Daily Living Activities (DLA-20)


Two studies evaluated the validity and reliability of the Daily Living Activities Scale (DLA), a 20-item functional assessment measure for adults with severe mental disorders. Method: The first study evaluated the internal consistency and interrater reliability of the DLA scoring for 85 clients with severe mental disorders currently receiving services from one of five different treatment programs. In the second study, symptomatology and functional assessment data were collected for 886 clients at time of admission to three different levels of care in community treatment and support services and at the time of 6-month progress reviews. Results: Internal consistency and interrater reliability were adequate. Criterion-related validity was evidenced by the ability of DLA scores to differentiate consumers in different levels of care and by diagnostic categories. Conclusions: Study findings provide evidence of the usefulness of the DLA to support the functional assessment data needs of service providers.

http://www.thenationalcouncil.org/galleries/resources-services%20files/DLA%20Sample.pdf

Aberrant Behavior Checklist (ABC)


The factor validity of the new Aberrant Behavior Checklist-Community (ABC-C) was determined with 1,024 (58.9% male) mentally retarded group home residents (aged 18–89 yrs). Copies of the ABC-C were completed by the home's team members who had knowledge of the S's behavior during the preceding 4 wks. Analyses for the effects of age, gender, and level of mental retardation indicated that some correction is appropriate for each of these variables when scoring the ABC-C. Although not intended for a residential setting, the original ABC factor structure appears valid for scoring the ABC-C with community-based adults.


This study was designed to compare and cross-validate two rating instruments [the Aberrant Behavior Checklist (ABC) and the Behavior Problems Inventory (BPI)] for assessing maladaptive behavior. The BPI assesses three types of behavior problems: Self-Injurious Behavior (SIB), Stereotyped Behavior and Aggressive/Destructive Behavior. The ABC assesses five domains including these three. We collected data on 226 adults, mostly with severe or profound mental retardation, from a medium-sized developmental center. Individuals with elevated BPI scores generally had higher ABC scores; however, the extent of covariation differed across subscales. Similarly, multiple regression analyses showed that BPI subscales significantly but selectively predicted ABC subscale scores. Measures of differential diagnostic value (positive and negative predictive power, sensitivity, specificity
and overall correct diagnostic efficiency) confirmed the anticipated partial overlap between instruments. Both instruments were used to rate participants with and without a Diagnosis of Stereotyped Movement Disorder. BPI, SIB and Stereotypy subscale composite had stronger positive predictive power than the ABC Stereotypy scale, while the ABC had higher negative predictive power and greater overall diagnostic efficiency. Thus, the ABC and the BPI cross-validated one another where expected, and they diverged for subscales thought to have little relationship.


Progress in clinical research and in empirically supported interventions in the area of psychopathology in intellectual disabilities (ID) depends on high-quality assessment instruments. To this end, psychometric properties of four instruments were examined: the Aberrant Behavior Checklist (ABC), the Assessment of Dual Diagnosis (ADD), the Anxiety, Depression and Mood Scale (ADAMS), and the Social Performance Survey Schedule (SPSS). Data were collected in two community-based groups of adults with mild to profound ID (n = 263). Subscale reliability (internal consistency) ranged from fair to excellent for the ABC, the ADAMS, and the SPSS (mean coefficient α across ABC subscales was .87 (ranging from fair to excellent), the ADAMS subscales .83 (ranging from fair to good), and the SPSS subscales .91 (range from good to excellent). The ADD subscales had generally lower reliability scores with a mean of .59 (ranging from unacceptable to good). Convergent and discriminant validity was determined by bivariate Spearman r correlations between subscales of one instrument and the subscales of the other three instruments. For the most part, all four instruments showed solid convergent and discriminant validity. To examine the factorial validity, Confirmatory Factor Analyses (CFA) were attempted with the interitem covariance matrix of each instrument. Generally, the data did not show good fits with the measurement models for the SPSS, ABC, or the ADAMS (CFA analyses with the ADD would not converge). However, most of the items on these three instruments had significant loadings on their respective factors.


