

Free, Brief, and Validated: Standardized Instruments for Low-Resource Mental Health Settings

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Evidence-based assessment has received little attention despite its critical importance to the evidence-based practice movement. Given the limited resources in the public sector, it is necessary for evidence-based assessment to utilize tools with established reliability and validity metrics that are free, easily accessible, and brief. We review tools that meet these criteria for youth and adult mental health for the most prevalent mental health disorders to provide a clinical guide and reference for the selection of assessment tools for public sector settings. We also discuss recommendations for how to move forward the evidence-based assessment agenda.

THE thorniest challenge facing the mental health field is the dissemination and implementation (DI) of evidence-based practices (EBPs) in community settings (McHugh & Barlow, 2010). EBPs refer to “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (American Psychological Association, 2006, p. 1). Despite the proliferation of many EBPs for both children and adults suffering from psychosocial difficulties (Chambless & Hollon, 1998), these treatments are not widely available in community settings where the majority of individuals receive services (President's New Freedom Commission on Mental Health, 2003). Implementation science focuses on determining how to most effectively transmit knowledge about EBPs (i.e., dissemination) and how to use strategies that allow for increased adoption of such treatments (i.e., implementation; Lomas, 1993). The desired result of implementation science is to ensure that community clinicians are providing EBPs to youth and adults with the ultimate goal of improved quality of care. One aspect to this pursuit that has to date received little attention is evidence-based assessment (EBA), a critical

foundational component of EBPs (American Psychological Association, 2006; Hunsley & Mash, 2007).

The scope of EBA is twofold, encompassing both the process through which assessment is conducted and the instruments utilized for evaluation (Hunsley & Mash, 2007). The scope of this review will focus on the latter (i.e., instruments used for evaluation). We first briefly highlight the importance of EBA in the context of EBP. Assessment is inherently a decision-making task fraught with the biases that plague clinical decision-making (Dawes, Faust, & Meehl, 1989; Garb, 1998). For example, clinicians are subject to cognitive heuristics and biases such as confirmatory bias (i.e., preferentially seeking evidence consistent with an initial conceptualization at the cost of considering emerging contradictory information; Garb, 2005). These biases may be more avoidable with a systematic and empirically based, research-driven approach to assessment. The importance of an accurate diagnosis is an implicit prerequisite to the selection of EBPs, which are largely organized by specific disorders. Moreover, diagnostic categories are the common language through which we think about, question, and communicate about research findings and clinical problems. Without accurate assessments yielding accurate diagnoses, we may widen the research-practice communication gap (Jensen & Weisz, 2002). There is also some evidence that accurate diagnosis is associated with better treatment outcomes (Jensen-Doss & Weisz, 2008; Pogge et al., 2001). Finally, emerging evidence suggests that simply tracking progress during treatment and providing feedback to clinicians results in better treatment outcomes (Bickman, Kelley, Breda, Vides

Keywords: evidence-based practice; evidence-based assessment; public sector

1077-7229/15/5-19\$1.00/0

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de Andrade, & Riemer, 2011; Lambert, Hansen, & Finch, 2001). Therefore, EBA is critical to any evidence-based treatment approach. Given the importance of EBA, to date, two special issues of peer-reviewed journals have focused on EBA in both adult and youth populations: see special issues of *Psychological Assessment* (Hunsley & Mash, 2005) and the *Journal of Clinical Child and Adolescent Psychology* (Mash & Hunsley, 2005). These special issues have resulted in recommendations on EBA for a variety of disorders, including youth and adult anxiety (Antony & Rowa, 2005; Silverman & Ollendick, 2005), adult depression (Joiner, Walker, Pettit, Perez, & Cukrowicz, 2005), youth disruptive behavior disorders (McMahon & Frick, 2005), and youth bipolar disorder (Youngstrom, Findling, Kogos-Youngstrom, & Calabrese, 2005).

