J., Horne, R., Cameron, L.D., & Buick, D. (2002). The Revised Illness Perception Questionnaire (IPQ-R). Psychology and Health. 17, 1-16 The original IPQ-paper can be cited as Weinman, J., Petrie, K.J., Moss-Morris, R., & Horne, R. (1996). The Illness Perception Questionnaire: A new method for assessing illness perceptions. Psychology and Health,	Self-completed. Less than or equal to 20 minutes to complete. Scoring Sheet must be used to assign and interpret values of responses given. *http://www.uib.no/ipq/files/Using%20and%20Scoring%20the%20IPQ-R.doc*

 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
				11, 431-446. The Brief – IPQ can be cited as: Broadbent, E., Petrie, K.J., Main, J., & Weinman, J. (2006). The Brief Illness Perception Questionnaire (BIPQ). Journal of Psychosomatic Research, 60, 631-637	
Impact of Events Scale.	Psychology Services. To measure the cognitive and emotional impact of traumatic events. It is an instrument that can be used for repeated measurement over a period of time. Used amongst Cambodian Refugee Youth Groups (translated by interviewer Administering the questionnaire).	Some normative data available – see *http://www.swin.edu.au/victims/resources/assessment/ptsd/ies.html*.	Reliability and validity. Its sensitivity to change renders it useful for monitoring the client's progress in therapy. Only in English.	Training is not required. Copyright information unavailable. A Word document version of this scale can be found at this URL: *http://mailer.fsu.edu/~cfigley/Tests/IES.doc OR PDF link to questionnaire http://www.swin.edu.au/victims/resources/assessment/ptsd/ies.html* **Developers:** Horowitz, M., Wilner, M., and Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. Psychosomatic Medicine, 41, 209-218.	Self-completed. Easy to score. Less than or equal to 20 minutes to complete. Each item scored 0, 1, 3 or 5, with the higher scores reflecting more stressful impact. It is suggested that the cut-off point is 26, above which a moderate or severe impact is indicated.
Internal State Scale.	Bi-polar affective disorder. Rates manic and depressive symptoms.	Collective data available and cut off scores. Public sector sample.	Reliability and validity. Appears to detect change within an intervention group.	Training is not required. No copyright. Bauer, MS; Crits-Christoph P; Ball WA; Dewees E; McAllister T; Alahi P; et.al. Independent assessment of manic and depressive symptoms by self-rating. Scale characteristics and implications for the study of mania. Archives of General Psychiatry 1991;48(9):807-12. The scale, a manual, and a scoring key are available from the author Mark S. Bauer, M.D Chief, Mental Healthcare and Behavioral Sciences Services	Self-completed. 10-15 minutes to complete. Handbook and scoring sheet – completed manually. Easy to score and interpret.

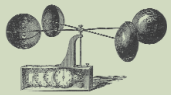
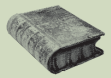
Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
				Department of Veterans Affairs Medical Center 830 Chalkstone Ave Providence, RI 02908-4799 **Available from author:** Mark S Bauer. MD.	
Liebowitz Social Anxiety Scale (LSAS).	Anxiety.	None reported.	Reliability and validity.	**Copyright:** Permissions required. **Developers:** Liebowitz MR. Social Phobia. Mod Probl Pharmacopsychiatry 1987;22:141-173 *Available to complete online: http://www.anxietyhelp.org/information/liebowitz.html* **Printable version from:** *http://healthnet.umassmed.edu/mhealth/LiebowitzSocialAnxietyScale.pdf*	Both self and practitioner completed. More than or equal to 20 minutes to complete.
Life Satisfaction Index.	The Life Satisfaction Index is a measure of general well-being or morale, in older people. It is designed to measure satisfaction or 'successful' ageing. It comprises 20 statements, of which 12 are positive and 8 are negative and the client either agrees or disagrees with the statement (each statement has a score or between 0 and 2). Older Adults.	None reported.	Reliability, validity. It can be used to measure change over time.	Training is not required. **Copyright:** Produced with permission from authors: Neugarten BL, Havighurst RJ, Tobin SS (1961) The measurement of life satisfaction. Journal of Gerontology, 16, 134-143. (Includes copy of the assessment) **Available at:** *http://www.gesher.org/Myers-Briggs/life_satis_index.html*	Self-completed Less than or equal to 20 minutes to complete. Easy to score and interpret.
Maslach Burnout Inventory (MBI).	The MBI is designed to assess the three components of the burnout syndrome: emotional exhaustion, depersonalization, and reduced personal accomplishment. There are 22 items, which are divided into three subscales. The general term recipients are used in the items to refer	Norms available in Manual.	Reliability and validity. **Translation:** Other individual researchers have translated the MBI into various languages, including French,	Training is not required. Copyrighted tool. **Developers:** Christina Maslach and Susan E. Jackson **Available from:** *http://www.cpp.com/detail/detailprod.asp?pc=35* **Costs:** see above website.	Self-completed. 10-15 minutes to complete. **Each score:** total of 3 can be scored using cut off points listed on scoring key.