The Aberrant Behavior Checklist (ABC; Aman, Singh, Stewart, & Field, 1985a, 1985b) is a 58-item third-party informant rating scale originally developed for institutionalized, low-functioning adolescents and adults. The present study investigated the appropriateness of the scale for youngsters with dual diagnosis of mental retardation and psychiatric disturbance. Over a period of 2 1/2 years, 204 patients (199 after data reduction) from a child psychiatry unit were rated twice daily by direct care staff. Data analysis addressed internal consistency, interrater reliability, criterion validity, and robustness of the factor structure. Internal consistency was satisfactory with alpha coefficients ranging from .82 to .94. Interrater reliability varied between subscales but was relatively low (Pearson correlations between .39 to .61). In terms of its criterion validity, the ABC was sensitive to psychiatric diagnoses and age and the original 5-factor structure was
robust (congruence coefficients ranged between .80 to .89). Yet, only a relatively small proportion of the variance (31.5%) was explained by factor analysis indicating possible limitations of the ABC for this population. Given the paucity of assessment instruments for this particular population and the difficulty involved in developing new population-specific instruments, the ABC can be recommended for children and adolescents with dual diagnosis.

http://www.stoeltingco.com/stoelting/2257/1467/1497/Psychological/Aberrant-Behavior-Checklist-ABC

Behavior Problems Inventory


Challenging behaviour may not be part of the diagnostic criteria for Autistic Disorder but they are frequently exhibited by children and adults with this condition. Levels of challenging behaviours are highest in individuals with an autism spectrum disorder (ASD) and co-occurring intellectual disability (ID). The sample for this study consisted of 57 institutionalized adults with ID who either did or did not meet criteria for an ASD on a screening instrument [*Autism Spectrum Disorders-Diagnosis for Intellectually Disabled Adults* (ASD-DA)]. These two groups were compared on two parallel measures of challenging behaviour commonly used with this population: the *Behavior Problems Inventory-01* (BPI-01) and *Autism Spectrum Disorders-Behavior Problems for Intellectually Disabled Adults* (ASD-BPA). Consistent with previous research, individuals with ASD demonstrated higher levels of overall challenging behaviour and especially with regard to self-injurious and stereotypical behaviours. The convergent validity of these two scales was also demonstrated for the entire sample and by group.


The aim of the present study was to evaluate the psychometric properties and factor structure of the Behavior Problems Inventory (BPI-01) in a community population. The Swedish version of the BPI-01 was administered by interviewing care staff of all adults (n = 915) with administratively defined intellectual disabilities (IDs) living in Örebro County, Sweden. Sixty-two percent of the participants had at least one behavior problem. Altogether, 30.9% showed self-injurious behavior, 41.3% stereotyped behavior, and 34.8% aggressive/destructive behavior. All but the self-injurious behavior scale reached acceptable levels of internal consistency. Confirmatory factor analysis supported the unidimensionality of the subscales as well as the proposed three factor structure of the original BPI-01. The present study demonstrates that the three subscales are highly similar constructs across different language and cultural settings, and that the BPI-01 is applicable in research on populations with varying mental functioning, diagnoses, ages, and living arrangements.

This study was conducted to assess the psychometric properties of 2 assessment instruments, the Behavior Problems Inventory-01 and the Nisonger Child Behavior Rating Form (NCBRF). The sample consisted of 237 ethnically diverse children and adolescents with intellectual disabilities who ranged in age from 4 to 22 years. Reliability parameters included internal consistency, inter-teacher agreement, teacher-parent agreement, and test-retest reliability. Factorial validity was assessed first by bivariate Spearman rank (ρ) correlations and then by examining the factor structure fit via confirmatory factor analysis (CFA). Convergent and discriminant validity was assessed by multiple regression analyses across the 2 instruments. Reliability coefficients (internal consistency, inter-teacher agreement, and test-retest reliability) of the BPI-01 and of the NCBRF subscales ranged from fair to excellent and from poor to excellent, respectively. The CFA suggested a poor fit between the present and the original BPI-01 and NCBRF factor structures, although item-total correlations were reasonable. Convergent and discriminant validity between the BPI-01 and the NCBRF, however, was strong. Limitations of the study are discussed and recommendations for future studies are presented.