Although these reviews have resulted in important recognition of the significance of EBA and preliminary guidelines, they have not always been as applicable to low-resource mental health settings such as those in the public sector because they have featured resource-intensive ways to engage in EBA. In the pages that follow, we identify and address issues related to the use of standardized tools in low-resource mental health settings. The challenge of identifying which standardized instruments to use in the public sector is complicated by the sheer volume of assessment methods and processes and the many purposes of assessment compared to treatment (Hunsley & Mash, 2005). Treatment providers in agencies in public settings must often contend with high workload, poor financial compensation, limited time, and intense demand for resources (Nunno, 2006). Assessments must not add unnecessarily to the paperwork burden for providers and agencies, lest the cost, time, and resource requirements of EBA become barriers that outweigh the potential benefits (Bumbarger & Campbell, 2012). Given the known barriers to implementation of EBP in community settings and our desire to increase EBA in the public sector, assessments must be brief; free or low cost; validated for use in multiple populations, particularly ethnic minority and low-socioeconomic-status individuals; and straightforward and brief to administer, score, and interpret (Jensen-Doss & Hawley, 2010). These recommendations are echoed by public health researchers who recommend that for standardized assessment instruments to be usable, they must be important to stakeholders in addition to researchers, low burden to administer, broadly applicable, sensitive to change, and represent constructs that are actionable (i.e., clinician or patient can do something about them; Glasgow & Riley, 2013).

Accordingly, the goal of this paper is to conduct a review of EBA instruments for the most prevalent mental health disorders in youths and adults that meet the criteria delineated above. We focus on instruments that can be used for screening (i.e., identifying those at risk for a disorder), diag-

nosis (i.e., identifying those who meet DSM criteria), and/or treatment monitoring and evaluation (i.e., evaluating the success of treatment or interim response to treatment; Hunsley & Mash, 2008). We hope this paper can serve as a clinical guide and reference for the selection of assessment instruments for low-resource mental health settings.

Methods

Search Methods

We searched PsycINFO, PubMed, and Google Scholar using this search term as our template: (“disorder name or type” or “mental health”) AND (instrument OR survey OR questionnaire OR measure OR assessment). For “disorder name or type,” we used the following terms: “trauma,” “trauma exposure,” “depression,” “anxiety,” “obsessive-compulsive disorder,” “panic,” “worry,” “generalized anxiety disorder,” “eating disorder,” “anorexia nervosa,” “bulimia nervosa,” “suicide,” “suicidality,” “self-injurious,” “schizophrenia,” “psychosis,” “personality disorders,” “borderline personality disorder,” “conduct disorder,” “oppositional defiant disorder,” “attention-deficit disorder,” “bipolar,” “mania,” “quality of life,” “functioning,” and “general functioning.” For disorders that could apply to both youth and adults (e.g., anxiety), we inserted “child,” “youth,” or “adolescent” in front of the disorder name or type when searching for youth-specific measures. We also searched for adolescent versions of all child and adult measures identified in our search. We employed a snowball sampling technique in which we searched the reference sections of located articles for potentially eligible measures. Also, due to its specific relevance, a textbook referencing EBA instruments was searched by hand for relevant measures (Hunsley & Mash, 2008). Finally, we reached out to experts to ensure that we did not miss any instruments. Specifically, the first author queried members of the Association for Behavioral and Cognitive Therapies (ABCT) via the ABCT members’ listserv and engaged in conversations with experts about measures they had used previously in studies. We also included measures we have used in previous studies in low-resource settings.

Inclusion and Exclusion Criteria

We utilized the following criteria when deciding whether or not to include measures: we required that the measures be free, easily accessible via the Internet or the author of the measure, brief (items < 50), have established reliability and validity, and be relevant for the most prevalent mental health disorders (e.g., anxiety, depression, trauma-associated disorders, oppositional behavior disorders; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Merikangas et al., 2010). We crafted these criteria based on a recent paper written by Glasgow and Riley (2013) encouraging the use of pragmatic measures. Specifically, Glasgow and Riley recommend that instruments be: important to stakeholders, low burden to

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