 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
	to the particular people for whom the respondent provides service, care, or treatment. The items are written in the form of statements about personal feelings or attitudes (e.g., "I feel burned out from my work," "I don't really care what happens to some recipients"). The items are answered in terms of the frequency with which the respondent experiences these feelings, on a 7-point, fully anchored scale (ranging from 0, "never" to 6, "every day"). Because such a response format is least similar to the typical format used in other self-report measures of attitudes and feelings, spurious correlations with other measures (due to similarities of response formats).		German, Dutch, Spanish, Italian, Swedish, Finnish, Polish, Hebrew, and Japanese. As yet, there are no "official" translations of the MBI that are available commercially, as each such translated version will need to be based on extensive psychometric research.		
Maudsley Addiction Profile (MAP).	Treatment outcome. Adults. The MAP is a brief, structured interview for treatment outcome research. It measures problems in four domains: substance use, health risk, physical and psychological health, and personal/social function. The MAP is comparatively brief (two pages) and has been rigorously validated.	None reported.	Reliability, validation stats. Trans cultural.	**Developers:** Marsden et al 1998. **Source ref:** Marsden J, Gossop G, Stewart D, Best D, Farrell M, Lehmann P, Edwards C, Strang J. The Maudsley Addiction Profile (MAP): A brief instrument for assessing treatment outcome. Addiction 1998;93(12):1847-1867. This instrument is in the public domain and can be used freely without charge for non-profit applications, provided the source reference is clearly cited. **Downloaded from:** *http://adai.washington.edu/instruments/pdf/Maudsley_Addiction_Profile_153.pdf* (ADAI)	Practitioner-completed. Less than or equal to 12 minutes to complete. Easy to score and interpret.

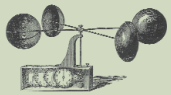
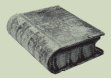
					
Tool	**What it Measures**	**Evidence Based**	**Psychometric Properties**	**Availability**	**Practicalities**
Mental Health Recovery Star. Based on the Outcomes Star that was developed by Triangle Consulting, originally for St Mungo's, and subsequently widely tested and revised for the London Housing Foundation.	Helping recovery from mental illness. Recovery usually means changing things in a number of areas of your life so that things work better Making changes, and understand change in relation to different stages. They find it helps to think about which stage they are in and to get a picture of where they are on their journey. Recovery Star looks at ten dimensions of life: Managing mental health, Relationships, Self-care, Addictive behaviour, Living skills, Responsibilities, Social networks, Identity and self-esteem, Work, Trust and hope.	None reported.	Not applicable.	**Copyrighted:** permissions required. **Free download for non profit organisations.** **Training required.** The Recovery Star is an official version of the Outcomes Star, a suite of tools developed by Triangle Consulting for measuring outcomes in social care. For more information see: *www.starsolutions.org.uk*. **User Guide available at:** *http://www.mhpf.org.uk/documentLibraryDocument.asp?id=286&asset_ID=203*	Self-completed. > 20 minutes to complete. Scoring not applicable. Assessment. No software required.
Mobility Inventory for Agoraphobia.	Agoraphobia. A 27-item inventory for the measurement of self-reported agoraphobic avoidance behaviour and frequency of panic attacks. On this instrument, 26 situations are rated for avoidance both when clients are accompanied and when they are alone.	Non patient control group and cut off scores.	Reliability validity and sensitivity.	**Training is not required.** **Instrument is free.** Chambles et al (1985). Copyrighted by Elsevier Science, the Netherlands. You have permission to download the measures for clinical and research use, and for these purposes you may make as many copiesas you like. It is expressly forbidden to make copies of these measures for sale or publication without explicit written permission from developer; Dianne L. Chambless, Ph.D Department of Psychology University of Pennsylvania 3720 Walnut Street Philadelphia, PA 19104-6241 **email:** *chambless@psych.upenn.edu* **Download measure:** *http://www.psych.upenn.edu/~dchamb/questionnaires/MIA1.jpg*	Self-completed. Less than or equal to 20 minutes to complete. No software required.

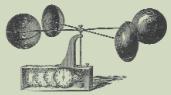
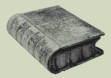




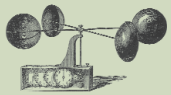
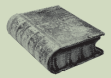

Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
Montgomery & Asberg Depression rating tool (MADRS).	Identifying presence and severity of depression.	None reported.	Reliability validity and sensitivity.	Training is required. Copyright permissions required please see: *http://www.psy-world.com/madrs.htm* Montgomery SA, Asberg M. 1979. A new depression scale designed to be sensitive to change. Br J Psychiatry 132:382–389.	Practitioner/Observer completed/semi structured. More than or equal to 20 minutes to complete. Easy to score and easy to interpret scores and influence practice.
Obsessive Compulsive Inventory (OCI).	For the diagnosis and severity of obsessive-compulsive disorder (OCD). The OCI consists of 42 items composing 7 subscales: Washing, Checking, Doubting, Ordering, Obsessing (i.e., having obsessional thoughts), Hoarding, and Mental Neutralizing.	Tested in non clinical sample.	Reliability validity, sensitivity and specificity.	Training is not required. Instrument is free. No copyright. See source article fro further details FOA, E. B., KOZAK, M. J., SALKOVSKIS, P. M., COLES, M. E., & AMIR, N. (1998). The validation of a new Obsessive-Compulsive Disorder scale: The Obsessive Compulsive Inventory. Psychological Assessment, 10, 206–214.	Self-completed. < 20 minutes to complete. Easy to score and no software required.
OHIO Consumer Assessment 1&2.	To measure how people change in treatment, and determine if the services they receive have an impact. To achieve that end, the Outcomes System is designed to capture information at the beginning and the end of treatment, and if there is long enough in between, to capture information at additional intervals between the beginning and the end. The Outcomes process is about making evidence-based, informed decisions regarding the care and treatment of people Further information from *http://www.mh.state.oh.us/oper/outcomes/outcomes.index.html*.	None reported.	None reported.	Not copyrighted. Available from CSIP webpage: *http://kc.csip.org.uk/viewresource.php?action=viewdocument&doc=81378&grp=1*	Part is self-completed and part is practitioner-completed.

