Cohen Veterans Network

A CLINICAL GUIDE FOR MEASUREMENT-BASED CARE

COHEN VETERANS NETWORK

Gregory K. Brown, PhD
Emilie Langlois, MHC
Stephanie Renno, DSW
Alisa A. Breetz, PhD
Ava Weiss, LMSW

Suggested citation: Brown, G.K., Langlois, M.H.C., Renno, S., Breetz, A.B., & Weiss, A. (2021). A Clinical Guide to Measurement-Based Care. Stamford, CT: Cohen Veterans Network.

MBC Clinical Guide V2.0
Last Updated – February 2022

Table of Contents

Introduction 3
Alcohol Use Disorders Identification Test (AUDIT-C) 5
CAGE AID Substance Abuse Screening Tool 9
Columbia Impairment Scale – Parent (CIS-P) 13
Columbia Impairment Scale – Youth (CIS-Y) 18
Couples Satisfaction Index 4 (CSI-4) 23
CRAFFT – Clinician Administered 27
Defense and Veterans Brain Injury Center TBI Screening Tool – modified (DVBIC) 34
Generalized Anxiety Disorder Assessment (GAD-7) 38
PTSD Checklist for The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) (PCL-5) 43
Patient Health Questionnaire (PHQ-9) 50
Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (QLES-SF) 56
Revised Dyadic Adjustment Scale (RDAS) ..... **Error! Bookmark not defined.**

Introduction

What is Measurement-Based Care?

Measurement-based care can be defined as "the practice of basing clinical care on client data collected during treatment"[1]. Using evidence-based assessment tools, measurement-based care is used to individualize treatment and coordinate care for clients.

How Does Measurement-Based Care Work?

ASSESS: Clinically appropriate, evidence-based measures are typically administered during screening, intake and regular intervals throughout treatment. Both clinician-administered and client self-report measures may be used.

USE: With the information collected from standardized measures, clinicians and clients work together to make informed decisions about clients' care including tailoring treatment to address clients' specific needs.

SHARE: Information gathered from standardized measures are shared not only with clients but with other clinicians involved in treatment to better coordinate care.

Why Use Measurement-Based Care?

Using measurement-based care to facilitate treatment has been shown to substantially improve clinical outcomes[2]. By routinely assessing clients' treatment and progress through measurements, clinicians are able to identify and address any clinical outcomes that do not appear to be improving over time. Further, clinicians may be better able to identify treatments that may be unhelpful if there is no improvement or worsening in assessment scores. Measurement-based care facilitates shared decision making between the clinician and the client. Clients will have a better understanding of their own treatment and have the chance to work with their clinicians to personalize and make changes to their own treatment. Using measurement-based care on a regular basis can help to identify symptoms or clinical issues that otherwise may be missed through using open-ended questions alone.

What is in the Clinical Guide for Measurement-Based Care?

In this guide, you will find information for specific behavioral health assessments you may use for client care if clinically appropriate. For each measure, the guide provides information about the intended clinical domain, a description and purpose of the measure, as well as the administration, scoring instructions, and interpretation guidelines for informing clinical care.

This guide was developed to be consistent with the standard operating procedures of the Cohen Veterans Network, as outlined in the CVN Clinic Guidebook[3].

Finally, the purpose of this guide is to help you in facilitate shared decision making with clients that will improve the coordination of care, improve the delivery of care provided, and ultimately, improve the mental health and well-being of clients within the Cohen Veterans Network.

Please contact Dr. Stephanie Renno with any questions:
Stephanie.Renno@CohenVeteransNetwork.org

Alcohol Use Disorders Identification Test (AUDIT-C)

About the Measure	
Domain:	Alcohol Use Disorder
Measure:	Alcohol Use Disorders Identification Test (AUDIT-C)
Definition:	A self-report instrument used to screen for alcohol problems and assess the severity of these problems.
Purpose:	The AUDIT-C is used to screen for active alcohol abuse or dependence. This measure can be used to quickly screen and measure the severity of clients' alcohol consumption. However, this measure is not intended for diagnostic use based on the *DSM-V* (Diagnostic and Statistical Manual, Fifth Edition).
About the Protocol	
Description of Protocol:	**What is it?** The Alcohol Use Disorders Identification Test (AUDIT–C) is a brief screening assessment tool used to identify active alcohol abuse or dependence. This assessment is modified from the full 10-question AUDIT assessment and is not intended for diagnostic purposes. The AUDIT-C consists of three self-report questions regarding alcohol consumption, each with 5 answer choices.
Clinical Indication:	**Screen**: This can be a powerful tool in screening for alcohol use disorders **Assess**: This is a useful tool in assessing the severity of alcohol consumption
Client:	Adults, ages 18 and older
Administration:	**How can it be administered?** • Self-administered by the client • By the interviewer **How often is it administered?** • At referral screener/initial clinical assessment

	How long does it take?
	• 2-5 minutes
	Where and when can it be done?
	• CVN Standard: Delivered at referral screening
	• In addition, can administer:
	  ○ Prior to session in the waiting area
	  ○ Beginning, during, or end of session
	  ○ At home prior to appointment for client to bring to the session
	
	Assume that a standard drink is equivalent to 10 grams of alcohol (one 12-ounce can of beer, one glass of wine, one cocktail/mixed drink, or one shot of liquor).

Guidelines for Scoring/ Interpretation:	**How do I use this?** Clients are asked to answer questions based on their level of alcohol consumption. To score the AUDIT-C, sum the 3 items to calculate the total score. The total score ranges from 0-12. a = 0 b = 1 c = 2 d = 3 e = 4 **How is the AUDIT-C Total score interpreted?** In **men**, a score of 4 points or higher indicates alcohol misuse. In **women**, a score of 3 points or higher indicates alcohol misuse. If a client scores positively on the AUDIT-C, it is recommended that further assessment be conducted to more thoroughly assess their drinking habits, including a diagnostic assessment. After the assessment has been scored, the therapist will interpret the score and explain to the client what their score means. For example, the therapist might say, "You scored a 7 on the AUDIT-C, which means you are drinking more than the recommended limit." Additionally, it is useful to gain the client's perspective on how their consumption habits have been impacting them. For example, "Have you noticed that your drinking habits have had an impact on your daily life?" or simply, "How do you feel about what this score says?"

How can this help me with my clients?

Potential Treatment Interventions	
Positive score	Brief counseling/intervention Psychoeducation Further assessment Referral to a substance use treatment program

The AUDIT-C helps to identify clients who may benefit from brief alcohol counseling interventions who may otherwise have been missed.