Reliability and concurrent validity of the Behavior Problems Inventory was examined in a sample of 130 community residing adults with mild to profound intellectual disabilities with high rates of behavior problems and concurrent mental health problems. The BPI-01 and the Inventory for Client and Agency Planning were administered twice within a mean time interval of 7.8 weeks by 20 trained and experienced staff members. All three BPI-01 subscales had high inter-rater agreement, and stable test–retest reliability (SIB, mean ICC=.91; mean Stereotyped Behavior, mean ICC=.89, and Aggressive/Destructive Behavior, mean ICC=.88); internal consistency ranged from poor (SIB: α=.61) to excellent (Stereotyped Behavior, α=.90). Using the ICAP as criterion measure, the BPI-01 showed robust convergent validity. Solid relationships between BPI-01 subscales and corresponding ICAP subscales corroborated the concurrent validity of the BPI-01.

Background The aim of this study was to reevaluate the reliability (internal consistency, inter-rater and re-test) and the factor structure of the Behavior Problems Inventory (BPI-01) with adults with intellectual disabilities who resided in a state-run developmental centre.

Methods BPI-01 was administered to informants who had known participants for a minimum of 6 months. For study 1, data were collected in two samples: 100 residents who were selected based on the challenging behaviour targeted in their behaviour treatment plan and 325 randomly selected residents.

Results The internal consistencies of the BPI-01 subscales were in the good to excellent range. Overall, the inter-rater and test–re-test reliability of the subscales and items were adequate with relatively lower reliability found for the Stereotypy subscale and items. For study 2, the data of the 425 participants from study 1 were used in a confirmatory factor analysis, which indicated that three a priori BPI-01 subscales (Self-Injurious Behavior, Stereotyped Behavior and Aggression/Destruction) were a reasonable fit.

Conclusions The current study provides additional support to the reliability and factor structure of the BPI-01 in adults with intellectual disabilities.

RSMB


The inter-rater and test-retest reliabilities, and internal consistencies of the Reiss Screen for Maladaptive Behavior (Reiss 1987) were evaluated on a random sample of adults with moderate through profound mental retardation living in an institutional setting. Generally, the Reiss Screen showed good inter-rater reliability, modest to good test-retest and good internal consistency. This suggests that the Reiss Screen has moderate to good psychometric robustness.


The present study was designed to study the diagnostic utility of RSM. Fifty six persons with ICD-10 diagnosis of MR and psychiatric diagnoses or behavioral disorders were selected through purposive sampling. RSMB was used to screen psychiatric problems and the findings were contrasted with that of the ICD-10 diagnoses. RSMB could differentiate well between those with and without psychiatric diagnoses. The diagnostic efficiency statistics were found to be satisfactory. Therefore, RSMB can be used in Indian settings without any cultural limitations.


The aim of this study was to obtain information on feasibility, reliability and validity of available instruments screening for depression applied in people with intellectual disabilities (ID). Therefore, literature was systematically reviewed. For self-report, the
Glasgow Depression scale for people with a Learning Disability appears most promising (internal consistency a = 0.90, test–retest reliability r = 0.97, sensitivity 96% and specificity 90%). For informant-report three instruments seem promising: the Assessment of Dual Diagnosis (internal consistency a = 0.77 and a = 0.91, test–retest reliability r = 0.94, interrater reliability r = 0.98), the Reiss Screen for Maladaptive Behaviour (internal consistency a = 0.58–0.83, interrater reliability r = 0.61–0.84, sensitivity 80%, specificity 83%), and the Children’s Depression Inventory (internal consistency a = 0.86, sensitivity 83%, specificity 93%). None of these three instruments have been studied satisfactorily in this group, yet. More research on psychometric properties, especially sensitivity and specificity in the ID population, is needed.

MoCA


Objectives: To develop a 10-minute cognitive screening tool (Montreal Cognitive Assessment, MoCA) to assist first-line physicians in detection of mild cognitive impairment (MCI), a clinical state that often progresses to dementia.

Design: Validation study.

Setting: A community clinic and an academic center.

Participants: Ninety-four patients meeting MCI clinical criteria supported by psychometric measures, 93 patients with mild Alzheimer's disease (AD) (Mini-Mental State Examination (MMSE) score ≥17), and 90 healthy elderly controls (NC).

Measurements: The MoCA and MMSE were administered to all participants, and sensitivity and specificity of both measures were assessed for detection of MCI and mild AD.

Results: Using a cutoff score 26, the MMSE had a sensitivity of 18% to detect MCI, whereas the MoCA detected 90% of MCI subjects. In the mild AD group, the MMSE had a sensitivity of 78%, whereas the MoCA detected 100%. Specificity was excellent for both MMSE and MoCA (100% and 87%, respectively).