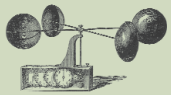
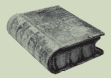

Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
Outcome Rating Scale. Related assessment/tools: GAF (Goal attainment scale).	Measuring change for a variety of therapeutic models and identifies clients at risk or null outcomes for therapy.	Some benchmarking data available.	Reliability & Validity.	Training is not required. Instrument is free. Not copyrighted Free to download at: *http://www.talkingcure.com/bookstore.asp* OR Questionnaire from the following paper: *http://www.talkingcure.com/documents/SessionRatingScale-JBTv3n1.pdf OR http://www.talkingcure.com/index.asp?id=106*	Self-completed. < 2 minutes to complete. Easy to score and interpret.
Panic Rating scale.	Assesses the frequency of panic attacks.	Randomised Clinical Trials data available. Cut off scores available.	Reliability, validity and sensitivity.	Training is not required. Instrument free but copyrighted. Permission required. Clark, D.M., Salkovskis, P.M., Hackman, Middleton, H., Anastasiades, P. and Gelder, M.G. (1994). A comparison of cognitive therapy, applied relaxation and imipramine in the treatment of panic disorder. Trust Psychological Therapies. Copies of both the approved measures and the guidance will be available for downloading and printing from the South London and Maudsley NHS Trust Intranet within the Electronic Patient Journey System.	Self-completed. < 20 minutes to complete. Easy to score and interpret. No software required.
Patient Experience Questionnaire (PEQ) Part 1.	This measure was developed specifically for the Department of Health Improving Assess to Psychological Therapies Programme. (IAPT) It is a measure of patient choice and used to determine	Epidemiological Survey data available.	Reliability and validity.	Training is not required. Instrument is free and can be downloaded from: *www.mhchoice.csip.org.uk/Pathfinder* .	Self-completed. Easy to score and interpret.

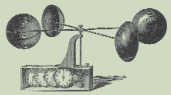
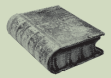
 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
	whether service users have been empowered to make a choice on the options of care and treatment available to them. This is administered once at the start of each step of care.				
Patient Experience Questionnaire (PEQ) Part 2.	This measure was developed specifically for the Department of Health Improving Assess to Psychological Therapies Programme (IAPT). It is a measure of satisfaction and assessing the quality of patient experience helps to determine quality, efficiencies and the effectiveness of services provided. It also enables service providers to appropriately re-design services so that the may have an equal place in the market of contestability. It is administered once at around the end of that step of care. It can either be administered before the end of treatment, or in the final session.	Epidemiological Survey data available.	Reliability and validity.	Training is not required. Instrument is free. Instrument is free and can be downloaded from: *www.mhchoice.csip.org.uk/Pathfinder*	Self-completed. Easy to score and interpret.
Patient Health Questionnaire (PHQ9).	Diagnostic tool of depression as well as severity measure. Like GAD, the PHQ9 is the depression module/ subscale derived from the 60-item Patient Health Questionnaire (PHQ; a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders). Diagnostic Monitoring System Used to measure depressive symptoms across all medical areas.	None reported.	Reliability, validity and sensitivity (established MCD). Several languages.	Training is not required. Instrument is free. PHQ9 Copyright: © Pfizer. Reprinted with permission, courtesy of Pfizer Limited. PRIME-MD ® is a trademark of Pfizer Availability *http://www.patient.co.uk/* Spitzer R, Kroenke K, Williams J. Validation and utility of a self-report version of PRIME-MD: the PHQ Primary Care Study. Journal of the American Medical Association 1999; 282: 1737-1744.	Self-completed. Less than or equal to 20 minutes to complete. Easy to score and interpret hand scored.

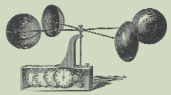
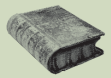
					
Tool	**What it Measures**	**Evidence Based**	**Psychometric Properties**	**Availability**	**Practicalities**
Penn State Worry.	This measure most frequently used to assess pathological worry in both clinical and non-clinical populations. The PSWQ is a 16-item inventory designed to capture the generality, excessiveness, and uncontrollability of pathological worry.	Normative data available.	Reliability, validity and sensitivity.	Training is not required. Instrument is free. **Copyrighted:** Permissions required Contact information: 99 Denmark Hill, London, SE5 8AF. **tel:** 020 3228 2101/020 3228 3286 **fax:** 020 3228 5215 **email:** *anxietydisordersunit@slam.nhs.uk.* Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. Behaviour Research and Therapy, 28, 487–495.	Self-completed. Easy to score. No software required.
Positive And Negative Syndrome Scale (PANSS). Related assessment/tools: PANSS is an advance on BPRS.	Schizophrenia and related disorders PANSS is a 30-item rating instrument evaluating the presence/absence and severity of positive, negative and general psychopathology of schizophrenia. The scale was developed from the BPRS and the Psychopathology Rating Scale. Drug-sensitive instrument.	None reported.	Reliability and validity. Lacks Sensitivity. Translated into several languages.	Personnel trained in psychiatric interview techniques, with experience working with populations with schizophrenia (e.g. psychiatrists, mental healthcare professionals). **Copyrighted.** Instrument pricing availability upon email contact only *customerservice@mhs.com* **Available to view:** *http://www.bli.unizh.ch/BLI/PDF/panss.pdf.* Kay SR, Fiszbein A, Opler LA. The Positive and Negative Syndrome Scale for schizophrenia. Schizophr Bull. 1987; 13:261-276. Kay SR. Positive and negative syndromes in schizophrenia. New York: Brunner-Mazel; 1991. Psychiatric University Hospital Zurich, Division of Clinical Psychiatry.	**Practitioner/Observer completed.** **30-40 minutes to complete.** **Hand scored.** **Software not required.** All 30 items are rated on a 7-point scale (1=absent; 7=extreme).