Protocol Text:

Alcohol Use Disorders Identification Test (AUDIT-C)

1) How often do you have a drink containing alcohol?
    a. Never
    b. Monthly or less
    c. 2-4 times a month
    d. 2-3 times a week
    e. 4 or more times a week
2) How many standard drinks containing alcohol do you have on a typical day?
    a. 1 or 2
    b. 3 or 4
    c. 5 or 6
    d. 7 to 9
    e. 10 or more
3) How often do you have six or more drinks on one occasion?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

Source:	Bush, K., Kivlahan, D. R., & McDonell, M. B. (1998). The AUDIT Alcohol Consumption Questions (AUDIT-C). An Effective Brief Screening Test for Problem Drinking. *Archives of Internal Medicine, 158*(16), 1789-1795. doi:10.1001/archinte.158.16.1789
Evidence-Based Support:	The AUDIT-C has been validated in mental health and primary care clinics.
Availability:	Publicly available. https://www.integration.samhsa.gov/images/res/tool_auditc.pdf

CAGE AID Substance Abuse Screening Tool

About the Measure	
Domain:	Alcohol and drug use
Measure:	CAGE AID Substance Abuse Screening Tool
Definition:	A conjoint assessment tool used to determine if substance abuse (alcohol and other drugs) is present.
Purpose:	This is a commonly used measure to quickly screen for drug and alcohol use and to determine if further assessment is needed. The CAGE AID consists of 4 questions.
About the Protocol	
Description of Protocol:	**What is it?** The CAGE AID is a conjoint questionnaire adapted from the CAGE questionnaire to include assessing the use of other drugs along with alcohol. This assessment should not be used to diagnose but rather to indicate a potential alcohol or drug problem. The information gathered from this assessment can be used by the clinician to engage the client in the therapeutic process, validating them as an active partner in their own treatment. Further assessment is required if a positive score on the CAGE AID is obtained.
Clinical Indication:	**Screen**: The CAGE AID can assist clinicians with screening for alcohol and other drug use. If indicated, further assessment is required. **Assess**: This tool can be used to assess for a potential alcohol or drug problem
Client:	First developed for use in adults. Frequently used with adolescents as well.

Administration:	**How can it be administered?** • Self-administered by the client • By interviewer **How often is it administered?** • At referral screener/initial clinical assessment **How long does it take?** • 2-5 minutes **Where and when can it be done?** • CVN Standard: Delivered at referral screening • In addition, can administer: • Prior to session in the waiting area (preferred for in-person) or sent virtually (for telehealth) • Beginning, during, or end of session • At home prior to appointment for client to bring to the session Clients are instructed to answer 4 questions to determine if substance abuse may exist and need to be further addressed.
Guidelines for Scoring/ Interpretation:	**How do I use this?** Clients are asked answer 4 questions pertaining to their use of drugs and alcohol. One or more positive answers on the CAGE AID is considered a positive screen and further assessment should be conducted. **How is the CAGE AID total score interpreted?** No = 0 Yes = 1 A total score 2 or more is considered clinically significant but a score of 1 indicates further assessment.

How can this help me with my clients?

Potential Treatment Intervention Based on Score	
0	No intervention needed
1	Brief assessment (clarify/confirm quantity, frequency and duration of use. Determine number and severity of substance related health/legal/social problems in the last 12 months.) Brief Intervention
2+	Brief intervention In-depth assessment to rule out substance use disorder

Protocol Text:

CAGE-AID

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

	Yes	No
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Source:

Brown RL, Leonard T, Saunders LA, Papasouliotis O. The prevalence and detection of substance use disorder among inpatients ages 18 to 49: an opportunity for prevention. Preventive Medicine. 1998;27:101-110.

Evidence-Based Support:	This measure is proven to be both reliable and valid in assessing risks of substance and alcohol use.
Availability:	Publicly available https://www.pedagogyeducation.com/PedagogyEducation/media/Resources/Posters/CAGE-AID-Questionnaire.pdf

Columbia Impairment Scale – Parent (CIS-P)

About the Measure	
Domain:	Child & Adolescent's Functional Impairment
Measure:	Columbia Impairment Survey – Parent
Definition:	A parent-report scale for children and adolescents (see also Youth self-report version) measuring functional impairment across multiple life domains, including family relationships, peer relationships, academic or occupational functioning, and involvement in general interests and activities.
Purpose:	To measure global functional impairment in children and adolescents via a parent-report measure.
About the Protocol	
Description of Protocol:	**What is it?** The Columbia Impairment Scale – Parent (CIS-P) is a 13-item self-report scale completed by the parent or caretaker of the child or adolescent client to provide a global measure of impairment. The 13 items tap 4 major areas of functioning: interpersonal relations, broad psychopathological domains, functioning in job or schoolwork, and use of leisure time. Items are scored on a spectrum ranging from 0 "no problem" to 4 "a very big problem."
Clinical Indication:	The Columbia Impairment Scale – Parent (CIS-P) is indicated as a global assessment of functioning for children and adolescent clients. Please see below note about age range.
Client:	Children and adolescents, ages 6-17. Note about age range: This measure is designed to be completed by parents/caretakers for children and adolescents ages 6-17. Older children/adolescent clients (approx. 12+) may also complete the self-report CIS-Y, and in some cases (e.g. older adolescents or parents with limited involvement), the CIS-Y may be more useful than the CIS-P. Please use your clinical

	discretion and knowledge of the specific client and family situation to decide between using the CIS-P, the CIS-Y, or both.
Administration:	**How can it be administered?** • Self-administered by the parent/caretaker of the child/adolescent client • By interviewer **How often is it administered?** • At referral screener • At each session **How long does it take?** • Approx. 2-5 minutes **Where and when can it be done?** • Prior to session in the waiting area (preferred) • Beginning, during, or end of session (beginning preferred) • At home prior to appointment for client to bring to the session
Guidelines for Scoring/ Interpretation:	**How do I use this?** Parents/caretakers are asked to rate the behavior of the child/adolescent client at the current time (past week or two) across 13 areas on a scale of 0 (No problem) to 4 (Very bad problem), with the option to select 5 (Not applicable/Don't know) if they cannot rate the item. **Scoring**: Add the scores for all 13 items, excluding any items that were scored 5 (Not applicable/Don't know). Total scores range from 0 to 52, with higher scores indicating more impairment. A total score of 15 or greater suggests functional impairment, and an item score of 3 or higher suggests impairment in that area of functioning. Clinicians may use the CIS-P to identify key problem areas, change in functioning over time, or discrepancies between youth report and parent report (if the youth is also completing the CIS-Y self-report measure).

How can this help me with my clients?

Potential Treatment Interventions	
1) Getting into trouble	Emotion regulation skills
2) Getting along with mother/mother figure	Assessment of relationship with mother figure Conjoint sessions with parent(s)
3) Getting along with father/father figure	Assessment of relationship with father figure Conjoint sessions with parent(s)
4) Feeling unhappy or sad	Behavioral activation, pleasant activity scheduling, cognitive restructuring
5) Behavior at school (or job)	Emotion regulation skills, problem-solving skills, assessment of at-school challenges Coordination with educators
6) Having fun	Behavioral activation, pleasant activity scheduling
7) Getting along with non-parent adults	Social skills, communication skills, interpersonal effectiveness
8) Feeling nervous or afraid	Cognitive restructuring, exposure
9) Getting along with siblings	Emotion regulation, frustration tolerance, communication, interpersonal effectiveness Possible involvement of family in sessions
10) Getting along with peers	Social skills, communication skills, interpersonal effectiveness
11) Getting involved in activities	Behavioral activation, pleasant activity scheduling, social skills, exposure
12) School work	Evaluation of learning abilities and potential skill deficits, study skills, organization skills, time management Coordination with educators
13) Behavior at home	Assessment of at-home challenges Emotion regulation skills, communication skills, problem-solving skills Conjoint sessions with parents; involvement of family in sessions

Protocol Text:

THE COLUMBIA IMPAIRMENT SCALE (C. I. S.)-- (Parent Version)

Please circle the number that you think best describes the child or youth's situation:

0 .....1.....2..... 3.....4 5

No problem Some problem Very bad problem Not applicable/Don't know

In general, how much of a problem do you think [she/he] has with:	
1)…getting into trouble?	0 1 2 3 4 5
2)…getting along with (you/[her/his] mother/mother figure).	0 1 2 3 4 5
3)…getting along with (you/[her/his] father/father figure).	0 1 2 3 4 5
4)…feeling unhappy or sad?	0 1 2 3 4 5
How much of a problem would you say [she/he] has:	
5)…with [her/his] behavior at school? (or at [her/his] job)	0 1 2 3 4 5
6)…with having fun?	0 1 2 3 4 5
7)…getting along with adults other than (you and/or [her/his] mother/father)?	0 1 2 3 4 5
How much of a problem does [she/he] have:	
8)…with feeling nervous or afraid?	0 1 2 3 4 5
9)…getting along with [her/his] [sister(s)/brother(s)]?	0 1 2 3 4 5
10) …getting along with other kids [her/his] age?	0 1 2 3 4 5
How much of a problem would you say [she/he] has:	
11)…getting involved in activities like sports or hobbies?	0 1 2 3 4 5
12)…with [her/his]school work (doing [her/his] job)?	0 1 2 3 4 5
13)…with [her/his] behavior at home?	0 1 2 3 4 5

Source:	Bird H, Shaffer D, Fisher P, et al. The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents. International Journal of Methods in Psychiatric Research. 1993 Oct;3(3):167-176
Evidence-Based Support:	Research on this measure shows high internal consistency, excellent test–retest reliability, and good validity when correlated with a clinician's score on the Children's Global Assessment Scale and with other measures indicative of impairment. Correlated with clinician-rated impairment.
Availability:	Publicly available. https://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/Columbia/CIS-Parent%20web%20system%20version%20w%20instructions_1.pdf

Columbia Impairment Scale – Youth (CIS-Y)

About the Measure	
Domain:	Child & Adolescent's Functional Impairment
Measure:	Columbia Impairment Survey – Youth
Definition:	A self-report scale for children and adolescents (see also Parent version, CIS-P) measuring functional impairment across multiple life domains, including family relationships, peer relationships, academic or occupational functioning, and involvement in general interests and activities.
Purpose:	To measure global functional impairment in older children and adolescents via a self-report measure.
About the Protocol	
Description of Protocol:	**What is it?** The Columbia Impairment Scale – Youth (CIS-Y) is a 13-item self-report scale completed by the child or adolescent to provide a global measure of impairment. The 13 items tap 4 major areas of functioning: interpersonal relations, broad psychopathological domains, functioning in job or schoolwork, and use of leisure time. Items are scored on a spectrum ranging from 0 "no problem" to 4 "a very big problem."
Clinical Indication:	The Columbia Impairment Scale – Youth (CIS-Y) is indicated as a global assessment of functioning for older children and adolescents engaging in individual therapy. Please see below note about age range.
Client:	Children and adolescents, approx. ages 12-17. Note about age range: Standard practice is for children/adolescents ages 12-17 to complete the self-report CIS-Y, but it has been used for clients as young as 9 and as old as 24. Please use your clinical discretion and knowledge of the individual client and family situation to decide between using the self-report CIS-Y, or the parent-report CIS-P (typically used for

	clients ages 6-17), or both. Keep in mind the client's developmental level, literacy, ability to self-reflect. When feasible, especially for younger clients (e.g. late elementary or middle school), it may be helpful to use both the CIS-Y and the CIS-P.
Administration:	**How can it be administered?** • Self-administered by the child/adolescent client (preferred) • By interviewer **How often is it administered?** • At each session **How long does it take?** • Approx. 2-5 minutes **Where and when can it be done?** • Prior to the session in the waiting area (preferred) • Beginning, during, or end of session (beginning preferred) • At home prior to appointment for client to bring to the session
Guidelines for Scoring/ Interpretation:	**How do I use this?** Client are asked to rate their behavior at the current time (past week or two) across 13 areas on a scale of 0 (No problem) to 4 (Very bad problem), with the option to select 5 (Not applicable/Don't know) if they cannot rate the item. **Scoring**: Add the scores for all 13 items, excluding any items that were scored 5 (Not applicable/Don't know). Total scores range from 0 to 52, with higher scores indicating more impairment. A total score of 15 or greater suggests functional impairment, and an item score of 3 or higher suggests impairment in that area of functioning. Therapists may use the CIS-Y to identify key problem areas, change in functioning over time, or discrepancies between youth report and parent report (if the parent is also completing the CIS-P).

How can this help me with my clients?

Potential Treatment Interventions	
1) Getting into trouble	Emotion regulation skills
2) Getting along with mother/mother figure	Assessment of relationship with mother figure Conjoint sessions with parent(s)
3) Getting along with father/father figure	Assessment of relationship with father figure Conjoint sessions with parent(s)
4) Feeling unhappy or sad	Behavioral activation, pleasant activity scheduling, cognitive restructuring
5) Behavior at school (or job)	Emotion regulation skills, problem-solving skills, assessment of at-school challenges Coordination with educators
6) Having fun	Behavioral activation, pleasant activity scheduling
7) Getting along with non-parent adults	Social skills, communication skills, interpersonal effectiveness
8) Feeling nervous or afraid	Cognitive restructuring, exposure
9) Getting along with siblings	Emotion regulation, frustration tolerance, communication, interpersonal effectiveness Possible involvement of family in sessions
10) Getting along with peers	Social skills, communication skills, interpersonal effectiveness
11) Getting involved in activities	Behavioral activation, pleasant activity scheduling, social skills, exposure
12) School work	Evaluation of learning abilities and potential skill deficits, study skills, organization skills, time management Coordination with educators
13) Behavior at home	Assessment of at-home challenges Emotion regulation skills, communication skills, problem-solving skills Conjoint sessions with parents; involvement of family in sessions

Protocol Text:

THE COLUMBIA IMPAIRMENT SCALE (C. I. S.)-- (Youth Version)

Please circle the number that you think best describes the child or youth's situation:
0 .....1.....2..... 3.....4 5
No problem Some problem Very bad problem Not applicable/Don't know

In general, how much of a problem do you think you have with:	
1)...getting into trouble?	0 1 2 3 4 5
2)...getting along with your mother/mother figure.	0 1 2 3 4 5
3)...getting along with your father/father figure.	0 1 2 3 4 5
4)...feeling unhappy or sad?	0 1 2 3 4 5
How much of a problem would you say you have:	
5)...with your behavior at school? (or at your job)	0 1 2 3 4 5
6)...with having fun?	0 1 2 3 4 5
7)...getting along with adults other than (your mother and/or your father)?	0 1 2 3 4 5
How much of a problem do you have:	
8)...with feeling nervous or afraid?	0 1 2 3 4 5
9)...getting along with your sister(s) and/or brother(s)?	0 1 2 3 4 5
10) ...getting along with other kids your age?	0 1 2 3 4 5
How much of a problem would you say you have:	
11)...getting involved in activities like sports or hobbies?	0 1 2 3 4 5
12)...with your school work (doing your job)?	0 1 2 3 4 5
13)...with your behavior at home?	0 1 2 3 4 5