Conclusion: MCI as an entity is evolving and somewhat controversial. The MoCA is a brief cognitive screening tool with high sensitivity and specificity for detecting MCI as currently conceptualized in patients performing in the normal range on the MMSE.


**Stages of Change**


Relationships among full constructs of the transtheoretical model using a sample of 121 adults with mild intellectual disabilities in Taiwan were examined. Self-reports of stages of change and
transtheoretical model psychosocial measures were gathered through interviews. Although MANCOVA revealed that behavioral processes of change, cognitive processes of change, self-efficacy, and perceived pros increased across stages, we did not find a clear linear pattern of association. Direct discriminant function analysis indicated that the most important predictors of stages of change were behavioral processes, cognitive processes, and self-efficacy. The overall stage of change classification accuracy using transtheoretical model psychosocial constructs was 56.2%. Psychosocial measures specifically developed for this population should be further explored.


Research on recovery has proliferated in recent years. Some investigators have advanced stages of change models that segment the overall process of recovery into discrete and sequential phases, through which a person progresses from being overwhelmed by mental illness to taking on an increasingly active role in understanding, managing and overcoming the impact of psychiatric disability. The authors review this body of literature, and reflect on the contributions and limitations of stages of change approaches to understanding mental health recovery. They conclude that stages of change models need to more accurately reflect the non-linear nature of recovery, the fact that processes are influenced by person-disorder-environment interactions, and the fact that the persons own motivations for change and decisions in this regard while of central importance are by no means exclusive factors in recovery, as they do not take into account sufficiently such issues as discrimination and the presence or absence of crucial resources and supports. A richer set of concepts is needed as we continue to deepen our understanding of the complex, dynamic and ongoing process of mental health recovery.

**GAD-7**


Generalized anxiety disorder (GAD) is one of the most common mental disorders; however, there is no brief clinical measure for assessing GAD. The objective of this study was to develop a brief self-report scale to identify probable cases of GAD and evaluate its reliability and validity. **Methods** A criterion-standard study was performed in 15 primary care clinics in the United States from November 2004 through June 2005. Of a total of 2740 adult patients completing a study questionnaire, 965 patients had a telephone interview with a mental health professional within 1 week. For criterion and construct validity, GAD self-report scale diagnoses were compared with independent diagnoses made by mental health professionals; functional status measures; disability days; and health care use. **Results** A 7-item anxiety scale (GAD-7) had good reliability, as well as criterion, construct, factorial, and procedural validity. A cut point was identified that optimized sensitivity (89%) and
specificity (82%). Increasing scores on the scale were strongly associated with multiple domains of functional impairment (all 6 Medical Outcomes Study Short-Form General Health Survey scales and disability days). Although GAD and depression symptoms frequently co-occurred, factor analysis confirmed them as distinct dimensions. Moreover, GAD and depression symptoms had differing but independent effects on functional impairment and disability. There was good agreement between self-report and interviewer-administered versions of the scale.

**Conclusion** The GAD-7 is a valid and efficient tool for screening for GAD and assessing its severity in clinical practice and research.

**PHQ-4**


**Background:** The most common mental disorders in both outpatient settings and the general population are depression and anxiety, which frequently coexist. Both of these disorders are associated with considerable disability. **Objective:** When the disorders co-occur, the disability is even greater. Authors sought to test an ultra-brief screening tool for both. **Method:** Validated two-item ultra-brief screeners for depression and anxiety were combined to constitute the Patient Health Questionnaire for Depression and Anxiety (the PHQ–4). Data were analyzed from 2,149 patients drawn from 15 primary-care clinics in the United States. **Results:** Factor analysis confirmed two discrete factors (Depression and Anxiety) that explained 84% of the total variance. Increasing PHQ–4 scores were strongly associated with functional impairment, disability days, and healthcare use. Anxiety had a substantial effect on functional status that was independent of depression. **Conclusion:** The PHQ–4 is a valid ultra-brief tool for detecting both anxiety and depressive disorders.