 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
Profile of Mood States (POMS).	Psychological assessment. Since its release in 1971, the POMS assessment has proven itself to be an excellent measure of affective mood state fluctuation in a wide variety of populations including psychiatric outpatients, medical patients, and in sports psychology. The POMS assessment is suitable for individuals aged 18 and older. It can be completed individually or in groups. Adults.	The POMS Brief form includes psychiatric outpatient norms. These were derived from a sample of 1000 persons who completed the POMS assessment at their initial visit to a University medical centre psychiatry clinic. The POMS Standard form includes the same psychiatric outpatient norms, as well as college student and updated adult and geriatric norms. College student norms were derived from 856 volunteer undergraduates at a large eastern university. Adult norms were taken from a group of 400 volunteers aged 18–94, stratified by age, gender, and race, according to the 1990 U.S. census. Geriatric norms came from a sample of 170	Reliability, validity and sensitivity.	Training is not required. **Source ref:** McNair DM; Lorr M. An analysis of mood in neurotics. Journal of Abnormal and Social Psychology 1964;69:620-627 **Copyright:** 2003 by Maurice Lorr, Ph.D.; Douglas M. McNair, Ph.D.; and JW P. Heuchert, Ph.D., under exclusive license to Multi-Health Systems, Inc. A POMS Bipolar version is also available. Multi-Health Systems, Inc. **tel:** 1-800-456-3003 **email:** *customerservice@mhs.com* For Pricing Information: *http://www.mhs.com*	Self-completed. 5-10 minutes to complete. Hand scored. No software required; paper and pencil.

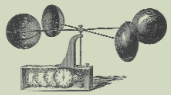
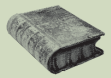
Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
		people aged 55 and older, selected to match census proportions on age, sex, and race.			
Psychotic Symptom Rating. Scales: Delusions.	Episodic Psychosis. Scales to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales (PSYRATS).	None reported.	Reliability and validity. English language only.	Trained professionals required to administer this tool. Not copyrighted. Haddock, G., McCarron, J., Tarrier, N. and Faragher, E.B. (1999). Scales to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales (PSYRATS). Psychological Medicine, 29, 879-889 Appendix A. The PSYRATS Scale detailed in Haddock et al. (1999)	Practitioner-completed. Semi Structured interview.
PSYCHLOPS.	Used in Primary Care. Mental Health Outcome Measure (subjective).	None reported.	Validity and sensitivity.	Training is not required. There is a small sum for use of the questionnaire to be invested equally in primary care mental health research and user group 'Depression Alliance', the two organisations that helped PSYCHLOPS. Address for correspondence: Mark Ashworth, GKT, Department of General Practice and Primary Care, King's College London, 5 Lambeth Walk, London SE11 6SP. *mark.ashworth@gp-G85053.nhs.uk*	Self-completed. < 20 minutes to complete. Easy to score. Meaningful scores.
Role Functioning Scale.	Assessing improvement in psychosocial functioning among persons with severe	None reported.	Reliability, validity and sensitivity.	Training only required after initial interview intake.	Practitioner-completed. Completed in few

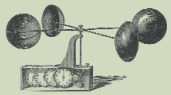
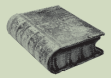
 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
	and persistent mental illness after exposure to different clinical interventions.		Tested in cultural populations i.e. African American.	Instrument is free and not copyrighted. Goodman SH, Sewell DR, Cooley EL, and Leavitt N Assessing levels of adaptive functioning: Role Function Scale Community Mental Health Journal April 1993, 29(2): 119-131.	minutes after standard interview intake. Easy to administer and interpret scores.
Schwartz Outcome Scale.	Outcome measure. Quality of Life. To measure the effectiveness of mental health treatment across a wide range of mental health services and populations.	Dr. Blais maintains and updates the SOS-10 normative and benchmark database.	Reliability, validity and translated into several languages.	Training is not required. Contact: *MBlais@Partners.Org* Blais et al. (1999). Instrument is free. Copyright: permissions required.	Self-completed. < 20 minutes to complete. Easy to score and administer.
Session Rating Scale. Related assessment/tools: GAF (Goal attainment scale)	Reports on therapeutic fit related to therapeutic outcomes.	None reported.	Reliability and validity.	Training is not required. Not copyrighted. Instrument is free. Questionnaire from the following paper: *http://www.talkingcure.com/documents/SessionRatingScale-JBTv3n1.pdf* OR *http://www.talkingcure.com/ index.asp?id=106*	Self-completed. < 2 minutes to complete. Easy to score and interpret.
Sheehan Disability Scale.	Panic disorder and depression. Further sourcing.	For primary care population norms for the work, social, and family subscales are 2.01 (2.49), 2.02 (2.70), and 2.08 (2.68), respectively.	Reliability, validity and sensitivity. Translated into several languages.	Training is not required. Dr David V. Sheehan. Copyright contact Developer for permissions. See following: *http://www.cqaimh.org/pdf/tool_lof_sds.pdf*	Self-completed. < 20 minutes to complete. Easy to score and interpret.
Short Form 36 (SF-36). Related assessment/ tools:	Generic. Quality of Life. The SF-36 is a multi-purpose short measure of quality of life developed by the	Benchmarking and normative data available.	Reliability, validity and sensitivity. Translated into several languages.	Training is not required. Developed by Ware JE (1990). Brazier JE, Harper R, Jones NMB, O'Cathain A, Thomas KJ, Usherwood	Self-completed. Less than or equal to 20 minutes to complete. Computer assisted