Source:	Bird H, Shaffer D, Fisher P, et al. The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents. International Journal of Methods in Psychiatric Research. 1993 Oct;3(3):167-176
Evidence-Based Support:	Research on this measure shows high internal consistency, excellent test–retest reliability, and good validity when correlated with a clinician's score on the Children's Global Assessment Scale and with other measures indicative of impairment. Correlated with clinician-rated impairment.
Availability:	Publicly available. http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/Columbia/CIS-Y%20-youth%20web%20system%20version%20w%20instructions_1.pdf

Couples Satisfaction Index 4 (CSI-4)

About the Measure	
Domain:	Relationship Satisfaction
Measure:	Couples Satisfaction Index-4 (CSI-4)
Definition:	A 4-item, psychometrically optimized, self-report scale assessing relationship satisfaction.
Purpose:	This self-report measure is designed to rapidly assess relationship satisfaction in intact couples. Assessing each partner's relationship satisfaction on an ongoing basis can help guide and inform couples therapy treatment. Having both partners complete this measure weekly can inform the therapist about any discrepancies between partners' relationship satisfaction as well as change in relationship satisfaction over time.
About the Protocol	
Description of Protocol:	**What is it?** This brief, 4-item self-report measure is used to assess relationship satisfaction in intact couples, including couples that are dating, cohabiting, or married. The CSI-4 is derived from the original 32-item CSI-32. This abbreviated measure asks about happiness in the relationship, warmth/comfort of the relationship, how rewarding the relationship is, and overall relationship satisfaction.
Clinical Indication:	**Screen**: The CSI-4 can be used to screen for relationship dissatisfaction. (Note: As of 2/8/21 within CVN the RDAS is currently used at intake/initial clinical assessment as the primary screen for relationship distress. This guidance may shift in the future and any changes will be reflected here). **Assess**: The CSI-4 can be used to assess intensity of relationship dissatisfaction and assess for discrepancies between partners in level of relationship satisfaction.

	Diagnose: The clinician may use the CSI-4 alongside clinical interviewing to determine whether V-codes related to relationship distress are indicated. **Monitor**: The CSI-4 can be a useful tool to keep track of and monitor treatment response for couples therapy.
Client:	Adults engaged in couples therapy
Administration:	**How can it be administered?** • Self-administered by the client (preferred) • By interviewer **How often is it administered?** • At each couples therapy session **How long does it take?** • Approx. 2 minutes **Where and when can it be done?** • Prior to the session in the waiting area (preferred) • Beginning, during, or end of session • At home prior to appointment for client to bring to the session • May be completed on paper or electronically
Guidelines for Scoring/ Interpretation:	**How do I use this?** To score the CSI-4, simply sum the responses across all of the items. **How is the CSI-4 Total score interpreted?** CSI-4 scores can range from 0 to 21. Higher scores indicate higher levels of relationship satisfaction. CSI-4 scores falling below 13.5 suggest notable relationship dissatisfaction. Upon scoring the CSI-4 for both partners, the therapist will compare the scores of the partners to identify any major discrepancies, and will compare each partner's current CSI-4 score to their past scores to assess for any change, positive or negative. Per clinical discretion, the therapist may choose to invite discussion around any score discrepancies or changes over time.

How can this help me with my clients?

Potential Treatment Interventions	
Very low total CIS-4 scores for one or both partners	Collaborative assessment and exploration of major relationship concerns, ruptures, or key conflicts. Assessment for intimate partner violence, safety planning as needed, and determination of whether couples therapy is indicated. Interventions to address key conflicts or major problems identified. Interventions to rebuild basic trust and affection.
Significant discrepancy in CIS-4 scores between partners	Possible individual session to assess for intimate partner violence followed by appropriate steps as needed. Assessment of communication gaps.
Rapid shift in CIS-4 score	Identify and explore recent relational changes and their impact.

Protocol Text:

Couples Satisfaction Index (CSI-4)

Please indicate the degree of happiness, all things considered, of your relationship.

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect
0	1	2	3	4	5	6

	Not at all TRUE	A little TRUE	Somewhat TRUE	Mostly TRUE	Almost completely TRUE	Completely TRUE
I have a warm and comfortable relationship with my partner.	0	1	2	3	4	5

	Not at all	A little	Somewhat	Mostly	Almost completely	Completely
How rewarding is your relationship with your partner?	0	1	2	3	4	5
In general, how satisfied are you with your relationship?	0	1	2	3	4	5

Source:

Funk, J.L., & Rogge, R.D. (2007). Testing the Ruler with Item Response Theory: Increasing Precision of Measurement for Relationship Satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21*, 572-583.

Evidence-Based Support:

The CSI scales were shown to have high precision of measurement and strong power for detecting differences in levels of satisfaction.

Availability:

The CSI scales were developed to be freely available for research and clinical use. No further permission is required and the authors will not generate study-specific permission letters. https://www.researchgate.net/publication/299432417_The_Couples_Satisfaction_Index_CSI-4

CRAFFT – Clinician Administered

About the Measure	
Domain:	Substance Use Disorder
Measure:	CRAFFT - Clinician Administered
Definition:	A health screening tool used to identify substance use, substance-related riding/driving risk, and substance use disorder in adolescents.
Purpose:	Substance use is one of the most predominant health risk behaviors among adolescents. This measure can be used to quickly identify substance use, risk behaviors, and preliminary diagnoses among adolescents. The CRAFFT serves as the basis for early intervention and provides guidance for offering information about substance abuse risks and referral to substance use disorder specific treatment or counseling.
About the Protocol	
Description of Protocol:	**What is it?** The CRAFFT is an efficient health screening tool established to identify the risk of substance use disorders among adolescents. This assessment is intended for use by clinicians as a brief interview with their clients and is available in several languages. CRAFFT stands for the key words of the 6 items in the second section of the assessment - Car, Relax, Alone, Forget, Friends, Trouble. Please see "Guidelines for Scoring/Interpretation – How do I use this" for more detailed instructions on its use.
Clinical Indication:	**Screen**: The CRAFFT can be a useful tool to screen for substance use and substance use disorders among adolescents. **Assess**: This tool can be useful in assessing the risk of substance use disorders among adolescents.

	Diagnose: This tool can be used to preliminarily diagnose a client; further clinical interviewing will be required.
Client:	Ages 12-18
Administration:	**How can it be administered?** • By interviewer **How often is it administered?** • At intake/initial clinical assessment **How long does it take?** • Variable **Where and when can it be done?** • Beginning or during the session
Guidelines for Scoring/ Interpretation:	**How do I use this?** Clinicians orally administer the assessment to the client and preface the administration with the following statement: "I'm going to ask you a few questions that I ask all my clients. Please be honest. I will keep your answers confidential." Clinicians then begin the assessment by asking the opening questions regarding the frequency of substance use in the past 12 months. If the client answered "0" to all opening questions the clinician should ask only the CAR question. However, if the client answered with a positive response to any of the opening frequency questions, the clinician is to ask the full set of CRAFFT questions to follow. Once the clients' score has been obtained, the clinician is to tell the client their score and show them where that score falls on the bar chart provided (located on page 2 of the assessment – see below). This chart represents the percentage of adolescents that meet criteria for a DSM-V substance use disorder according to this assessment. The clinician should then continue by discussing with the client their likelihood of having a potential problem with substance use based on their score.

Next, have a brief motivational enhancement discussion with the client using the recommended talking points for brief counseling (found on page 2 of the assessment – see below).