The 4-item Patient Health Questionnaire-4 (PHQ-4) is an ultra-brief self-report questionnaire that consists of a 2-item depression scale (PHQ-2) and a 2-item anxiety scale (GAD-2). Given that PHQ-4, PHQ-2, and GAD-2 have not been validated in the general population, this study aimed to investigate their reliability and validity in a large general population sample and to generate normative data. **Methods:** A nationally representative face-to-face household survey was conducted in Germany in 2006. The survey questionnaire consisted of the PHQ-4, other self-report instruments, and demographic characteristics.
Results: Of the 5030 participants (response rate=72.9%), 53.6% were female and mean (SD) age was 48.4 (18.0) years. The sociodemographic characteristics of the study sample closely match those of the total populations in Germany as well as those in the United States. Confirmatory factor analyses showed very good fit indices for a two-factor solution (RMSEA .027; 90% CI .023–.032). All models tested were structurally invariant between different age and gender groups. Construct validity of the PHQ-4, PHQ-2, and GAD-2 was supported by intercorrelations with other self-report scales and with demographic risk factors for depression and anxiety. PHQ-2 and GAD-2 scores of 3 corresponded to percentile ranks of 93.4% and 95.2%, respectively, whereas PHQ-2 and GAD-2 scores of 5 corresponded to percentile ranks of 99.0% and 99.2%, respectively.

Conclusions: Results from this study support the reliability and validity of the PHQ-4, PHQ-2, and GAD-2 as ultra-brief measures of depression and anxiety in the general population. The normative data provided in this study can be used to compare a subject's scale score with those determined from a general population reference group.

PHQ-9


While considerable attention has focused on improving the detection of depression, assessment of severity is also important in guiding treatment decisions. Therefore, we examined the validity of a brief, new measure of depression severity.

MEASUREMENTS: The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as “0” (not at all) to “3” (nearly every day). The PHQ-9 was completed by 6,000 patients in 8 primary care clinics and 7 obstetrics-gynecology clinics. Construct validity was assessed using the 20-item Short-Form General Health Survey, self-reported sick days and clinic visits, and symptom-related difficulty. Criterion validity was assessed against an independent structured mental health professional (MHP) interview in a sample of 580 patients.

RESULTS: As PHQ-9 depression severity increased, there was a substantial decrease in functional status on all 6 SF-20 subscales. Also, symptom-related difficulty, sick days, and health care utilization increased. Using the MHP reinterview as the criterion standard, a PHQ-9 score ≥10 had a sensitivity of 88% and a specificity of 88% for major depression. PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively. Results were similar in the primary care and obstetrics-gynecology samples.

CONCLUSION: In addition to making criteria-based diagnoses of depressive disorders, the PHQ-9 is also a reliable and valid measure of depression severity. These characteristics plus its brevity make the PHQ-9 a useful clinical and research tool.

Objective: The aim of this study was to assess the validity of the Patient Health Questionnaire depression module (PHQ-9). It has been subject to studies in medical settings, but its validity as a screening for depression in the general population is unknown.

Method: A representative population sample (2066 subjects, 14–93 years) filled in the PHQ-9 for diagnosis [major depressive disorder, other depressive disorder, depression screen-positive (DS+) and depression screen-negative (DS_)] and other measures for distress (GHQ-12), depression (Brief-BDI) and subjective health perception (EuroQOL; SF-36).

Results: A prevalence rate of 9.2% of a current PHQ depressive disorder (major depression 3.8%, subthreshold other depressive disorder 5.4%) was identified. The two depression groups had higher Brief-BDI and GHQ-12 scores, and reported lower health status (EuroQOL) and health-related quality of life (SF-36) than did the DS_ group (P’sb.001). Strong associations between PHQ-9 depression severity and convergent variables were found (with BDI r =.73, with GHQ-12 r =.59).

Conclusion: The results support the construct validity of the PHQ depression scale, which seems to be a useful tool to recognize not only major depression but also subthreshold depressive disorder in the general population.

Clinical Global Impression


Background

The Clinical Global Impression scale (CGI) is frequently used in medical care and clinical research because of its face validity and practicability. This study proposes to improve the reliability of the Clinical Global Impression (CGI) scale in depressive disorders by the use of a semi-standardized interview, a new response format, and a Delphi procedure.

Methods

Thirty patients hospitalised for a major depressive episode were filmed at T1 (first week in hospital) and at T2 (2 weeks later) during a 5’ specific interview. The Hamilton Depressive Rating Scale and the Symptom Check List were also rated. Eleven psychiatrists rated these videos using either the usual CGI response format or an improved response format, with or without a Delphi procedure.