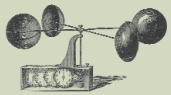
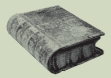
					
Tool	**What it Measures**	**Evidence Based**	**Psychometric Properties**	**Availability**	**Practicalities**
SF20, SF12	Medical Outcomes Trust. It contains 36 items, assesses general health status and can be used to demonstrate outcomes. It focuses on eight health concepts: physical function, role limitations due to physical health problems, pain, general health, vitality (energy and fatigue), social function, role limitations due to emotional problems, and mental health (psychological distress and well being). It was designed for use in clinical practice, health policy evaluations and general population surveys. Suitable for all areas primary care community.			T, Westlake L (1992) Validating the SF-36 health survey questionnaire: a new outcome measure for primary care. British Medical Journal, 305, 160-164. **Copyright and licence must be purchased from:** QualityMetric Inc., 640 George Washington Highway, Lincoln, RI 02865, USA. Tel: 001 401 334 8800, *http://www.qmetric.com/* OR *http://www.sf-36.com* OR from: Medical Outcomes Trust PMB #503, 198 Tremont Street, Boston, MA 02116-4705. **tel:** 001 617 426 4046, **fax:** 001 617 587 4232, *http://www.outcomes-trust.org*	packages available for scoring if required.
Social Adaptation Self-Evaluation Scale.	Assessment of successful social adjustment in community living, for people with depression. It was designed primarily to evaluate the effects of drug treatment and psychotherapy, but can be also used before and after occupational therapy. It includes 42 questions covering role performance in six areas of role functioning: work, social and leisure activities, relationships with extended family, roles as spouse, parent and members of the family unit. Generic.	European, UK and American Clinical trials. Published norms available.	Reliability, validity and sensitivity. Spanish version available as tested in American – Hispanic populations.	**Training is not required.** Weissman MM, Bothwell S (1976) Assessment of social adjustment by patient self-report. Archives of General Psychiatry, 33, 1111-1115. Produced with permission. **Can be obtained from:** Myrna Weissman, PhD, College of Physicians and Surgeons of Columbia University, 722 west 168th Street, Box 14, New York, USA 10032.	**Self-completed. Less than or equal to 20 minutes to complete.**
Social Adjustment Scale.	The Social Adjustment Scale is a self-report assessment of successful social adjustment in community living, for people with depression. It was designed	Published clinical trial data.	Reliability, validity and sensitivity. Cultural comparisons.	**Training is not required. Instrument is free. Copyright:** Permissions required see below	**Self-completed. Less than or equal to 20 minutes to complete.**

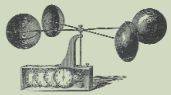
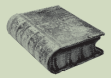





Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
	primarily to evaluate the effects of drug treatment and psychotherapy, but can be also used before and after occupational therapy. It includes 42 questions covering role performance in six areas of role functioning: work, social and leisure activities, relationships with extended family, roles as spouse, parent and members of the family unit. Generic measure of social function.		Translated into several languages.	Weissman MM, Bothwell S (1976) Assessment of social adjustment by patient self-report. Archives of General Psychiatry, 33, 1111-1115. Can be obtained from Myrna Weissman, PhD, College of Physicians and Surgeons of Columbia University, 722 west 168th Street, Box 14, New York, USA 10032.	
Social Functioning Scale (SFS). Related assessment/ tools: Similarities with MRC Needs of care assessment	To measure the efficacy of family interventions including: the measurement of skill/behaviour relevant to the impairments and the demography of schizophrenic patients; the ability to yield considerable information with an economy of clinical time; and the establishment of 'comparative' need through comparison between subscales and with appropriate reference groups. Schizophrenia. Community.	Normative data available on family intervention.	Reliability, validity and sensitivity. Also has been used in Chinese communities *http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1440-1819.2007.01630.x* Clinical utility.	**Training is not required. Please refer to the following article for permissions and requests:** The Social Functioning Scale. The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. M Birchwood, J Smith, R Cochrane, S Wetton and S Copestake.	**Self-completed. Less than or equal to 20 minutes to complete. No software required.**
Social Phobia Inventory (SPIN).	Screening and diagnostic tool for social phobia presence or absence.	Randomised Clinical Trial data available.	Reliability, validity and sensitivity. Available in English only.	**Training is not required. Copyright:** ©2000 J.R. Davidson. **Scale can be viewed:** *http://healthnet.umassmed.edu/mhealth/SocialPhobiaInventory.pdf* From Connor K., Davidson J., Churchill L., Sherwood A., Foa E., Weisler R., "Psychometric properties of the Social Phobia Inventory". Br J Psychiatry.2000: 176:379-86.	**Self-completed. Brief and easy to score. No software required.**