1. **REVIEW** screening results
2. **RECOMMEND** not to use
3. **RIDING/DRIVING** risk counseling
4. **RESPONSE:** elicit self-motivational statements
5. **REINFORCE** self-efficacy

Lastly, provide each client with the contract for life (see below).

How is the CRAFFT Total score interpreted?

Total scores range from 0-6. Each "yes" response to Part B of the assessment equals 1 point to the total score. For clients ages 12-17, a score of 2 or more has been found to be an optimal cutoff point for identifying a DSM-V substance use disorder. For clients ages 18-21, a score of 3 or more has been found to be an optimal cutoff point. The higher the CRAFFT score, the higher the likelihood that the client meets criteria for a substance use disorder.

Determining Risk Level

- **"Low risk" client:** A client that reports no use in the past 12 months and answers "NO" to the CAR question indicating a total score of "0".
- **"Medium risk" client:** No use in the past 12 months and YES to the CAR question **or** ANY use in the past 12 months and total score of 0 or 1
- **"High risk" client:** A client who reports any use in the past 12 months and has a total score of 2 or more.

How can this help me with my clients?

Potential Treatment Interventions	
1) Low Risk	Provide information about risks of substance use and substance use related riding/driving Offer praise and encouragement
2) Medium Risk	Provide information about risks of substance use and substance use related riding/driving Brief advice Regularly monitor in treatment
3) High Risk	Provide information about risks of substance use and substance use related riding/driving Brief advice Regularly monitor in treatment Discuss a higher level of care

Protocol Text:

The CRAFFT Interview (version 2.1)

To be orally administered by the clinician

Begin: ***"I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."***

Part A

During the PAST 12. MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol?** Put "0" if none. _____ # of days
2. Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or **"synthetic marijuana"** (like "K2," "Spice")? Put "0" if none. _____ # of days
3. Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" .if none; _____ # of days

Did the patient answer "0" for all questions in Part A?

Yes ☐ → **Ask CAR question only, then stop**

No ☐ → **Ask all six CRAFFT* questions below**

Part B

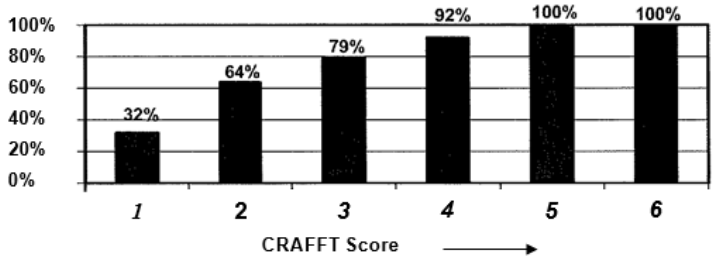
		No	Yes
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
R	Do you ever use alcohol or drugs to **RELAX,** feel better about yourself, or fit in?	☐	☐
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE?**	☐	☐
F	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
F	Do your **FAMILY or FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

***Two or more YES answers suggest a serious problem and need for further assessment. See back for further instructions** --

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

1. Show your patient his/her score on this graph and discuss level of risk for a substance use disorder.

Percent with a DSM-5 Substance Use Disorder by CRAFFT score*



•Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376-80.

2. Use these talking points for brief counseling.

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*
2. **RECOMMEND** not to use
   ".As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."
3. **RIDING/DRIVING** risk counseling
   "Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."
4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink or use drugs, what would you say?"* Users: *"What would be some of the benefits of not using?"*
5. **REINFORCE** self-efficacy
   "I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals."

3. Give patient Contract for Life. Available at www.crafft.org/contract

---

(617) 355-5433

For more information and versions in other languages, see www.crafft.org.

Pledge for Life:

http://crafft.org/wp-content/uploads/2018/10/Pledge-for-Life.pdf

Source:	Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med. 1999;153(6):591-596. (n.d.). Retrieved from http://crafft.org/
Evidence-Based Support	Research has shown that CRAFFT has relatively high sensitivity and specificity, internal consistency, and test-retest reliability as a screener for alcohol and substance misuse. This measure is proven to be valid for screening for substance use risk and potential substance use disorders in adolescents.
Availability:	Publicly available: http://crafft.org/wp-content/uploads/2019/03/CRAFFT-2.1_Clinician-Interview_2018-04-23.pdf http://crafft.org/wp-content/uploads/2018/10/Pledge-for-Life.pdf

Defense and Veterans Brain Injury Center TBI Screening Tool – modified (DVBIC)

About the Measure	
Domain:	Traumatic Brain Injury
Measure:	Defense and Veterans Brain Injury Center TBI Screening Tool – modified (DVBIC)
Definition:	A self-report instrument used to screen for possible traumatic brain injury.
Purpose:	The DVBIC is used to screen for traumatic brain injury. This measure can be used to identify clients who may need further evaluation: a positive screen warrants further assessment to determine if traumatic brain injury is present, and this measure is not intended for diagnostic use.
About the Protocol	
Description of Protocol:	**What is it?** The DVBIC is a brief tool used to screen for possible traumatic brain injury. The version of this tool used at CVN has been modified from the original DVBIC TBI Screening Tool (Schwab et al, 2006), also called The Brief Traumatic Brain Injury Screen (BTBIS), to be more broadly applicable to non-deployment-related injuries and civilians as well as military/veteran clients. The DVBIC consists of 3 self-report questions related to head injuries and post-injury symptoms, each with several "check all that apply" answer options. The DVBIC is intended as an initial screener only, with a positive screen indicating additional assessment for TBI.
Clinical Indication:	**Screen**: The DVBIC can be a useful tool in screening for possible TBI
Client:	Veterans and servicemembers, ages 18 and older

Administration:	**How can it be administered?** • Self-administered by the client (recommended) • By the interviewer **How often is it administered?** • At intake/initial clinical assessment **How long does it take?** • Approx. 2 minutes **Where and when can it be done?** • Prior to the session in the waiting area (preferred for in-person) or sent virtually (for telehealth) • Beginning, during, or end of session • At home prior to appointment for client to bring to the session
Guidelines for Scoring/ Interpretation:	**How do I use this?** Clients are asked to answer questions about past injuries and past and present post-injury symptoms, and are asked to check any of the items that apply. **Question 1:** A checked response to any item A through F verifies injury. **Question 2:** A checked response to A-E meets criteria for a **positive screen**. Further interview is indicated. A positive response to F or G does not indicate a positive screen, but should be further evaluated in a clinical interview. **Question 3:** Endorsement of any item A-H verifies current symptoms which may be related to a mild TBI if the screening and interview process determines a mild TBI occurred. **Significance of a positive screen:** A client who endorses an injury [Question 1], as well as an alteration of consciousness [Question 2 A-E], should be further evaluated via clinical interview because he/she is more highly suspect for having sustained a mild TBI or concussion. The TBI screen alone does not provide diagnosis of TBI. A clinical interview is required.

How can this help me with my clients?