Results

The new response format slightly improved (but not significantly) the interrater agreement, the Delphi procedure did not. The best results were obtained when ratings by 4 independent raters were averaged. In this situation, intraclass correlation coefficients were about 0.9. Conclusion The Clinical Global Impression is a useful approach in psychiatry since it apprehends patients in their entirety. This study shows that it is possible to quantify such impressions with a high level of interrater agreement.

Clinical Global Impression–Schizophrenia Scale

Objective: To describe the development and validation of the Clinical Global Impression–Schizophrenia (CGI-SCH) scale, designed to assess positive, negative, depressive and cognitive symptoms in schizophrenia. Method: The CGI-SCH scale was adapted from the CGI scale. Concurrent validity and sensitivity to change were assessed by comparison with the Positive and Negative Symptom Severity (PANSS) and Global Assessment of Functioning (GAF) scales. To evaluate inter-rater reliability, all patients were assessed by two clinicians. Results: Symptoms were assessed in 114 patients. Correlation coefficients between the CGI-SCH and the GAF and PANSS scores were high (most above 0.75), and were highest for positive and negative symptoms. Reliability was substantial (intraclass correlation coefficient, ICC > 0.70) in all but one dimension (depressive dimension, ICC = 0.64). Conclusion: The CGI-SCH scale is a valid, reliable instrument to evaluate severity and treatment response in schizophrenia. Given its simplicity, brevity and clinical face validity, the scale is appropriate for use in observational studies and routine clinical practice.

Abnormal Involuntary Movement Scale (AIMS)


The AIMS is a 12-item clinician-rated scale to assess severity of dyskinesias (specifically, or facial movements and extremity and truncal movements) in patients taking neuroleptic medications. Additional items assess the overall severity, incapacitation, and the patient’s level of awareness of the movements, and distress associated with them. The AIMS has been used extensively to assess dyskinesia in clinical trials of antipsychotic medications. Due to its simple design and short assessment time, the AIMS can easily be integrated into a routine clinical evaluation by the clinician or another trained rater.

Personal and Social Performance Scale (PSP)


This report describes the measurement properties of the Personal and Social Performance scale (PSP), a clinician-reported measure of severity of personal and social dysfunction, in an outpatient population with stabilized schizophrenia. Pooled data from two similar antipsychotic clinical studies were analyzed (n=411). The PSP showed good test–retest reliability (intraclass correlation coefficient=0.79). The PSP was more highly correlated with the Strauss–Carpenter Level of Function, an instrument measuring a similar construct, than the Positive and Negative Syndrome Scale, an instrument measuring a different construct. There was a statistically significant difference between mean PSP scores in subjects grouped by their severity rating on the Clinical Global Impression-Severity (CGI-S) (mild or less versus at least moderate),

indicating the ability to discriminate between known groups. Effect sizes for mean change in the PSP based on 1-category improvement (0.72) or worsening (−0.88) versus no change in the CGI-S were moderate to large, demonstrating the ability to detect change. Estimates of between-group minimum important difference suggest that a 7-point improvement in the PSP may be clinically meaningful in a clinical trial setting. Initial reliability and validity assessments suggest the PSP may be a useful measure of social functioning in patients with stable schizophrenia.


Introduction Symptoms and cognitive impairments of schizophrenia affect social integration and functioning. Accurate measurement is essential in evaluating treatment needs and outcomes. The Personal and Social Performance scale (PSP; Morosini et al. Acta Psychiatrica Scandinavica 101(4):323–329, 2000) is a clinical tool assessing social functioning in rehabilitation settings. Methods One hundred and twenty-nine patient/informant dyads at eight US sites participated in this study. Patients were at least 18 years old, have had schizophrenia/schizoaffective disorder for one year or more, and were currently residing in the community. Informants were at least 21 years old, cared for the patient for at least one month, and had contact at least twice weekly. The PSP, Personal Evaluation of Transitions in Treatment (PETiT), Positive and Negative Syndrome Scale (PANSS), Clinical Global Impressions—Severity (CGI-S), and Quality of Life Scale (QLS) tools were completed. Analyses focused on descriptive statistics, item characteristics, reliability, and validity. Results Patients were community-dwelling outpatients without severe difficulties. The PSP scores were well correlated with each other and related measures. Socially useful activities and personal and social relationships were the strongest indicators, suggesting separate aspects of functioning. Internal consistency reliability was adequate (α = 0.76). The PSP was sensitive to differences in social functioning by clinical severity. Conclusions The PSP suggested scale reliability and validity among outpatients. Future examination should expand validity analyses and evaluate responsiveness.