					
Tool	**What it Measures**	**Evidence Based**	**Psychometric Properties**	**Availability**	**Practicalities**
Social Summary Rating Scale. Related assessment/tools: adaptation of the Social Phobia Weekly Summary Scale (SPWSS).	To assess social anxiety.	None reported.	Reliability, validity and sensitivity.	Training is not required. Instrument is free but copyright.	Self-completed. Easy to score and interpret. No software required.
The Barrett Lennard Inventory.	Psychological therapies. Client change due to therapy.	None reported.	Validity.	Training is not required. Copyrighted. Instrument is not free. Contact: *David.Glentworth@bstmht.nhs.uk*	Self-completed. < 20 minutes to complete. Scores easily interpreted.
The How are you scale.	A quality-of-life outcomes measure for routine practice: Measures the user's view of their participation in Daily activities, relationships, circumstances, physical and Mental well-being. Developed in consultation with service users with long-term mental health problems. Generates a CORE Outcome measure score.	UK National norms available from National Psychiatric Morbidity Survey. Scientific programme based at CORE, UCL is developing further national norms and benchmarks.	Reliability, validity and sensitivity.	Training is not required. Clifford P., Katsavdakis K., Lyle J., Fultz J., Allen J., Graham P., (2002) How Are You? Further development of a generic quality of life outcome measure. Journal of Mental Health 11,4, pp. 389-404. Copyrighted, contact developers: FACE Recording & Measurement Systems, 12 Bridlesmith Walk, Bridlesmith Gate, Nottingham NG1 2GR. Tel: 0115 983 8789, Fax: 0115 983 8788. **Further information on cost and software:** *info@facecode.com, http://www.facecode.com/tools.html*	Self-completed. Brief and user friendly. Easy to score and interpret. Service user can indicate 'key concerns'.

 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
The Inventory Of Interpersonal Problems. (IIP-127 Item Version) Related assessment/tools: Several Annexes.	Personality Disorder. The Inventory for Interpersonal Problems (IIP) is designed to identify the most common interpersonal problems reported by psychotherapy clients.	Non-clinical population data.	Reliability, validity and sensitivity	Training is not required. No copyright information. Refer to source article Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasonor, V. S. (1988). Inventory of Interpersonal Problems: Psychometric properties and clinical applications. Journal of Consulting and Clinical Psychology, 56, 885–892.	Self-completed. Easy to score. No software required.
The Severity Dependence Scale.	The SDS is a short, easily administered instrument developed to provide a brief, easily administered measure of the psychological aspects of dependence experienced by users of various types of illicit drugs. It is a measure of compulsive use; its five items relate to an individual's preoccupation and anxieties about their own drug taking, as well as feelings of impaired control over their drug use. Adults. Adolescents.	None reported.	The psychometric properties of the SDS have been well established in adult populations, as well as adolescent ones. It demonstrates high test-retest correlations and good internal consistency. Detailed psychometric information can be found in the source references and other references above The scale is available in multiple languages (including English, Chinese, Czech, Farsi, Indonesian, Lithuanian, Polish, Russian, and Thai)	No training. Not copyrighted, Gossop, Michael; Darke, Shane; Griffiths, Paul;Hando, Julie; Powis, Beverly; Hall, Wayne; Strang, John *http://adai.washington.edu/instruments/pdf/Severity_of_Dependence_Scale_397.pdf*	Self-completed. Less than or equal to 20 minutes to complete. The five items in this scale are scored on a four-point Likert scale. The total score can be obtained by addition of scores for all items, with higher total scores indicating higher levels of dependence.

 Tool	 What it Measures	 Evidence Based	 Psychometric Properties	 Availability	 Practicalities
			from the World Health Organization: *http://www.who.int/substance_abuse/research_tools/severitydependencescale/en/index.html.*		
Threshold Assessment Grid (TAG).	To identify those people whose mental health problems are of sufficient severity to warrant access to secondary mental health services.	Some benchmarking data available. Used in Randomised Clinical Trials NHS Service Delivery and Organisation R&D Programme *www.sdo.lshtm.ac.uk* UK Mental Health Research Network *www.mhrn.info.*	Reliability, validity and sensitivity.	Training is not required. Not copyrighted. Developers Original TAG development team (1994 – 1996) Robin Powell, Mike Slade Geraldine Strathdee Download available: *http://www.iop.kcl.ac.uk/virtual/?path=/hsr/prism/tag/* Developers Slade et al (2000) see ref below Score sheet included in appendix *http://www.springerlink.com/content/8qhex62w0ryxpp5b/fulltext.pdf* Mike Slade, Section of Community Mental Health *m.slade@iop.kcl.ac.uk*	Practitioner-completed. Less than or equal to 20 minutes to complete. Easy to score and no software required.
Work & Social Adjustment Scale (WSAS).	A 5-item measure of general impairment. This measure has been used in Department of Health to improve access to Psychological Therapies pilots.	None reported.	Reliability and validity.	The copyright in WSAS is owned by I. M. M. Financial support from Pfizer, Inc *http://cat.inist.fr/?aModele=afficheN&cpsidt=13777885* Marks et al adapted it further to measure outcome of most patients in treatment and later added its fifth item	Self-completed. Less than or equal to 5 minutes to complete.