Potential Treatment Interventions	
Positive screen	Further clinical interview to verify presence of head injury and assess for TBI If warranted, referral for formal TBI evaluation (e.g. neuroimaging tests)

Protocol Text:

DVBIC TBI Screening Tool – modified by CVN

The following questions are about any physical injuries you may have had <u>at some point in your life.</u>

1. Did you have any injury(ies) during your deployment from any of the following?
   (Check all that apply):

   ❑A Fragment

   ❑B Bullet

   ❑C Vehicular (any type of vehicle, including airplane)

   ❑D Fall

   ❑E Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)

   ❑F Other (specify): _____

2. Did an injury received while you were deployed result in any of the following?
   (Check all that apply):

   ❑A Being dazed, confused, or "seeing stars"

   ❑B Not remembering the injury

   ❑C Losing consciousness (knocked out) for less than a minute

   ❑D Losing consciousness for 1-20 minutes

   ❑E Losing consciousness for longer than 20 minutes

   ❑F Having any symptoms of concussion afterward (such as headache, dizziness, irritability, etc.)

   ❑G Head injury

   ❑H None of the above

	3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? *(Check all that apply)* **:** ❑A Headaches ❑B Dizziness ❑C Memory problems ❑D Balance problems ❑E Ringing in the ears ❑F Irritability ❑G Sleep problems ❑H Other: _____
Source:	Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. Neurology, 66(5)(Supp. 2), A235.
Evidence-Based Support:	The original 3 Question DVBIC TBI Screening Tool, also called The Brief Traumatic Brain Injury Screen (BTBIS), was validated in a small, initial study conducted with active duty service members who served in Iraq/Afghanistan between January 2004 and January 2005.
Availability:	Original DVBIC TBI Screening Tool is publicly available: https://www.mirecc.va.gov/docs/visn6/5_TBI_3_Question_Screening_Tool.pdf Modified DVBIC (used within CVN) is available only within CVN's Evolv EHR and by request to Central Office.

Generalized Anxiety Disorder Assessment (GAD-7)

About the Measure	
Domain:	Generalized Anxiety Disorder
Measure:	Generalized Anxiety Disorder Assessment (GAD-7)
Definition:	A 7-item self-report scale to screen for generalized anxiety disorder
Purpose:	Anxiety is one of the most principal mental health diagnoses presenting in clinical practice today. This measure can be used to quickly screen and measure the frequency and severity of anxiety in clients. The GAD-7 consists of seven self-report questions based on the diagnostic criteria in the *DSM-V*. It was modeled after the PHQ-9 to be used quickly and effectively within a clinical setting.
About the Protocol	
Description of Protocol:	**What is it?** The Generalized Anxiety Disorder Assessment (GAD-7) is a brief, self-report instrument that is based on seven of the diagnostic criteria for Generalized Anxiety Disorder in the *DSM-V*. The GAD-7 includes 7 items that assess: Feeling nervous, anxious, or on edge; Not being able to stop or control worrying; Worrying too much about different things; Trouble relaxing; Being so restless that it is hard to sit still; Becoming easily annoyed or irritable; and feeling afraid as if something awful might happen. This assessment aids in guiding diagnosis of symptoms, identifying treatment goals, determining symptom severity, and guiding clinical intervention. A higher score suggests more severe anxiety. When considering a diagnosis of Generalized Anxiety Disorder, the clinician will need to still use clinical interviewing skills to determine whether the symptoms are

	causing clinically significant distress or impairment. Additionally, clinicians need to consider whether the symptoms are better explained by other conditions. The information gathered from this assessment can be used by the clinician to engage the client in the therapeutic process.
Clinical Indication:	**Screen**: The GAD-7 can be a powerful tool to screen clients for anxiety disorders **Assess**: The GAD-7 can be a useful tool in determining the severity of anxiety symptoms **Diagnose**: The clinician will need to use clinical interviewing skills to determine whether a diagnosis of Generalized Anxiety Disorder is indicated. **Monitor:** The GAD-7 is a powerful tool to monitor the client's response to treatment.
Client:	Adolescents and adults, ages 12 and older.
Administration:	**How can it be administered?** • Self-administered by the client (preferred) • By interviewer **How often is it administered?** • At referral screener / initial clinical assessment • At each session **How long does it take?** • 2-5 minutes **Where and when can it be done?** • Prior to the session in the waiting area (preferred for in-person) or sent virtually (for telehealth) • Beginning, during, or end of session • At home prior to appointment for client to bring to the session

Guidelines for Scoring/ Interpretation

How do I use this?

Clients are asked to rate the frequency of anxiety symptoms in the last 2 weeks on a Likert scale ranging from 0-3. Items 1-7 are then summed to provide a total score.

How is the GAD-7 total score interpreted?

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

A total score of 10 or more indicates a preliminary diagnosis of GAD, whereas most clients without a GAD diagnosis scored below 10. The GAD-7 is also a good screening tool for panic disorder, social anxiety disorder, and post-traumatic stress disorder. Further clinical interviewing skills are necessary for a definitive diagnosis of GAD or other anxiety disorders.

Severity can be determined by examining the total score. For tracking change over time, a meaningful change is 5 or more points on the total score.

Total Score Interpretation

1-4	Minimal symptoms
5-9	Mild symptoms
10-14	Moderate symptoms
15-21	Severe symptoms

How can this help me with my clients?

Potential Treatment Interventions	
1) Feeling nervous, anxious, or on edge	Diaphragmatic breathing Thought monitoring Challenging maladaptive thoughts/feelings
2) Not being able to stop or control worrying	Identifying maladaptive thoughts/feelings Challenging maladaptive thoughts/feelings Relaxation techniques
3) Worrying too much about different things	Thought monitoring Solvable vs. Unsolvable worries Identify possible solutions
4) Trouble relaxing	Diaphragmatic breathing Autogenic relaxation Guided imagery
5) Being so restless that it is hard to sit still	Diaphragmatic breathing Progressive muscle relaxation Guided imagery
6) Becoming easily annoyed or irritable	Challenging maladaptive thoughts/feelings Breathing techniques Identify consequences to actions
7) Feeling afraid as if something awful might happen	Thought monitoring Solvable vs. Unsolvable worries Challenging maladaptive thoughts/feelings

Protocol Text:

Generalized Anxiety Disorder Assessment (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Source:

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder. *Archives of Internal Medicine, 166*(10), 1092. doi:10.1001/archinte.166.10.1092

Evidence-Based Support

This measure is proven to be both reliable and valid in assessing anxiety and is routinely used to measure changes in symptoms and track treatment progress. Routinely using this tool to measure symptom changes and tracking treatment progress are associated with superior client outcomes when compared to usual care. The data obtained from this assessment can be used to improve communication between providers as well.

Availability:

Publicly available

http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/GAD-7_English.pdf

PTSD Checklist for The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) (PCL-5)

About the Measure	
Domain:	Post-Traumatic Stress Disorder (PTSD)
Measure:	PTSD Checklist for The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) (PCL-5)
Definition:	A self-report questionnaire to assess PTSD symptoms.
Purpose:	The PCL-5 is used to screen for PTSD. This measure is also used as a measure of PTSD symptom severity, changes in symptoms, and as a provisional diagnosis of PTSD.
About the Protocol	
Description of Protocol:	**What is it?** The PTSD Checklist (PCL-5) for *The Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-V) is a 20-item self-report measure that assesses PTSD severity and symptoms based on DSM-V criteria. Each item is rated on a 5-point Likert scale that indicates how much the client has been bothered by an identified stressful event in the past month. The PCL-5 includes 20 items that assess: *intrusion* symptoms (repeated, disturbing, and unwanted memories and/or dreams; feeling and/or acting as if the experience was happening again; feeling upset and/or having physical reactions when reminded of the experience); *avoidance* (avoiding memories and/or external reminders of the experience; trouble remembering parts of the experience); *negative alterations in cognition or mood* (strong negative beliefs and/or negative feelings; blaming yourself or others for the experience; loss of interest in activities and/or feeling cut off; trouble experiencing positive feelings); and *alterations in arousal and reactivity* (irritable behavior, feeling jumpy, and/or being "super-alert"; taking risks; difficulty concentrating; and trouble sleeping).