Specific Levels of Functioning (SLOF): Self-Report Version

Alcohol Use Scale (AUS)


The AUS and DUS were developed to help clinicians assess and monitor substance use in persons with severe mental illness. A companion scale, the SATS, was developed to aid in matching dually diagnosed persons with appropriate interventions and to assess and monitor their progress toward recovery from substance disorders.

The Community Alcohol Use Scale (CAUS) was developed as a continuous, reliable, valid, and acceptable measure for primary prevention studies. Items were written following a comprehensive review of the literature on alcohol dependence and alcoholism. Based upon the responses of 315 respondents to the 100-item initial version of the scale, the 45-item CAUS was developed. The CAUS was then cross-validated on a local sample (n = 274) and a provincial sample (n = 745). Estimates of internal consistency were .91, .96, and .94, respectively, for the initial and cross-validation samples. Correlations of .48 and .69 were obtained between the CAUS and the Michigan Alcohol Screening Test for the initial and local cross-validation samples. In the provincial cross-validation sample a correlation of .62 was obtained between the CAUS and the Usual Weekly Alcohol Index. Preliminary cutting scores were developed to identify those at risk for alcoholism, and alcoholics. The CAUS has potential use as an evaluative and predictive instrument in a variety of primary prevention programs.

**CAGE-AID**


*Background:* The more commonly used screening instruments for substance abuse were largely developed for addictive populations. We compared several alcohol and drug abuse scales to determine their efficiency and validity for psychiatric patients. *Method:* The subjects were 100 consecutively admitted patients to a public psychiatric facility. DSM-III-R diagnoses, obtained from the alcohol and drug scales of the SCID-P, were the criterion measure. Methods of reliability included inter-rater agreement, estimates of internal consistency, and repeat test administration. Sensitivity, specificity and more infrequently used accuracy indices, such as likelihood ratios and Receiver Operating Characteristic (ROC) analysis, were utilized to assess scale validity. *Results:* First, the reliability of all scales was high. Second, the instruments generally demonstrated highly acceptable levels of screening accuracy. Third, the intake evaluation was as reliable and valid as screening after admission on the unit. Finally, instruments were least discriminating for current problems (past 30 days). *Conclusions:* Lifetime measures were found to be reliable and valid for public psychiatric patients but further research is needed on increasing the accuracy of screening for current substance abuse problems and the effectiveness of multiple screening approaches.

**Drug Use Scale (DUS)**
The DUS is designed to rate the drug use of persons with severe mental illness, especially psychotic disorders. The instrument uses clinicians' ratings to classify patient drug use according to DSM-III-R criteria. The scale does not currently incorporate changes in the diagnostic criteria for substance use disorders made in DSM-IV. The DUS consists of a single item that asks the clinician to "rate your client's use of drugs over the past 6 months according to the following scale." The clinician is instructed to draw on the patient's self-reported behavior and clinical observations, interview, and collateral requests. The DUS can be completed in 5 minutes by a clinician with longitudinal knowledge about a patient's drug use. It is intended to be used by clinicians rating their own patients. It is brief and the format is simple and it is easy to explain to patients. The DUS is potentially useful in the assessment and monitoring of drug use disorders in individual clients.


**AIMS:** The aims of this study were to examine evidence for the concurrent validity of two self-report measures and two staff-report measures measuring alcohol and drug problems in seriously mentally ill people and to examine if psychotic patients under-report their alcohol and drug problems in an early intervention clinic.

**METHODS:** This is a cross-sectional study of 48 patients (26 inpatients and 22 outpatients) from an early intervention clinic for psychosis. To examine the sensitivity and specificity, we compared both the staff-report measures Clinical Alcohol Use Scale (AUS) and Clinical Drug Use Scale (DUS) and the self-report measures Short Michigan Alcohol Screening Test (SMAST-13) and Drug Abuse Screening Test (DAST-20), with the current ICD-10 diagnostic criteria as the gold-standard for alcohol and drug problems. To examine whether the patients under-report their alcohol and drug problems, we also compared the self-report measures SMAST-13 and DAST-20 with the staff-report measures AUS and DUS and ICD-10 consensus substance abuse diagnoses.