Tool	What it Measures	Evidence Based	Psychometric Properties	Availability	Practicalities
				concerning interpersonal relations. Training is not required. Downloadable from: *http://www.iapt.nhs.uk/2008/07/improving-access-to-psychological-therapies-iapt-outcomes-toolkit/*	
World Health Organisation Short Disability Assessment Schedule (WHODAS-S). Available in eleven versions.	The WHODAS-S can be used for measuring the level of disability across various conditions and interventions. It includes six domains: understanding and communicating, getting around, self care, getting along with others, household and work activities, and participation in society. Adults aged 18 and over.	Normative data available.	Reliability, validity and sensitivity. Cross-culturally developed, and applicable across the spectrum of cultural and educational backgrounds. Available in sixteen languages.	Versions of the WHODAS II are available through the WHO – namely a fully structured self administered version, an interviewer administered version, and a proxy version. There is a short and a long item version of each. A semi structured questionnaire is being developed. It can be downloaded from: *http://www.who.int/ icidh/whodas/ index.html*	Self-completed. 12-item versions: Less than or equal to 5 minutes to complete. 36-item versions: Less than or equal to 20 minutes to complete.
Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). Related assessment/tools: YBOCS –hd (heavy drinkers available)	OCD. Nervous anorexia; Alimentary behaviour disturbance; Concomitant disease. Evaluation scale. Symptom severity. And outcome measure in clinical trials. The primary use of the Y-BOCS is in rating the severity of obsessive-compulsive disorder (OCD), with emphasis on its ability to reflect changes in severity during treatment.	Randomised Clinical Trial data.	The measure shows a high degree of internal consistency, and all items significantly correlated with the total Y-BOCS score. Also has MCID values, i.e. sensitivity to treatment effects.	Training required. Can be downloaded from Internet: *http://www.brainphysics.com/research/ybocs.pdf* Developers should be acknowledged Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, Heninger GR, Charney DS. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. Arch Gen Psychiatry 198946(11):1006-11 Goodman WK, Price LH, Rasmussen SA, Mazure C, Delgado P, Heninger GR, Charney DS. The Yale-Brown Obsessive Compulsive Scale. II. Validity. Arch Gen Psychiatry 1989;46(11):1012-6.	Practitioner-completed. 25-30 minutes to administer. Trained interviewers.

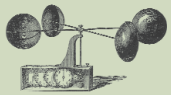
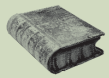
					
Tool	**What it Measures**	**Evidence Based**	**Psychometric Properties**	**Availability**	**Practicalities**
Zanarini scale for Borderline.	Borderline Personality Disorder. The scale also measures meaningful changes in symptoms over time. This 9-item measure includes four categories: affective, cognitive, impulsive, interpersonal.	None reported.	Reliability & Validity. Validated on a population of 200 community patients: 139 with BPD who were neither psychotic nor manic, and 61 without BPD who met criteria for a DSM-IV Axis 1 disorder such as Major Depression or Substance Abuse. The large majority of BPD patients were female (76%), and Caucasian (84%), with an average age of 33 years.	Copyright. Developers: Reference: Zanarini MC, Vujanovic AA, Parachini EA, Boulanger JL, Frankenburg FR, Hennen J. (2003). Zanarini rating scale for borderline personality disorder (ZAN-BPD): A continuous measure of DSM-IV borderline psychopathology. Journal of Personality Disorders, 17(3): 233-242. Training required. Can be purchased for $19.95/pack 20. See website: *http://www.compactclinicals.com/assessment-tools/zanarini-rating.html*	Practitioner-completed. Completed More than or equal to 20 minutes. The 0-4 points rating ranges from No Symptoms (0) to Severe Symptoms (4).

Table 4 - Alphabetical listing of 188

This table lists alphabetically the instruments retrieved by literature searching and Practice Group recommendations.

☞ Instruments that were short listed by QM, or put forward by the practice group or recommended by both have been highlighted.

KEY:

* QM recommended instrument based on our quality scoring

† Practice Group/Stakeholder recommended instrument

‡ QM and Practice Group recommended instrument

Assessment/Tool
*Abnormal Involuntary Movement Scale.
*Addiction Severity Scale/Index
Adult Psychiatric Morbidity Questionnaire (1982)
Agoraphobic Self Statements Questionnaire (ASQ)
*Alcohol Use Disorder Identification Test (AUDIT)
Alcohol Withdrawal Symptom Scale
Allen Cognitive Level Screen Assessment
*Amritsar Depression Inventory
Anxiety Disorders Interview Schedule for DSM
Assessment of Communication & Interaction Skills (ACIS)
Assessment of Motor and Process Skills (AMPS)
†Auditory Hallucination Scale
AVON Mental Health Measure
Barthel Index
*Beck Depression Inventory
*Beck Hopelessness Scale
Behaviour and Symptom Identification Scale
Blessed Dementia Rating Scale
*Borderline Personality Disorder Severity Index (BPDSI),
Borderline Syndrome Index
Brief Psychiatric Rating Scale

Assessment/Tool
Brief Social Phobia Scale
Brief Symptom Inventory (BSI)
Bristol Activities of Daily Living Scale
Brown Assessment of Beliefs Scale
Brown Attention Deficit Disorder Scales
Camberwell Assessment of Needs (CANSAS)
Cambridge Cognitive Examination (CAMCOG)
‡Carers & Users Expectations of Service (CUES)
‡Centre for Epidemiological Studies Depression Scale
†Chronic Fatigue Questionnaire
‡Client Satisfaction Questionnaire
Clinical Global Impressions Scale
‡Clinical Outcomes Routine Evaluation (CORE)
Community Program Practice Scale
†Comprehensive Assessment of At Risk Mental States CAARMS
Connors Adult ADHD Rating Scale-
Consumer Assessment of Behavioural Health Survey (CABHS)
Controlled Oral Word Association Test
Crichton Royal behaviour rating scale
Depression – Arkansas rating scale
Depression Attitude Questionnaire
†DREEM
Drug taking confidence questionnaire
Eating Attitudes Test 26 (EAT 26)
‡Eating Disorders Examination Questionnaire (EDE-Q)
Eating Disorders Inventory
*Edinburgh Postnatal Depression Scale (EPDS)
Environment Behaviour Interaction Scale
Environment Behaviour Interaction Code (EBIC)
*EuroQol 5-dimensions (EQ-5D)