Clinical Indication	**Screen**: The PCL-5 can be a powerful tool to screen clients for PTSD symptoms **Assess**: This tool can be used to assess the severity of PTSD symptoms **Monitor**: This can be a useful tool in monitoring the client's response to treatment and to track changes in symptom severity over time. **Diagnose**: This tool can be used to provisionally diagnose PTSD. Further clinical interviewing is warranted to establish a non-provisional diagnosis of PTSD.
Client:	Adults, ages 18 and older
Administration	**How can it be administered?** • Self-administered (preferred) • By interviewer in-person or by phone **How often is it administered?** • At intake / clinical assessment • At each session to monitor PTSD symptoms **How long does it take?** • 5-10 minutes **Where and when can it be done?** • Prior to the session in the waiting area (preferred) or electronically (for telehealth) • At home prior to appointment for client to bring • Beginning or end of the session
Guidelines for Scoring/ Interpretation:	**How do I use this?** Clients are asked to rate each item on a 5-point Likert scale ranging from 0-4 indicating how much they have been bothered by each symptom in relation to the identified the traumatic event in the past month. Not at all = 0 A little bit = 1 Moderately = 2 Quite a bit = 3 Extremely = 4

Items 1-20 are then summed to provide a total score which ranges from 0-80. Interpretation of the PCL-5 should be made by a clinician.

How is the PCL-5 Total score interpreted?

A total score of 33 or higher suggests a preliminary diagnosis of PTSD and further assessment of symptoms should be explored. DSM-V symptom cluster severity scores can be calculated by summing the scores for the items within each cluster:

Cluster B – sum items 1-5

Cluster C – sum items 6-7

Cluster D – sum items 8-14

Cluster E – sum items 15-20

To provisionally diagnose PTSD, treat each item rated as 2 = "Moderately" or higher as a symptom endorsed, then by following the *DSM-V* diagnostic rule which requires at least:

1 B item (questions 1-5)

1 C item (questions 6-7)

2 D items (questions 8-14)

2 E items (questions 15-20)

How can this help me with my clients?

The PCL-5 can be used to provide a preliminary diagnosis of PTSD. In monitoring client progress in treatment, it is important to be aware of a change in scores on the PCL-5. The PCL-5 can be used to help determine appropriate next steps and treatment options.

Potential Treatment Interventions	
A total score of 33 or higher suggests the client may need more specific treatment for PTSD symptoms.	Prolonged Exposure Cognitive Processing Therapy
A total score lower than 33 may indicate either the client does not fully meet criteria for a diagnosis of PTSD or has subthreshold PTSD	If subthreshold: Prolonged Exposure Cognitive Processing Therapy

While change scores are currently being determined, it is expected that reliable and clinically meaningful change will be in a similar range to its previous version for the *DSM-IV*. The PCL for *DSM-IV* suggests that a 5-10 point change suggests reliable change and a 10-20 point change suggests clinically significant change.

Protocol Text:

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4

	8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
	9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
	10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
	11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
	12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
	13. Feeling distant or cut off from other people?	0	1	2	3	4
	14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
	15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4

	16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
	17. Being "super-alert" or watchful or on guard?	0	1	2	3	4
	18. Feeling jumpy or easily startled?	0	1	2	3	4
	19. Having difficulty concentrating?	0	1	2	3	4
	20. Trouble falling or staying asleep?	0	1	2	3	4

Source:	Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for *DSM-5* (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*, 489-498. doi: 10.1002/jts.22059 Protocol - PTSD Symptoms, Self-report - DSM 5. (n.d.). Retrieved from https://www.phenxtoolkit.org/protocols/view/122002 National Center for PTSD. (2018, September 24). Retrieved from https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
Evidence-Based Support:	This measure is proven to be both reliable and valid in assessing PTSD symptoms and is commonly used as a screening tool of the degree of post-traumatic stress symptoms.
Availability:	Publicly available https://www.ptsd.va.gov/professional/assessment/documents/PCL-5_Standard.pdf

Patient Health Questionnaire (PHQ-9)

About the Measure	
Domain:	Major Depressive Disorder (MDD)
Measure:	Patient Health Questionnaire-9 (PHQ-9)
Definition:	A self-report scale to screen for major depressive disorder, as well as depressive symptoms, insomnia and suicide risk.
Purpose:	Depression is one of the most predominant mental health diagnoses presenting in clinical practice today. This measure can be used to quickly screen and measure the frequency and severity of depression in clients. The PHQ-9 consists of ten self-report questions based on the diagnostic criteria in the *DSM-V*.
About the Protocol	
Description of Protocol:	**What is it?** The Patient Health Questionnaire (PHQ-9) is a brief, self-report instrument that is based directly on the nine diagnostic criteria for Major Depressive Disorder in the *DSM-V*. The PHQ-9 includes 9 items that assess: little interest or pleasure in doing things; feeling down, depressed, or hopeless; trouble falling asleep or staying asleep or sleeping too much; feeling tired or having little energy; poor appetite or overeating; feeling bad about yourself or that you are a failure or have let yourself or your family down; difficulty concentrating; moving or speaking slowly or being fidgety or restless; and suicidal thoughts. This assessment aids in guiding diagnosis of depressive symptoms, identifying treatment goals, determining symptom severity (scale of 0 to 3), and guiding clinical intervention. A higher score suggests more severe depression. When considering a diagnosis of Major Depressive Disorder, the clinician will need to still use clinical interviewing skills to determine whether the symptoms are causing clinically significant

	distress or impairment. Additionally, clinicians need to consider whether or not the symptoms are better explained by other conditions. The information gathered from this assessment can be used by the clinician to engage the client in the therapeutic process, validating them as an active partner in their own treatment.
Clinical Indication:	**Screen**: The PHQ-9 can be a powerful tool to screen clients for depression. **Assess**: The PHQ-9 is a useful tool to assess the severity of a clients' symptoms. **Diagnose**: The clinician will need to use clinical interviewing skills to determine whether a diagnosis of Major Depressive Disorder is indicated. **Monitor**: The PHQ-9 can be a useful tool to keep track of and monitor treatment response.
Client:	Adolescents and adults, ages 12 and older
Administration:	**How can it be administered?** • Self-administered by the client (preferred) • By interviewer **How often is it administered?** • At referral screener / initial clinical assessment • At each session **How long does it take?** • 2-5 minutes **Where and when can it be done?** • Prior to the session in the waiting area (preferred) • Beginning, during, or end of session • At home prior to appointment for client to bring to the session Clients are instructed to rate their symptoms during the past two weeks, but therapists may change the instructions to "past week" if clients are assessed on a weekly basis.

Guidelines for Scoring/ Interpretation	

How do I use this?

Clients are asked to rate the frequency of depression symptoms in the last 2 weeks on a Likert scale ranging from 0-3. Items 1-9 are then summed to provide a total score. (Question 10 is not scored.)