**RESULTS:** The results show that the concurrent validity compared with ICD-10 diagnoses was moderate for both the staff-report measures AUS and DUS and for the self-report measures SMAST-13 and DAST-20. Three out of seven patients under-report alcohol problems and one patient out of seven under-report drug use problems according to consensus ICD-10 substance abuse diagnoses.

**CONCLUSIONS:** We conclude that the SMAST-13 and DAST-20 in combination with the AUS and DUS, which are easy and quick to perform, are helpful in establishing a common understanding of the patient's alcohol and drug problems in an early intervention clinic.

**Mental Illness Drug & Alcohol Screening (MIDAS)**

http://www.smhealth.org/sites/default/files/docs/1320767133MIDAS3RevisedKM.pdf
UNCOPE


Efficient and accurate screening for alcohol and other drug dependences is critical if addictions are to be addressed in correctional populations. The UNCOPE, a six-item screen developed on clinical and corrections populations, was evaluated for accuracy in a state inmate population. Results using receiver operating characteristics calculated the overall expected accuracy of the UNCOPE to approach 0.90, with 1.0 being a perfect prediction. The UNCOPE performed comparably on gender and ethnic subgroups as well as subgroups identified by education level. The findings suggest that the UNCOPE could be an effective aid in identifying treatment needs among state prison inmates.


A national multi-site monitoring system for determining prevalence of alcohol and drug involvement in arrestees sought to refine the screening for substance dependence among persons arrested and incarcerated in local jails. Fifteen items were selected from the content of existing alcohol and drug abuse screens. These items were evaluated against a detailed diagnostic interview covering criteria of the DSM-IV. A total of 310 prisoners incarcerated within the previous 48 hours were recruited as subjects. Almost 65% of the subjects had a positive diagnosis of dependence for one or more substances. A six-item screen identified by the acronym UNCOPE emerged as the best set of screening items for identifying dependence on alcohol and/or drugs. The UNCOPE had sensitivity of 88% and specificity of 83% for the sample as a whole. It performed similarly irrespective of gender or ethnicity and appears to have potential utility in a wide range of populations.

Trauma History Screen

The Trauma History Screen (THS) is a brief, 13-item self-report measure that examines 11 events and one general event, including military trauma, sexual assault and natural disasters. For each event, respondents are asked to indicate whether the event occurred ("yes" or "no") and the number of times something like this happened. For each event endorsed, additional dimensions are assessed, including age when it happened, a description of what happened, whether there was actual or a threat of death or injury, feelings of helplessness and feelings of dissociation, a 4-point scale for duration of distress ("not at all" to "a month or more") and a 5-point scale for distress level ("not at all" to "very much"). The THS is suitable both for clinical and research purposes, and can be administered to a wide population with its low reading level, use of common language and simple responses.
DSQIID Dementia Screening Questionnaire for Individuals with ID


Many adults with Down's syndrome develop Alzheimer's dementia relatively early in their lives, but accurate clinical diagnosis remains difficult.

**Aims** To develop a user-friendly observer-rated dementia screening questionnaire with strong psychometric properties for adults with intellectual disabilities.

**Method** We used qualitative methods to gather information from carers of people with Down's syndrome about the symptoms of dementia. This provided the items for the Dementia Screening Questionnaire for Individuals with Intellectual Disabilities (DSQIID), which we then tested for its psychometric properties.

**Results** The DSQIID was administered to carers of 193 adults with Down's syndrome, 117 of whom were examined by clinicians who confirmed a diagnosis of dementia for 49 according to modified ICD-10 criteria. We established that a total score of 20 provides maximum sensitivity (0.92) and optimum specificity (0.97) for screening. The DSQIID has sound internal consistency ($\alpha=0.91$) for all its 53 items, and good test-retest and interrater reliability. We established a good construct validity by dividing the items into four factors.

**Conclusions** The DSQIID is a valid, reliable and user-friendly observer-rated questionnaire for screening for dementia among adults with Down's syndrome.

http://www.ld-medication.bham.ac.uk/1questionnaire.pdf

Additional Resources:

**General Info**

http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=Vineland-II


http://www.assessmentpsychology.com/adaptivebehavior.htm