Assessment/Tool
Experience of Care and Health Outcomes Survey
Experiential Shame Scale (ESS)
Eysenck Personality Questionnaire
Family Accommodation Scale
Fear of Negative Evaluation Scale
†Fear Questionnaire
Follow Up Adjustment Scale
†Functional assessment of the Care Environment (FACE)
GADS (Aspergers)
†GAD7
GARS -2 (Autism)
‡General Health Questionnaire 12 (GHQ-12)
General-Demand Orientated Care Questionnaire (DOC-G)
General-Demand Orientated Supplementary Questionnaire (DOC-S)
†Geriatric Depression Scale
Geriatric Scale of Recent Life Events
Global Assessment of Functioning Scale (GAF)
Global Assessment Scale (GAS)
Goal Attainment Scale
Goteborg Quality of Life
Greenley Stigma Scale
Hamilton Depression Rating Scale (HDRS)
Harvard Trauma Questionnaire
†Health Anxiety Inventory (HAI)
‡Health of the Nation Outcome Scale (HoNos) - Various Annexes
*Historical Clinical, Risk-20 HCR-20
Hopkins Symptom Checklist
*Hospital Anxiety and Depression Scale (HADS)
‡Illness Perception Questionnaire IPQ
‡Impact of Events Scale

Assessment/Tool
Independent Living Skills Survey
†Internal State Scale
Interpersonal Problem Area Rating Scale
Inventory of Depressive Symptomatology
Inventory of Emotional Distress
Kessler 10 Psychological Distress Scale (K10)
KGV-M Scale
Lancashire Quality of Life
Lehman's Quality of Life Scale
‡Liebowitz Social Anxiety Scale (LSAS)
Life Experiences Checklist (LEC)
*Life Satisfaction Index
Life Stressors & Social Resources Inventory
Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS)
Longitudinal Interval Follow up Evaluation
MacNeill-Lichtenberg Decision Tree (MLDT)
Manchester Short Assessment of Quality of Life (MANSA)
*Maslach Burnout Inventory
Mattis Dementia Scale
‡Maudsley Addiction Profile
†Mental Health Recovery Star
Mental Health Statistics Improvement Program (MHSIP)
Millon Clinical Multi-Axial Inventory-111
Mini - Psychiatric Assessment Schedule for Adults with a Developmental Disability (PAS-ADD) Checklist
Mini-Mental State Examination (MMSE)
Minnesota Multi phasic Personality Inventory
MOHOST Assessment
†Mobility Inventory for Agoraphobia
†Montgomery & Asberg Depression rating tool (MADRS)

Assessment/Tool
Mood Disorder Questionnaire
MRC-Needs for Psychiatric Care Assessment Schedule
Nijmegen Motivation List for Prevention
†Obsessive Compulsive Inventory (OCI)
OCAIRS Assessment
†OHIO Consumer Assessment 1& 2
Opiate Treatment Index (OTI)
Opiate Withdrawal Scale
†Outcome Rating Scale
OSA Assessment
Panic Outcomes Module
†Panic Rating scale
†Patient Experience Questionnaire (PEQ) Part 1
†Patient Experience Questionnaire (PEQ) Part 2
‡Patient Health Questionnaire (PHQ9)
†Penn State Worry
Personal Feelings Questionnaire (PFQ-2)
Personality Diagnostic Questionnaire
†Positive And Negative Syndrome Scale (PANSS)
Present State Examination
*Profile of Mood States (POMS)
Psychiatric Assessment Schedule
Psychiatric Care Satisfaction Questionnaire
†PSYCHLOPS
Psychopathy Checklist PCL (Hare Psychopathy Scale)
‡Psychotic Symptom Rating Scales: Delusions
PTSD Checklist
Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q),
Rivermead Assessment of Somtosensory Performance
Rivermead Behavioural Memory Test

Assessment/Tool
*Role Functioning Scale
Rosenberg's Self-Esteem Scale
RSVP for sex offenders
*Schwartz Outcome Scale
†Session Rating Scale
Severity of Alcohol Dependence Questionnaire SADQ
Shedler-Westen Assessment Procedure (SWAP)
*Sheehan Disability Scale
*Short Form 36
Sickness Impact Profile (SIP)
*Social Adaptation Self-Evaluation Scale
*Social Adjustment Scale
Social and Occupational Functioning Scale (SOFAS)
Social Anxiety Questionnaire
Social Behaviour Scale
*Social Functioning Scale
Social Interaction and Anxiety Scale SIAS
‡Social Phobia Inventory (SPIN)
Social Phobia Scale SPS
Social Problems Questionnaire
Social Provision Scale
†Social Summary Rating Scale
STAR Clinician (STAR-P) and patient scales (STAR-C)
State-Trait Anger Expression Inventory
Structured Clinical Interview fro DSM
Symptom checklist 90-R
Test of Self-Conscious Affect (TOSCA-3)
†The Barrett Lennard Inventory
The Burden Assessment Scale
The Family Burden Scale

Assessment/Tool
‡The How are you scale
The Interview Schedule for Social Interaction
‡The Inventory Of Interpersonal Problems (IIP-127 Item Version)
The Mental Illness Needs Index
‡The Severity Dependence Scale
The Social Avoidance and Distress Scale (SADS)
‡Threshold Assessment Grid (TAG)
Verona Satisfaction with Services Scale
Weschler Abbreviated Scale of Intelligence (WASI)
Weschler Adult Intelligence Scale (WAIS)
Weschler Memory Scale (WSM)
Wessex Head Injury Matrix (WHIM)
World Health Organisation Short Disability Assessment Schedule (WHODAS-S)
†Work and Social Adjustment Scale
‡Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
Young Adult Self Report Form
†Zanarini scale for Borderline
Zarit Burden Scale

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