How is the PHQ-9 Total score interpreted?

0 – 4 = None to minimal depression

5 – 9 = Mild depression

10 – 14 = Moderate depression

15 – 19 = Moderately severe depression

20 – 27 = Severe depression

A total score of less than 10 may indicate a partial treatment response, and a score less than 4 may indicate a remission of depression.

After the PHQ-9 has been scored, the therapist will interpret the score and ask the client if that is how they have been feeling. Next, the therapist compares the current PHQ-9 total score with the score obtained during the previous administration(s) and describes how the score has changed or not changed.

Pay particular attention to item 9 of the PHQ-9: "Thoughts that you would be better off dead or of hurting yourself in some way." Given that clients with suicidal ideation are at an increased risk of suicide, the therapist should further assess the client's suicidal ideation for any non-zero response to this question to determine if further action is indicated for increasing client safety and lowering the risk of suicide.

How can this help me with my clients?

Potential Treatment Interventions	
1) Diminished interest or pleasure in most things	SMART Goal setting Homework assignments Encourage social activities
2) Depressed mood	Pleasant events scheduling Identifying maladaptive thoughts/feelings
3) Insomnia/Hypersomnia	Psycho-education regarding sleep hygiene CBT for insomnia
4) Fatigue or energy loss	SMART Goal setting Encourage physical activities
5) Change in weight/appetite	Food diary Nutrition education SMART Goal setting
6) Feelings of worthlessness or inappropriate guilt	Identifying maladaptive thoughts/feelings Challenging maladaptive thoughts/feelings
7) Trouble concentrating	Deep breathing exercises Guided imagery exercise Challenging maladaptive thoughts/feelings
8) Psychomotor agitation or retardation	Deep breathing exercises Guided imagery exercise Progressive muscle relaxation
9) Recurrent thoughts of death/suicidal ideation	Conduct Suicide Risk Assessment, if appropriate Develop/Revise the Safety Plan Elevate to higher level of care per guidelines Further assess using C-SSRS

Protocol Text:

Patient Health Questionnaire (PHQ-9)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Source:	Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9 Validity of a Brief Depression Severity Measure. *Journal of General Internal Medicine, 16*(9), 606-613. doi:10.1046/j.1525-1497.2001.016009606.x
Evidence-Based Support	This measure is proven to be both reliable and valid in assessing depression and is routinely used to measure changes in symptoms and track treatment progress. Routinely using this tool to measure symptom changes and tracking treatment progress are associated with superior client outcomes when compared to usual care.
Availability:	No permission is required from Pfizer, Inc., to reproduce, translate, display or distribute the PHQ-9. http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (QLES-SF)

About the Measure	
Domain:	Quality of Life
Measure:	Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (QLES-SF)
Definition:	A self-report scale measuring the domains of physical health, subjective feelings, leisure activities, social relationships, general activities, satisfaction with medications, and life satisfaction.
Purpose:	Quality of life is an essential part of clinical treatment in clients. It represents how a client perceives their overall quality of life, life enjoyment, and life satisfaction. This measure is a brief and sufficient way to measure quality of life in individual clients.
About the Protocol	
Description of Protocol:	**What is it?** The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (QLES-SF) is a self-report measure derived from the original 93-item long-form questionnaire. It consists of 16 items evaluating an individual's overall satisfaction with: physical health, mood, work, household and leisure activities, social and family relationships, daily functioning, sexual life, economic status, overall well-being and medications.
Clinical Indication:	The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form can be a useful tool in evaluating how clients perceive the quality of their life.
Client:	Adolescents and Adults
Administration:	**How can it be administered?** • Self-administered by the client (preferred)

	• By interviewer **How often is it administered?** • At intake • At discharge **How long does it take?** • Approx. 2-5 minutes **Where and when can it be done?** • Prior to the session in the waiting area (preferred) • Beginning, during, or end of session • At home prior to appointment for client to bring to the session
Guidelines for Scoring/ Interpretation:	**How do I use this?** Clients are instructed to rate their overall satisfaction on a 5-point scale (very poor, poor, fair, good, or very good) during the past week with the specified items on the assessment. Scores range from 14-70 with higher scores indicating better life enjoyment and satisfaction. To obtain the total score, sum the first 14 items. The last two items of the measure are not included in the total score. Once the total score has been obtained, transform the raw score into a percentage maximum possible score by using the following equation: $$\frac{\text{(raw total score} - 14)}{56}$$

The following table converts total raw scores in % maximum scores:

Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum	Raw Score	% Maximum
14	0	28	25	42	50	56	75
15	2	29	27	43	52	57	77
16	4	30	29	44	54	58	79
17	5	31	30	45	55	59	80
18	7	32	32	46	57	60	82
19	9	33	34	47	59	61	84
20	11	34	36	48	61	62	86
21	13	35	38	49	63	63	88
22	14	36	39	50	64	64	89
23	16	37	41	51	66	65	91
24	18	38	43	52	68	66	93
25	20	39	45	53	70	67	95
26	21	40	46	54	71	68	96
27	23	41	48	55	73	69	98
						70	100

How can this help me with my clients?

Initial use of the QLES at intake can help deepen assessment and facilitate developing a hierarchy of treatment targets. When used at discharge, the QLES can help to identify areas of growth/positive change and areas of continued need to be addressed through referral resources.

Protocol Text:

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (QLES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your……

	Very Poor	Poor	Fair	Good	Very Good
…..physical health?	1	2	3	4	5
…..mood?	1	2	3	4	5
…..work?	1	2	3	4	5
…..household activities?	1	2	3	4	5
…..social relationships?	1	2	3	4	5
…..family relationships?	1	2	3	4	5
…..leisure time activities?	1	2	3	4	5
…..ability to function in daily life?	1	2	3	4	5
…..sexual drive, interest and/or performance?	1	2	3	4	5
…..economic status?	1	2	3	4	5
…..living/housing situation?	1	2	3	4	5
…..ability to get around physically without feeling dizzy or unsteady or falling?	1	2	3	4	5
…..your vision in terms of ability to do work or hobbies?	1	2	3	4	5
…..overall sense of well being?	1	2	3	4	5
…..medication? (If not taking any, check here _____ and leave item clank."	1	2	3	4	5
…..How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

Source:	Stevanovic, D. (2011). Quality of Life Enjoyment and Satisfaction Questionnaire - short form for quality of life assessments in clinical practice: A psychometric study. *Journal of Psychiatric and Mental Health Nursing, 18*(8), 744-750. doi:10.1111/j.1365-2850.2011.01735.x
Evidence-Based Support:	This measure is proven to be both reliable and valid in assessing quality of life and is routinely used to track treatment progress.
Availability:	Publicly available. https://www.outcometracker.org/library/Q-LES-Q-SF.pdf

---

[1] Scott, K., & Lewis, C. C. (2015). Using measurement-based care to enhance any treatment. *Cognitive and Behavioral Practice, 22*(1), 49-59.

[2] Lewis, C. C., Boyd, M., Puspitasari, A., Navarro, E., Howard, J., Kassab, H., . . . Douglas, S. (2019). Implementing measurement-based care in behavioral health: A review. *JAMA psychiatry, 76*(3), 324-335.

[3] Cohen Veterans Network (2020). The Steven A. Cohen Military Family Clinic Guidebook. Stamford, CT.